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 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 14-0210 Worksheet S Peri od: From 04/01/2022 Parts I-III AND SETTLEMENT SUMMARY 03/31/2023 Date/Time Prepared: 9/11/2023 9:16 am PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 9/11/2023 9:16 am ] Manually prepared cost report use only Ilf this is an amended report enter the number of times the provider resubmitted this cost report [Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Final Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. NPR Date:
[12] 13. NPR Date:
[13] 14. NPR Date:
[14] 15. NPR Date:
[15] 15. NPR Date:
[16] 16. NPR Date:
[17] 17. NPR Date:
[18] 17. NPR Date:
[18] 18. NPR Date:
[18] 18. NPR Date:
[18] 19. NPR Da Contractor use only (3) Settled with Audit number of times reopened = 0-9.

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

(4) Reopened (5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HARRISBURG MEDICAL CENTER, INC. (14-0210) for the cost reporting period beginning 04/01/2022 and ending 03/31/2023 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.

|   | SIGNATURE OF CHIEF FINA | NCIAL OFFICER OR ADMINISTRATOR    | CHECKBOX | ELECTRONI C   |   |
|---|-------------------------|-----------------------------------|----------|---|---|
|   |                         | 1                                 | 2        | SI GNATURE STATEMENT  |   |
| 1 | Warren Ladner           |                                   | Y        | I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature. | 1 |
| 2 | Signatory Printed Name  | Warren Ladner                     |          |   | 2 |
| 3 | Signatory Title         | SENI OR VP / CFO                  |          |   | 3 |
| 4 | Date                    | (Dated when report is electronica |          |   | 4 |

|        |                               |         | Title XVIII |          |       |           |        |
|--------|-------------------------------|---------|-------------|----------|-------|-----------|--------|
|        |                               | 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       | 100, 864    | -64, 717 | 0     | 0         | 1.00   |
| 2.00   | SUBPROVIDER - IPF             | 0       | -50, 110    | 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   |
| 10.00  | RURAL HEALTH CLINIC I         | 0       |             | 72, 601  |       | 0         | 10.00  |
| 10.01  | RURAL HEALTH CLINIC II        | 0       |             | 51, 880  |       | 0         | 10. 01 |
| 200.00 | TOTAL                         | 0       | 50, 754     | 59, 764  | 0     | 0         | 200.00 |

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-0210 Peri od: Worksheet S-2 From 04/01/2022 Part I 03/31/2023 Date/Time Prepared: 9/11/2023 9:16 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 100 DR WARREN TUTTLE DRIVE 1.00 PO Box: 1.00 2.00 Ci ty: HARRI SBURG State: IL Zip Code: 62946 County: SALINE 2.00 Payment System (P, Component Name 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 Hospi tal HARRISBURG MEDICAL 140210 99914 07/01/1966 Ν Р N 3.00 1 CENTER, INC. HARRI SBURG MEDI CAL 99914 Р 4.00 Subprovider - IPF 14S210 06/19/1989 N 4 Ν 4.00 CENTER, INC. 5.00 Subprovider - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF HARRISBURG MEDICAL 11/03/1988 7.00 14U210 99914 N Р N 7.00 CENTER, INC. 8.00 Swing Beds - NF 8.00 Hospi tal -Based SNF 9.00 9.00 10.00 Hospital -Based NF 10 00 11.00 Hospi tal -Based OLTC 11.00 Hospi tal -Based HHA 12.00 12.00 13.00 Separately Certified ASC 13.00 14.00 Hospi tal -Based Hospi ce 14 00 15.00 Hospital-Based Health Clinic - RHC FLDORADO PRIMARY CARE 143473 99914 12/31/2001 Ν 0 Ν 15.00 Hospital-Based Health Clinic - RHC 148590 99914 06/05/2018 15.01 15.01 HMC AT MARION Hospital - Based Health Clinic - FQHC 16.00 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 04/01/2022 03/31/2023 20.00 21.00 Type of Control (see instructions) 21.00 1.00 2.00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for 22.00 Υ Ν 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 UCPs, including supplemental UCPs, for 22.01 this cost reporting period? Enter in column 1, " $\check{Y}$ " for yes or " $\check{N}$ " 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 a final UCP to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to Ν 22.03 Ν 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 yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 22.04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? 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, yes 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.

|       | no in column 2, for discharges on or after October 1. (see instructions)                        |       |       |      |        |
|-------|---|-------|-------|------|--------|
|       |   | V     | XVIII | XI X |        |
|       |   | 1. 00 | 2.00  | 3.00 |        |
|       | Prospective Payment System (PPS)-Capital  |       |       |      |        |
| 45.00 | Does this facility qualify and receive Capital payment for disproportionate share in accordance | e N   | N     | N    | 45. 00 |
|       | with 42 CFR Section §412.320? (see instructions)  |       |       |      |        |
|       | Is this facility eligible for additional payment exception for extraordinary circumstances      | N     | N     | N    | 46. 00 |
|       | pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through  |       |       |      |        |
|       | Pt. III.  |       |       |      |        |
| 47.00 | Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.    | N     | N     | N    | 47.00  |
| 48.00 | Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.         | N     | N     | N    | 48. 00 |
|       | Teaching Hospitals  |       |       |      |        |
| 56.00 | Is this a hospital involved in training residents in approved GME programs? For cost reporting  |       |       |      | 56. 00 |
|       | periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For  |       |       |      |        |
|       | cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see  |       |       |      |        |
|       | the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was     |       |       |      |        |
|       | involved in training residents in approved GME programs in the prior year or penultimate year,  |       |       |      |        |
|       | and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter | r     |       |      |        |
|       | "Y" for yes; otherwise, enter "N" for no in column 2.   |       |       |      |        |
|       | For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes,  |       |       |      | 57. 00 |
|       | is this the first cost reporting period during which residents in approved GME programs traine  | d     |       |      |        |
|       | at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did          |       |       |      |        |
|       | residents start training in the first month of this cost reporting period? Enter "Y" for yes    | or    |       |      |        |
|       | "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N",         |       |       |      |        |
|       | complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods     |       |       |      |        |
|       | beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of   |       |       |      |        |
|       | which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y  | "     |       |      |        |
|       | for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.   |       |       |      |        |
|       | If line 56 is yes, did this facility elect cost reimbursement for physicians' services as       | N     |       |      | 58. 00 |
|       | defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.                        |       |       |      |        |

|        | program code. Enter in column 3, the IME FTE          |                        |                |               |       |        |
|--------|---|------------------------|----------------|---------------|-------|--------|
|        | unweighted count. Enter in column 4, the direct GME   |                        |                |               |       |        |
|        | FTE unweighted count.                                 |                        |                |               |       |        |
| 61. 20 | Of the FTEs in line 61.05, specify each expanded      |                        |                | 0. 00         | 0. 00 | 61. 20 |
|        | program specialty, if any, and the number of FTE      |                        |                |               |       |        |
|        | residents for each expanded program. (see             |                        |                |               |       |        |
|        | instructions) Enter in column 1, the program name.    |                        |                |               |       |        |
|        | Enter in column 2, the program code. Enter in column  |                        |                |               |       |        |
|        | 3, the IME FTE unweighted count. Enter in column 4,   |                        |                |               |       |        |
|        | the direct GME FTE unweighted count.                  |                        |                |               |       |        |
|        |   |                        |                |               |       |        |
|        |   |                        |                |               | 1. 00 |        |
|        | ACA Provisions Affecting the Health Resources and Ser | rvices Administration  | (HRSA)         |               |       |        |
| 62.00  | Enter the number of FTE residents that your hospital  |                        | reporting peri | od for which  | 0.00  | 62.00  |
|        | your hospital received HRSA PCRE funding (see instruc | ctions)                |                |               |       |        |
| 62. 01 | Enter the number of FTE residents that rotated from a | a Teaching Health Cent | er (THC) into  | your hospital | 0.00  | 62. 01 |
|        | during in this cost reporting period of HRSA THC proc | gram. (see instruction | ıs)            |               |       |        |
|        | Teaching Hospitals that Claim Residents in Nonprovide | er Settings            |                |               |       |        |
| 63.00  | Has your facility trained residents in nonprovider se | ettings during this co | st reporting p | eriod? Enter  | N     | 63.00  |
|        | "Y" for yes or "N" for no in column 1. If yes, comple | ete lines 64 through 6 | 7. (see instru | ıcti ons)     |       |        |
|        |   |                        |                |               |       |        |
|        |   |                        |                |               |       |        |
|        |   |                        |                |               |       |        |

| Uool +h | Financial Systems  | HADDI ÇDIIDO   | C MEDICAL (                            | SENTED INC                         |  | ln lie                                       | of Form CMS  | 2552 10 |
|---------|--|--|--|------------------------------------|--|--|--|---------|
|         | n Financial Systems<br>TAL AND HOSPITAL HEALTH CARE COMP   |  |  | <u>CENTER, INC.</u><br>Provider CC | CN: 14-0210                                  | Peri od:<br>From 04/01/2022<br>To 03/31/2023 | Date/Time Pre  | pared:  |
|         |  |  |  |                                    | Unwei ghted<br>FTEs<br>Nonprovi der<br>Si te | FTEs in                                      | 9/11/2023 9:1<br>Ratio (col. 1/<br>(col. 1 + col.<br>2)) |         |
|         | Section 5504 of the ACA Base Yea   | ar ETE Residents in No   | onnrovi der                            | Settings                           | 1.00<br>This base yea                        | 2.00   | 3.00   |         |
| 44.00   | period that begins on or after a<br>Enter in column 1, if line 63 is   | July 1, 2009 and before  | re June 30                             | , 2010.                            | 0.   |  |  | 64.00   |
| 64.00   | in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)  Program Name Program Code   |  |  |                                    | 0.   | 00 0. 00                                     | 0. 000000  | 64.00   |
|         |  |  |  |                                    | Unwei ghted<br>FTEs<br>Nonprovi der<br>Si te | FTEsin                                       | Ratio (col. 3/<br>(col. 3 + col.<br>4))                  |         |
|         |  | 1. 00  | 2                                      | . 00                               | 3. 00  | 4. 00  | 5. 00  | -       |
| 65. 00  | Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)   |  |  |                                    | 0.  Unwei ghted                              | 0. 00  |  |         |
|         |  |  |  |                                    | FTEs<br>Nonprovi der<br>Si te                | FTEs in                                      | (col. 1 + col.<br>2))                                    |         |
|         | Section 5504 of the ACA Current  | Voor ETE Docidonts in  | n Nonnrovi                             | dor Cotting                        | 1. 00  | 2.00   | 3. 00  |         |
|         | beginning on or after July 1, 20   | )10  | <u> </u>                               |                                    |  |  |  |         |
| 66. 00  | Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (col | occurring in all nonpr<br>unweighted non-primar<br>al. Enter in column 3 | rovider se<br>ry care re<br>3 the rati | ttings.<br>sident<br>o of          | 0.   | 0. 00  | 0. 000000  | 66.00   |
|         |  | Program Name   | Progr                                  | am Code                            | Unwei ghted<br>FTEs<br>Nonprovi der<br>Si te | FTEs in                                      | Ratio (col. 3/<br>(col. 3 + col.<br>4))                  |         |
| 67.00   | Enter in column 1, the program   | 1.00   | 2                                      | . 00                               | 3. 00  | 4. 00<br>00 0. 00                            | 5. 00<br>0. 000000                                       | 67.00   |
| 5 50    | 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)  |  |  |                                    |  |  | 3. 555500  | 350     |

| OSPI TA      | Financial Systems HARRISBURG MEDICAL C<br>AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA  | ENTER, INC.<br>Provider CCN  | l: 14-0210                 | Peri od:<br>From 04/01/                 |            | u of Form<br>Workshee<br>Part I                 |                      |               |
|--------------|--|------------------------------|----------------------------|---|------------|---|----------------------|---------------|
|              |  |                              |                            | To 03/31/                               |            | Date/Tir<br>9/11/202                            | me Pre<br>23 9:1     | pared<br>6 am |
|              |  |                              |                            |   |            | 1. 00   | 0                    |               |
|              | Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 F<br>For a cost reporting period beginning prior to October 1, 2022,   |                              |                            |   | ue         | N   |                      | 68. 0         |
| ı            | MAC to apply the new DGME formula in accordance with the FY 202<br>(August 10, 2022)?  |                              |                            |   |            | IN .  |                      | 00.0          |
|              |  |                              |                            |   | 1.00       | 2. 00   | 3. 00                |               |
|              | Inpatient Psychiatric Facility PPS<br>Is this facility an Inpatient Psychiatric Facility (IPF), or do  | es it contai                 | n an IPF su                | bprovi der?                             | Υ          |   |                      | <br>  70. (   |
| 1. 00        | Enter "Y" for yes or "N" for no.<br>If line 70 is yes: Column 1: Did the facility have an approved<br>recent cost report filed on or before November 15, 2004? Enter   | GME teaching                 | , program in               | the most                                | N          | N   | 0                    | 71. (         |
| I<br>(       | 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train<br>program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter<br>Column 3: If column 2 is Y, indicate which program year began d<br>(see instructions)  | residents i<br>"Y" for yes   | n a new tea<br>or "N" for  | chi ng<br>no.                           |            |   |                      |               |
| 5. 00        | Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or  | does it cor                  | ntain an IRF               |   | N          |   |                      | 75.           |
| 6. 00        | subprovider? Enter "Y" for yes and "N" for no.<br>If line 75 is yes: Column 1: Did the facility have an approved   |                              |                            |   | N          | N   | 0                    | 76.           |
| ļ            | recent cost reporting period ending on or before November 15, 2<br>no. Column 2: Did this facility train residents in a new teachi<br>CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Co<br>indicate which program year began during this cost reporting pe | ng program i<br>lumn 3: If o | n accordanc<br>column 2 is | e with 42<br>Y,                         |            |   |                      |               |
| 11           | That eater million program year began during this cost reporting pe  | 1100. (300 )                 | 113 11 40 11 0113          | <i>)</i>                                |            | 1. 00   | 0                    |               |
|              | Long Term Care Hospital PPS  |                              |                            |   |            |   | 0                    |               |
| . 00         | Is this a long term care hospital (LTCH)? Enter "Y" for yes an<br>Is this a LTCH co-located within another hospital for part or a<br>"Y" for yes and "N" for no.<br>TEFRA Providers  |                              |                            | g period? E                             | nter       | N<br>N  |                      | 80.<br>81.    |
| . 00<br>. 00 | Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TE<br>Did this facility establish a new Other subprovider (excluded u<br>§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.   |                              |                            |   | no.        | N   |                      | 85.<br>86.    |
| . 00         | Is this hospital an extended neoplastic disease care hospital c<br>1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.   | lassified ur                 | nder section               |   | _          | N   |                      | 87.           |
|              |  |                              |                            | Approved<br>Permane<br>Adjustm<br>(Y/N) | ent<br>ent | Number<br>Appro<br>Perman<br>Adjustm            | ved<br>nent<br>nents |               |
| i            | Column 1: Is this hospital approved for a permanent adjustment amount per discharge? Enter "Y" for yes or "N" for no. If yes, 89. (see instructions)   |                              |                            | 1. 00<br>e                              |            | 2. 00   |                      | 88.           |
|              | Column 2: Enter the number of approved permanent adjustments.  |                              | M/I + A I :                | - F661:                                 | D-+-       | A   | 1                    |               |
|              |  |                              | Wkst. A Lin<br>No.         | e Effective                             | Date       | Approv<br>Perman<br>Adjusti<br>Amount<br>Discha | ment<br>ment<br>Per  |               |
| 00 (         | Column 1: If line 88, column 1 is Y, enter the Worksheet A line  | numbor                       | 1. 00                      | 2.00                                    |            | 3. 00   |                      | 89.           |
| (<br>        | on which the per discharge permanent adjustment approval was ba Column 2: Enter the effective date (i.e., the cost reporting pe beginning date) for the permanent adjustment to the TEFRA targe per discharge.   | sed.<br>ri od                | 0.                         |   |            |   | 0                    |               |
| Ö            | Column 3: Enter the amount of the approved permanent adjustment<br>TEFRA target amount per discharge.  | to the                       |                            |   |            |   |                      |               |
|              |  | <u> </u>                     |                            | V<br>1. 00                              |            | XI X<br>2. 00                                   |                      |               |
|              | Title V and XIX Services   |                              | \/                         |   |            |   |                      | 00            |
| 1            | Does this facility have title V and/or XIX inpatient hospital s<br>yes or "N" for no in the applicable column.   |                              |                            | N                                       |            | Y   |                      | 90            |
| -            | Is this hospital reimbursed for title V and/or XIX through the<br>full or in part? Enter "Y" for yes or "N" for no in the applica  | ble column.                  |                            | N                                       |            | N   |                      | 91.           |
|              | Are title XIX NF patients occupying title XVIII SNF beds (dual<br>instructions) Enter "Y" for yes or "N" for no in the applicable  |                              | on)? (see                  |   |            | N   |                      | 92            |
|              | Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter N"Y" for yes or "N" for no in the applicable column.   |                              |                            |   |            | N   |                      | 93            |
|              | Does title V or XIX reduce capital cost? Enter "Y" for yes, and applicable column.   | "N" for no                   | in the                     | N                                       |            | N   |                      | 94            |
| 00           | If line 94 is "Y", enter the reduction percentage in the applic<br>Does title V or XIX reduce operating cost? Enter "Y" for yes or<br>applicable column.   |                              |                            | 0. 00<br>N                              |            | O. 00<br>N                                      | 0                    | 95<br>96      |
| I.           | COAO I CZOJI E. COI 1880.  |                              |                            |   |            | 0.00  |                      | 97            |

| Health Financial Systems HARRISBURG MEDICA  | AL CENTER, INC.  |  | In Lie                                      | u of Form CM        | S-2552-10          |  |
|---|--|--|---|---------------------|--------------------|--|
| HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA   | Provi der Co   | F  | Period:<br>From 04/01/2022<br>To 03/31/2023 | Date/Time P         | repared:           |  |
|   |  |  | V   | 9/11/2023 9<br>XI X | 7: 16 alli         |  |
|   |  |  | 1. 00                                       | 2.00                |                    |  |
| 98.00 Does title V or XIX follow Medicare (title XVIII) for the i stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" column 1 for title V, and in column 2 for title XIX.   | nterns and res<br>for yes or "N"   | idents post<br>for no in   | Y   | Y                   | 98. 00             |  |
| 98.01 Does title V or XIX follow Medicare (title XVIII) for the r C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for t title XIX.  |  |  | Y   | Y                   | 98. 01             |  |
| 98.02 Does title V or XIX follow Medicare (title XVIII) for the closed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes   |  |  | Y   | Y                   | 98. 02             |  |
| for title V, and in column 2 for title XIX.  98.03 Does title V or XIX follow Medicare (title XVIII) for a cri reimbursed 101% of inpatient services cost? Enter "Y" for y for title V, and in column 2 for title XIX.  |  |  | N   | N                   | 98. 03             |  |
| 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no i   | O4 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, an in column 2 for title XIX. |  |   |                     |                    |  |
| 98.05 Does title V or XIX follow Medicare (title XVIII) and add b Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 2 for title XIX.  |  |  | Y   | Y                   | 98. 05             |  |
| 98.06 Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.  |  |  | Y   | Y                   | 98. 06             |  |
| Rural Provi ders  |  |  | ,   | '                   |                    |  |
| 105.00 Does this hospital qualify as a CAH?  106.00 If this facility qualifies as a CAH, has it elected the all for outpatient services? (see instructions)   | -inclusive met   | hod of payment   | N<br>N                                      |                     | 105. 00<br>106. 00 |  |
| 107.00 Column 1: If line 105 is Y, is this facility eligible for c training programs? Enter "Y" for yes or "N" for no in colum Column 2: If column 1 is Y and line 70 or line 75 is Y, do approved medical education program in the CAH's excluded I  | nn 1. (see ins<br>) you train I&R  | tructions)<br>s in an  | N   |                     | 107. 00            |  |
| Enter "Y" for yes or "N" for no in column 2. (see instruct 108.00 s this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.  | i ons)   |  | N   |                     | 108. 00            |  |
| CFR Section 9412.113(c). Enter 1 101 yes of N 101 110.  | Physi cal  | Occupati onal  | Speech                                      | Respi rator         | У                  |  |
|   | 1.00   | 2.00   | 3.00  | 4.00                |                    |  |
| 109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.   | e N  | N  | N   | N                   | 109. 00            |  |
|   |  |  |   | 1.00                |                    |  |
| 110.00 Did this hospital participate in the Rural Community Hospit Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable.  | "Y" for yes or   | "N" for no. I  | f yes,                                      | N                   | 110. 00            |  |
|   |  |  | 1. 00                                       | 2.00                |                    |  |
| 111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a for tele-health services.                           | cost reporting column 1 is Y, articipating in  | period? Enter<br>enter the<br>column 2.  | N   |                     | 111. 00            |  |
|   |  | 4.22   | 0.22  | 0.00                |                    |  |
| 112.00 Did this hospital participate in the Pennsylvania Rural Hea  | l th Model   | 1. 00<br>N   | 2. 00                                       | 3. 00               | 112. 00            |  |
| (PARHM) demonstration for any portion of the current cost r period? Enter "Y" for yes or "N" for no in column 1. If c "Y", enter in column 2, the date the hospital began partici demonstration. In column 3, enter the date the hospital ce participation in the demonstration, if applicable.   | eporting<br>column 1 is<br>pating in the   | , and the second |   |                     | 112.00             |  |
| Miscellaneous Cost Reporting Information  |  |  |   |                     | 011-               |  |
| 115.00 s this an all-inclusive rate provider? Enter "Y" for yes of in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either "for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provide the definition in CMS Pub. 15-1, chapter 22, §2208.1. | B, or E only)<br>93" percent<br>(includes  | N  |   |                     | 0 115.00           |  |
| 116.00 Is this facility classified as a referral center? Enter "Y" $^{\rm "N"}$ for no.   | ,  | N  |   |                     | 116. 00            |  |
| 117.00 Is this facility legally-required to carry malpractice insu "Y" for yes or "N" for no.   |  | Y  |   |                     | 117. 00            |  |
| 118.00 Is the malpractice insurance a claims-made or occurrence po<br>if the policy is claim-made. Enter 2 if the policy is occur   |  |  | 2   |                     | 118. 00            |  |

| Health Financial Systems  | HARRI SBURG                                    | MEDI CAL  | CENTER, INC.  |             |        | In Lie                                | u of Form CMS | 5-2552-10          |
|---|--|-----------|---------------|-------------|--------|---------------------------------------|---------------|--------------------|
| HOSPITAL AND HOSPITAL HEALTH CARE COMPLE  |  |           | Provi der CC  | N: 14-0210  |        | ri od:<br>om 04/01/2022<br>03/31/2023 | Worksheet S-  | -2<br>repared:     |
|   |  |           |               |             |        |                                       | 1, 00         | _                  |
| 147.00 Was there a change in the statisti   | cal basis? Enter "Y"                           | for ve    | s or "N" for  | no          |        |                                       | N N           | 147. 00            |
| 148.00 Was there a change in the order of   |  |           |               |             |        |                                       | N N           | 148. 00            |
| 149.00 Was there a change to the simplifi   |  |           |               |             | for no |                                       | N             | 149. 00            |
|   | -  |           | Part A        | Part E      | В      | Title V                               | Title XIX     |                    |
|   |  |           | 1. 00         | 2. 00       |        | 3. 00                                 | 4. 00         |                    |
| Does this facility contain a prov<br>or charges? Enter "Y" for yes or   |  |           |               |             |        |                                       |               |                    |
| 155. 00 Hospi tal   |  |           | N             | N           |        | N                                     | N             | 155. 00            |
| 156.00 Subprovi der - IPF   |  |           | N             | N           |        | N                                     | N             | 156. 00            |
| 157.00 Subprovi der - IRF   |  |           | N             | N           |        | N                                     | N             | 157. 00            |
| 158. 00 SUBPROVI DER  |  |           |               |             |        |                                       |               | 158. 00            |
| 159. 00 SNF   |  |           | N             | N           |        | N                                     | N             | 159. 00<br>160. 00 |
| 160.00 HOME HEALTH AGENCY<br>161.00 CMHC  |  |           | N             | N<br>N      |        | N<br>N                                | N<br>N        | 161. 00            |
| 161. OUICINITO  |  |           |               | IN          |        | IN                                    | IN            | 161.00             |
|   |  |           |               |             |        |                                       | 1.00          |                    |
| Multicampus   |  |           |               |             |        | 1 ODCA O                              |               | 1/5 00             |
| 165.00 Is this hospital part of a Multica<br>Enter "Y" for yes or "N" for no.   | ampus hospital that h                          | as one    | or more campu | ises in di1 | rferen | t CBSAs?                              | N             | 165. 00            |
|   | Name   |           | County        |             | Zip C  |                                       | FTE/Campus    |                    |
|   | 0  |           | 1. 00         | 2. 00       | 3. 0   | 0 4.00                                | 5. 00         |                    |
| 166.00 If line 165 is yes, for each   |  |           |               |             |        |                                       | 0. (          | 00 166. 00         |
| campus enter the name in column   |  |           |               |             |        |                                       |               |                    |
| 0, county in column 1, state in column 2, zip code in column 3,   |  |           |               |             |        |                                       |               |                    |
| CBSA in column 4, FTE/Campus in   |  |           |               |             |        |                                       |               |                    |
| column 5 (see instructions)   |  |           |               |             |        |                                       |               |                    |
|   |  |           |               |             |        | · '                                   |               |                    |
| Health Information Technology (HI   | T) incentive in the A                          | lmeri can | Recovery and  | l Reinvest  | ment Δ | ct                                    | 1.00          |                    |
| 167.00 s this provider a meaningful user  |  |           |               |             |        | ic t                                  | Υ             | 167. 00            |
| 168.00 If this provider is a CAH (line 10   |  |           |               |             |        | nter the                              | ·             | 168. 00            |
| reasonable cost incurred for the I  |  |           |               |             | ,,     |                                       |               |                    |
| 168.01 If this provider is a CAH and is a   |  |           |               |             |        | hardshi p                             |               | 168. 01            |
| exception under §413.70(a)(6)(ii)   | ? Enter "Y" for yes o                          | or "N" f  | or no. (see i | nstruction  | ns)    |                                       |               |                    |
| 169.00 If this provider is a meaningful   |  | ) and i   | s not a CAH ( | line 105 i  | is "N" | ), enter the                          | 0.            | 00 169. 00         |
| transition factor. (see instruction   | ons)   |           |               |             |        | Begi nni ng                           | Endi ng       |                    |
|   |  |           |               |             |        | 1. 00                                 | 2.00          |                    |
| 170.00 Enter in columns 1 and 2 the EHR I period respectively (mm/dd/yyyy)  | oeginning date and en                          | ndi ng da | te for the re | porting     |        |                                       |               | 170. 00            |
| [F-11-12-1-12-1-1-1-1-1-1-1-1-1-1-1-1-1-1   |  |           |               |             |        | 1.00                                  | 2.00          |                    |
| 171 00 If line 167 is "V" does this pro-  | ildor havo any daya f                          | or Indi   | viduale opeal | Lodin       |        | 1. 00<br>N                            | 2.00          | 0171 00            |
| 171.00 If line 167 is "Y", does this pro-<br>section 1876 Medicare cost plans i<br>"Y" for yes and "N" for no in colu<br>1876 Medicare days in column 2. (s | reported on Wkst. S-3<br>umn 1. If column 1 is | B, Pt. I  | , line 2, col | . 6? Enter  |        | N                                     |               | 0 171.00           |

|        | Financial Systems HARRISBURG MEDIC  |                 |                 |  | u of Form CMS-         |         |
|--------|---|-----------------|-----------------|--|------------------------|---------|
| OSPI I | AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE   | Provi der C     | CN: 14-0210     | Peri od:<br>From 04/01/2022<br>To 03/31/2023 |                        | epared: |
|        |   |                 |                 | Y/N  | 9/11/2023 9: 1<br>Date | ib am   |
|        |   |                 |                 | 1. 00  | 2. 00                  |         |
|        | PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSE   |                 |                 |  |                        |         |
|        | General Instruction: Enter Y for all YES responses. Enter M<br>mm/dd/yyyy format.<br>COMPLETED BY ALL HOSPITALS   | l for all NO re | sponses. Ente   | er all dates in t                            | the                    |         |
|        | Provider Organization and Operation   |                 |                 |  |                        |         |
| . 00   | Has the provider changed ownership immediately prior to the   |                 |                 | N  |                        | 1.00    |
|        | reporting period? If yes, enter the date of the change in o   | column 2. (see  | Y/N             | Date   | V/I                    |         |
|        |   |                 | 1.00            | 2. 00  | 3. 00                  |         |
| 00     | Has the provider terminated participation in the Medicare F   |                 | N               |  |                        | 2. 00   |
|        | yes, enter in column 2 the date of termination and in column  | nn 3, "V" for   |                 |  |                        |         |
| 00     | voluntary or "I" for involuntary.<br>Is the provider involved in business transactions, including                 | na management   | Y               |  |                        | 3.0     |
| 00     | contracts, with individuals or entities (e.g., chain home of  |                 | '               |  |                        | 3.0     |
|        | 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  | er similar      |                 |  |                        |         |
|        | relationships? (see instructions)   |                 | Y/N             | Туре   | Date                   |         |
|        |   |                 | 1. 00           | 2. 00  | 3. 00                  |         |
|        | Financial Data and Reports  |                 |                 |  |                        |         |
| 00     | Column 1: Were the financial statements prepared by a Cert  |                 | Y               | Α  |                        | 4. 0    |
|        | Accountant? Column 2: If yes, enter "A" for Audited, "C" 1  |                 |                 |  |                        |         |
|        | or "R" for Reviewed. Submit complete copy or enter date avacolumn 3. (see instructions) If no, see instructions.  | arrabre in      |                 |  |                        |         |
| 00     | Are the cost report total expenses and total revenues diffe   | erent from      | l N             |  |                        | 5.0     |
|        | those on the filed financial statements? If yes, submit red   |                 |                 |  |                        |         |
|        |   |                 |                 | Y/N  | Legal Oper.            |         |
|        | Approved Educational Activities   |                 |                 | 1. 00  | 2. 00                  | +       |
| 00     | Approved Educational Activities  Column 1: Are costs claimed for a nursing program? Column                        | 2. If ves is    | the provide     | ~ N  |                        | 6.00    |
| 00     | the legal operator of the program?  | 2. 11 you, 10   | the provider    | ,,,  |                        | 0.0     |
| 00     | Are costs claimed for Allied Health Programs? If "Y" see in   | nstructions.    |                 | N  |                        | 7.00    |
| 00     | Were nursing programs and/or allied health programs approve   | ed and/or renew | ed during the   | e N  |                        | 8. 00   |
| 00     | cost reporting period? If yes, see instructions.  Are costs claimed for Interns and Residents in an approved      | araduata madia  | al aducation    | N  |                        | 9. 00   |
| 00     | program in the current cost report? If yes, see instruction   |                 | ai education    | IN   |                        | 9.00    |
| . 00   | Was an approved Intern and Resident GME program initiated of  |                 | he current      | N  |                        | 10.00   |
|        | cost reporting period? If yes, see instructions.  |                 |                 |  |                        |         |
| . 00   | Are GME cost directly assigned to cost centers other than I   | & R in an App   | roved           | N  |                        | 11. 0   |
|        | Teaching Program on Worksheet A? If yes, see instructions.  |                 |                 |  | Y/N                    |         |
|        |   |                 |                 |  | 1. 00                  |         |
|        | Bad Debts   |                 |                 |  |                        |         |
|        | Is the provider seeking reimbursement for bad debts? If yes   |                 |                 |  | Y                      | 12. 0   |
| . 00   | If line 12 is yes, did the provider's bad debt collection p   | oolicy change o | luring this co  | ost reporting                                | N                      | 13. 0   |
| 00     | period? If yes, submit copy.<br>If line 12 is yes, were patient deductibles and/or coinsura                       | ance amounts wa | ived2 If ves    | 200  | N                      | 14. 0   |
| +. 00  | instructions.   | ance amounts wa | ii veu: 11 yes, | 366  | IN                     | 14.0    |
|        | Bed Complement  |                 |                 |  |                        |         |
| 5. 00  | Did total beds available change from the prior cost reporti   |                 |                 |  | N                      | 15. 0   |
|        |   | Y/N             | T Date          | Y/N  | t B<br>Date            |         |
|        |   | 1.00            | 2.00            | 3.00   | 4. 00                  | +       |
|        | PS&R Data   | 1.00            | 2.00            | 0.00   | 1. 00                  |         |
| . 00   | Was the cost report prepared using the PS&R Report only?  | Y               | 08/21/2023      | Υ  | 08/21/2023             | 16.0    |
|        | 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)  |                 |                 |  |                        |         |
| . 00   | Was the cost report prepared using the PS&R Report for  | N               |                 | N  |                        | 17. 0   |
|        | 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)  |                 |                 |  |                        | 1.00    |
| 00     | If line 16 or 17 is yes, were adjustments made to PS&R<br>Report data for additional claims that have been billed | N               |                 | N  |                        | 18. 0   |
|        | but are not included on the PS&R Report used to file this   |                 |                 |  |                        |         |
|        | cost report? If yes, see instructions.  |                 |                 |  |                        |         |
|        | If line 16 or 17 is yes, were adjustments made to PS&R  | N               | 1               | N  |                        | 19. 0   |
| . 00   |   |                 |                 |  |                        |         |
| . 00   | Report data for corrections of other PS&R Report information? If yes, see instructions.                           |                 |                 |  |                        |         |

| Heal th | Financial Systems HARRISBURG MEDICA   | L CENTER, INC.  |                | In Lie                                       | u of Form CM           | S-2552-10 |
|---------|---|-----------------|----------------|--|------------------------|-----------|
|         | AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE   | Provi der C     | CN: 14-0210    | Peri od:<br>From 04/01/2022<br>To 03/31/2023 | Worksheet S<br>Part II | repared:  |
|         |   | Descr           | iption         | Y/N  | Y/N                    |           |
|         |   | 1               | 0              | 1. 00  | 3. 00                  |           |
| 20. 00  | If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:   |                 |                | N  | N                      | 20. 00    |
|         |   | Y/N             | Date           | Y/N  | Date                   |           |
|         |   | 1.00            | 2. 00          | 3. 00  | 4. 00                  |           |
| 21. 00  | Was the cost report prepared only using the provider's records? If yes, see instructions.   | N               |                | N  |                        | 21. 00    |
|         |   |                 |                |  | 1. 00                  |           |
|         | COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE   | PT CHILDRENS E  | IOSPLTALS)     |  | 1.00                   |           |
|         | Capi tal Related Cost   |                 |                |  |                        |           |
| 22.00   | Have assets been relifed for Medicare purposes? If yes, see   | i nstructi ons  |                |  | N                      | 22. 00    |
|         | Have changes occurred in the Medicare depreciation expense or reporting period? If yes, see instructions.   |                 | sals made dur  | ing the cost                                 | N                      | 23. 00    |
| 24. 00  | Were new leases and/or amendments to existing leases entered if yes, see instructions   | porting period? | N              | 24. 00                                       |                        |           |
| 25. 00  | Have there been new capitalized leases entered into during instructions.  | If yes, see     | N              | 25. 00                                       |                        |           |
| 26. 00  | Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.   | e cost reporti  | ng period? I   | f yes, see                                   | N                      | 26. 00    |
| 27. 00  | Has the provider's capitalization policy changed during the copy.   | cost reportir   | ng period? If  | yes, submit                                  | N                      | 27. 00    |
| 28. 00  | Interest Expense Were new loans, mortgage agreements or letters of credit en  | tered into dur  | ing the cost   | reporti ng                                   | N                      | 28. 00    |
| 29. 00  | period? If yes, see instructions. Did the provider have a funded depreciation account and/or  | N               | 29. 00         |  |                        |           |
| 30. 00  | treated as a funded depreciation account? If yes, see instru<br>Has existing debt been replaced prior to its scheduled maturistics.                   | , see           | Υ              | 30. 00                                       |                        |           |
| 31. 00  | <pre>instructions. Has debt been recalled before scheduled maturity without is: instructions.</pre>   | , see           | N              | 31. 00                                       |                        |           |
|         | Purchased Services  |                 |                |  |                        |           |
| 32.00   | Have changes or new agreements occurred in patient care serv  | vices furnishe  | ed through co  | ntractual                                    | N                      | 32. 00    |
| 33. 00  | arrangements with suppliers of services? If yes, see instructions. If line 32 is yes, were the requirements of Sec. 2135.2 applino, see instructions. |                 | ng to competi  | tive bidding? If                             | N                      | 33. 00    |
|         | Provi der-Based Physi ci ans  |                 |                |  |                        |           |
|         | Were services furnished at the provider facility under an a   | rrangement wit  | h provider-b   | ased physicians?                             | Υ                      | 34. 00    |
|         | If yes, see instructions. If line 34 is yes, were there new agreements or amended exi:  | 9               | ·              | . ,  | Y                      | 35. 00    |
| 00.00   | physicians during the cost reporting period? If yes, see in   |                 | its with the   | provider basea                               |                        | 00.00     |
|         |   |                 |                | Y/N  | Date                   |           |
|         |   |                 |                | 1. 00  | 2. 00                  |           |
| 0/ 00   | Home Office Costs   |                 |                |  |                        | 0         |
|         | Were home office costs claimed on the cost report?  |                 | h 66' - 6      | Y  |                        | 36.00     |
| 37.00   | If line 36 is yes, has a home office cost statement been pro  | epared by the   | home office?   | Υ  |                        | 37. 00    |
| 38. 00  | If yes, see instructions. If line 36 is yes , was the fiscal year end of the home off   |                 |                | N  |                        | 38. 00    |
| 39. 00  | the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other                              |                 |                | , N  |                        | 39. 00    |
| 40. 00  | see instructions. If line 36 is yes, did the provider render services to the libertrations.   | home office?    | If yes, see    | N  |                        | 40. 00    |
|         | instructions.   |                 |                |  |                        |           |
|         |   | 1               | 00             | 2  | 00                     |           |
|         | Cost Report Preparer Contact Information  |                 |                | 2.   |                        |           |
| 41. 00  | Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,                                       | LUANNE          |                | WARREN                                       |                        | 41. 00    |
| 42. 00  | '   | SOUTHERN ILLIN  | IOIS HEALTHCAI | RE   |                        | 42. 00    |
| 43. 00  | preparer. Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.                                  | 618-457-5200 E  | XT 67202       | LUANNE. WARREN@S                             | SIH. NET               | 43. 00    |
|         |   |                 |                | •  |                        |           |

| Health Financial Systems HARRISBURG MEDIC |   |                 | ICAL CENTER, INC. In Lieu of Form C |  |  |              | 2552-10 |
|---|---|-----------------|-------------------------------------|--|--|--------------|---------|
| HOSPI T                                   | AL AND HOSPITAL HEALTH CARE REIMBURSEMENT | QUESTI ONNAI RE | Provider CCN: 14-02                 |  | eriod:<br>rom 04/01/2022<br>o 03/31/2023 |              | =       |
|   |   |                 |                                     |  |  | 9/11/2023 9: | 16 am   |
|   |   |                 |                                     |  |  |              |         |
|   |   |                 | 3. 00                               |  |  |              |         |
|   | Cost Report Preparer Contact Information  |                 |                                     |  |  |              |         |
| 41.00                                     | Enter the first name, last name and the t |                 | REIMBURSEMENT DIRECTOR              |  |  |              | 41.00   |
|   | held by the cost report preparer in colum | ns 1, 2, and 3, |                                     |  |  |              |         |
|   | respecti vel y.                           |                 |                                     |  |  |              |         |
| 42.00                                     | Enter the employer/company name of the co | st report       |                                     |  |  |              | 42.00   |
|   | preparer.                                 |                 |                                     |  |  |              |         |
| 43.00                                     | Enter the telephone number and email addr | ess of the cost |                                     |  |  |              | 43.00   |
|   | report preparer in columns 1 and 2, respe | cti vel y.      |                                     |  |  |              |         |

| Peri od: | Worksheet S-3 | From 04/01/2022 | Part | To 03/31/2023 | Date/Time Prepared: Health Financial Systems HARRISBURG HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 14-0210

|        |  |             |             |              | 0 03/31/2023   | 9/11/2023 9:16 |        |
|--------|--|-------------|-------------|--------------|----------------|----------------|--------|
|        |  |             |             |              |                | I/P Days / 0/P | ) aiii |
|        |  |             |             |              |                | Visits / Trips |        |
|        | Component                                    | Worksheet A | No. of Beds | Bed Days     | CAH/REH Hours  | Title V        |        |
|        | osiiiporierre                                | Li ne No.   | No. or bods | Avai I abl e | Oran Ren Hours | """            |        |
|        |  | 1.00        | 2. 00       | 3.00         | 4. 00          | 5. 00          |        |
|        | PART I - STATISTICAL DATA                    |             |             |              |                |                |        |
| 1.00   | Hospital Adults & Peds. (columns 5, 6, 7 and | 30. 00      | 40          | 14, 600      | 0.00           | 0              | 1. 00  |
|        | 8 exclude Swing Bed, Observation Bed and     |             |             |              |                |                |        |
|        | Hospice days) (see instructions for col. 2   |             |             |              |                |                |        |
|        | for the portion of LDP room available beds)  |             |             |              |                |                |        |
| 2.00   | HMO and other (see instructions)             |             |             |              |                |                | 2.00   |
| 3.00   | HMO IPF Subprovider                          |             |             |              |                |                | 3.00   |
| 4.00   | HMO IRF Subprovider                          |             |             |              |                |                | 4.00   |
| 5.00   | Hospital Adults & Peds. Swing Bed SNF        |             |             |              |                | o              | 5.00   |
| 6.00   | Hospital Adults & Peds. Swing Bed NF         |             |             |              |                | o              | 6.00   |
| 7.00   | Total Adults and Peds. (exclude observation  |             | 40          | 14, 600      | 0.00           | o              | 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)                     |             | 40          | 14, 600      | 0.00           | 0              | 14.00  |
| 15.00  | CAH visits                                   |             |             |              |                | 0              | 15.00  |
| 15. 10 | REH hours and visits                         |             |             |              |                |                | 15. 10 |
| 16.00  | SUBPROVI DER - I PF                          | 40. 00      | 31          | 11, 315      | 5              | 0              | 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)                  | 30. 00      |             |              |                |                | 24. 10 |
| 25. 00 | CMHC - CMHC                                  |             |             |              |                |                | 25. 00 |
| 26. 00 | RURAL HEALTH CLINIC                          | 88. 00      |             |              |                | 0              | 26. 00 |
| 26. 01 | RURAL HEALTH CLINIC II                       | 88. 01      |             |              |                | 0              | 26. 01 |
| 26. 25 | FEDERALLY QUALIFIED HEALTH CENTER            | 89. 00      |             |              |                | 0              | 26. 25 |
| 27. 00 | Total (sum of lines 14-26)                   |             | 71          |              |                |                | 27. 00 |
| 28. 00 | Observation Bed Days                         |             |             |              |                | 0              | 28. 00 |
| 29. 00 | Ambul ance Tri ps                            |             |             |              |                |                | 29. 00 |
| 30. 00 | Employee discount days (see instruction)     |             |             |              |                |                | 30. 00 |
| 31. 00 | Employee discount days - IRF                 |             |             |              |                |                | 31. 00 |
| 32. 00 | Labor & delivery days (see instructions)     |             | 0           | (            | )              |                | 32. 00 |
| 32. 01 | Total ancillary labor & delivery room        |             |             |              |                |                | 32. 01 |
| 00.00  | outpatient days (see instructions)           |             |             |              |                |                | 00.00  |
| 33. 00 | LTCH non-covered days                        |             |             |              |                |                | 33. 00 |
| 33. 01 | LTCH site neutral days and discharges        | 20.00       | _           |              |                |                | 33. 01 |
| 34.00  | Temporary Expansion COVID-19 PHE Acute Care  | 30. 00      | 0           | (            | ין             | ا              | 34. 00 |

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0210

Peri od: Worksheet S-3 From 04/01/2022 Part I To 03/31/2023 Date/Time Prepared:

9/11/2023 9:16 am Full Time Equivalents I/P Days / O/P Visits / Trips 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 PART I - STATISTICAL DATA Hospital Adults & Peds. (columns 5, 6, 7 and 1.00 829 27 1,828 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) 385 216 2.00 3.00 HMO IPF Subprovider 216 3.00 4.00 HMO IRF Subprovider 0 4.00 0 Hospital Adults & Peds. Swing Bed SNF 70 110 5.00 Ω 5.00 6.00 Hospital Adults & Peds. Swing Bed NF 6.00 Total Adults and Peds. (exclude observation 899 27 1, 943 7.00 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 Total (see instructions) 14.00 899 27 1,943 0.00 261.27 14.00 15.00 CAH visits 15.00 15.10 REH hours and visits 15.10 16.00 SUBPROVIDER - IPF 620 3, 459 5, 559 0.00 52.18 16.00 SUBPROVIDER - IRF 17.00 17.00 18 00 SUBPROVI DER 18 00 SKILLED NURSING FACILITY 19.00 19.00 20.00 NURSING FACILITY 20.00 OTHER LONG TERM CARE 21.00 21.00 HOME HEALTH AGENCY 22 00 22 00 23.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 HOSPI CE 24.00 24.00 24.10 HOSPICE (non-distinct part) 0 24. 10 25.00 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 3,658 13, 142 0.00 13.69 26.00 26.01 RURAL HEALTH CLINIC II 2,390 10, 149 0.00 12.71 26.01 FEDERALLY QUALIFIED HEALTH CENTER 0.00 0.00 0 26, 25 26, 25 0 0 27 00 Total (sum of lines 14-26) 0.00 339.85 27 00 28. 00 Observation Bed Days 1, 284 28.00 29.00 Ambul ance Trips 29.00 0 Employee discount days (see instruction) 30.00 0 30.00 31.00 Employee discount days - IRF 0 31.00 Labor & delivery days (see instructions) 0 32.00 0 0 32.00 Total ancillary labor & delivery room 32.01 32.01 0 outpatient days (see instructions) 33.00 33.00 LTCH non-covered days LTCH site neutral days and discharges 0 33.01 34.00 Temporary Expansion COVID-19 PHE Acute Care 0 34.00

Health Financial Systems HARRISBURG HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA In Lieu of Form CMS-2552-10 Provider CCN: 14-0210 

|                  |  |                          |         |             | 03/31/2023 | 9/11/2023 9: 10       |                  |
|------------------|--|--------------------------|---------|-------------|------------|-----------------------|------------------|
|                  |  | Full Time<br>Equivalents |         | Di sch      | arges      |                       |                  |
|                  | Component  | Nonpai d<br>Workers      | Title V | Title XVIII | Title XIX  | Total All<br>Patients |                  |
|                  |  | 11. 00                   | 12.00   | 13. 00      | 14. 00     | 15. 00                |                  |
|                  | PART I - STATISTICAL DATA  |                          |         |             |            |                       |                  |
| 1. 00            | Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) |                          | 0       | 302         | 100        | 636                   | 1. 00            |
| 2.00             | HMO and other (see instructions)   |                          |         | 109         | 0          |                       | 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  |                          |         |             | ٦          |                       | 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       | 302         | 100        | 636                   | 14.00            |
| 15. 00           | CAH visits   |                          |         |             |            |                       | 15. 00           |
| 15. 10           | REH hours and visits   |                          |         |             |            |                       | 15. 10           |
| 16. 00           | SUBPROVI DER - I PF  | 0. 00                    | 0       | 65          | 446        | 703                   | 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. ) HOSPICE  |                          |         |             |            |                       | 23. 00<br>24. 00 |
| 24. 00<br>24. 10 | HOSPICE (non-distinct part)  |                          |         |             |            |                       | 24. 00           |
| 25. 00           | CMHC - CMHC  |                          |         |             |            |                       | 25. 00           |
| 26. 00           | RURAL HEALTH CLINIC  | 0. 00                    |         |             |            |                       | 26. 00           |
| 26. 01           | RURAL HEALTH CLINIC II   | 0. 00                    |         |             |            |                       | 26. 01           |
| 26. 25           | FEDERALLY QUALIFIED HEALTH CENTER  | 0. 00                    |         |             |            |                       | 26. 25           |
| 27. 00           | Total (sum of lines 14-26)   | 0. 00                    |         |             |            |                       | 27. 00           |
| 28. 00           | Observation Bed Days   |                          |         |             |            |                       | 28. 00           |
| 29. 00           | Ambul ance Trips   |                          |         |             |            |                       | 29. 00           |
| 30.00            | Employee discount days (see instruction)   |                          |         |             |            |                       | 30. 00           |
| 31.00            | Employee discount days - IRF   |                          |         |             |            |                       | 31. 00           |
| 32.00            | Labor & delivery days (see instructions)   |                          |         |             |            |                       | 32.00            |
| 32. 01           | Total ancillary labor & delivery room  |                          |         |             |            |                       | 32. 01           |
|                  | outpatient days (see instructions)   |                          |         |             |            |                       |                  |
| 33. 00           | LTCH non-covered days  |                          |         | 0           |            |                       | 33. 00           |
| 33. 01           | LTCH site neutral days and discharges  |                          |         | 0           |            |                       | 33. 01           |
| 34.00            | Temporary Expansion COVID-19 PHE Acute Care  |                          |         |             | I          |                       | 34. 00           |

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0210

| Peri od: | Worksheet S-3 | From 04/01/2022 | Part II | To 03/31/2023 | Date/Time Prepared:

|   |  |                        |                           | _   | T                                       | 03/31/2023                              | Date/Time Pre 9/11/2023 9:1                 | 6 am                       |
|---|--|------------------------|---------------------------|---|---|---|---|----------------------------|
|   |  | Wkst. A Line<br>Number | Amount<br>Reported        | Reclassificati<br>on of Salaries<br>(from Wkst. | (col.2 ± col.                           | Paid Hours<br>Related to<br>Salaries in | Average Hourly<br>Wage (col. 4 ÷<br>col. 5) |                            |
|   |  | 1.00                   | 2. 00                     | A-6)<br>3.00                                    | 3)<br>4. 00                             | col . 4<br>5. 00                        | 6. 00                                       |                            |
|   | PART II - WAGE DATA SALARIES   |                        |                           |   |   |   |   |                            |
| 1.00                                    | Total salaries (see  | 200. 00                | 23, 042, 735              | 0   | 23, 042, 735                            | 706, 885. 71                            | 32. 60                                      | 1.00                       |
| 2. 00                                   | instructions)<br>Non-physician anesthetist Part  |                        | 0                         | 0   | 0                                       | 0.00                                    | 0. 00                                       | 2. 00                      |
| 3. 00                                   | A<br>Non-physician anesthetist Part  |                        | 414, 739                  | 0   | 414, 739                                | 3, 932. 75                              | 105. 46                                     | 3.00                       |
| 4. 00                                   | Physician-Part A -<br>Administrative   |                        | 0                         | 0   | 0                                       | 0.00                                    | 0. 00                                       | 4.00                       |
| 4. 01<br>5. 00                          | Physicians - Part A - Teaching<br>Physician and Non                                      |                        | 0<br>1, 414, 611          | 0   | 1                                       | 0. 00<br>7, 907. 75                     |   |                            |
| 6. 00                                   | Physician-Part B<br>Non-physician-Part B for<br>hospital-based RHC and FQHC              |                        | 1, 016, 384               | О   | 1, 016, 384                             | 47, 007. 93                             | 21. 62                                      | 6. 00                      |
| 7. 00                                   | services Interns & residents (in an  | 21. 00                 | 0                         | 0   | 0                                       | 0.00                                    | 0. 00                                       | 7. 00                      |
| 7. 01                                   | approved program) Contracted interns and residents (in an approved programs)             |                        | 0                         | 0   | О                                       | 0.00                                    | 0. 00                                       | 7. 01                      |
| 8. 00                                   | Home office and/or related organization personnel  |                        | 0                         | 0   | 0                                       | 0.00                                    | 0. 00                                       | 8. 00                      |
| 9. 00<br>10. 00                         | SNF<br>Excluded area salaries (see   | 44. 00                 | 0<br>3, 540, 933          | 0   | -                                       | 0. 00<br>117, 978. 75                   | l .   |                            |
| 11. 00                                  | instructions) OTHER WAGES & RELATED COSTS Contract Labor: Direct Patient                 |                        | 2, 685, 550               | 0   | 2, 685, 550                             | 21, 260. 77                             | 126. 31                                     | 11 00                      |
| 12. 00                                  | Care Contract labor: Top level   |                        | 0                         |   | , | 0.00                                    |   | 12. 00                     |
|   | management and other<br>management and administrative<br>services                        |                        |                           |   |   |   |   |                            |
| 13. 00                                  | Contract Labor: Physician-Part<br>A - Administrative                                     |                        | 0                         | _   | 0                                       | 0.00                                    |   |                            |
| 14. 00                                  | Home office and/or related organization salaries and wage-related costs                  |                        | 0                         | 0   | 0                                       | 0.00                                    | 0.00  | 14.00                      |
| 14. 01<br>14. 02<br>15. 00              | Home office salaries<br>Related organization salaries<br>Home office: Physician Part A   |                        | 3, 878, 580<br>0<br>0     | 0   | 0                                       | 94, 938. 38<br>0. 00<br>0. 00           | 0. 00                                       |                            |
| 16. 00                                  | - Administrative<br>Home office and Contract   |                        | 0                         | 0   | 0                                       | 0. 00                                   | 0. 00                                       | 16. 00                     |
| 16. 01                                  | Physicians Part A - Teaching<br>Home office Physicians Part A                            |                        | 0                         | 0   | 0                                       | 0.00                                    | 0. 00                                       | 16. 0°                     |
| 16. 02                                  | - Teaching<br>Home office contract<br>Physicians Part A - Teaching<br>WAGE-RELATED COSTS |                        | 0                         | 0   | 0                                       | 0.00                                    | 0. 00                                       | 16. 0                      |
| 17. 00                                  | Wage-related costs (core) (see instructions)   |                        | 3, 821, 421               | 0   | 3, 821, 421                             |   |   | 17. 0                      |
| 18. 00                                  | Wage-related costs (other) (see instructions)  |                        |                           |   |   |   |   | 18. 0                      |
| 19. 00<br>20. 00                        | Excluded areas Non-physician anesthetist Part  |                        | 834, 543<br>0             | 0   | 834, 543<br>0                           |   |   | 19. 00<br>20. 00           |
| 21. 00                                  | Non-physician anesthetist Part<br>B  |                        | 44, 141                   | 0   | 44, 141                                 |   |   | 21. 0                      |
| 22. 00                                  | Physician Part A -<br>Administrative   |                        | 0                         | 0   | 0                                       |   |   | 22. 00                     |
| 22. 01<br>23. 00<br>24. 00              | Physician Part A - Teaching<br>Physician Part B<br>Wage-related costs (RHC/FQHC)         |                        | 0<br>113, 470<br>302, 115 |   | 0<br>113, 470<br>302, 115               |   |   | 22. 0°<br>23. 00<br>24. 00 |
| <ul><li>25. 00</li><li>25. 50</li></ul> | Interns & residents (in an approved program) Home office wage-related                    |                        | 0<br>1, 568, 030          | 0   | 0<br>1, 568, 030                        |   |   | 25. 00<br>25. 50           |
| 25. 50                                  | (core) Related organization  |                        | 1, 568, 030               |   |   |   |   | 25. 50                     |
| 25. 52                                  | wage-related (core) Home office: Physician Part A - Administrative -                     |                        | 0                         |   | 0                                       |   |   | 25. 52                     |
|   | - Administrative -<br> wage-related (core)   |                        |                           |   |   |   |   |                            |

Provider CCN: 14-0210

| Peri od: | Worksheet S-3 | From 04/01/2022 | Part II | To 03/31/2023 | Date/Time Prepared:

|        |                                 |              |             |                  | 11            | 03/31/2023  | 9/11/2023 9:10 |        |
|--------|---------------------------------|--------------|-------------|------------------|---------------|-------------|----------------|--------|
|        |                                 | Wkst. A Line | Amount      | Reclassi fi cati | Adj usted     | Pai d Hours | Average Hourly |        |
|        |                                 | Number       | Reported    | on of Salaries   | Sal ari es    |             | Wage (col. 4 ÷ |        |
|        |                                 |              | ·           | (from Wkst.      | (col.2 ± col. | Salaries in | col . 5)       |        |
|        |                                 |              |             | A-6)             | 3)            | col. 4      |                |        |
|        |                                 | 1.00         | 2.00        | 3. 00            | 4. 00         | 5. 00       | 6. 00          |        |
| 25. 53 | Home office: Physicians Part A  |              | 0           | 0                | 0             |             |                | 25. 53 |
|        | - Teaching - wage-related       |              |             |                  |               |             |                |        |
|        | (core)                          |              |             |                  |               |             |                |        |
|        | OVERHEAD COSTS - DIRECT SALARII |              |             |                  |               |             |                |        |
| 26. 00 | Employee Benefits Department    | 4. 00        | 91, 586     |                  | 91, 586       | ·           |                | 26. 00 |
| 27. 00 | Administrative & General        | 5. 00        | 3, 822, 873 |                  | 3, 822, 873   | ·           |                | 27. 00 |
| 28. 00 | Administrative & General under  |              | 520, 682    | 0                | 520, 682      | 1, 207. 66  | 431. 15        | 28. 00 |
|        | contract (see inst.)            |              |             |                  |               |             |                |        |
| 29. 00 | Maintenance & Repairs           | 6. 00        | 0           | 0                | 0             | 0.00        |                | 29. 00 |
| 30. 00 | Operation of Plant              | 7. 00        | 386, 872    | 0                | 386, 872      | 18, 754. 71 |                |        |
| 31. 00 | Laundry & Linen Service         | 8. 00        | 0           | 0                | 0             | 0. 00       |                |        |
| 32. 00 | Housekeepi ng                   | 9. 00        | 612, 453    | 0                | 612, 453      | 37, 557. 49 |                |        |
| 33. 00 | Housekeeping under contract     |              | 0           | 0                | 0             | 0. 00       | 0. 00          | 33. 00 |
|        | (see instructions)              |              |             |                  |               |             |                |        |
| 34. 00 | Dietary                         | 10. 00       | 674, 183    | 0                | 674, 183      | ·           |                | 34. 00 |
| 35. 00 | Dietary under contract (see     |              | 0           | 0                | 0             | 0. 00       | 0. 00          | 35. 00 |
|        | instructions)                   | 44.00        |             |                  |               |             |                | 0, 00  |
| 36. 00 | Cafeteri a                      | 11. 00       | 0           | 0                | 0             | 0.00        |                | 36. 00 |
| 37. 00 | Maintenance of Personnel        | 12. 00       | 0           | 0                | 0             | 0.00        |                | 37. 00 |
| 38. 00 | Nursing Administration          | 13. 00       | 325, 435    |                  | 325, 435      | 5, 593. 52  |                |        |
| 39. 00 | Central Services and Supply     | 14. 00       | 286, 741    |                  | 286, 741      | 13, 528. 51 |                |        |
| 40. 00 | Pharmacy                        | 15. 00       | 598, 737    |                  |               | 0. 00       |                | 40. 00 |
| 41. 00 | Medical Records & Medical       | 16. 00       | 414, 620    | 0                | 414, 620      | 19, 968. 11 | 20. 76         | 41. 00 |
|        | Records Li brary                |              | _           | _                |               |             |                |        |
| 42. 00 | Soci al Servi ce                | 17. 00       | 0           | 0                | 0             | 0.00        |                | 42. 00 |
| 43. 00 | Other General Service           | 18. 00       | 0           | ] 0              | 0             | 0. 00       | 0. 00          | 43.00  |

Health Financial Systems HARRISBURG MEDICAL CENTER, INC. In Lieu of Form CMS-2552-10
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 14-0210 Period: Worksheet S-3

Worksheet S-3 Peri od: From 04/01/2022 To 03/31/2023 Part III Date/Time Prepared: 9/11/2023 9:16 am Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Average Hourly Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 ÷ (col . 2 ± col . col. 5) (from Salaries in Works<u>heet A-6)</u> 3) col. 4 1.00 5.00 6.00 2.00 3.00 4.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 20, 717, 683 20, 717, 683 649, 244. 94 31. 91 1.00 instructions) 2.00 3, 540, 933 ol 3, 540, 933 117, 978. 75 30.01 2.00 Excluded area salaries (see instructions) 3.00 Subtotal salaries (line 1 17, 176, 750 0 17, 176, 750 531, 266. 19 32. 33 3.00 minus line 2) 4.00 Subtotal other wages & related 6, 564, 130 6, 564, 130 116, 199. 15 56.49 4.00 costs (see inst.) Subtotal wage-related costs 5.00 5, 389, 451 0 5, 389, 451 0.00 31. 38 5.00

29, 130, 331

7, 135, 445

-598, 737

647, 465. 34

246, 148. 05

29, 130, 331

7, 734, 182

6.00

7.00

44 99

28.99

(see inst.)

instructions)

6.00

7.00

Total (sum of lines 3 thru 5)

Total overhead cost (see

|        | To 03/31/2023   | Date/Time Prep<br>9/11/2023 9:10 |                  |
|--------|---|----------------------------------|------------------|
|        |   | Amount                           | J dill           |
|        |   | Reported                         |                  |
|        |   | 1. 00                            |                  |
|        | PART IV - WAGE RELATED COSTS  |                                  |                  |
|        | Part A - Core List  |                                  |                  |
|        | RETI REMENT COST  |                                  |                  |
| 1.00   | 401K Employer Contributions   | 0                                | 1.00             |
| 2.00   | Tax Sheltered Annuity (TSA) Employer Contribution   | 617, 368                         | 2.00             |
| 3.00   | Nonqualified Defined Benefit Plan Cost (see instructions)   | 0                                | 3.00             |
| 4.00   | Qualified Defined Benefit Plan Cost (see instructions)  | 0                                | 4.00             |
|        | PLAN ADMINISTRATIVE COSTS (Paid to External Organization)   |                                  |                  |
| 5.00   | 401K/TSA Plan Administration fees   | 0                                | 5.00             |
| 6.00   | Legal /Accounting/Management Fees-Pension Plan  | 0                                | 6.00             |
| 7.00   | Employee Managed Care Program Administration Fees   | 0                                | 7.00             |
|        | HEALTH AND INSURANCE COST   |                                  |                  |
| 8.00   | Health Insurance (Purchased or Self Funded)   | 0                                | 8.00             |
| 8. 01  | Health Insurance (Self Funded without a Third Party Administrator)                                    | 0                                | 8. 01            |
| 8. 02  | Health Insurance (Self Funded with a Third Party Administrator)                                       | 3, 286, 536                      | 8. 02            |
| 8.03   | Health Insurance (Purchased)  | 0                                | 8. 03            |
| 9.00   | Prescription Drug Plan  | 0                                | 9. 00            |
| 10.00  | Dental, Hearing and Vision Plan   | -17, 111                         | 10.00            |
| 11. 00 | Life Insurance (If employee is owner or beneficiary)  | 12, 284                          | 11. 00           |
| 12.00  | Accident Insurance (If employee is owner or beneficiary)  | 0                                | 12.00            |
| 13.00  | Disability Insurance (If employee is owner or beneficiary)  | 27, 801                          | 13.00            |
| 14. 00 | Long-Term Care Insurance (If employee is owner or beneficiary)  | 0                                | 14.00            |
| 15. 00 | 'Workers' Compensation Insurance  | 161, 088                         | 15. 00           |
| 16. 00 | Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.   | 0                                | 16.00            |
|        | Noncumulative portion)  |                                  |                  |
|        | TAXES   |                                  |                  |
| 17. 00 |   | 812, 159                         | 17. 00           |
| 18. 00 | Medicare Taxes - Employers Portion Only   | 189, 941                         |                  |
| 19. 00 | Unempl oyment Insurance   | 19, 710                          |                  |
| 20. 00 |   | 0                                | 20. 00           |
|        | OTHER   |                                  |                  |
| 21. 00 | Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see | 0                                | 21. 00           |
| 22.00  | instructions))  | 0                                | 22.00            |
| 22. 00 | Day Care Cost and Allowances  | 0                                | 22. 00<br>23. 00 |
| 23. 00 | Tuition Reimbursement   | 5, 915                           |                  |
| 24. 00 |   | 5, 115, 691                      | 24. 00           |
| 25 00  | Part B - Other than Core Related Cost OTHER WAGE RELATED COSTS (SPECIFY)                              |                                  | 25 00            |
| ∠5. 00 | UITER WAGE RELATED COSTS (SPECIFY)  |                                  | 25. 00           |

| Health Financial Systems                 | HARRISBURG MEDICAL CENTER, INC. | In Lieu of Form CMS-2552-10   |
|--|---------------------------------|---|
| HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provi der CCN: 14-0210          | Peri od: Worksheet S-3<br>From 04/01/2022 Part V<br>To 03/31/2023 Date/Time Prepared: |

|        |   | o 03/31/2023   | Date/Time Prep<br>9/11/2023 9:10 |        |  |  |  |  |  |
|--------|---|----------------|----------------------------------|--------|--|--|--|--|--|
|        | Cost Center Description                               | Contract Labor | Benefit Cost                     |        |  |  |  |  |  |
|        |   | 1. 00          | 2. 00                            |        |  |  |  |  |  |
|        | PART V - Contract Labor and Benefit Cost              |                |                                  |        |  |  |  |  |  |
|        | Hospital and Hospital-Based Component Identification: |                |                                  |        |  |  |  |  |  |
| 1.00   | Total facility's contract labor and benefit cost      | 3, 133, 965    | 5, 115, 691                      | 1. 00  |  |  |  |  |  |
| 2.00   | Hospi tal   | 2, 685, 550    | 3, 881, 476                      | 2.00   |  |  |  |  |  |
| 3.00   | SUBPROVI DER - I PF                                   | 448, 415       | 694, 513                         | 3.00   |  |  |  |  |  |
| 4.00   | SUBPROVI DER - I RF                                   |                |                                  | 4.00   |  |  |  |  |  |
| 5.00   | Subprovi der - (Other)                                | 0              | 0                                | 5.00   |  |  |  |  |  |
| 6.00   | Swi ng Beds - SNF                                     | 0              | 0                                | 6.00   |  |  |  |  |  |
| 7.00   | Swing Beds - NF                                       | 0              | 0                                | 7.00   |  |  |  |  |  |
| 8.00   | SKILLED NURSING FACILITY                              |                |                                  | 8. 00  |  |  |  |  |  |
| 9.00   | NURSING FACILITY                                      |                |                                  | 9. 00  |  |  |  |  |  |
| 10. 00 | OTHER LONG TERM CARE I                                |                |                                  | 10.00  |  |  |  |  |  |
| 11. 00 | Hospi tal -Based HHA                                  |                |                                  | 11. 00 |  |  |  |  |  |
| 12.00  | AMBULATORY SURGICAL CENTER (D. P.) I                  |                |                                  | 12.00  |  |  |  |  |  |
| 13. 00 | Hospi tal -Based Hospi ce                             |                |                                  | 13.00  |  |  |  |  |  |
| 14. 00 | Hospital-Based Health Clinic RHC                      | 0              | 310, 287                         | 14.00  |  |  |  |  |  |
| 14. 01 | Hospital-Based Health Clinic RHC 1                    | 0              | 229, 415                         | 14. 01 |  |  |  |  |  |
| 15. 00 | Hospital-Based Health Clinic FQHC                     |                |                                  | 15.00  |  |  |  |  |  |
| 16. 00 | Hospi tal -Based-CMHC                                 |                |                                  | 16.00  |  |  |  |  |  |
| 17. 00 | RENAL DIALYSIS I                                      |                |                                  | 17.00  |  |  |  |  |  |
| 18. 00 | Other   | 0              | 0                                | 18.00  |  |  |  |  |  |

| 1.00 \$                                       | Clinic Address and Identification   |                                 |                               | CN: 14-0210<br>CCN: 14-3473 | Peri od:<br>From 04/01/2022<br>To 03/31/2023 | Worksheet S-8 Date/Time Pre |              |
|---|---|---------------------------------|-------------------------------|-----------------------------|--|-----------------------------|--------------|
| 2.00  |   |                                 |                               |                             |  |                             |              |
| 2.00  |   |                                 |                               |                             | RHC I  | 9/11/2023 9:1<br>Cost       | io aiii      |
| 2.00  |   |                                 |                               |                             |  |                             |              |
| 2.00  |   |                                 |                               |                             | 1.   | 00                          | +            |
| 2.00  |   |                                 |                               |                             | 1007 USE ROUTE                               | 45                          | 1.00         |
|   |   |                                 |                               | ty                          | State  | ZIP Code                    |              |
|   | 011 011 718 011 0   |                                 |                               | 00                          | 2. 00  | 3.00                        | 0.00         |
| 3. 00   I                                     | City, State, ZIP Code, County   | ļ!                              | ELDORADO                      |                             | I L  | 62930                       | 2.00         |
| 3. 00 I                                       |   |                                 |                               |                             |  | 1.00                        | +            |
|   | HOSPITAL-BASED FQHCs ONLY: Designation - Ente   | r "R" for rura                  | l or "U" for ι                |                             |  | 0                           | 3.00         |
|   |   |                                 |                               |                             | nt Award<br>1.00                             | Date<br>2.00                | 1            |
| ç   | Source of Federal Funds   |                                 |                               | 1                           | 1.00   | 2.00                        | _            |
|   | Community Health Center (Section 330(d), PHS  | Act)                            |                               |                             |  |                             | 4.00         |
|   | Migrant Health Center (Section 329(d), PHS Ac   |                                 |                               |                             |  |                             | 5. 0         |
|   | Health Services for the Homeless (Section 340<br>Appalachian Regional Commission  | (d), PHS Act)                   |                               |                             |  |                             | 6. 0<br>7. 0 |
|   | Look-Alikes   |                                 |                               |                             |  |                             | 8.0          |
|   | OTHER (SPECIFY)   |                                 |                               |                             |  |                             | 9. 0         |
|   |   |                                 |                               |                             | 1.00   | 0.00                        |              |
| 0.00  | Does this facility operate as other than a ho   | snital_hased R                  | HC or FOHC2 Fr                | nter "V" for                | 1. 00<br>N                                   | 2.00                        | 10.0         |
| 3   | yes or "N" for no in column 1. If yes, indica<br>2.(Enter in subscripts of line 11 the type of<br>hours.)   | te number of o                  | ther operation                | ns in column                |  |                             | 7 10.0       |
|   |   | Sund                            | day                           | N                           | londay                                       | Tuesday                     |              |
|   |   | from                            | to                            | from                        | to   | from                        |              |
| E   | Facility hours of operations (1)  | 1.00                            | 2.00                          | 3.00                        | 4. 00  | 5. 00                       | _            |
|   | CLINIC  |                                 |                               | 08: 00                      | 20: 00                                       | 08: 00                      | 11.0         |
|   |   |                                 |                               |                             |  |                             |              |
| 2 00 1  | llave you received an engroval for an exception   | n to the produ                  | ativity atand                 | - mdO                       | 1. 00<br>N                                   | 2. 00                       | 12. 0        |
| 3. 00 . 3. 3. 3. 3. 3. 3. 3. 3. 3. 3. 3. 3. 3 | Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report. numbers below.   | in CMS Pub. 19<br>mn 1. If yes, | 00-04, chapter enter in colum | 9, section<br>nn 2 the      | N N  | 0                           | 13.0         |
|   | Hamber's berow.   |                                 |                               | Provi                       | ider name                                    | CCN                         |              |
|   |   |                                 |                               |                             | 1. 00  | 2. 00                       | <b>+</b>     |
| 14.00 [1                                      | RHC/FQHC name, CCN  | Y/N                             | V                             | XVIII                       | XIX  | Total Visits                | 14. 0        |
|   |   | 1.00                            | 2.00                          | 3.00                        | 4. 00  | 5. 00                       |              |
|   | Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the |                                 |                               |                             |  |                             | 15. 00       |
|   | number of total visits for this provider. (see instructions)  |                                 |                               |                             |  |                             |              |
|   | (see Instructions)  |                                 | Cou                           | L<br>unty                   |  |                             |              |
|   |   |                                 | 4.                            | 00                          |  |                             |              |
| 2.00  | City, State, ZIP Code, County   |                                 | SALI NE                       |                             |  |                             | 2. 0         |
|   |   | Tuesday<br>to                   | Wedn<br>from                  | esday<br>to                 | Thur<br>from                                 | sday<br>to                  |              |
|   |   | 6.00                            | 7.00                          | 8.00                        | 9.00   | 10.00                       |              |
|   | Facility hours of operations (1)  | 2. 30                           |                               | 3.00                        |  |                             |              |

| Health Financial Systems HA              | ARRISBURG MEDICA | AL CENTER, INC |              | In Lie          | u of Form CMS- | 2552-10 |
|--|------------------|----------------|--------------|-----------------|----------------|---------|
| HOSPITAL-BASED RHC/FQHC STATISTICAL DATA |                  | Provi der C    | CN: 14-0210  | Peri od:        | Worksheet S-8  |         |
|  |                  |                |              | From 04/01/2022 |                |         |
|  |                  | Component      | CCN: 14-3473 | To 03/31/2023   |                |         |
|  |                  | ·              |              |                 | 9/11/2023 9: 1 | 6 am    |
|  |                  |                |              | RHC I           | Cost           |         |
|  | Fri              | day            | Sa           | turday          |                |         |
|  | from             | to             | from         | to              |                |         |
|  | 11. 00           | 12.00          | 13. 00       | 14. 00          |                |         |
| Facility hours of operations (1)         |                  |                |              |                 |                |         |
| 11. 00 CLINIC                            | 08: 00           | 16: 50         |              |                 |                | 11.00   |

| alth Financial Systems<br>OSPITAL-BASED RHC/FQHC STATISTICA   |  | SBURG MEDICA                  | AL CENTER, INC.  Provider C      |                        | Peri od:                         | worksheet        |      | 552-   |
|---|--|-------------------------------|----------------------------------|------------------------|----------------------------------|------------------|------|--------|
| STIME BISES MIST GIO STATISTICA   |  |                               |                                  | CCN: 14-8590           | From 04/01/2022<br>To 03/31/2023 | Date/Time        | Prep |        |
|   |  |                               |                                  |                        | RHC II                           | 9/11/2023<br>Cos |      | alli   |
|   |  |                               |                                  |                        |                                  |                  |      |        |
| 01:   |  |                               |                                  |                        | 1.                               | 00               |      |        |
| Clinic Address and Identific<br>Street  | ation  |                               |                                  |                        | 3106 OUTER DRI                   | VF               |      | 1.     |
| 00   011 001  |  |                               | Ci                               | ty                     | State                            | ZIP Code         |      |        |
|   |  |                               |                                  | 00                     | 2. 00                            | 3. 00            |      |        |
| OO City, State, ZIP Code, Coun  | ty   |                               | MARI ON                          |                        |                                  | 62959            |      | 2.     |
|   |  |                               |                                  |                        |                                  | 1.00             |      |        |
| 00 HOSPITAL-BASED FQHCs ONLY:   | Designation - Enter '                        | 'R" for rura                  | l or "U" for u                   | rban                   |                                  |                  | 0    | 3      |
|   |  |                               |                                  |                        | nt Award                         | Date             |      |        |
| Source of Federal Funds   |  |                               |                                  |                        | 1. 00                            | 2.00             |      |        |
| Community Health Center (See  | ction 330(d), PHS Act                        | t)                            |                                  |                        |                                  |                  |      | 4      |
| 00 Migrant Health Center (Sect  |  |                               |                                  |                        |                                  |                  |      | 5      |
| Health Services for the Home  |  | ), PHS Act)                   |                                  |                        |                                  |                  |      | 6      |
| OO Appalachian Regional Commiss<br>OO Look-Alikes   | 110 16                                       |                               |                                  |                        |                                  |                  |      | 7<br>8 |
| O OTHER (SPECIFY)   |  |                               |                                  |                        |                                  |                  |      | 9      |
|   |  |                               |                                  |                        |                                  |                  |      |        |
| 00 Does this facility operate   | as other than a besti                        | ital based Pi                 | UC or EOUC2 En                   | tor "V" for            | 1. 00<br>N                       | 2. 00            |      | 10     |
| yes or "N" for no in column<br>2. (Enter in subscripts of I<br>hours.)  | 1. If yes, indicate                          | number of o                   | ther operation                   | s in column            | IN                               |                  |      | 10     |
| , most or y   |  | Suno                          | day                              | N                      | londay                           | Tuesday          |      |        |
|   |  | from                          | to                               | from                   | to                               | from             |      |        |
| Facility hours of operations  | (1)  | 1. 00                         | 2. 00                            | 3.00                   | 4.00                             | 5. 00            |      |        |
| OO CLINIC   | (1)  |                               |                                  | 07: 30                 | 16: 30                           | 07: 30           |      | 11     |
|   |  |                               |                                  |                        |                                  |                  |      |        |
| 00 Have you received an approve   | al for an exception :                        | to the produc                 | ctivity standa                   | rd2                    | 1. 00                            | 2.00             |      | 12     |
| 100 Is this a consolidated cost 30.8? Enter "Y" for yes or number of providers included numbers below.                      | report as defined in<br>"N" for no in column | n CMS Pub. 10<br>1. If yes, 6 | 00-04, chapter<br>enter in colum | 9, section<br>in 2 the | N                                |                  |      | 13     |
| Transer's berow.  |  |                               |                                  | Provi                  | ider name                        | CCN              |      |        |
| 20 1000 (5000   |  |                               |                                  |                        | 1. 00                            | 2. 00            |      |        |
| 00 RHC/FQHC name, CCN   |  | Y/N                           | V                                | XVIII                  | XIX                              | Total Visi       |      | 14     |
|   |  | 1.00                          | 2.00                             | 3.00                   | 4. 00                            | 5. 00            |      |        |
| ON Have you provided all or sul<br>GME cost? Enter "Y" for yes<br>column 1. If yes, enter in<br>4 the number of program vis | or "N" for no in columns 2, 3 and            |                               |                                  |                        |                                  |                  |      | 15     |
| Intern & Residents for title XIX, as applicable. Enter in number of total visits for (see instructions)                     | n column 5 the                               |                               |                                  |                        |                                  |                  |      |        |
|   |  |                               |                                  | nty                    |                                  |                  |      |        |
| 0 0 1 0 1 7 0 1 0   |  |                               |                                  | 00                     |                                  |                  |      |        |
| ILI LLITV STATA ZID COMA COLIN  | ξy   | Tuesday                       | WILLIAMSON<br>Wedne              | esday                  | Thur                             | sday             |      | 2      |
| 00   City, State, ZIP Code, Coun  |  | lucsuay                       | weare                            | Jauay                  |                                  |                  | _    |        |
| or orty, state, zir code, codir   |  | to                            | from                             | to                     | from                             | to               |      |        |
| OO   City, State, ZIP Code, Coun  |  | to<br>6.00                    | from<br>7.00                     | to<br>8.00             | from<br>9.00                     | 10. 00           |      |        |

| Health Financial Systems HA              | ARRISBURG MEDICA | AL CENTER, INC. |              | In Lie          | u of Form CMS- | 2552-10 |
|--|------------------|-----------------|--------------|-----------------|----------------|---------|
| HOSPITAL-BASED RHC/FQHC STATISTICAL DATA |                  | Provi der C     | CN: 14-0210  | Peri od:        | Worksheet S-8  |         |
|  |                  |                 |              | From 04/01/2022 |                |         |
|  |                  | Component       | CCN: 14-8590 | To 03/31/2023   | Date/Time Pre  | pared:  |
|  |                  | ,               |              |                 | 9/11/2023 9:1  | 6 am    |
|  |                  |                 |              | RHC II          | Cost           |         |
|  | Fri              | day             | Sa           | turday          |                |         |
|  | from             | to              | from         | to              |                |         |
|  | 11. 00           | 12.00           | 13. 00       | 14. 00          |                |         |
| Facility hours of operations (1)         |                  |                 |              |                 |                |         |
| 11. 00 CLINIC                            | 07: 30           | 16: 30          |              |                 |                | 11.00   |

| )SPI T   | Financial Systems HARRISBURG MEDICAL CENTER, AL UNCOMPENSATED AND INDIGENT CARE DATA Provide  | der CCN: 14-0210  | Peri od:   | ieu of Form CMS-<br>Worksheet S-1   |  |
|--|---|---|--|---|--|
| JSPII  | AL UNCOMPENSATED AND INDIGENT CARE DATA   | del CCN. 14-0210  | From 04/01/20  |   | 10   |
|  |   |   | To 03/31/20  |   | epared<br>16 am  |
|  |   |   |  | 1. 00   |  |
|  | Uncompensated and indigent care cost computation  |   |  |   |  |
| 00   | Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided   | by line 202 colu  | ımn 8)   | 0. 445708   | 1.   |
| 00   | Medicaid (see instructions for each line)   |   |  | F 040 711   |  |
| 00   | Net revenue from Medicaid   |   |  | 5, 848, 711<br>Y  | 1 2.<br>3.   |
| 00   | Did you receive DSH or supplemental payments from Medicaid?  If line 3 is yes, does line 2 include all DSH and/or supplemental pa   | vmants from Madi  | cai d2   | Y   | 4.   |
| 00   | If line 4 is no, then enter DSH and/or supplemental payments from Me  | -   | cara:  | , o   |  |
| 00   | Medicaid charges  |   |  | 34, 928, 606  |  |
| 00   | Medicaid cost (line 1 times line 6)   |   |  | 15, 567, 959  |  |
| 00   | Difference between net revenue and costs for Medicaid program (line   | 7 minus sum of I  | ines 2 and 5; it   | 9, 719, 248   | 8.   |
|  | < zero then enter zero)   |   |  |   |  |
|  | Children's Health Insurance Program (CHIP) (see instructions for each   | h line)   |  |   |  |
| 00   | Net revenue from stand-alone CHIP   |   |  | 6, 437  |  |
| . 00   | Stand-alone CHIP charges  |   |  | 28, 579   |  |
| . 00   | Stand-alone CHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone CHIP (line  | 12, 738<br>6, 301   |  |   |  |
| . 00   | enter zero)   | TI IIII IIIGS TITIC 7,  | TT \ Zero then   | 0, 301  | '  '-  |
|  | Other state or local government indigent care program (see instructi  | ons for each lir  | ne)  | _   |  |
| . 00   | Net revenue from state or local indigent care program (Not included   | on lines 2, 5 or  | 9)   | C   | 13.  |
| . 00   | Charges for patients covered under state or local indigent care prog  | ram (Not include  | ed in lines 6 or   | 0   | 14.  |
|  | [10]  |   |  | _   |  |
| . 00   | State or local indigent care program cost (line 1 times line 14)  | <b>71</b>   | . 45   | 0   |  |
| . 00   | Difference between net revenue and costs for state or local indigent  |   |  |   |  |
|  | 12: if < zoro then enter zoro)  | care program (i   | The 15 minus iii   | ie  | 16.  |
|  | 13; if < zero then enter zero)  Grants, donations and total unreimbursed cost for Medicaid. CHLP and  |   |  |   | 16.  |
|  | 13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line)   |   |  |   | 16.  |
| 7. 00  | Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line) Private grants, donations, or endowment income restricted to funding   | state/local ind   |  | rams (see   | 17.  |
| 3. 00  | Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line)  Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit   | state/local inc   | ligent care progi  | rams (see   | ) 17.<br>) 18.   |
| 3. 00  | Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line)  Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local indi   | state/local inc   | ligent care progi  | rams (see   | ) 17.<br>) 18.   |
| 3. 00  | Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line)  Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit   | state/local inc<br>charity care<br>al operations<br>gent care progra  | ligent care progr  | 0 0 0 0 9, 725, 549   | 19.  |
| 3. 00  | Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line)  Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local indi   | state/local inc   | digent care programs (sum of lines                           | rams (see   | ) 17.<br>) 18.<br>) 19.  |
| . 00   | Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line)  Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local indi   | state/local inc charity care al operations gent care progra   | digent care programs (sum of lines                           | o   | ) 17.<br>) 18.<br>) 19.  |
| . 00   | Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line)  Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local indi 8, 12 and 16)  Uncompensated Care (see instructions for each line)  | state/local incomplete charity care all operations gent care programmed uninsure patients 1.00  | d Insured patients 2.00                                      | Total (col. 1 + col. 2) 3.00  | ) 17.<br>) 18.<br>) 19.  |
| s. 00<br>9. 00   | Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line)  Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local indi 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facility  | state/local incomplete charity care all operations gent care programmed uninsure patients 1.00  | d Insured patients 2.00                                      | 7 (see ) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0  | ) 17.<br>) 18.<br>) 19.  |
| 3. 00  | Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line)  Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local indi 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facility (see instructions)   | state/local inconcharity care al operations gent care progra  Uninsure patients 1.00  | d Insured patients 2.00                                      | Total (col. 1 + col. 2) 3.00  | 17.<br>18.<br>19.<br>19.   |
| 3. 00<br>9. 00<br>0. 00  | Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line)  Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local india, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facility (see instructions)  Cost of patients approved for charity care and uninsured discounts (  | state/local inconcharity care al operations gent care progra  Uninsure patients 1.00  | d Insured patients 2.00                                      | Total (col. 1 + col. 2) 3.00  | 17.<br>18.<br>19.<br>19.   |
| 3. 00<br>9. 00<br>0. 00  | Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line)  Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local indi 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facility (see instructions)   | state/local inc charity care al operations gent care progra  Uninsure patients 1.00  1,408, see 627,  | d Insured patients 2.00                                      | Total (col. 1 + col. 2) 3.00  | ) 17.<br>) 18.<br>) 19.<br>33 20.  |
| 3. 00<br>9. 00<br>0. 00  | Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line)  Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local indi 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facility (see instructions)  Cost of patients approved for charity care and uninsured discounts (instructions)  | state/local inc charity care al operations gent care progra  Uninsure patients 1.00  1,408, see 627,  | d Insured patients 2.00  046 21,1                            | Total (col. 1 + col. 2) 3.00  17 1,429,193  | ) 17.<br>) 18.<br>) 19.<br>3 20.   |
| 0.00   | Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line)  Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local indi 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facility (see instructions)  Cost of patients approved for charity care and uninsured discounts (instructions)  Payments received from patients for amounts previously written off a charity care   | state/local incontrol charity care all operations gent care progrations gent care progrations.  Uninsure patients 1.00  1,408, see 627, s   | d Insured patients 2.00  046 21,1                            | Total (col. 1 + col. 2) 3.00  17 1,429,193 17 648,724   | 3 20.<br>1 21.   |
| . 00   | Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line)  Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local india, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facility (see instructions)  Cost of patients approved for charity care and uninsured discounts (instructions)  Payments received from patients for amounts previously written off a charity care  | state/local incontrol charity care all operations gent care progrations gent care progrations.  Uninsure patients 1.00  1,408, see 627, s   | d Insured patients 2.00  046 21,1                            | Total (col. 1 + col. 2) 3.00  47  | 3 20.<br>17.<br>18.<br>19.   |
| 0.00   | Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line)  Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local india, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facility (see instructions)  Cost of patients approved for charity care and uninsured discounts (instructions)  Payments received from patients for amounts previously written off a charity care  Cost of charity care (line 21 minus line 22)  | state/local inconcharity care al operations gent care progra  Uninsure patients 1.00  1,408, see 627, s 627,  | d Insured patients 2.00  046 21,1  577 21,1                  | Total (col. 1 + col. 2) 3.00  47  | 3 20.<br>1 21.<br>2 22.<br>1 23.   |
| 0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00  | Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line)  Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local indi 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facility (see instructions)  Cost of patients approved for charity care and uninsured discounts (instructions)  Payments received from patients for amounts previously written off a charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient day   | state/local inconcharity care all operations gent care progrations gent care progrations.  Uninsure patients 1.00  1,408, 627, s 627, s beyond a length   | d Insured patients 2.00  046 21,1  577 21,1                  | Total (col. 1 + col. 2) 3.00  47  | 3 20.<br>1 21.   |
| 3. 00<br>2. 00<br>3. 00<br>3. 00<br>4. 00  | Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line)  Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local india, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facility (see instructions)  Cost of patients approved for charity care and uninsured discounts (instructions)  Payments received from patients for amounts previously written off a charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient day imposed on patients covered by Medicaid or other indigent care prograff line 24 is yes, enter the charges for patient days beyond the indigent care programments.  | state/local incomplete charity care all operations gent care progrations gent care progrations and the state of the state | ms (sum of lines described patients 2.00 046 21,1 0 577 21,1 | Total (col. 1 + col. 2) 3.00  47  | 3 20.<br>17.<br>18.<br>19.<br>19.<br>20.<br>21.<br>22.<br>24.                      |
| 33.00<br>3.00<br>3.00<br>3.00<br>3.00<br>4.00<br>4.00  | Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line)  Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local indi 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facility (see instructions)  Cost of patients approved for charity care and uninsured discounts (instructions)  Payments received from patients for amounts previously written off a charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient day imposed on patients covered by Medicaid or other indigent care progriffline 24 is yes, enter the charges for patient days beyond the indistay limit   | state/local incontrol charity care all operations gent care progrations gent care progrations.  Uninsure patients 1.00  1,408, see 627, s 627, s s beyond a lengtam? igent care progrations.  | ms (sum of lines described patients 2.00 046 21,1 0 577 21,1 | Total (col. 1 + col. 2) 3.00  47  | 3 20.<br>1 21.<br>2 22.<br>2 24.<br>2 25.  |
| 3. 00<br>3. 00<br>3. 00<br>3. 00<br>4. 00<br>4. 00<br>5. 00<br>5. 00                                     | Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line)  Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local india, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facility (see instructions)  Cost of patients approved for charity care and uninsured discounts (instructions)  Payments received from patients for amounts previously written off a charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient day imposed on patients covered by Medicaid or other indigent care progrif line 24 is yes, enter the charges for patient days beyond the indistaly limit  Total bad debt expense for the entire hospital complex (see instructions)  | state/local inconcharity care all operations gent care progrations gent care progrations.  Uninsure patients 1.00  1,408, see 627, s 627, s beyond a lengtam? igent care progrations)   | ms (sum of lines described patients 2.00 046 21,1 0 577 21,1 | Total (col. 1 + col. 2) 3.00  47  | 3 20. 17. 22. 14. 23. 24. 25. 22. 26.  |
| 3. 00<br>0. 00<br>0. 00<br>1. 00<br>2. 00<br>1. 00<br>5. 00<br>7. 00                                     | Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line)  Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local india, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facility (see instructions)  Cost of patients approved for charity care and uninsured discounts (instructions)  Payments received from patients for amounts previously written off a charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient day imposed on patients covered by Medicaid or other indigent care progrately limit  Total bad debt expense for the entire hospital complex (see instruct Medicare reimbursable bad debts for the entire hospital complex (see   | state/local inconcharity care all operations gent care progrations gent care progrations.  Uninsure patients 1.00  1,408, see 627, s 627, s s beyond a lengtam? i gent care progrations) i nstructions)   | ms (sum of lines described patients 2.00 046 21,1 0 577 21,1 | Total (col. 1 + col. 2) 3.00  47  | 3 20.<br>17.<br>18.<br>19.<br>21.<br>22.<br>24.<br>24.<br>25.<br>26.<br>26.<br>27. |
| 33. 00<br>9. 00<br>1. 00<br>1. 00<br>2. 00<br>4. 00<br>55. 00<br>77. 00<br>77. 01                        | Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line)  Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local india, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facility (see instructions)  Cost of patients approved for charity care and uninsured discounts (instructions)  Payments received from patients for amounts previously written off a charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient day imposed on patients covered by Medicaid or other indigent care progrately limit  Total bad debt expense for the entire hospital complex (see instruct Medicare reimbursable bad debts for the entire hospital complex (see instruct Medicare allowable bad debts for the entire hospital complex (see instruct Medicare allowable bad debts for the entire hospital complex (see instruct Medicare allowable bad debts for the entire hospital complex (see instruct Medicare allowable bad debts for the entire hospital complex (see instruct Medicare allowable bad debts for the entire hospital complex (see instruct Medicare allowable bad debts for the entire hospital complex (see instruct Medicare allowable bad debts for the entire hospital complex (see instruct Medicare allowable bad debts for the entire hospital complex (see instruct Medicare allowable bad debts for the entire hospital complex (see instruct Medicare allowable bad debts for the entire hospital complex (see | state/local inconcharity care all operations gent care progrations gent care progrations.  Uninsure patients 1.00  1,408, see 627, s 627, s s beyond a lengtam? i gent care progrations) i nstructions)   | ms (sum of lines described patients 2.00 046 21,1 0 577 21,1 | Total (col. 1 + col. 2) 3.00  17  | 3 20.<br>1 21.<br>2 22.<br>2 24.<br>2 25.<br>2 26.<br>2 27.<br>3 27.               |
| 33. 00<br>9. 00<br>1. 00<br>1. 00<br>4. 00<br>5. 00<br>7. 00<br>7. 01<br>33. 00                          | Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line)  Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local india, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facility (see instructions)  Cost of patients approved for charity care and uninsured discounts (instructions)  Payments received from patients for amounts previously written off a charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient day imposed on patients covered by Medicaid or other indigent care prografiline 24 is yes, enter the charges for patient days beyond the indistal limit total bad debt expense for the entire hospital complex (see instruct Medicare reimbursable bad debts for the entire hospital complex (see Medicare allowable bad debts for the entire hospital complex (see in Non-Medicare bad debt expense (see instructions)  | state/local incomplete charity care all operations gent care progrations gent care progrations.  Uninsure patients 1.00  1,408, see 627, see 627, see 627, see incomplete care program? i gent care program? i ons) i instructions)   | d Insured patients 2.00  046 21,1 577 21,1 ch of stay limit  | Total (col. 1 + col. 2) 3.00  17 1, 429, 193  17 648, 724  1.00  N  2, 281, 942 275, 616 424, 024 1, 857, 918 | 3 20. 22. 24. 27. 25. 6 27. 4 27. 38 28.   |
| 7. 00<br>8. 00<br>9. 00<br>1. 00<br>1. 00<br>2. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 01<br>8. 00<br>9. 00 | Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line)  Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local india, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facility (see instructions)  Cost of patients approved for charity care and uninsured discounts (instructions)  Payments received from patients for amounts previously written off a charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient day imposed on patients covered by Medicaid or other indigent care progrately limit  Total bad debt expense for the entire hospital complex (see instruct Medicare reimbursable bad debts for the entire hospital complex (see instruct Medicare allowable bad debts for the entire hospital complex (see instruct Medicare allowable bad debts for the entire hospital complex (see instruct Medicare allowable bad debts for the entire hospital complex (see instruct Medicare allowable bad debts for the entire hospital complex (see instruct Medicare allowable bad debts for the entire hospital complex (see instruct Medicare allowable bad debts for the entire hospital complex (see instruct Medicare allowable bad debts for the entire hospital complex (see instruct Medicare allowable bad debts for the entire hospital complex (see instruct Medicare allowable bad debts for the entire hospital complex (see instruct Medicare allowable bad debts for the entire hospital complex (see | state/local incomplete charity care all operations gent care progrations gent care progrations.  Uninsure patients 1.00  1,408, see 627, see 627, see 627, see incomplete care program? i gent care program? i ons) i instructions)   | d Insured patients 2.00  046 21,1 577 21,1 ch of stay limit  | Total (col. 1 + col. 2) 3.00  17  | 3 20.<br>1 21.<br>2 22.<br>1 23.<br>2 24.<br>2 26.<br>2 26.<br>2 27.<br>3 29.      |

| Heal th          | Fi nanci | ial Systems HAF  | RRISBURG MEDICAL                       | CENTER, INC. |               | In Lie                         | eu of Form CMS-2               | 2552-10             |
|------------------|----------|--|--|--------------|---------------|--------------------------------|--------------------------------|---------------------|
| RECLAS           | SIFICAT  | ION AND ADJUSTMENTS OF TRIAL BALANCE OF                    | EXPENSES                               | Provi der Co |               | eri od:                        | Worksheet A                    |                     |
|                  |          |  |  |              | F             | rom 04/01/2022<br>o 03/31/2023 | Date/Time Pre<br>9/11/2023 9:1 |                     |
|                  | C        | Cost Center Description                                    | Sal ari es                             | Other        | Total (col. 1 | Recl assi fi cati              |                                | O dill              |
|                  | _        |  |  |              | + col . 2)    | ons (See A-6)                  |                                |                     |
|                  |          |  |  |              |               | , ,                            | (col. 3 +-                     |                     |
|                  |          |  |  |              |               |                                | col . 4)                       |                     |
|                  |          |  | 1. 00                                  | 2. 00        | 3. 00         | 4. 00                          | 5. 00                          |                     |
|                  | GENERAL  | _ SERVICE COST CENTERS                                     |  |              |               |                                |                                |                     |
| 1.00             |          | CAP REL COSTS-BLDG & FLXT                                  |  | 2, 538, 348  | 2, 538, 348   |                                |                                | 1.00                |
| 2.00             |          | CAP REL COSTS-MVBLE EQUIP                                  |  | 0            | 0             | 819, 286                       | 819, 286                       | 2. 00               |
| 3.00             |          | OTHER CAP REL COSTS  |  | 0            |               | 0                              | 0                              | 3. 00               |
| 4.00             |          | MPLOYEE BENEFITS DEPARTMENT                                | 91, 586                                | 5, 260, 665  |               |                                | 5, 352, 251                    | 4. 00               |
| 5. 00            |          | ADMINISTRATIVE & GENERAL                                   | 3, 822, 873                            | 6, 390, 887  |               |                                | 10, 202, 537                   | 5. 00               |
| 7.00             |          | OPERATION OF PLANT   | 386, 872                               | 942, 520     |               |                                |                                | 1                   |
| 8.00             |          | AUNDRY & LINEN SERVICE                                     | 0                                      | 97, 459      |               |                                | 90, 398                        | 1                   |
| 9.00             |          | HOUSEKEEPI NG  | 612, 453                               | 274, 312     |               |                                | 1                              | 1                   |
| 10.00            | 01000 D  |  | 674, 183                               | 277, 005     | 1             |                                | 951, 188                       | 1                   |
| 11.00            |          | CAFETERI A   | 0                                      | 0            | 1             | _                              | 0                              | 11. 00              |
| 13.00            |          | JURSI NG ADMI NI STRATI ON                                 | 325, 435                               | 16, 214      |               |                                | 341, 649                       | 1                   |
| 14. 00           |          | CENTRAL SERVICES & SUPPLY                                  | 286, 741                               | 1, 377, 400  |               |                                | 1                              | ł                   |
| 15. 00           |          | PHARMACY   | 598, 737                               | 1, 931, 049  |               |                                |                                | 15. 00              |
| 16. 00<br>19. 00 |          | MEDICAL RECORDS & LIBRARY                                  | 414, 620                               | 148, 007     |               |                                | 562, 445                       | ł                   |
| 19.00            |          | IONPHYSICIAN ANESTHETISTS ENT ROUTINE SERVICE COST CENTERS | ······································ | 0            | 0             | 414, 739                       | 414, 739                       | 19.00               |
| 30. 00           |          | ADULTS & PEDIATRICS  | 2, 611, 435                            | 2, 543, 498  | 5, 154, 933   | -787                           | 5, 154, 146                    | 30.00               |
| 40. 00           |          | SUBPROVIDER - IPF  | 3, 128, 313                            | 2, 032, 033  |               |                                |                                | 40.00               |
| 40.00            |          | ARY SERVICE COST CENTERS                                   | 3, 120, 313                            | 2,032,033    | 5, 100, 340   | -13                            | 3, 100, 331                    | 40.00               |
| 50. 00           |          | PERATING ROOM  | 769, 928                               | 507, 210     | 1, 277, 138   | -8, 326                        | 1, 268, 812                    | 50.00               |
| 53. 00           |          | NESTHESI OLOGY   | 414, 739                               | 282, 826     |               |                                |                                | •                   |
| 54. 00           |          | RADI OLOGY-DI AGNOSTI C                                    | 811, 541                               | 229, 784     |               |                                |                                | 1                   |
| 54. 01           |          | JLTRASOUND   | 224, 313                               | 99, 704      |               |                                | 324, 017                       | 1                   |
| 54. 02           |          | MAMMOGRAPHY  | 95, 590                                | 75, 278      |               |                                | 170, 868                       |                     |
| 56. 00           |          | RADI OI SOTOPE   | 90, 543                                | 155, 952     |               |                                | 200, 545                       | •                   |
| 57. 00           | 05700 0  |  | 265, 972                               | 166, 509     |               |                                | 432, 481                       | •                   |
| 58. 00           | 1 1      | MAGNETIC RESONANCE IMAGING (MRI)                           | 108, 233                               | 110, 556     |               |                                | 218, 789                       | 1                   |
| 60.00            |          | ABORATORY  | 941, 452                               | 2, 124, 609  |               |                                | 3, 066, 001                    | 1                   |
| 64. 00           |          | NTRAVENOUS THERAPY   | 0                                      | 0            |               |                                | 0                              | 1                   |
| 65.00            |          | RESPI RATORY THERAPY                                       | 557, 593                               | 504, 851     | 1, 062, 444   | -34, 951                       | 1, 027, 493                    | •                   |
| 66.00            |          | PHYSI CAL THERAPY  | 643, 842                               | 17, 275      |               |                                | 432, 935                       | 1                   |
| 67.00            |          | OCCUPATI ONAL THERAPY                                      | 0                                      | 0            | 1             |                                |                                | 1                   |
| 68.00            | 06800 S  | SPEECH PATHOLOGY   | 0                                      | 0            | 0             | 15, 517                        | 15, 517                        | 68. 00              |
| 69.00            | 06900 E  | LECTROCARDI OLOGY  | 87, 671                                | 68, 000      | 155, 671      | 0                              | 155, 671                       | 69. 00              |
| 71.00            | 07100 N  | MEDICAL SUPPLIES CHARGED TO PATIENTS                       | O                                      | 0            | 0             | 1, 281, 304                    | 1, 281, 304                    | 71. 00              |
| 72.00            | 07200 I  | MPL. DEV. CHARGED TO PATIENTS                              | 0                                      | 0            | 0             | 0                              | 0                              | 72. 00              |
| 73.00            | 07300 D  | DRUGS CHARGED TO PATIENTS                                  | 0                                      | 0            | 0             | 2, 494, 480                    | 2, 494, 480                    | 73. 00              |
| 75. 00           |          | ASC (NON-DISTINCT PART)                                    | 846, 174                               | 105, 636     | 951, 810      | 0                              | 951, 810                       | 75. 00              |
| 76.00            |          | FAITH CENTER CHEMOTHERAPY                                  | 111, 317                               | 7, 525       |               |                                | 118, 842                       |                     |
| 76. 97           |          | CARDIAC REHABILITATION                                     | 97, 319                                | 7, 968       | 105, 287      |                                | 105, 287                       |                     |
| 77. 00           |          | ALLOGENEIC HSCT ACQUISITION                                | 0                                      | 0            | 0             | 0                              | 0                              | 77. 00              |
|                  |          | ENT SERVICE COST CENTERS                                   |  |              |               | 1                              |                                |                     |
| 88. 00           |          | RURAL HEALTH CLINIC  | 1, 397, 634                            | 258, 595     |               |                                |                                |                     |
| 88. 01           |          | RURAL HEALTH CLINIC II                                     | 1, 033, 361                            | 624, 495     |               |                                |                                |                     |
| 91. 00           |          | MERGENCY   | 1, 179, 645                            | 3, 332, 280  | 4, 511, 925   | -1, 517                        | 4, 510, 408                    | 1                   |
| 92. 00           |          | DBSERVATION BEDS (NON-DISTINCT PART)                       |  |              |               |                                |                                | 92. 00              |
|                  |          | REIMBURSABLE COST CENTERS                                  |  |              | _             | _                              | _                              |                     |
| 102.00           |          | OPIOID TREATMENT PROGRAM                                   | 0                                      | 0            | 0             | 0                              | 0                              | 102. 00             |
| 110 00           |          | _ PURPOSE COST CENTERS                                     |  | 075 000      | 075 000       | 075 000                        | _                              | 110 00              |
|                  | 1 1      | NTEREST EXPENSE  | 00 (00 115                             | 375, 883     |               |                                | l                              | 113.00              |
| 118. 00          |          | SUBTOTALS (SUM OF LINES 1 through 117)                     | 22, 630, 115                           | 32, 884, 333 | 55, 514, 448  | 14, 983                        | 55, 529, 431                   | J118.00             |
| 100.00           |          | MBURSABLE COST CENTERS                                     | 201 (00                                | /F 000       | 2// /22       | 44 7/0                         | 254.072                        | 102.00              |
|                  |          | PHYSICIANS' PRIVATE OFFICES                                | 301, 609                               | 65, 029      |               | 1                              | l                              | •                   |
|                  |          | MARKETI NG/COMMUNI CATI ON<br>AUXI LI ARY                  | 59, 581<br>51, 420                     | 37, 734      |               |                                |                                |                     |
|                  |          | FOUNDATION   | 51, 430<br>0                           | 1, 059       |               |                                | 52, 489<br>55, 262             |                     |
| 200.00           |          | OTAL (SUM OF LINES 118 through 199)                        | 23, 042, 735                           | 55, 334      |               |                                |                                |                     |
| ∠∪U. UC          | ון וי    | OTAL (SUM OF LINES 118 LITTOUGH 199)                       | 23, 042, 735                           | 33, 043, 489 | 56, 086, 224  | ·I 0                           | J 50, 086, 224                 | <sub> </sub> ∠00.00 |
|                  |          |  |  |              |               |                                |                                |                     |

| Health Financial Systems HARECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (            | ARRISBURG MEDICA         |                                | l. 14 0210 | In Lie          | u of Form CMS-<br>Worksheet A  | 2552-10          |
|---|--------------------------|--------------------------------|------------|-----------------|--------------------------------|------------------|
| RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (                                       | JF EXPENSES              | Provi der CCN                  | 1: 14-0210 | From 04/01/2022 |                                | norod.           |
|   |                          |                                |            | To 03/31/2023   | Date/Time Pre<br>9/11/2023 9:1 |                  |
| Cost Center Description   | Adjustments<br>(See A-8) | Net Expenses<br>For Allocation |            |                 |                                |                  |
|   | 6.00                     | 7. 00                          |            |                 |                                |                  |
| GENERAL SERVICE COST CENTERS  |                          |                                |            |                 |                                |                  |
| 1. 00 00100 CAP REL COSTS-BLDG & FLXT   | 700, 478                 | 3, 027, 332                    |            |                 |                                | 1.00             |
| 2. 00   00200   CAP REL COSTS-MVBLE EQUIP   | 0                        | 819, 286                       |            |                 |                                | 2.00             |
| 3.00   00300 OTHER CAP REL COSTS<br>4.00   00400 EMPLOYEE BENEFITS DEPARTMENT             | -70, 679                 | 5, 281, 572                    |            |                 |                                | 3. 00<br>4. 00   |
| 5. 00   00500   ADMINISTRATIVE & GENERAL  | 2, 174, 334              | 12, 376, 871                   |            |                 |                                | 5. 00            |
| 7. 00   00700   OPERATION OF PLANT  | -115, 186                | 1, 342, 506                    |            |                 |                                | 7. 00            |
| 8. 00 00800 LAUNDRY & LINEN SERVICE   | 0                        | 90, 398                        |            |                 |                                | 8. 00            |
| 9. 00   00900   HOUSEKEEPI NG   | o o                      | 886, 232                       |            |                 |                                | 9. 00            |
| 10. 00   01000   DI ETARY   | -67, 140                 | 884, 048                       |            |                 |                                | 10.00            |
| 11. 00   01100   CAFETERI A   | 0                        | 0                              |            |                 |                                | 11. 00           |
| 13.00 01300 NURSING ADMINISTRATION  | 0                        | 341, 649                       |            |                 |                                | 13. 00           |
| 14.00 01400 CENTRAL SERVICES & SUPPLY   | 0                        | 412, 631                       |            |                 |                                | 14. 00           |
| 15. 00 01500 PHARMACY   | 0                        | 83, 791                        |            |                 |                                | 15. 00           |
| 16.00 01600 MEDICAL RECORDS & LIBRARY   | -24, 539                 | 537, 906                       |            |                 |                                | 16. 00           |
| 19.00 01900 NONPHYSICIAN ANESTHETISTS   | -414, 739                | 0                              |            |                 |                                | 19. 00           |
| INPATIENT ROUTINE SERVICE COST CENTERS  |                          |                                |            |                 |                                |                  |
| 30. 00   03000   ADULTS & PEDI ATRI CS  | -915, 104                | 4, 239, 042                    |            |                 |                                | 30. 00           |
| 40. 00   04000   SUBPROVI DER -   PF  | -1, 127, 456             | 4, 032, 875                    |            |                 |                                | 40. 00           |
| ANCILLARY SERVICE COST CENTERS  | 2/ /25                   | 1 242 107                      |            |                 |                                |                  |
| 50. 00   05000   OPERATI NG ROOM<br>53. 00   05300   ANESTHESI OLOGY                      | -26, 625                 | 1, 242, 187                    |            |                 |                                | 50.00            |
| 54. 00   05400   RADI OLOGY - DI AGNOSTI C  | -176, 338<br>0           | 106, 488<br>1, 031, 157        |            |                 |                                | 53. 00<br>54. 00 |
| 54. 00   05400   RADI OLOGI - DI AGNOSTI C<br>54. 01   05401   ULTRASOUND                 | 0                        | 324, 017                       |            |                 |                                | 54. 00           |
| 54. 02   03440   MAMMOGRAPHY  |                          | 170, 868                       |            |                 |                                | 54. 02           |
| 56. 00   05600   RADI OI SOTOPE   | 0                        | 200, 545                       |            |                 |                                | 56.00            |
| 57. 00   05700   CT   SCAN  | 14                       | 432, 495                       |            |                 |                                | 57. 00           |
| 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)  | 0                        | 218, 789                       |            |                 |                                | 58. 00           |
| 60. 00   06000   LABORATORY   | -3, 190                  | 3, 062, 811                    |            |                 |                                | 60.00            |
| 64.00 06400 INTRAVENOUS THERAPY   | 0                        | О                              |            |                 |                                | 64. 00           |
| 65. 00 06500 RESPIRATORY THERAPY  | -48, 443                 | 979, 050                       |            |                 |                                | 65. 00           |
| 66. 00 06600 PHYSI CAL THERAPY  | 147                      | 433, 082                       |            |                 |                                | 66. 00           |
| 67. 00 06700 OCCUPATI ONAL THERAPY  | 0                        | 212, 665                       |            |                 |                                | 67. 00           |
| 68. 00 06800 SPEECH PATHOLOGY   | 0                        | 15, 517                        |            |                 |                                | 68. 00           |
| 69. 00 06900 ELECTROCARDI OLOGY   | -13, 610                 | 142, 061                       |            |                 |                                | 69. 00           |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS   | 0                        | 1, 281, 304                    |            |                 |                                | 71. 00           |
| 72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS  | 0                        | 0 404 400                      |            |                 |                                | 72. 00           |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS  | 0                        | 2, 494, 480                    |            |                 |                                | 73. 00           |
| 75.00 O7500 ASC (NON-DISTINCT PART) 76.00 O3950 FAITH CENTER CHEMOTHERAPY                 | 100                      | 951, 910                       |            |                 |                                | 75. 00<br>76. 00 |
| 76. 00   03930   PALTH CENTER CHEMOTHERAPT<br>76. 97   07697   CARDI AC REHABI LI TATI ON | 0                        | 118, 842<br>105, 287           |            |                 |                                | 76. 00           |
| 77. 00 07700 ALLOGENEIC HSCT ACQUISITION  | 0                        | 103, 287                       |            |                 |                                | 77. 00           |
| OUTPATIENT SERVICE COST CENTERS   | ١                        | O <sub>I</sub>                 |            |                 |                                | 17.00            |
| 88. 00 08800 RURAL HEALTH CLINIC  | 0                        | 1, 596, 213                    |            |                 |                                | 88. 00           |
| 88. 01   08801   RURAL HEALTH CLINIC II   | l ol                     | 1, 415, 140                    |            |                 |                                | 88. 01           |
| 91. 00   09100   EMERGENCY  | -1, 067, 129             |                                |            |                 |                                | 91. 00           |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)  |                          |                                |            |                 |                                | 92.00            |
| OTHER REIMBURSABLE COST CENTERS   |                          |                                |            |                 |                                |                  |
| 102.00 10200 OPIOID TREATMENT PROGRAM   | 0                        | 0                              |            |                 |                                | 102. 00          |
| SPECIAL PURPOSE COST CENTERS  |                          |                                |            |                 |                                |                  |
| 113. 00 11300 I NTEREST EXPENSE   | 0                        | 0                              |            |                 |                                | 113. 00          |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117)   | -1, 195, 105             | 54, 334, 326                   |            |                 |                                | 118. 00          |
| NONREI MBURSABLE COST CENTERS   |                          |                                |            |                 |                                |                  |
| 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES   | 0                        | 354, 869                       |            |                 |                                | 192. 00          |
| 194. 00 07950 MARKETI NG/COMMUNI CATI ON  | 0                        | 94, 173                        |            |                 |                                | 194. 00          |
| 194. 01 07951 AUXI LI ARY   | 0                        | 52, 489                        |            |                 |                                | 194. 01          |
| 194. 02 07952 FOUNDATION  | 1 105 105                | 55, 262                        |            |                 |                                | 194. 02          |
| 200.00   TOTAL (SUM OF LINES 118 through 199)   | -1, 195, 105             | 54, 891, 119                   |            |                 |                                | 200. 00          |
|   |                          |                                |            |                 |                                |                  |

| Peri od: | Worksheet A-6 | From 04/01/2022 | To 03/31/2023 | Date/Time Prepared: Provider CCN: 14-0210

|        |                                |             |                               |                   | To 03    | 3/31/2023 | Date/Time P 9/11/2023 9 |        |
|--------|--------------------------------|-------------|-------------------------------|-------------------|----------|-----------|-------------------------|--------|
|        |                                | Increases   |                               |                   | <u> </u> |           |                         |        |
|        | Cost Center                    | Li ne #     | Sal ary                       | 0ther             |          |           |                         |        |
|        | 2. 00                          | 3. 00       | 4. 00                         | 5. 00             |          |           |                         |        |
|        | A - INTEREST EXP & BOND AMORT  |             | _1                            |                   |          |           |                         |        |
| 1.00   | CAP REL COSTS-BLDG & FIXT      |             | 0                             | 37 <u>5, 8</u> 83 |          |           |                         | 1. 00  |
|        | B - MME DEPRECIATION           |             | U]                            | 375, 883          |          |           |                         |        |
| 1. 00  | CAP REL COSTS-MVBLE EQUIP      | 2. 00       | 0                             | 806, 874          |          |           |                         | 1.00   |
| 1.00   | O KEE COSTS-WVBEE EQUIF        |             |                               | 806, 874          |          |           |                         | 1.00   |
|        | C - PROPERTY INSURANCE         |             | <u> </u>                      | 000, 074          |          |           |                         |        |
| 1.00   | OTHER CAP REL COSTS            | 3.00        | 0                             | 65, 956           |          |           |                         | 1.00   |
| 2.00   |                                | 0.00        | o                             | 0                 |          |           |                         | 2.00   |
|        | TOTALS                         |             | 0                             | 65, 956           |          |           |                         |        |
|        | D - IMPLANTABLE DEVICES        |             |                               | <del>.</del>      |          |           |                         |        |
| 1.00   | MEDICAL SUPPLIES CHARGED TO    | 71. 00      | 0                             | 7, 620            |          |           |                         | 1.00   |
|        | PATI ENTS                      |             |                               |                   |          |           |                         |        |
|        | 0                              |             | 0                             | 7, 620            |          |           |                         |        |
|        | E - THERAPY                    |             |                               |                   |          |           |                         |        |
| 1.00   | OCCUPATI ONAL THERAPY          | 67. 00      | 207, 108                      | 5, 557            |          |           |                         | 1.00   |
| 2.00   | SPEECH PATHOLOGY               |             | 1 <u>5, 1</u> 12              | 405               |          |           |                         | 2. 00  |
|        | TOTALS                         |             | 222, 220                      | 5, 962            |          |           |                         |        |
| 1 00   | F - CRNA COSTS                 | 10.00       | 44.4.720                      | 0                 |          |           |                         | 1 1 00 |
| 1. 00  | NONPHYSI CI AN ANESTHETI STS   |             | 41 <u>4, 7</u> 39<br>414, 739 | 0                 |          |           |                         | 1.00   |
|        | G - OVERHEAD COSTS             |             | 414, 739                      | U                 |          |           |                         |        |
| 1.00   | CAP REL COSTS-BLDG & FIXT      | 1.00        | 0                             | 165, 953          |          |           |                         | 1.00   |
| 2. 00  | ADMI NI STRATI VE & GENERAL    | 5. 00       | o                             | 66, 438           |          |           |                         | 2.00   |
| 3. 00  | OPERATION OF PLANT             | 7. 00       | o                             | 128, 300          |          |           |                         | 3. 00  |
| 4. 00  |                                | 0.00        | o                             | 0                 |          |           |                         | 4. 00  |
| 5.00   |                                | 0.00        | o                             | 0                 |          |           |                         | 5. 00  |
| 6.00   |                                | 0.00        | o                             | 0                 |          |           |                         | 6. 00  |
| 7.00   |                                | 0.00        | О                             | 0                 |          |           |                         | 7. 00  |
| 8.00   |                                | 0.00        | o                             | 0                 |          |           |                         | 8.00   |
| 9.00   |                                | 0.00        | 0                             | 0                 |          |           |                         | 9. 00  |
| 10.00  |                                | 0.00        | 0                             | 0                 |          |           |                         | 10.00  |
| 11. 00 |                                | 0.00        | 0                             | 0                 |          |           |                         | 11.00  |
| 12. 00 |                                | 0. 00       | 0                             | 0                 |          |           |                         | 12.00  |
| 13. 00 |                                | 0.00        | 0                             | 0                 |          |           |                         | 13.00  |
| 14.00  |                                | 0.00        | 0                             | 0                 |          |           |                         | 14. 00 |
| 15. 00 |                                | 0.00        | 0                             | 0                 |          |           |                         | 15. 00 |
|        | H - DRUGS CHARGED TO PATIENTS  |             | U]                            | 360, 691          |          |           |                         |        |
| 1. 00  | DRUGS CHARGED TO PATTENTS      | 73. 00      | 598, 737                      | 1, 895, 743       |          |           |                         | 1.00   |
| 2. 00  | DROGS CHARGED TO FATTERTS      | 0.00        | 370, 737                      | 0                 |          |           |                         | 2. 00  |
| 3. 00  |                                | 0.00        | o                             | Ö                 |          |           |                         | 3. 00  |
| 4. 00  |                                | 0.00        | o                             | Ö                 |          |           |                         | 4. 00  |
| 5. 00  |                                | 0.00        | o                             | 0                 |          |           |                         | 5. 00  |
| 6. 00  |                                | 0.00        | ol                            | 0                 |          |           |                         | 6. 00  |
|        | TOTALS                         |             | 598, 737                      | 1, 895, 743       |          |           |                         |        |
|        | I - MEDICAL SUPPLIES CHARGED T | TO PATIENTS | <u> </u>                      | <u> </u>          |          |           |                         |        |
| 1.00   | MEDICAL SUPPLIES CHARGED TO    | 71. 00      | 0                             | 1, 273, 684       |          |           |                         | 1.00   |
|        | PATI ENTS                      |             |                               |                   |          |           |                         |        |
| 2.00   |                                | 0.00        | 0                             | 0                 |          |           |                         | 2. 00  |
| 3.00   |                                | 0.00        | •                             | 0                 |          |           |                         | 3. 00  |
|        | TOTALS                         |             | 0                             | 1, 273, 684       |          |           |                         |        |
| 500.00 | Grand Total: Increases         |             | 1, 235, 696                   | 4, 792, 413       |          |           |                         | 500.00 |

Health Financial Systems RECLASSIFICATIONS Peri od: Worksheet A-6
From 04/01/2022
To 03/31/2023 Date/Time Prepared: Provider CCN: 14-0210

| 1.00   S   |        |                               |                 |             |                   |                | 0 00/01/2020 | 9/11/2023 9: 16 | am     |
|--|--------|-------------------------------|-----------------|-------------|-------------------|----------------|--------------|-----------------|--------|
| A - INTEREST EXP & BOND ANDRET   113.00  |        |                               | Decreases       |             |                   |                |              |                 |        |
| A - INTEREST EXP & BOND ANORT   113.00   0   375,883   11   1   1.00   0   375,883   11   1   1.00   0   375,883   11   1   1.00   0   375,883   11   1   1.00   0   375,883   11   1   1.00   0   375,883   11   1   1.00   0   366,874   9   0   1.00   10   366,874   9   0   1.00   10   366,874   9   0   1.00   10   366,874   9   0   1.00   10   366,874   9   0   1.00   10   366,874   9   0   12   1.00   10   366,874   9   0   12   1.00   10   1.00   10   1.00   10   1   |        | Cost Center                   | Li ne #         | Sal ary     | 0ther             | Wkst. A-7 Ref. |              |                 |        |
| 1.00   NITEREST EXPENSE   113.00   0   375,883   11   1.00   0   375,883   11   1.00   0   375,883   11   1.00   0   375,883   11   1.00   0   375,883   11   1.00   0   375,883   11   1.00   0   375,883   11   1.00   0   375,883   11   1.00   0   375,883   11   1.00   0   375,883   11   1.00   0   375,883   11   1.00   0   375,883   11   1.00   0   375,883   11   1.00    |        | 6. 00                         | 7. 00           | 8. 00       | 9. 00             | 10.00          |              |                 |        |
| 1.00   S   |        | A - INTEREST EXP & BOND AMORT |                 |             |                   |                |              |                 |        |
| 1.00   CAP REL COSTS - BLOS & FIXT   1.00   0   806, 874   9   1.00   C PROPERTY INSURANCE   1.00   0   0   0.5, 956   12   1.00   12   2.00   10   12   2.00   10   12   2.00   10   12   2.00   10   12   2.00   10   12   2.00   10   12   2.00   10   12   2.00   10   12   2.00   10   12   2.00   10   12   2.00   10   10   12   2.00   10   12   2.00   10   10   12   2.00   10   12   2.00   10   12   2.00   10   12   2.00   10   10   12   2.00   10   12   2.00   10   12   2.00   10   12   2.00   10   12   2.00   10   12   2.00   10   12   2.00   12        | 1.00   | INTEREST EXPENSE              | 1 <u>13.</u> 00 | o           | 37 <u>5, 8</u> 83 | 11             |              |                 | 1.00   |
| 1.00   |        | 0                             |                 | 0           | 375, 883          | 3              |              |                 |        |
| C  |        | B - MME DEPRECIATION          |                 |             |                   |                |              |                 |        |
| C - PROPERTY INSURANCE   | 1.00   | CAP REL COSTS-BLDG & FIXT     | 1.00            | 0           | 806, 874          | 9              |              |                 | 1.00   |
| Depart   Color   Depart   De   |        | 0                             |                 | 0           | 806, 874          | ļ.             |              |                 |        |
| 2.00   |        | C - PROPERTY INSURANCE        |                 |             |                   |                |              |                 |        |
| TOTALS   | 1.00   | ADMINISTRATIVE & GENERAL      | 5. 00           | 0           | 65, 956           | 12             |              |                 | 1.00   |
| TOTALS   | 2.00   |                               | 0.00            | o           | C                 | 12             |              |                 | 2.00   |
| 1.00   |        | TOTALS                        |                 |             | 65, 956           |                |              |                 |        |
| The part    |        | D - IMPLANTABLE DEVICES       |                 | · ·         | ·                 | <u>'</u>       |              |                 |        |
| The part    | 1.00   | OPERATING ROOM                | 50, 00          | 0           | 7, 620            | 0              |              |                 | 1.00   |
| E - THERAPY  1.00 PYSI CAL THERAPY  0.00 0.00 0.00 0.00 0.00 0.00 0.00 0   |        |                               |                 |             |                   |                |              |                 |        |
| 1.00   |        | F - THERAPY                   |                 | -,          |                   | 1              |              |                 |        |
| 1.00   | 1.00   |                               | 66, 00          | 222, 220    | 5. 962            | 0              |              |                 | 1. 00  |
| TOTALS   |        |                               |                 | 0           | •                 |                |              |                 |        |
| The content of the    | 2.00   | TOTALS — — — —                | <del></del>     | 222 220     |                   |                |              |                 | 2.00   |
| 1.00   |        |                               |                 | 222, 220    | 0, 702            | -              |              |                 |        |
| C   ADMIN IN STRATI VE & GENERAL   S. 00   0   11, 705   10   1. 00  | 1 00   |                               | 53.00           | A1A 730     |                   | 0              |              |                 | 1 00   |
| C - OVERHEAD COSTS   1.00   ADMINISTRATI VE & GENERAL   5.00   0   11,705   10   1.00   2.00   ADMINISTRATI VE & GENERAL   5.00   0   11,705   10   0   2.00   3.00   HOUSEKEEPI NG   9.00   0   5.33   0   3.00   4.00   CENTRAL SERVI CES & SUPPLY   14.00   0   13,167   0   4.00   0   0   0   0   0   0   0   0   0   | 1.00   | 0                             | 33.00           |             | }                 | <del></del>    |              |                 | 1.00   |
| 1.00   |        | G - OVERHEAD COSTS            |                 | 717, 737    |                   | 1              |              |                 |        |
| 2. 00 LAUNDRY & LINEN SERVICE  | 1 00   |                               | 5.00            | ٥           | 11 705            | 10             |              |                 | 1 00   |
| 3.00 HOUSEKEEPING 9.00 0 5333 0 3.00 4.00 CENTRAL SERVICES & SUPPLY 14.00 0 13,167 0 4.00 6.00 KEDICAL RECORDS & LIBRARY 16.00 0 182 0 0 5.00 6.00 SUBPROVIDER - IPF 40.00 0 155 0 6.00 8.00 RADIOLOGY-DIAGNOSTIC 54.00 0 10,168 0 7.00 9.00 LABORATORY 60.00 0 60 0 9.00 11.00 RURAL HEALTH CLINIC 1 88.00 0 60,016 0 10.00 11.00 RURAL HEALTH CLINIC 1 88.01 0 242,716 0 11.00 12.00 EMERGENCY 91.00 0 11,769 0 12.00 14.00 HAYSELTING/COMMUNICATION 194.00 0 3.142 0 14.00 15.00 DAMERITING/COMMUNICATION 194.00 0 360,691 1.00 RURAL HEALTH CS 30.00 0 598,737 1,847,258 0 1.00 2.00 ADULTS & PEDIATRICS 30.00 0 787 0 2.00 3.00 OPERATING ROOM 50.00 0 14.769 0 5.00 0.00 RADIOLOGY-DIAGNOSTIC 550.00 0 14.00 0.00 RADIOLOGY-DIAGNOSTIC 550.00 0 150.00 0.00 RESPIRATORY 1ERRAPY 65.00 0 14.99 0 5.00 0.00 RADIOLOGY-DIAGNOSTIC 550.00 0 1.00 0.00 RESPIRATORY THERAPY 65.00 0 1.273,684 0 3.00 0 PERSTING ROOM 50.00 0 3.4784 0 3.00 0 PERSTING ROOM 50.00 0 1.273,684 0 3.00 0 PERSTING ROOM 50.00 0 3.4784 0 3.00 0 PERSTING ROOM 50.00 0 3.4784 0 3.00 0 PERSTING ROOM 50.00 0 1.273,684 0 3.00   |        | · ·                           |                 |             |                   |                |              |                 |        |
| 4. 00 CENTRAL SERVICES & SUPPLY 14. 00 0 13, 167 0 5.00 MEDICAL RECORDS & LIBRARY 16. 00 0 182 0 5.00 MEDICAL RECORDS & LIBRARY 16. 00 0 185 0 6. 00 5. 00 0 185 0 0 6. 00 7. 00 0 0 0 0 185 0 0 7. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0   |        | · ·                           |                 | -1          | •                 |                |              |                 |        |
| 5.00 MEDICAL RECORDS & LIBRARY   |        | •                             |                 | 0           |                   |                |              |                 |        |
| 6. 00 SUBPROVIDER - IPF  |        | •                             |                 | 0           |                   |                |              |                 |        |
| 7. 00   OPERATING ROOM   50. 00   0   66   0   7. 00   8. 00   RADI OLOGY-DI AGNOSTI C   54. 00   0   10, 168   0   9. 00   10. 00   RURAL HEALTH CLINI C   88. 00   0   60, 016   0   11. 00   RURAL HEALTH CLINI C   11   88. 01   0   242, 716   0   12. 00   EMERGENCY   91. 00   0   19   0   13. 00   PHYSI CI ANS' PRI VATE OFFI CES   192. 00   0   11, 769   0   15. 00   FOUNDATI ON   194. 00   0   3, 142   0   15. 00   FOUNDATI ON   194. 02   0   72   0   0   0   360, 691    H - DRUGS CHARGED TO PATI ENTS  2. 00   ADULT S & PEDI ATRI CS   30. 00   0   45, 950   0   4. 00   RADI OI SOTOPE   56. 00   0   167   0   5. 00   EMERGENCY   91. 00   0   1, 498   0   1. 00   EMERGENCY   91. 00   0   1, 238, 343   0   2. 00   OPERATI NG ROOM   50. 00   0   1, 498   0   1. 00   EMERGENCY   91. 00   0   1, 238, 343   0   2. 00   OPERATI NG ROOM   50. 00   0   1, 498   0   1. 00   EMERGENCY   91. 00   0   1, 238, 343   0   2. 00   OPERATI NG ROOM   50. 00   0   3, 4784   0   3. 00   OPER |        | •                             |                 | 0           |                   |                |              |                 |        |
| 8. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 10, 168 0 9. 00 LABORATORY 60. 00 0 60 0 9. 00 10. 00 RURAL HEALTH CLINI C 88. 00 0 60, 016 0 11. 00 RURAL HEALTH CLINI C 11 88. 01 0 242, 716 0 11. 00 12. 00 EMERGENCY 91. 00 0 19. 00 12. 00 13. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 0 11, 769 0 12. 00 MARKETI NG/COMMUNI CATI ON 194. 00 0 3. 142 0 14. 00 MARKETI NG/COMMUNI CATI ON 194. 00 0 3. 142 0 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 16. 0 |        |                               |                 | 0           |                   |                |              |                 |        |
| 9. 00 LABORATORY 60. 00 0 60. 00 9. 00 10. 00 RURAL HEALTH CLINIC 88. 00 0 60. 016. 00 110. 00 11. 00 RURAL HEALTH CLINIC II 88. 001 0 242, 716 0 110. 00 12. 00 EMERGENCY 91. 00 0 19 0 12. 00 13. 00 PHYSICIANS' PRIVATE OFFICES 192. 00 0 11, 769 0 13. 00 14. 00 MARKETING/COMMUNICATION 194. 00 0 3, 142 0 14. 00 15. 00 FOUNDATION 194. 02 0 72 0 15. 00 0 10. 00 360, 691 1 15. 00 15. 00 PHARMACY 15. 00 598, 737 1, 847, 258 0 1. 00 2. 00 ADULTS & PEDIATRICS 30. 00 0 787 0 2. 00 3. 00 OPERATING ROOM 50. 00 0 45, 950 0 3. 00 4. 00 RADIO ISOTOPE 56. 00 0 45, 950 0 4. 00 6. 00 EMERGENCY 91. 00 0 1, 498 0 6. 00 10. 00 0 10 0 1, 498 0 1. 00 10. 00 0 1, 498 0 1. 00 10. 00 0 1, 498 0 1. 00 11. 00 CENTRAL SERVICES & SUPPLY 14. 00 0 1, 238, 343 0 1. 00 2. 00 OPERATING ROOM 50. 00 0 1, 238, 343 0 1. 00 2. 00 OPERATING ROOM 50. 00 0 1, 238, 343 0 1. 00 3. 00 OPERATING ROOM 50. 00 0 1, 238, 343 0 1. 00 3. 00 OPERATING ROOM 50. 00 0 1, 238, 343 0 1. 00 3. 00 OPERATING ROOM 50. 00 0 34, 787 0 0 5. 00 3. 00 OPERATING ROOM 50. 00 0 1, 238, 343 0 1. 00 3. 00 OPERATING ROOM 50. 00 0 34, 788 0 0 0 0 0. 00 3. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0   |        |                               |                 | 0           |                   |                |              |                 |        |
| 10.00   RURAL HEALTH CLINIC   88.00   0   60,016   0   10.00     11.00   RURAL HEALTH CLINIC   1   88.01   0   242,716   0     12.00   EMERGENCY   91.00   0   19   0     13.00   PHYSI CI ANS' PRI VATE OFFI CES   192.00   0   11,769   0     14.00   MARKETI NG/COMMUNI CATI ON   194.00   0   3,142   0     15.00   FOUNDATI ON   194.02   0   72   0     0     0     0   360,691     1 - DRUGS CHARGED TO PATI ENTS     1.00   PHARMACY   15.00   598,737   1,847,258   0     2.00   ADULTS & PEDI ATRI CS   30.00   0   787   0     3.00   OPERATI NG ROOM   50.00   0   83   0     4.00   RADI OI SOTOPE   56.00   0   45,950   0     5.00   RESPI RATORY THERAPY   65.00   0   1,498   0     1 - MEDI CAL SUPPLIES CHARGED TO PATI ENTS     1 - MEDI CAL SUPPLIES CHARGED TO PATI ENTS     1 - MEDI CAL SUPPLIES CHARGED TO PATI ENTS     1 - MEDI CAL SUPPLIES CHARGED TO PATI ENTS     1 - MEDI CAL SUPPLIES CHARGED TO PATI ENTS     1 - MEDI CAL SUPPLIES CHARGED TO PATI ENTS     2 - 00   OPERATI NG ROOM   50.00   0   1,238,343   0     3 - 00   RESPI RATORY THERAPY   65.00   0   1,238,343   0     3 - 00   OPERATI NG ROOM   50.00   0   34,784   0     3 - 00   OPERATI NG ROOM   50.00   0   34,784   0     3 - 00   OPERATI NG ROOM   50.00   0   34,784   0     3 - 00   OPERATI NG ROOM   50.00   0   34,784   0     3 - 00   OPERATI NG ROOM   50.00   0   34,784   0     3 - 00   OPERATI NG ROOM   50.00   0   34,784   0     3 - 00   OPERATI NG ROOM   50.00   0   34,784   0     10 - 00   0   0   0   0   0   0   0   0  |        | •                             |                 | 0           |                   |                |              |                 |        |
| 11.00   RURAL HEALTH CLINIC II   |        | •                             |                 | 0           |                   |                |              |                 |        |
| 12.00   EMERGENCY   91.00   0   19   0   12.00   13.00   14.00   14.00   14.00   14.00   14.00   14.00   14.00   15.00   16.   |        | •                             |                 | 0           |                   |                |              |                 |        |
| 13. 00   |        |                               |                 | 0           |                   |                |              |                 |        |
| 14. 00 MARKETI NG/COMMUNI CATI ON 194. 00 0 3, 142 0 15. 00  |        |                               | •               | 0           |                   |                |              |                 |        |
| 15. 00   |        |                               |                 | 0           |                   | I I            |              |                 |        |
| D  |        | •                             |                 | 0           | •                 | 1              |              |                 |        |
| H - DRUGS CHARGED TO PATIENTS   1.00   | 15. 00 | FOUNDATION                    | 1 <u>94.</u> 02 | 0           |                   |                |              | 1               | 15. 00 |
| 1. 00 PHARMACY 15. 00 598, 737 1,847, 258 0 1. 00 2. 00 ADULTS & PEDIATRICS 30. 00 0 787 0 2. 00 3. 00 OPERATING ROOM 50. 00 0 83 0 3. 00 4. 00 RADIOI SOTOPE 56. 00 0 45, 950 0 4. 00 5. 00 RESPIRATORY THERAPY 65. 00 0 167 0 5. 00 6. 00 EMERGENCY 91. 00 0 1,498 0 6. 00 TOTALS 598, 737 1,895, 743 1 - MEDICAL SUPPLIES CHARGED TO PATIENTS 1. 00 CENTRAL SERVICES & SUPPLY 14. 00 0 1,238, 343 0 2. 00 2. 00 OPERATING ROOM 50. 00 0 557 0 2. 00 3. 00 RESPIRATORY THERAPY 65. 00 0 34, 784 0 3. 00 TOTALS 0 1,273, 684  |        | 0                             |                 | 0           | 360, 691          |                |              |                 |        |
| 2. 00 ADULTS & PEDI ATRI CS 30. 00 0 787 0 2. 00 3. 00 OPERATI NG ROOM 50. 00 0 83 0 0 3. 00 4. 00 RADI OI SOTOPE 56. 00 0 45, 950 0 4. 00 5. 00 RESPI RATORY THERAPY 65. 00 0 167 0 5. 00 6. 00 EMERGENCY 91. 00 0 1, 498 0 6. 00 TOTALS 598, 737 1, 895, 743  1. 00 CENTRAL SERVI CES & SUPPLY 14. 00 0 1, 238, 343 0 2. 00 0 OPERATI NG ROOM 50. 00 0 557 0 2. 00 3. 00 RESPI RATORY THERAPY 65. 00 0 34, 784 0 3. 00 TOTALS 0 1, 273, 684  |        |                               |                 |             |                   |                |              |                 |        |
| 3. 00 OPERATING ROOM 50. 00 0 83 0 0 3. 00 4. 00 RADI OI SOTOPE 56. 00 0 45, 950 0 4. 00 5. 00 RESPIRATORY THERAPY 65. 00 0 167 0 5. 00 6. 00 EMERGENCY 91. 00 0 1, 498 0 6. 00 TOTALS 598, 737 1, 895, 743  1. 00 CENTRAL SERVICES & SUPPLY 14. 00 0 1, 238, 343 0 2. 00 0 OPERATING ROOM 50. 00 0 557 0 2. 00 3. 00 RESPIRATORY THERAPY 65. 00 0 34, 784 0 3. 00 TOTALS 0 1, 273, 684  |        |                               |                 | 598, 737    |                   |                |              |                 |        |
| 4. 00 RADI OI SOTOPE 56. 00 0 45, 950 0 5. 00  5. 00 RESPI RATORY THERAPY 65. 00 0 167 0 5. 00  6. 00 EMERGENCY 91. 00 0 1, 498 0 6. 00  TOTALS 598, 737 1, 895, 743  1 MEDI CAL SUPPLIES CHARGED TO PATI ENTS  1. 00 CENTRAL SERVI CES & SUPPLY 14. 00 0 1, 238, 343 0 1. 00  2. 00 OPERATI NG ROOM 50. 00 557 0 2. 00  3. 00 RESPI RATORY THERAPY 65. 00 0 34, 784 0 3. 00  TOTALS 0 1, 273, 684   |        | 1                             |                 | 0           |                   |                |              |                 |        |
| 5. 00         RESPIRATORY THERAPY         65. 00         0         167         0         5. 00           6. 00         EMERGENCY         91. 00         0         1,498         0         6. 00           TOTALS         598,737         1,895,743         1         1         1. 00         1. 00         1. 00         1. 00         1. 00         1. 00         1. 00         1. 00         0         1. 238,343         0         0         1. 00         2. 00         0         2. 00         0         2. 00         0         2. 00         34,784         0         3. 00         3. 00         1. 273,684         0         3. 00         3. 00         1. 273,684         0         3. 00         3.  |        |                               |                 | 0           |                   |                |              |                 | 3.00   |
| 6. 00 EMERGENCY 91. 00 0 1, 498 0 6. 00 TOTALS 598, 737 1, 895, 743  1 - MEDI CAL SUPPLIES CHARGED TO PATIENTS  1. 00 CENTRAL SERVI CES & SUPPLY 14. 00 0 1, 238, 343 0 1. 00  2. 00 OPERATI NG ROOM 50. 00 0 557 0 2. 00  3. 00 RESPIRATORY THERAPY 65. 00 0 34, 784 0 3. 00  TOTALS 0 1, 273, 684  |        |                               |                 | 0           | •                 |                |              |                 | 4. 00  |
| TOTALS  I - MEDI CAL SUPPLI ES CHARGED TO PATI ENTS  1. 00 CENTRAL SERVI CES & SUPPLY 14. 00 0 1, 238, 343 0 1. 00  2. 00 OPERATI NG ROOM 50. 00 0 557 0 2. 00  3. 00 RESPIRATORY THERAPY 65. 00 0 34, 784 0 3. 00  TOTALS 0 1, 273, 684   | 5.00   | RESPIRATORY THERAPY           | 65.00           | 0           | 167               | 0              |              |                 | 5.00   |
| I - MEDICAL SUPPLIES CHARGED TO PATIENTS   | 6.00   |                               | 91.00           | 0           |                   |                |              |                 | 6. 00  |
| 1. 00     CENTRAL SERVICES & SUPPLY     14. 00     0     1, 238, 343     0       2. 00     OPERATING ROOM     50. 00     0     557     0       3. 00     RESPIRATORY THERAPY     65. 00     0     34, 784     0       TOTALS     0     1, 273, 684   |        | TOTALS                        |                 | 598, 737    | 1, 895, 743       | 3              |              |                 |        |
| 2. 00     OPERATING ROOM     50. 00     0     557     0       3. 00     RESPIRATORY THERAPY     65. 00     0     34, 784     0       TOTALS     0     1, 273, 684  |        |                               | O PATIENTS      |             |                   |                |              |                 |        |
| 3. 00 RESPIRATORY THERAPY 65. 00 0 34, 784 0 0 TOTALS 0 1, 273, 684  | 1.00   | CENTRAL SERVICES & SUPPLY     | 14. 00          | 0           | 1, 238, 343       | 0              |              |                 | 1.00   |
| TOTALS 0 1, 273, 684   | 2.00   | OPERATING ROOM                | 50.00           | o           | 557               | ' o            |              |                 | 2.00   |
| TOTALS 0 1, 273, 684   | 3.00   | RESPIRATORY THERAPY           | 65. 00          | ol          | 34, 784           | ıl ol          |              |                 | 3. 00  |
|  |        |                               |                 |             |                   |                |              |                 |        |
|  | 500.00 | Grand Total: Decreases        |                 | 1, 235, 696 | 4, 792, 413       |                |              | 50              | 00.00  |

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 14-0210 Peri od: Worksheet A-7 From 04/01/2022 Part I 03/31/2023 Date/Time Prepared: 9/11/2023 9:16 am Acqui si ti ons Begi nni ng Purchases Donati on Total Di sposal s and Bal ances Retirements 2.00 3.00 4. 00 1 00 5 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 772, 443 0 1.00 513, 255 0 2.00 Land Improvements 667, 589 0 2.00 38, 242, 567 34, 075 0 3.00 34, 075 3.00 Buildings and Fixtures 17, 463, 101 0 4.00 Building Improvements 4.00 5.00 Fixed Equipment 43, 061 0 43, 061 5.00 0 6.00 Movable Equipment 18, 559, 713 292, 093 292, 093 13, 801, 991 6.00 0 7.00 HIT designated Assets 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 58, 242, 312 369, 229 369, 229 31, 778, 347 8.00 9.00 Reconciling Items -372, 013 0 -372, 013 9.00 Total (line 8 minus line 9) 10.00 58, 242, 312 741, 242 0 741, 242 31, 778, 347 10.00 Endi ng Bal ance Fully Depreciated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 772, 443 1.00 2.00 Land Improvements 154, 334 0 2.00 3.00 Buildings and Fixtures 0 3.00 20, 813, 541 0 4.00 Building Improvements 4.00 5.00 Fi xed Equipment 43, 061 0 5.00 Movable Equipment 0 6.00 5, 049, 815 6.00 7. 00 7.00 HIT designated Assets 0

26, 833, 194

27, 205, 207

-372, 013

0

0

In Lieu of Form CMS-2552-10

8.00

9.00

10.00

Subtotal (sum of lines 1-7)

Reconciling Items

10.00 Total (line 8 minus line 9)

8.00

9.00

| Heal th | n Financial Systems HA                       | ARRI SBURG MEDI CA | AL CENTER. INC. |                   | In Lie          | eu of Form CMS-2 | 2552-10 |
|---------|--|--------------------|-----------------|-------------------|-----------------|------------------|---------|
|         | CILIATION OF CAPITAL COSTS CENTERS           |                    | Provi der Co    |                   | Peri od:        | Worksheet A-7    |         |
|         |  |                    |                 |                   | From 04/01/2022 |                  |         |
|         |  |                    |                 |                   | To 03/31/2023   | Date/Time Pre    |         |
|         |  |                    | CI              | JMMARY OF CAP     | I TAI           | 9/11/2023 9: 1   | o am    |
|         |  |                    | 30              | JIVIIVIARY OF CAP | ITAL            |                  |         |
|         | Cost Center Description                      | Depreciation       | Lease           | Interest          | Insurance (see  | Taxes (see       |         |
|         | cost center bescription                      | Depi cei ati on    | LCGSC           | Titterest         | ,               | instructions)    |         |
|         |  | 9, 00              | 10.00           | 11.00             | 12.00           | 13. 00           |         |
|         | PART II - RECONCILIATION OF AMOUNTS FROM WOR | KSHEET A, COLUM    |                 | nd 2              |                 |                  |         |
| 1.00    | CAP REL COSTS-BLDG & FLXT                    | 2, 538, 348        | 0               |                   | 0 0             | 0                | 1.00    |
| 2.00    | CAP REL COSTS-MVBLE EQUIP                    | 0                  | 0               |                   | 0 0             | 0                | 2. 00   |
| 3.00    | Total (sum of lines 1-2)                     | 2, 538, 348        | 0               |                   | 0 0             | 0                | 3. 00   |
|         |  | SUMMARY 0          | F CAPITAL       |                   |                 |                  |         |
|         |  |                    |                 |                   |                 |                  |         |
|         | Cost Center Description                      |                    | Total (1) (sum  |                   |                 |                  |         |
|         |  | Capi tal -Relate   | of cols. 9      |                   |                 |                  |         |
|         |  | d Costs (see       | through 14)     |                   |                 |                  |         |
|         |  | instructions)      |                 |                   |                 |                  |         |
|         |  | 14. 00             | 15. 00          |                   |                 |                  |         |
|         | PART II - RECONCILIATION OF AMOUNTS FROM WOR | KSHEET A, COLUM    | N 2, LINES 1 a  | nd 2              |                 |                  |         |
| 1.00    | CAP REL COSTS-BLDG & FLXT                    | 0                  | 2, 538, 348     |                   |                 | ļ                | 1. 00   |
| 2.00    | CAP REL COSTS-MVBLE EQUIP                    | 0                  | 0               |                   |                 | l                | 2. 00   |
|         | 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -      |                    | 0 500 040       | 1                 |                 |                  |         |

0 0 0

2, 538, 348

1. 00 2. 00 3. 00

1.00 CAP REL COSTS-BLDG & FLX1
2.00 CAP REL COSTS-MVBLE EQUIP
3.00 Total (sum of lines 1-2)

| Heal th | n Financial Systems HA   | RRI SBURG MEDI C                               | AL CENTER, INC.  |   | In Lie                                      | eu of Form CMS-2 | 2552-10 |
|---------|--|--|------------------|---|---|------------------|---------|
| RECON   | CILIATION OF CAPITAL COSTS CENTERS                                     |  | Provider Co      |   | Period:<br>From 04/01/2022<br>To 03/31/2023 |                  | pared:  |
|         |  | COM  | PUTATION OF RAT  | TI 0S                                       | ALLOCATION OF                               | OTHER CAPITAL    |         |
|         | Cost Center Description  | Gross Assets                                   | Capi tal i zed   | Gross Assets                                |   | Insurance        |         |
|         |  |  | Leases           | for Ratio                                   | instructions)                               |                  |         |
|         |  |  |                  | (col . 1 - col<br>2)                        |   |                  |         |
|         |  | 1. 00  | 2.00             | 3.00  | 4, 00                                       | 5. 00            |         |
|         | PART III - RECONCILIATION OF CAPITAL COSTS C                           |  |                  |   | 1   |                  |         |
| 1.00    | CAP REL COSTS-BLDG & FLXT  | 21, 783, 379                                   | 0                | 21, 783, 37                                 | 9 0. 811807                                 | 53, 544          | 1.00    |
| 2.00    | CAP REL COSTS-MVBLE EQUIP  | 5, 049, 815                                    |                  | -, ,  |   |                  | 2. 00   |
| 3.00    | Total (sum of lines 1-2)   | 26, 833, 194                                   |                  | 26, 833, 19                                 |   |                  | 3. 00   |
|         |  | ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL |                  |   |   |                  |         |
|         | Cost Center Description  | Taxes  | Other            | Total (sum of                               | Depreciation                                | Lease            |         |
|         |  |  | Capi tal -Relate |   |   |                  |         |
|         |  |  | d Costs          | through 7)                                  |   |                  |         |
|         | DART III DECONOLITATION OF CARLTAL COCTO O                             | 6. 00  | 7. 00            | 8. 00                                       | 9. 00                                       | 10.00            |         |
| 1. 00   | PART III - RECONCILIATION OF CAPITAL COSTS C CAP REL COSTS-BLDG & FIXT | ENTERS   |                  | 53, 54                                      | 4 2, 431, 952                               | 165, 953         | 1. 00   |
| 2.00    | CAP REL COSTS-BLDG & FIXT  | 0  |                  | 12, 41                                      |   |                  | 2.00    |
| 3.00    | Total (sum of lines 1-2)   | 0  |                  | 65, 95                                      |   |                  | 3.00    |
| 3.00    | Total (Saill of Triles 1 2)  |  | SI               | JMMARY OF CAPI                              |   | 100, 700         | 3.00    |
|         |  |  | 00               | Julius 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | 1712  |                  |         |
|         | Cost Center Description  | Interest                                       | Insurance (see   | Taxes (see                                  | 0ther                                       | Total (2) (sum   |         |
|         |  |  | instructions)    | instructions)                               | Capi tal -Relate                            |                  |         |
|         |  |  |                  |   | d Costs (see                                | through 14)      |         |
|         |  | 11 00  | 10.00            | 10.00                                       | instructions)                               | 45.00            |         |
|         | PART III - RECONCILIATION OF CAPITAL COSTS C                           | 11.00  | 12.00            | 13.00                                       | 14. 00                                      | 15. 00           |         |
| 1. 00   | CAP REL COSTS-BLDG & FIXT  | 375, 883                                       | 53, 544          |   | 0 0   | 3, 027, 332      | 1. 00   |
| 2.00    | CAP REL COSTS-BEDG & TTAT  | 375, 863                                       |                  |   |   |                  | 2.00    |
| 3.00    | Total (sum of lines 1-2)   | 375, 883                                       |                  |   | o o   |                  |         |
| 0.00    | 1.2.2. (22 0. 1.1.60 1.2)  | 3,3,000  | 1 25, 700        | ı   | -1  | 0,0.0,010        | 0.00    |

Health Financial Systems
ADJUSTMENTS TO EXPENSES HARRISBURG MEDICAL CENTER, INC. In Lieu of Form CMS-2552-10 Provider CCN: 14-0210 Peri od: From 04/01/2022 To 03/31/2023 Worksheet A-8 Date/Time Prepared: 9/11/2023 9:16 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted

| Cost Center Description Basis/Code (2) Amount Cost Center  |                     | Wkst. A-7 Ref. |                  |
|--|---------------------|----------------|------------------|
| 1.00 2.00 3.00<br>1.00 Investment income - CAP REL 00CAP REL COSTS-BLDG & I                        | 4. 00<br>FIXT 1. 00 | 5. 00          | 1. 00            |
| COSTS-BLDG & FIXT (chapter 2) 2.00 Investment income - CAP REL OCAP REL COSTS-MVBLE EC             | QUI P 2.00          | 0              | 2. 00            |
| COSTS-MVBLE EQUIP (chapter 2) 3.00 Investment income - other                                       | 0.00                |                | 3. 00            |
| (chapter 2)  |                     |                |                  |
| 4.00 Trade, quantity, and time B -897 ADMINISTRATIVE & GENEI discounts (chapter 8)                 |                     |                | 4. 00            |
| 5.00 Refunds and rebates of expenses (chapter 8)   | 0.00                | 0              | 5. 00            |
| 6.00 Rental of provider space by suppliers (chapter 8)   | 0.00                | 0              | 6. 00            |
| 7.00 Telephone services (pay A -1,645 ADMINISTRATIVE & GENEI stations excluded) (chapter 21)       | RAL 5.00            | 0              | 7. 00            |
| 8.00 Television and radio service 0  | 0.00                | 0              | 8. 00            |
| (chapter 21) 9.00 Parking Lot (chapter 21)   | 0.00                |                | 9. 00            |
| 10.00 Provider-based physician A-8-2 -3,394,493 adjustment   |                     |                | 10. 00           |
| 11.00 Sale of scrap, waste, etc. (chapter 23)  | 0.00                | 0              | 11. 00           |
| 12.00 Related organization A-8-1 6,003,331 transactions (chapter 10)                               |                     | 0              | 12. 00           |
| 13.00 Laundry and linen service 14.00 Cafeteria-employees and guests B -67,140DLETARY              | 0. 00<br>10. 00     |                | 13. 00<br>14. 00 |
| 15.00 Rental of quarters to employee 0   | 0.00                |                | 15. 00           |
| and others 16.00 Sale of medical and surgical 0  | 0.00                | 0              | 16. 00           |
| supplies to other than patients  |                     |                |                  |
| 17.00 Sale of drugs to other than patients   | 0.00                | 0              | 17. 00           |
| 18.00 Sale of medical records and B -24,539 MEDICAL RECORDS & LIBI abstracts                       | RARY 16.00          | 0              | 18. 00           |
| 19.00 Nursing and allied health education (tuition, fees,  | 0.00                | o              | 19. 00           |
| books, etc.) 20.00 Vendi ng machi nes B -5, 157 ADMI NI STRATI VE & GENEI                          |                     |                | 20. 00           |
| 21.00 Income from imposition of interest, finance or penalty                                       | 0.00                | 0              | 21. 00           |
| charges (chapter 21)  22.00 Interest expense on Medicare overpayments and borrowings to            | 0.00                | O              | 22. 00           |
| repay Medicare overpayments  | 4F 00               |                | 22.00            |
| 23.00 Adjustment for respiratory A-8-3 ORESPIRATORY THERAPY therapy costs in excess of             | 65. 00              |                | 23. 00           |
| I i mi tati on (chapter 14) 24.00   Adj ustment for physical   A-8-3   OPHYSICAL THERAPY           | 66.00               |                | 24. 00           |
| therapy costs in excess of limitation (chapter 14)   |                     |                |                  |
| 25.00 Utilization review - 0 *** Cost Center Delete  | ed *** 114.00       |                | 25. 00           |
| (chapter 21) 26.00 Depreciation - CAP REL OCAP REL COSTS-BLDG & I                                  | FIXT 1.00           | 0              | 26. 00           |
| COSTS-BLDG & FIXT  |                     |                |                  |
| COSTS-MVBLE EQUIP  |                     | 0              | 27. 00           |
| 28. 00 Non-physician Anesthetist A -414, 739 NONPHYSICIAN ANESTHETI 29. 00 Physicians' assistant 0 | 0.00                |                | 28. 00<br>29. 00 |
| 30.00 Adjustment for occupational A-8-3 00CCUPATIONAL THERAPY therapy costs in excess of           | 67. 00              |                | 30. 00           |
| limitation (chapter 14) 30.99 Hospice (non-distinct) (see OADULTS & PEDIATRICS                     | 30.00               |                | 30. 99           |
| instructions)  31.00 Adjustment for speech  A-8-3  OSPEECH PATHOLOGY                               | 68.00               |                | 31. 00           |
| pathology costs in excess of   | 68.00               |                | 31.00            |
| I i mi tati on (chapter 14) 32.00 CAH HIT Adjustment for 0   | 0.00                | 0              | 32. 00           |
| Depreciation and Interest  33. 00 MISCELLANEOUS INCOME  B -10, 613 ADMINISTRATIVE & GENER          | RAL 5.00            | 0              | 33. 00           |

| Expense Classification on Worksheet A   To/From Which the Amount is to be Adjusted   |        |                                |              |              | Т                            | o 03/31/2023   | Date/Time Pre 9/11/2023 9:1 |        |
|--|--------|--------------------------------|--------------|--------------|------------------------------|----------------|-----------------------------|--------|
| Cost Center Description  |        |                                |              |              | Expense Classification on    | Worksheet A    |                             |        |
| 1.00   2.00   3.00   4.00   5.00   33.01   33.01   RENTAL INCOME   B   -115, 220 OPERATION OF PLANT   7.00   0.33.01   34.00   ADVERTISING   A   -13, 875 ADMINISTRATIVE & GENERAL   5.00   0.34.00   35.00   CRNA BENEFITS   A   -70, 679 EMPLOYEE BENEFITS DEPARTMENT   4.00   0.35.00   37.00   CAPITALIZED INTEREST   A   34 OPERATION OF PLANT   7.00   0.37.00   37.01   CAPITALIZED INTEREST   A   75 OPERATING ROOM   50.00   0.37.01   37.02   CAPITALIZED INTEREST   A   14CT SCAN   57.00   0.37.02   37.03   CAPITALIZED INTEREST   A   147 PHYSICAL THERAPY   66.00   0.37.03   37.04   CAPITALIZED INTEREST   A   100 ASC (NON-DISTINCT PART)   75.00   0.37.04   37.05   CAPITALIZED INTEREST   A   87 EMERGENCY   91.00   0.37.05   38.00   PENALTY FEES   A   -20 ADMINISTRATIVE & GENERAL   5.00   0.38.00   39.00   LOBBYINNG DUES   A   -14, 528 ADMINISTRATIVE & GENERAL   5.00   0.39.00   40.00   PHYSICIAN RECRUITMENT   A   -24, 528 ADMINISTRATIVE & GENERAL   5.00   0.41.00   50.00   TOTAL (sum of lines 1 thru 49)   (Transfer to Worksheet A,   50.00   0.41.00   50.00   TOTAL (sum of lines 1 thru 49)   (Transfer to Worksheet A,   50.00   0.41.00   50.00   Contact   40.00   Contact      |        |                                |              |              | To/From Which the Amount is  | to be Adjusted |                             |        |
| 1.00   2.00   3.00   4.00   5.00   33.01   33.01   RENTAL INCOME   B   -115, 220 OPERATION OF PLANT   7.00   0.33.01   34.00   ADVERTISING   A   -13, 875 ADMINISTRATIVE & GENERAL   5.00   0.34.00   35.00   CRNA BENEFITS   A   -70, 679 EMPLOYEE BENEFITS DEPARTMENT   4.00   0.35.00   37.00   CAPITALIZED INTEREST   A   34 OPERATION OF PLANT   7.00   0.37.00   37.01   CAPITALIZED INTEREST   A   75 OPERATING ROOM   50.00   0.37.01   37.02   CAPITALIZED INTEREST   A   14CT SCAN   57.00   0.37.02   37.03   CAPITALIZED INTEREST   A   147 PHYSICAL THERAPY   66.00   0.37.03   37.04   CAPITALIZED INTEREST   A   100 ASC (NON-DISTINCT PART)   75.00   0.37.04   37.05   CAPITALIZED INTEREST   A   87 EMERGENCY   91.00   0.37.05   38.00   PENALTY FEES   A   -20 ADMINISTRATIVE & GENERAL   5.00   0.38.00   39.00   LOBBYINNG DUES   A   -14, 528 ADMINISTRATIVE & GENERAL   5.00   0.39.00   40.00   PHYSICIAN RECRUITMENT   A   -24, 528 ADMINISTRATIVE & GENERAL   5.00   0.41.00   50.00   TOTAL (sum of lines 1 thru 49)   (Transfer to Worksheet A,   50.00   0.41.00   50.00   TOTAL (sum of lines 1 thru 49)   (Transfer to Worksheet A,   50.00   0.41.00   50.00   Contact   40.00   Contact      |        |                                |              |              |                              |                |                             |        |
| 1.00   2.00   3.00   4.00   5.00   33.01   33.01   RENTAL INCOME   B   -115, 220 OPERATION OF PLANT   7.00   0.33.01   34.00   ADVERTISING   A   -13, 875 ADMINISTRATIVE & GENERAL   5.00   0.34.00   35.00   CRNA BENEFITS   A   -70, 679 EMPLOYEE BENEFITS DEPARTMENT   4.00   0.35.00   37.00   CAPITALIZED INTEREST   A   34 OPERATION OF PLANT   7.00   0.37.00   37.01   CAPITALIZED INTEREST   A   75 OPERATING ROOM   50.00   0.37.01   37.02   CAPITALIZED INTEREST   A   14CT SCAN   57.00   0.37.02   37.03   CAPITALIZED INTEREST   A   147 PHYSICAL THERAPY   66.00   0.37.03   37.04   CAPITALIZED INTEREST   A   100 ASC (NON-DISTINCT PART)   75.00   0.37.04   37.05   CAPITALIZED INTEREST   A   100 ASC (NON-DISTINCT PART)   75.00   0.37.05   38.00   PENALTY FEES   A   -20 ADMINISTRATIVE & GENERAL   5.00   0.38.00   39.00   LOBBYINNG DUES   A   -14, 528 ADMINISTRATIVE & GENERAL   5.00   0.39.00   40.00   PHYSICIAN RECRUITMENT   A   -24, 528 ADMINISTRATIVE & GENERAL   5.00   0.41.00   50.00   TOTAL (sum of lines 1 thru 49)   (Transfer to Worksheet A,   50.00   0.41.00   50.00   TOTAL (sum of lines 1 thru 49)   (Transfer to Worksheet A,   50.00   0.41.00   50.00   (Transfer to Worksheet A,   50.   |        |                                |              |              |                              |                |                             |        |
| 1.00   2.00   3.00   4.00   5.00   33.01   33.01   RENTAL INCOME   B   -115, 220 OPERATION OF PLANT   7.00   0.33.01   34.00   ADVERTISING   A   -13, 875 ADMINISTRATIVE & GENERAL   5.00   0.34.00   35.00   CRNA BENEFITS   A   -70, 679 EMPLOYEE BENEFITS DEPARTMENT   4.00   0.35.00   37.00   CAPITALIZED INTEREST   A   34 OPERATION OF PLANT   7.00   0.37.00   37.01   CAPITALIZED INTEREST   A   75 OPERATING ROOM   50.00   0.37.01   37.02   CAPITALIZED INTEREST   A   14CT SCAN   57.00   0.37.02   37.03   CAPITALIZED INTEREST   A   147 PHYSICAL THERAPY   66.00   0.37.03   37.04   CAPITALIZED INTEREST   A   100 ASC (NON-DISTINCT PART)   75.00   0.37.04   37.05   CAPITALIZED INTEREST   A   100 ASC (NON-DISTINCT PART)   75.00   0.37.05   38.00   PENALTY FEES   A   -20 ADMINISTRATIVE & GENERAL   5.00   0.38.00   39.00   LOBBYINNG DUES   A   -14, 528 ADMINISTRATIVE & GENERAL   5.00   0.39.00   40.00   PHYSICIAN RECRUITMENT   A   -24, 528 ADMINISTRATIVE & GENERAL   5.00   0.41.00   50.00   TOTAL (sum of lines 1 thru 49)   (Transfer to Worksheet A,   50.00   0.41.00   50.00   TOTAL (sum of lines 1 thru 49)   (Transfer to Worksheet A,   50.00   0.41.00   50.00   (Transfer to Worksheet A,   50.   |        |                                |              |              |                              |                |                             |        |
| 1.00   2.00   3.00   4.00   5.00   33.01   33.01   RENTAL INCOME   B   -115, 220 OPERATION OF PLANT   7.00   0.33.01   34.00   ADVERTISING   A   -13, 875 ADMINISTRATIVE & GENERAL   5.00   0.34.00   35.00   CRNA BENEFITS   A   -70, 679 EMPLOYEE BENEFITS DEPARTMENT   4.00   0.35.00   37.00   CAPITALIZED INTEREST   A   34 OPERATION OF PLANT   7.00   0.37.00   37.01   CAPITALIZED INTEREST   A   75 OPERATING ROOM   50.00   0.37.01   37.02   CAPITALIZED INTEREST   A   14CT SCAN   57.00   0.37.02   37.03   CAPITALIZED INTEREST   A   147 PHYSICAL THERAPY   66.00   0.37.03   37.04   CAPITALIZED INTEREST   A   100 ASC (NON-DISTINCT PART)   75.00   0.37.04   37.05   CAPITALIZED INTEREST   A   87 EMERGENCY   91.00   0.37.05   38.00   PENALTY FEES   A   -20 ADMINISTRATIVE & GENERAL   5.00   0.38.00   39.00   LOBBYINNG DUES   A   -14, 528 ADMINISTRATIVE & GENERAL   5.00   0.39.00   40.00   PHYSICIAN RECRUITMENT   A   -24, 528 ADMINISTRATIVE & GENERAL   5.00   0.41.00   50.00   TOTAL (sum of lines 1 thru 49)   (Transfer to Worksheet A,   50.00   0.41.00   50.00   TOTAL (sum of lines 1 thru 49)   (Transfer to Worksheet A,   50.00   0.41.00   50.00   Contact   40.00   Contact      |        |                                | 5 , (0 , (0) |              |                              | T "            |                             |        |
| RENTAL INCOME   B  |        | Cost Center Description        |              |              |                              |                |                             |        |
| 34. 00 ADVERTISING A -13, 875 ADMINISTRATIVE & GENERAL 5. 00 0 34. 00 35. 00 CRNA BENEFITS A -70, 679 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 35. 00 37. 00 CAPITALIZED INTEREST A 34 OPERATINO OF PLANT 7. 00 0 37. 00 37. 01 CAPITALIZED INTEREST A 14 CT SCAN 50. 00 0 37. 01 37. 02 CAPITALIZED INTEREST A 147 PHYSICAL THERAPY 66. 00 0 37. 02 37. 03 CAPITALIZED INTEREST A 147 PHYSICAL THERAPY 66. 00 0 37. 03 37. 04 CAPITALIZED INTEREST A 100 ASC (NON-DISTINCT PART) 75. 00 0 37. 04 37. 05 CAPITALIZED INTEREST A 87 EMERGENCY 91. 00 0 37. 05 38. 00 PENALTY FEES A -20 ADMINISTRATIVE & GENERAL 5. 00 0 38. 00 39. 00 LOBBYINNG DUES A -14, 528 ADMINISTRATIVE & GENERAL 5. 00 0 39. 00 40. 00 PHYSICIAN RECRUITMENT A -24, 528 ADMINISTRATIVE & GENERAL 5. 00 0 40. 00 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, 50. 00   |        |                                |              |              |                              |                |                             |        |
| 35. 00 CRNA BENEFITS   |        |                                | В            |              |                              |                |                             |        |
| 37. 00 CAPITALIZED INTEREST A 34 OPERATION OF PLANT 7. 00 0 37. 00 37. 01 CAPITALIZED INTEREST A 75 OPERATING ROOM 50. 00 0 37. 01 37. 02 CAPITALIZED INTEREST A 14 CT SCAN 57. 00 0 37. 02 37. 03 CAPITALIZED INTEREST A 147 PHYSICAL THERAPY 66. 00 0 37. 03 37. 04 CAPITALIZED INTEREST A 100 ASC (NON-DISTINCT PART) 75. 00 0 37. 04 37. 05 CAPITALIZED INTEREST A 87 EMERGENCY 91. 00 0 37. 05 38. 00 PENALTY FEES A -20 ADMINISTRATIVE & GENERAL 5. 00 0 38. 00 39. 00 LOBBYINNG DUES A -14, 528 ADMINISTRATIVE & GENERAL 5. 00 0 40. 00 40. 00 PHYSICIAN RECRUITMENT A -24, 528 ADMINISTRATIVE & GENERAL 5. 00 0 41. 00 41. 00 PROVIDER TAX A -3, 040, 820 ADMINISTRATIVE & GENERAL 5. 00 0 41. 00 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A,  | 34.00  | ADVERTI SI NG                  | A            | -13, 875     | ADMINISTRATIVE & GENERAL     | 5. 00          | 0                           | 34.00  |
| 37. 01 CAPITALIZED INTEREST A 75 OPERATING ROOM 50. 00 37. 01 37. 02 CAPITALIZED INTEREST A 14 CT SCAN 57. 00 0 37. 02 37. 03 CAPITALIZED INTEREST A 147 PHYSICAL THERAPY 66. 00 0 37. 03 37. 04 CAPITALIZED INTEREST A 100 ASC (NON-DISTINCT PART) 75. 00 0 37. 04 37. 05 CAPITALIZED INTEREST A 87 EMERGENCY 91. 00 0 37. 05 38. 00 PENALTY FEES A 2 -20 ADMINISTRATIVE & GENERAL 5. 00 0 38. 00 9 PHYSICIAN RECRUITMENT A -24, 528 ADMINISTRATIVE & GENERAL 5. 00 0 40. 00 PHYSICIAN RECRUITMENT A -3, 040, 820 ADMINISTRATIVE & GENERAL 5. 00 0 41. 00 PROVIDER TAX A -3, 040, 820 ADMINISTRATIVE & GENERAL 5. 00 0 41. 00 FOOL OF TAX A -1, 195, 105 0 50. 00 50. | 35.00  | CRNA BENEFITS                  | A            | -70, 679     | EMPLOYEE BENEFITS DEPARTMENT | 4.00           | 0                           | 35. 00 |
| 37. 02 CAPITALIZED INTEREST A 14 CT SCAN 57. 00 0 37. 02 37. 03 CAPITALIZED INTEREST A 147 PHYSICAL THERAPY 66. 00 0 37. 03 37. 04 CAPITALIZED INTEREST A 100 ASC (NON-DISTINCT PART) 75. 00 0 37. 04 37. 05 CAPITALIZED INTEREST A 87 EMERGENCY 91. 00 0 37. 05 38. 00 PENALTY FEES A -20 ADMINISTRATIVE & GENERAL 5. 00 0 38. 00 39. 00 LOBBYINNG DUES A -14, 528 ADMINISTRATIVE & GENERAL 5. 00 0 39. 00 40. 00 PHYSICIAN RECRUITMENT A -24, 528 ADMINISTRATIVE & GENERAL 5. 00 0 40. 00 41. 00 PROVIDER TAX A -3, 040, 820 ADMINISTRATIVE & GENERAL 5. 00 0 41. 00 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A,   | 37.00  | CAPITALIZED INTEREST           | A            | 34           | OPERATION OF PLANT           | 7. 00          | 0                           | 37. 00 |
| 37. 03 CAPITALIZED INTEREST A 147 PHYSICAL THERAPY 66. 00 0 37. 03 37. 04 CAPITALIZED INTEREST A 100 ASC (NON-DISTINCT PART) 75. 00 0 37. 04 37. 05 CAPITALIZED INTEREST A 87 EMERGENCY 91. 00 0 37. 05 38. 00 PENALTY FEES A -20 ADMINISTRATIVE & GENERAL 5. 00 0 38. 00 39. 00 LOBBYINNG DUES A -14, 528 ADMINISTRATIVE & GENERAL 5. 00 0 39. 00 40. 00 PHYSICIAN RECRUITMENT A -24, 528 ADMINISTRATIVE & GENERAL 5. 00 0 40. 00 41. 00 PROVIDER TAX A -3, 040, 820 ADMINISTRATIVE & GENERAL 5. 00 0 41. 00 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A,  | 37. 01 | CAPITALIZED INTEREST           | A            | 75           | OPERATING ROOM               | 50.00          | 0                           | 37. 01 |
| 37. 04 CAPITALIZED INTEREST A 100 ASC (NON-DISTINCT PART) 75. 00 0 37. 04 37. 05 CAPITALIZED INTEREST A 87 EMERGENCY 91. 00 0 37. 05 38. 00 PENALTY FEES A -20 ADMINISTRATIVE & GENERAL 5. 00 0 38. 00 39. 00 LOBBYINNG DUES A -14, 528 ADMINISTRATIVE & GENERAL 5. 00 0 39. 00 40. 00 PHYSICIAN RECRUITMENT A -24, 528 ADMINISTRATIVE & GENERAL 5. 00 0 40. 00 41. 00 PROVIDER TAX A -3, 040, 820 ADMINISTRATIVE & GENERAL 5. 00 0 41. 00 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, 50. 00  | 37. 02 | CAPITALIZED INTEREST           | A            | 14           | CT SCAN                      | 57. 00         | 0                           | 37. 02 |
| 37. 05 CAPITALIZED INTEREST A 87 EMERGENCY 91. 00 0 37. 05 38. 00 PENALTY FEES A -20 ADMINISTRATIVE & GENERAL 5. 00 0 38. 00 39. 00 LOBBYINNG DUES A -14, 528 ADMINISTRATIVE & GENERAL 5. 00 0 39. 00 40. 00 PHYSICIAN RECRUITMENT A -24, 528 ADMINISTRATIVE & GENERAL 5. 00 0 40. 00 41. 00 PROVIDER TAX A -3, 040, 820 ADMINISTRATIVE & GENERAL 5. 00 0 41. 00 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, 50. 00  | 37. 03 | CAPITALIZED INTEREST           | A            | 147          | PHYSI CAL THERAPY            | 66.00          | 0                           | 37. 03 |
| 38. 00 PENALTY FEES A -20 ADMINISTRATIVE & GENERAL 5. 00 0 38. 00 39. 00 LOBBYINNG DUES A -14, 528 ADMINISTRATIVE & GENERAL 5. 00 0 39. 00 40. 00 PHYSICIAN RECRUITMENT A -24, 528 ADMINISTRATIVE & GENERAL 5. 00 0 40. 00 41. 00 PROVIDER TAX A -3, 040, 820 ADMINISTRATIVE & GENERAL 5. 00 0 41. 00 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, 50. 00 50. 00  | 37.04  | CAPITALIZED INTEREST           | A            | 100          | ASC (NON-DISTINCT PART)      | 75.00          | 0                           | 37. 04 |
| 39.00 LOBBYINNG DUES A -14,528 ADMINISTRATIVE & GENERAL 5.00 0 39.00 40.00 PHYSICIAN RECRUITMENT A -24,528 ADMINISTRATIVE & GENERAL 5.00 0 40.00 41.00 PROVIDER TAX A -3,040,820 ADMINISTRATIVE & GENERAL 5.00 0 41.00 50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, 50.00 50.00  | 37. 05 | CAPITALIZED INTEREST           | l A          | 87           | EMERGENCY                    | 91.00          | 0                           | 37. 05 |
| 40.00 PHYSICIAN RECRUITMENT A -24, 528 ADMINISTRATIVE & GENERAL 5.00 0 40.00 41.00 PROVIDER TAX A -3,040,820 ADMINISTRATIVE & GENERAL 5.00 0 41.00 50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, 50.00  | 38.00  | PENALTY FEES                   | l A          | -20          | ADMINISTRATIVE & GENERAL     | 5. 00          | 0                           | 38. 00 |
| 41.00 PROVIDER TAX A -3,040,820 ADMINISTRATIVE & GENERAL 5.00 0 41.00 50.00 (Transfer to Worksheet A,  | 39.00  | LOBBYI NNG DUES                | l A          | -14, 528     | ADMINISTRATIVE & GENERAL     | 5. 00          | 0                           | 39. 00 |
| 50.00 TOTAL (sum of lines 1 thru 49) -1,195,105 50.00 (Transfer to Worksheet A,  | 40.00  | PHYSICIAN RECRUITMENT          | l A          | -24, 528     | ADMINISTRATIVE & GENERAL     | 5. 00          | 0                           | 40.00  |
| (Transfer to Worksheet A,  | 41.00  | PROVI DER TAX                  | A            | -3, 040, 820 | ADMINISTRATIVE & GENERAL     | 5.00           | 0                           | 41.00  |
|  | 50.00  | TOTAL (sum of lines 1 thru 49) |              | -1, 195, 105 |                              |                |                             | 50.00  |
| column 6. Line 200.)   |        |                                |              |              |                              |                |                             |        |
|  |        | column 6, line 200.)           |              |              |                              |                |                             |        |

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

<sup>(2)</sup> Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

6,003,331

5.00

| <br>p                         | cor anno i aria, or 2, tho amoun |               |                              |                |  |
|-------------------------------|----------------------------------|---------------|------------------------------|----------------|--|
|                               |                                  |               | Related Organization(s) and/ | or Home Office |  |
|                               |                                  |               |                              |                |  |
|                               |                                  |               |                              |                |  |
|                               |                                  |               |                              |                |  |
| Symbol (1)                    | Name                             | Percentage of | Name                         | Percentage of  |  |
|                               |                                  | Ownershi p    |                              | Ownershi p     |  |
| 1. 00                         | 2. 00                            | 3. 00         | 4. 00                        | 5. 00          |  |
| B. INTERRELATIONSHIP TO RELAT | TED ORGANIZATION(S) AND/OR HO    | ME OFFICE:    |                              |                |  |
|                               |                                  |               |                              |                |  |

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

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

| 6. 00  | В                       | 0. 00 SI H 100. 00 | 6. 00  |
|--------|-------------------------|--------------------|--------|
| 7.00   |                         | 0.00               | 7. 00  |
| 8.00   |                         | 0.00               | 8. 00  |
| 9.00   |                         | 0.00               | 9. 00  |
| 10.00  |                         | 0.00               | 10.00  |
| 100.00 | G. Other (financial or  |                    | 100.00 |
|        | non-financial) specify: |                    |        |

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

5.00

line 12.

TOTALS (sum of lines 1-4).

Transfer column 6, line 5 to Worksheet A-8, column 2,

| Heal th            | Financial Syste | ems             | Н              | HARRI SBURG MEDI CAL | CENTER, INC.    |             | In Lie                                       | u of Form CMS | -2552-10     |
|--------------------|-----------------|-----------------|----------------|----------------------|-----------------|-------------|--|---------------|--------------|
| STATEME<br>OFFI CE |                 | SERVICES FROM   | RELATED ORGANI | ZATIONS AND HOME     | Provider CCN    | : 14-0210   | Peri od:<br>From 04/01/2022<br>To 03/31/2023 |               | epared:      |
|                    |                 |                 |                |                      |                 |             |  | 9/11/2023 9:  | <u>16 am</u> |
|                    |                 | Wkst. A-7 Ref.  |                |                      |                 |             |  |               |              |
|                    | Adjustments     |                 |                |                      |                 |             |  |               |              |
|                    | (col. 4 minus   |                 |                |                      |                 |             |  |               |              |
|                    | col. 5)*        |                 |                |                      |                 |             |  |               |              |
|                    | 6. 00           | 7. 00           |                |                      |                 |             |  |               |              |
|                    | A. COSTS INCUR  | RED AND ADJUSTN | MENTS REQUIRED | AS A RESULT OF TR    | ANSACTIONS WITH | H RELATED C | ORGANIZATIONS OR                             | CLAI MED      |              |
|                    | HOME OFFICE CO  | STS:            |                |                      |                 |             |  |               |              |
| 1.00               | 700, 478        | 9               |                |                      |                 |             |  |               | 1.00         |
| 2.00               | 5, 302, 853     | 0               |                |                      |                 |             |  |               | 2.00         |
| 3.00               | 0               | 0               |                |                      |                 |             |  |               | 3.00         |
| 4.00               | 0               | 0               |                |                      |                 |             |  |               | 4.00         |
| 5.00               | 6, 003, 331     |                 |                |                      |                 |             |  |               | 5. 00        |
| * The              | amounts on line | es 1-4 (and sub | scripts as app | propriate) are tra   | nsferred in det | ail to Wor  | ksheet A. column                             | 6. Lines as   | •            |
|                    |                 |                 |                | jative amounts deci  |                 |             |  |               | whi ch       |

has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

Related Organization(s) and/or Home Office

Type of Business

6.00

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

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

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

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

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

| Period: | Worksheet A-8-2 | From 04/01/2022 | To 03/31/2023 | Date/Time Prepared: Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 14-0210

|                 |                |                                    |                |               | -                          | To 03/31/2023      | B Date/Time Pro 9/11/2023 9: |                |
|-----------------|----------------|------------------------------------|----------------|---------------|----------------------------|--------------------|------------------------------|----------------|
|                 | 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            |                | ADMINISTRATIVE & GENERAL           | 16, 436        |               |                            | 1                  |                              |                |
| 2.00            |                | ADULTS & PEDIATRICS                | 915, 104       |               |                            | C                  | 0                            |                |
| 3. 00           |                | SUBPROVIDER - IPF                  | 1, 127, 456    |               |                            | C                  | 0                            |                |
| 4.00            |                | OPERATING ROOM                     | 26, 700        |               |                            | 0                  | 0                            |                |
| 5.00            |                | ANESTHESI OLOGY                    | 176, 338       |               |                            | ) C                | 0                            |                |
| 6.00            |                | LABORATORY                         | 3, 190         |               |                            | 0                  | 0                            |                |
| 7.00            |                | RESPI RATORY THERAPY               | 48, 443        |               |                            | C                  | 0                            |                |
| 8.00            |                | ELECTROCARDI OLOGY                 | 13, 610        |               |                            | ) C                | 0                            |                |
| 9.00            |                | EMERGENCY                          | 1, 067, 216    |               |                            | ) C                | 0                            | 7.00           |
| 10.00           | 0.00           |                                    | 0              | 1             | 1                          | ) C                | 0                            |                |
| 200.00          |                |                                    | 3, 394, 493    |               |                            |                    | 0                            |                |
|                 | Wkst. A Line # | Cost Center/Physician              | Unadjusted RCE |               | Cost of                    | Provi der          | Physician Cost               |                |
|                 |                | ldenti fi er                       | Limit          |               | Memberships &              |                    | of Mal practice              |                |
|                 |                |                                    |                | Limit         | Conti nui ng<br>Educati on | Share of col.      | Insurance                    |                |
|                 | 1.00           | 2.00                               | 8.00           | 9. 00         | 12. 00                     | 13. 00             | 14.00                        |                |
| 1.00            |                | ADMINISTRATIVE & GENERAL           | 8.00           |               |                            |                    |                              | 1. 00          |
| 2. 00           |                | ADULTS & PEDIATRICS                |                | 1             | 1                          |                    | 0                            | 1              |
| 3. 00           |                | SUBPROVIDER - IPF                  | 0              | 1             | 1                          |                    |                              | 1              |
| 4.00            |                | OPERATING ROOM                     | 0              |               |                            |                    |                              | 4. 00          |
| 5. 00           |                | ANESTHESI OLOGY                    | 0              |               | 3, 337                     | ď                  | 45, 504                      |                |
| 6.00            |                | LABORATORY                         | 0              |               |                            | l .                | 0                            | 1              |
| 7. 00           | 65. 00         | RESPI RATORY THERAPY               | 0              |               | o c                        | o c                | 0                            | 1              |
| 8. 00           | 69. 00         | ELECTROCARDI OLOGY                 | 0              |               |                            | ol c               | 0                            | 8. 00          |
| 9.00            | 91.00          | EMERGENCY                          | 0              |               | o c                        | o c                | 0                            | 9. 00          |
| 10.00           | 0.00           |                                    | 0              |               |                            | o c                | 0                            | 10.00          |
| 200.00          |                |                                    | 0              | (             | 3, 337                     | ď                  | 58, 640                      | 200.00         |
|                 | Wkst. A Line # | Cost Center/Physician              | Provi der      | Adjusted RCE  | RCE                        | Adjustment         |                              |                |
|                 |                | I denti fi er                      | Component      | Limit         | Di sal I owance            |                    |                              |                |
|                 |                |                                    | Share of col.  |               |                            |                    |                              |                |
|                 |                |                                    | 14             |               |                            |                    |                              |                |
| 1 00            | 1. 00          | 2.00                               | 15. 00         | 16. 00        | 17. 00                     | 18. 00             |                              | 1 00           |
| 1.00            |                | ADMINISTRATIVE & GENERAL           | 0              |               |                            |                    |                              | 1.00           |
| 2.00            | 1              | ADULTS & PEDIATRICS                | 0              | 1             |                            |                    |                              | 2.00           |
| 3.00            |                | SUBPROVIDER - IPF                  | 0              | 1             | ٧ -                        | 1, 127, 456        |                              | 3. 00          |
| 4. 00           |                | OPERATING ROOM                     | 0              |               |                            | 26, 700            |                              | 4. 00          |
| 5. 00<br>6. 00  |                | ANESTHESI OLOGY<br>LABORATORY      |                |               |                            | 176, 338           | •                            | 5. 00<br>6. 00 |
| 6. 00<br>7. 00  |                | LABURATURY<br>RESPI RATORY THERAPY |                |               |                            | 3, 190<br>48, 443  | •                            |                |
| 7. 00<br>8. 00  |                | ELECTROCARDI OLOGY                 |                |               |                            | 48, 443<br>13, 610 | •                            | 7. 00<br>8. 00 |
| 8. 00<br>9. 00  |                | ELECTROCARDI OLOGY<br>EMERGENCY    |                |               |                            |                    | •                            | 9.00           |
| 9. 00<br>10. 00 | 0.00           | LIVILNUENUT                        |                |               |                            | 1, 067, 216        |                              | 10.00          |
| 200.00          | 0.00           |                                    |                |               |                            | 3, 394, 493        | (                            | 200.00         |
| ∠∪∪. ∪∪         | 1              |                                    | 1              | η             | ار ا                       | y 3, 374, 493      | 'I                           | 1 200. UU      |

Health Financial Systems

HARRISBURG MEDICAL CENTER, INC.

In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0210

Period:
From 04/01/2022
To 03/31/2023

Part I
Date/Time Prepared:
9/11/2023 9: 16 am

CAPITAL RELATED COSTS

Cost Center Description

Net Expenses

BLDG & FIXT | MVBLE EQUIP | EMPLOYEE | Subtotal

| CAPITAL SELATE COSTS   Subtrate   |   |              |              | To          | 03/31/2023  | Date/Time Pre 9/11/2023 9:1 | pared:<br>6 am |
|--|---|--------------|--------------|-------------|-------------|-----------------------------|----------------|
| COST Center Description  |   |              | CAPI TAL REI | ATED COSTS  |             | 77 117 2023 7. 1            | O alli         |
| FOR COST   A   1.00   2.00   4.00   4A   |   |              |              |             |             |                             |                |
| STATE   STAT   | Cost Center Description                       |              | BLDG & FIXT  | MVBLE EQUIP |             | Subtotal                    |                |
| CENERAL SERVICE COST CENTERS   COUNTY   |   |              |              |             |             |                             |                |
| DIRECTAL SERVICE COST CENTERS  |   |              |              |             | DEPARTMENT  |                             |                |
| SPIESMAL SERVICE COST CINTERS   1.00   1.00   2.00   4.00   4.6  |   |              |              |             |             |                             |                |
| GERBRAL SERVICE COST CENTERS   |   |              | 1 00         | 2.00        | 4 00        | 4A                          |                |
| 1.00   00100   CAP REL COSTS-BLIGG & FIXT   3, 027, 332   819, 286   2.00   00200   CAP REL COSTS-SINDE EQUIP   819, 286   2.00   | GENERAL SERVICE COST CENTERS                  |              | 11.00        | 2.00        | 1. 00       |                             |                |
| 4.00   0.0400   Demi-Cover Berneth ITS DEPARTMENT    5.281,572   38,386   207   5,320, 165   4.00   5.00   0.0500   DAMIN ISTRATIL VE GEMERAL   12,376,871   311,366   6.222   5,073   96,616   1,506,457   7.00   0.00     |   | 3, 027, 332  | 3, 027, 332  |             |             |                             | 1.00           |
| 0.0000   ADMINISTRATIVE & CENERAL   12,376,871   311,356   172,144   954,716   13,815,087   5  | 2.00 00200 CAP REL COSTS-MVBLE EQUIP          | 819, 286     |              | 819, 286    |             |                             | 2. 00          |
| 7.00         0000000 (DREADTION) OF PIANT         1,342,506         62,262         5,073         96,161         1,506,457         7,00           9.00         000000 (BUJSEKEFFING         886,232         11,262         676         152,922         1,051,122         9,00           11.00         01000 (DITTARY         886,432         11,262         676         152,922         1,051,122         9,00           11.00         01000 (DITTARY         886,432         11,262         670         10         0         0         0         10         10         10         10         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         11,00         11,00         0         1,00         10           |   | 5, 281, 572  | 38, 386      | 207         | 5, 320, 165 |                             | 4. 00          |
| 0.000   0.0000   LAUNDRY & LINEN SERVICE   90, 398   4, 505   4, 699   0   99,002   8, 000   10.000   0   157,877   10.51,122   9.00   10.000   0   168,366   1, 107,555   10.00   10.000   0   10.000   0   10.0000   10.000   10.000   10.000   10.000   10.000   10.000   10.0000   10.000   10.000   10.000   10.000   10.000   10.000   10.0000   10.000   10.000   10.000   10.000   10.000   10.000   10.0000   10.000   10.00000   10.00000   10.00000   10.00000   10.00000   10.00000   10.000000   10.0000000000  |   |              |              |             | 954, 716    |                             | •              |
| 9.00   00900   HOUSEKEEPINK   886, 232   11, 262   676   152, 952   1, 051, 122   9.00   11.00   01000   DI FARRY   884, 048   55, 149   0   0   0   0   0   0   11.00   11.00   01000   DI FARRY   978   881, 273   436, 419   13.00   13.00   01300   URISIN AN ARMINISTRATION   341, 649   12, 519   978   811, 273   436, 419   13.00   13.00   01300   DIRSIN AN ARMINISTRATION   341, 649   12, 519   978   811, 273   436, 419   13.00   14.00   01400   CENTRAL SERVICES & SUPPLY   412, 631   121, 560   11, 897   71, 610   617, 698   14.00   16.00   01400   DIRRIANCY   633, 790   15, 625   1, 005   102, 546   658, 142   16.00   16.00   01600   DIRRIANCY   633, 790   15, 625   1, 005   102, 546   658, 142   16.00   16.00   01600   DIRRIANCY   633, 790   15, 625   1, 005   102, 546   658, 142   16.00   16.00   01000   DIRRIANCY   634, 790   100, 790   1878   1879   1878  |   |              |              |             |             |                             | •              |
| 10.00   01000   DIETARY   884, 048   55, 149   0   168, 368   1,107, 565   10. 00   13. 00   0300   NURSING ADMINISTRATION   341, 649   12, 519   978   81, 273   436, 419   13. 00   15. 00   0500    |   | 1            |              |             | - 1         |                             | •              |
| 11.00   01100   CAFFERR  | · · · · · · · · · · · · · · · · · · ·         |              |              |             |             |                             | •              |
| 13.00   01300   NURSING ADMINISTRATION   341, 649   12, 519   978   81, 273   436, 419   13.00   15.00   01500   PHARMACY   CST SUPPLY   412, 631   121, 560   11, 756   11, 756   0   161, 568   15.00   19.00   01500   PHARMACY   83, 791   19, 821   61, 756   0   0   0   0   19.00   1   | · · · · · · · · · · · · · · · · · · ·         | 884, 048     |              |             |             |                             | •              |
| 14. 00   01400  CENTRAL SERVICES & SUPPLY  | · · · · · · · · · · · · · · · · · · ·         | 341 649      | _            |             | ٩           |                             | •              |
| 15 00   01500   PHARMACY   15 0   0   15 0   10   16 5 0   16 5 0   16 0   16 0   10   10   10   10   1  |   | 1            |              |             |             |                             | •              |
| 16. 00   01600   MEDICAL RECORDS & LIBRARY   537, 906   15, 625   1, 065   103, 546   658, 142   16. 00   0   0   0   0   19. 0   | · · · · · · · · · · · · · · · · · · ·         |              |              |             | 0           |                             | •              |
| INPATIENT ROUTINE SERVICE COST CENTERS   4, 239, 042   223, 061   65, 686   652, 169   5, 179, 958   30, 00   4000   50UERS & PEDIATRIC S   4, 239, 042   223, 061   65, 686   652, 169   5, 179, 958   30, 00   4000   50UERS & PEDIATRIC S   4, 239, 042   223, 061   65, 686   652, 169   5, 179, 958   30, 00   4000   50UERS & VERTON   5000   700   | · · · · · · · · · · · · · · · · · · ·         |              |              |             | 103, 546    |                             | •              |
| 30. 00   303000 ADULTS & PEDIATRICS   4, 239, 042   223, 061   65, 686   652, 169   5, 179, 986   30. 00   | 19.00 01900 NONPHYSICIAN ANESTHETISTS         | 0            | 0            | 0           | 0           | 0                           | 19. 00         |
| ADDITION    |   |              |              |             |             |                             |                |
| ANCIL LLARY SERVICE COST CENTERS   1,242,187   165,423   101,049   192,279   1,700,938   50,00   53,00   015300   OPERATIN ROOM   1,242,187   165,423   101,049   192,279   0   109,787   53,00   05300   ANESTHESI OLOGY   106,488   0   3,299   0   109,787   53,00   105,400   OS400   RADIOLOGY DIAGNOSTIC   1,331,157   51,545   3,550   202,671   1,298,923   54,00   24,00      |   |              |              | · ·         |             |                             | ł              |
| SOLIC   GOSOO   OPERATING ROOM   1, 242, 187   165, 423   101, 049   192, 279   1, 700, 928   50. 00   53. 00   05300   OBSOON   ABSTHEST   DIOSY   106, 488   50. 00   53. 00   05300   ABSTHEST   DIOSY   10, 648   7, 303   12, 499   56, 019   404, 366   54, 010   54, 02   03440   MAMMOGRAPHY   170, 868   7, 303   0   23, 872   202, 043   54, 02   56, 00   05600   RADIO ISOTOPE   200, 545   44, 290   460   22, 612   267, 907   56, 00   57, 00   5700   CT SCAN   432, 495   12, 471   1, 431   66, 423   512, 820   57, 00   5700   CT SCAN   432, 495   12, 471   1, 431   66, 423   512, 820   57, 00   5700   CT SCAN   432, 495   388, 114   139, 366   27, 030   743, 299   58, 00   64, 00   0500   LABORATORY   3, 062, 811   68, 142   76, 461   235, 114   3, 442, 288   60, 00   600   0600   RESPIRATORY   HERAPY   3, 062, 811   68, 142   76, 461   235, 114   3, 442, 288   60, 00   600   0600   RESPIRATORY   HERAPY   3, 062, 811   68, 142   76, 461   235, 114   3, 442, 288   60, 00   600   0600   RESPIRATORY   HERAPY   433, 082   79, 262   5, 002   105, 294   622, 640   66, 00   66, 00   0600   0600   RESPIRATORAL   164, 550   65, 00   0500   SESPIRATORAL   164, 550   65, 00   0500   SESPIRATORAL   164, 550   65, 00   0500   SESPIRATORAL   164, 550   65, 00   65   |   | 4, 032, 875  | 343, 080     | 12, 698     | 740, 163    | 5, 128, 816                 | 40. 00         |
| 10, 10, 10, 10, 10, 10, 10, 10, 10, 10,  |   | 1 242 107    | 1/5 422      | 101 040     | 100 070     | 1 700 020                   | <br>           |
| 54 00   0.5400   RADIOLOGY-DIAGNOSTIC   1.031,157   51,545   13,550   202,671   1.298,923   54,00     54 01   0.5401   ULTRASOUND   324,017   11,831   12,499   56,019   404,366   54,01     54 02   0.3440   MAMMOGRAPHY   170,868   7,303   0   23,872   202,043   34,02     55 0.0   0.5600   RADIOLISOTOPE   200,545   44,290   460   22,612   267,907   56.00     58 0.0   0.5800   MAGNETIC RESONANCE IMAGING (MRI)   218,789   358,114   139,366   27,030   743,299   58,00     60 0.0   0.000   LBORRATORY   3,062,811   68,142   76,461   235,114   3,442,528   60,00     60 0.0   0.000   LBORRATORY   146,879   979,050   31,415   16,739   139,251   1,166,455   65,00     65 0.0   0.5600   RESPIRATORY HERAPY   979,050   31,415   16,739   139,251   1,166,455   65,00     66 0.0   0.6600   RESPIRATORY HERAPY   433,082   79,262   5,002   105,294   622,640   66,00     66 0.0   0.6600   0.0   0.0   0.0   3,774   19,291   68,00     68 0.0   0.8600   SEECH PATHOLOGY   15,517   0   0   3,774   19,291   68,00     69 0.0   0.000   0.0   0.0   0   0   72,00     70 0.0   70 0.000   LECTROCARDIOLOGY   15,517   0   0   0   0   0   72,00     70 0.0   70 0.000   LECTROCARDIOLOGY   142,061   38,979   6,615   21,895   209,550   69,00     70 0.000   0.000   0.000   0   0   0   0  |   |              |              |             |             |                             | ł              |
| 54.00   05401   ULTRASOUND   324,017   11,831   12,499   56,019   404,366   54.01  |   |              |              |             | -1          | · ·                         | ł              |
| S4 02   03440   MAMMOGRAPHY  |   | 1            |              |             |             |                             | •              |
| 56.00   05600   RADIO I SOTOPE   200, 545   44, 290   460   22, 612   267, 907   56. 00  |   |              |              |             |             |                             | •              |
| 57.00   05700   CT SCAN   432, 495   12, 471   1, 431   66, 423   512, 820   57. 00   58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)   218, 789   358, 114   139, 366   27, 030   743, 299   58. 00   60.00   05000   LABDRATORY   3. 0, 62, 811   68, 142   76, 461   235, 114   3. 442, 528   60. 00   64. 00   65.00   05000   CRESPIRATORY THERAPY   979, 050   31, 415   16, 739   139, 251   1, 166, 455   65. 00   66.00   06000   RESPIRATORY THERAPY   433, 082   79, 262   5, 002   105, 294   622, 640   66. 00   66. 00   07. 00   07   |   |              |              |             |             |                             | •              |
| 60.00   06000   LABORATORY   3, 062, 811   68, 142   76, 451   235, 114   3, 442, 528   60.00   64.00   06400   INTRAVENOUS THERAPY   979, 050   31, 415   16, 739   139, 251   1, 166, 455   65.00   66.00   06500   RESPI RATORY THERAPY   979, 050   31, 415   16, 739   139, 251   1, 166, 455   65.00   66.00   06600   PHYSI CAL THERAPY   433, 082   79, 262   5, 002   105, 294   622, 640   66.00   66.00   0600   0700   00000   00000   00000   00000   00000   00000   00000   000000   |   |              |              |             |             |                             | •              |
| 64.00   06400   INTRAVENOUS THERAPY   0   0   0   0   0   0   0   0   0  | 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)  | 218, 789     | 358, 114     | 139, 366    | 27, 030     | 743, 299                    | 58. 00         |
| 65.00   06500   RESPI RATORY THERAPY   979,050   31,415   16,739   139,251   1,166,455   65.00   66.00   06600   PHYSI CAL THERAPY   212,665   4,552   0   51,722   268,939   67.00   67.00   06700   OCCUPATIONAL THERAPY   212,665   4,552   0   51,722   268,939   67.00   68.00   06800   SPEECH PATHOLOGY   15,517   0   0   0   3,774   19,291   68.00   69.00   06900   ELECTROCARDI OLOGY   142,061   38,979   6,615   21,895   209,550   69.00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   1,281,304   0   0   0   0   0   0   72.00   07200   IMPL DEV. CHARGED TO PATIENTS   2,494,480   0   0   0   0   0   0   75.00   07500   ASC (NON-DISTINCT PART)   951,910   130,522   38,367   211,320   1,332,119   75.00   76.00   03950   FAITH CENTER CHEMOTHERAPY   118,842   26,484   6,941   27,800   180,067   76.00   77.00   07700   ALLOGENEIC HSCT ACQUISITION   0   0   0   0   0   77.00   07000   TOTO   TOTO   TOTO   TOTO   TOTO   TOTO   88.01   08800   RURAL HEALTH CLINIC   1,415,140   228,491   4,129   161,130   1,308,890   88.01   89.01   08801   RURAL HEALTH CLINIC   1   1,415,140   228,491   4,129   161,130   1,308,890   88.01   89.01   09200   09SERVATION BEDS (NON-DISTINCT PART)   54,334,326   2,909,804   802,710   5,229,317   54,109,374   102.00   09200   DESERVATION BEDS (NON-DISTINCT PART)   54,334,326   2,909,804   802,710   5,229,317   54,109,374   103.00   113.00   INTEREST EXPENSE   130,001,1300   INTEREST EXPENSE   130,001,1300   INTEREST EXPENSE   130,001,1300   INTEREST EXPENSE   10,000,000,000,000,000,000,000,000,000,   | 60. 00   06000   LABORATORY                   | 3, 062, 811  | 68, 142      | 76, 461     | 235, 114    | 3, 442, 528                 | 60.00          |
| 66.00   06600   PHYSI CAL THERAPY   433, 082   79, 262   5,002   105, 294   622, 640   66.00   67.00   06700   0CCUPATI ONAL THERAPY   212, 665   4,552   0   51, 722   268, 939   67.00   68.00   06800   SPEECH PATHOLOGY   15, 517   0   0   3, 774   19, 291   68.00   69.00   06900   ELECTROCARDI OLOGY   142, 061   38, 979   6, 615   21, 895   209, 550   69.00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   1, 281, 304   0   0   0   0   1, 281, 304   71.00   72.00   07200   IMPL. DEV. CHARGED TO PATIENTS   2, 494, 480   0   0   0   0   0   0   0   72.00   73.00   07300   DRUGS CHARGED TO PATIENTS   2, 494, 480   0   0   0   149, 526   2, 644, 006   73.00   75.00   07500   ASC (NON-DI STINCT PART)   951, 910   130, 522   38, 367   211, 320   1, 332, 119   75.00   76.00   03950   FAI TH CENTER CHEMOTHERAPY   118, 842   26, 484   6, 941   27, 800   180, 067   76.00   76.00   03950   FAI TH CENTER CHEMOTHERAPY   118, 842   26, 484   6, 941   27, 800   180, 067   76.00   76.00   0700   ALDEROCAL CACOULS ITION   0   0   0   0   0   0   77.00   0700   ALDEROCAL CACOULS ITION   0   0   0   0   0   0   77.00   0700   ALDEROCAL CACOULS ITION   0   0   0   0   0   0   77.00   0700   ALDEROCAL CACOULS ITION   0   0   0   0   0   0   77.00   0700   ALDEROCAL CACOULS ITION   0   0   0   0   0   77.00   0700   ALDEROCAL CACOULS ITION   0   0   0   0   0   78.00   09200   09SERVATI ON BEDS (NON-DISTINCT PART)   0   09200   09SERVATION BEDS (NON-DISTINCT PART)   0   0   0   0   0   0   78.00   09200   09SERVATION BEDS (NON-DISTINCT PART)   0   0   0   0   0   0   0   78.00   09200   09SERVATION BEDS (SUM OF LINES 1 Through 117)   54, 334, 326   2, 909, 804   802, 710   5, 229, 317   54, 109, 374   118.00   78.00   09200   0910   TREATMENT PROGRAM   0   0   0   0   0   0   0   0   79.00   09200   0910 |   | 0            | _            | -           | - 1         |                             | 1              |
| 67. 00   06700   0CCUPATI ONAL THERAPY   212, 665   4, 552   0   51,722   268, 939   67. 0.0   68. 00   06800   SPEECH PATHOLOGY   15,517   0   0   0   3,774   19, 291   68. 00   69. 00   06900   ELECTROCARDI OLOGY   142, 061   38, 979   6, 615   21, 895   209, 550   69. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   1, 281, 304   0   0   0   0   0   0   0   0   72. 00   072.00   IMPL. DEV. CHARGED TO PATI ENTS   2, 494, 480   0   0   0   0   0   0   0   0   0   |   | 1            |              | · ·         | ·           |                             | •              |
| 68.00   06800   SPEECH PATHOLOGY   15,517   0   0   3,774   19,291   68.00   69.00   06900   ELECTROCARDI OLOGY   142,061   38,979   6,615   21,895   209,550   69.00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   1,281,304   0   0   0   0   0   1,281,304   72.00   07200   IMPL. DEV. CHARGED TO PATIENTS   2,494,480   0   0   0   149,526   2,644,006   73.00   73.00   07300   DRUGS CHARGED TO PATIENTS   2,494,480   0   0   149,526   2,644,006   73.00   75.00   07500   ASC (NON-DISTINCT PART)   951,910   130,522   38,367   211,320   1,332,119   75.00   76.00   03950   FAITH CENTER CHEMOTHERAPY   118,842   26,484   6,941   27,800   180,067   76.00   77.00   07700   ALLOGENEI CHECK ACQUISITION   0   0   0   0   0   0   77.00   07700   ALLOGENEI CHECK ACQUISITION   0   0   0   0   0   0   88.01   08800   RURAL HEALTH CLINIC   1,596,213   277,380   6,660   191,268   2,071,521   88.00   88.01   08801   RURAL HEALTH CLINIC   1   1,415,140   228,491   4,129   161,130   1,808,890   88.01   92.00   09200   08ERGENCY   3,443,279   155,014   26,565   294,600   3,919,458   91.00   92.00   09200   08ERGENCY   3,443,279   155,014   26,565   294,600   3,919,458   91.00   92.00   09200   09ERVATION BEDS (NON-DISTINCT PART)   0   0   0   0   0   0   00   010   010   010   010   010   010   010   0118.00   SUBTOTALS (SUM OF LINES   1 through 117)   54,334,326   2,909,804   802,710   5,229,317   54,109,374   118.00   0190.00   PHYSICI ANS' PRIVATE OFFICES   354,869   95,455   15,418   63,124   528,866   192.00   0190.00   00   00   00   00   00   00   00   |   |              |              |             | ·           |                             | •              |
| 69.00   06900   ELECTROCARDI OLOGY   142,061   38,979   6,615   21,895   209,550   69.00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   1,281,304   0   0   0   0   72.00   07200   MPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   0   73.00   07300   DRUGS CHARGED TO PATI ENTS   2,494,480   0   0   149,526   2,644,006   73.00   75.00   07500   ASC (NON-DISTI NCT PART)   951,910   130,522   38,367   211,320   1,332,119   75.00   76.00   03950   FAITH CENTER CHEMOTHERAPY   118,842   26,484   6,941   27,800   180,067   76.00   76.97   07697   CARDI AC REHABI LI TATI ON   105,287   0   7,298   24,304   136,889   76.97   77.00   07700   ALLOGENEI C HSCT ACQUI SI TION   0   0   0   0   0   0   77.00   0700   0700   0700   0700   0700   0700   88.01   08800   RURAL HEALTH CLINI C   1,596,213   277,380   6,660   191,268   2,071,521   88.00   88.01   08801 RURAL HEALTH CLINI C   1,415,140   228,491   4,129   161,130   1,808,890   88.01   92.00   09200   08SERVATI ON BEDS (NON-DISTI NCT PART)   0   9200   09100   08SERVATI ON BEDS (NON-DISTINCT PART)   0   0   0   0   0   0   0   0   0   0   |   |              |              |             |             |                             | •              |
| 77. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   1, 281, 304   0   0   0   0   1, 281, 304   71. 00   72. 00   72. 00   72. 00   72. 00   72. 00   72. 00   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   2, 494, 480   0   0   0   149, 526   2, 644, 006   73. 00   75. 00   07500   ASC (NON-DISTINCT PART)   951, 910   130, 522   38, 367   211, 320   1, 332, 119   75. 00   76. 00   76. 00   7950   ASC (NON-DISTINCT PART)   118, 842   26, 484   6, 941   27, 800   180, 067   76. 00   77. 00   77. 00   77. 00   77. 00   77. 00   77. 00   77. 00   77. 00   77. 00   77. 00   77. 00   77. 00   07. 00   0   0   0   0   0   0   0   0   0  |   |              | -            | · ·         |             |                             | •              |
| 72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   2, 494, 480   0   0   0   149, 526   2, 644, 006   73. 00   75. 00   07500   ASC (NON-DISTINCT PART)   951, 910   130, 522   38, 367   211, 320   1, 332, 119   75. 00   76. 00   03950   FAI TH CENTER CHEMOTHERAPY   118, 842   26, 484   6, 941   27, 800   180, 067   76. 00   76. 97   07697   CARDI AC REHABI LI TATI ON   105, 287   0   7, 298   24, 304   136, 889   76. 97   77. 00   0700   ALLOGENEI CHESCT ACQUI SITION   0   0   0   0   0   0   0   0   0   | · · · · · · · · · · · · · · · · · · ·         |              | _            | 1           |             |                             | 1              |
| 73. 00   07300   DRUGS CHARGED TO PATIENTS   2, 494, 480   0   0   149, 526   2, 644, 006   73. 00   75. 00   07500   ASC (NON-DISTINCT PART)   951, 910   130, 522   38, 367   211, 320   1, 332, 119   75. 00   76. 00   03950   FAI TH CENTER CHEMOTHERAPY   118, 842   26, 484   6, 941   27, 800   180, 067   76. 00   76. 00   07600   ALLOGENEIC HSCT ACQUISITION   0   0   0   0   0   0   0   0   0   |   | 1, 201, 304  |              |             | - 1         |                             | 1              |
| 75. 00   | · · · · · · · · · · · · · · · · · · ·         | 2, 494, 480  | _            |             | - 1         | -                           | •              |
| 76. 00 03950 FAITH CENTER CHEMOTHERAPY 76. 00 03950 FAITH CENTER CHEMOTHERAPY 77. 00 07697 CARDI AC REHABI LI TATI ON 76. 70 07700 ALLOGENEI C HSCT ACQUI SI TI ON 76. 70 0 07700 ALLOGENEI C HSCT ACQUI SI TI ON 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 78. 00 00 ALLOGENEI C HSCT ACQUI SI TI ON 78. 00 00 ALLOGENEI C HSCT ACQUI SI TI ON 78. 00 00 ALLOGENEI C HSCT ACQUI SI TI ON 78. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0  | · · · · · · · · · · · · · · · · · · ·         | 1            |              | 38, 367     |             |                             | 1              |
| 77. 00   07700   ALLOGENEI C HSCT ACQUI SITION   0   0   0   0   0   0   0   0   0   |   |              | 26, 484      |             | 27, 800     |                             | 76. 00         |
| SR. 00   |   | 105, 287     | 0            | 7, 298      | 24, 304     | 136, 889                    | 76. 97         |
| 88. 00   |   | 0            | 0            | 0           | 0           | 0                           | 77. 00         |
| 88. 01   |   |              |              |             |             |                             |                |
| 91. 00   |   |              |              |             |             |                             |                |
| 92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART)   0   92. 00   0THER REIMBURSABLE COST CENTERS   102. 00   10200   OPI OI D TREATMENT PROGRAM   0   0   0   0   0   0   0   102. 00   0   103. 00   113.00   INTEREST EXPENSE   113. 00   SUBTOTALS (SUM OF LINES 1 through 117)   54, 334, 326   2, 909, 804   802, 710   5, 229, 317   54, 109, 374   118. 00   NONREI MBURSABLE COST CENTERS   113. 00   NONREI MBURSABLE COST CENTERS   114. 00   NONREI MBURSABLE COST CENTERS   15, 418   63, 124   528, 866   192. 00   194. 00   07950   MARKETI NG/COMMUNI CATI ON   94, 173   5, 690   1, 158   14, 880   115, 901   194. 00   194. 01   07951   AUXI LI ARY   52, 489   16, 383   0   12, 844   81, 716   194. 01   194. 02   07952   FOUNDATION   55, 262   0   0   0   55, 262   194. 02   200. 00   Negati ve Cost Centers   0   0   0   0   0   0   201. 00   0   0   0   0   0   0   0   0   0  |   |              |              |             |             |                             |                |
| OTHER REIMBURSABLE COST CENTERS   102.00   10200   OPI OI D TREATMENT PROGRAM   O   O   O   O   O   O   102.00   |   | 3, 443, 279  | 155, 014     | 26, 565     | 294, 600    |                             |                |
| 102. 00   10200   OPI OI D TREATMENT PROGRAM   O   O   O   O   O   O   O   O   O   |   |              |              |             |             | 0                           | 72.00          |
| SPECIAL PURPOSE COST CENTERS   113.00   11300   INTEREST EXPENSE   SUBTOTALS (SUM OF LINES 1 through 117)   54, 334, 326   2, 909, 804   802, 710   5, 229, 317   54, 109, 374   118.00   NONREI MBURSABLE COST CENTERS   354, 869   95, 455   15, 418   63, 124   528, 866   192.00   192.00   192.00   192.00   193.00   194.00   194.00   194.00   194.01   1   |   | 0            | 0            | 0           | 0           | 0                           | 102.00         |
| 118.00   SUBTOTALS (SUM OF LINES 1 through 117)   54,334,326   2,909,804   802,710   5,229,317   54,109,374   118.00   |   | _            |              | -1          | -,          |                             |                |
| NONRET MBURSABLE COST CENTERS   192.00   19200   PHYSI CI ANS' PRI VATE OFFI CES   354, 869   95, 455   15, 418   63, 124   528, 866   192.00  |   |              |              |             |             |                             | 113. 00        |
| 192. 00  | 118.00 SUBTOTALS (SUM OF LINES 1 through 117) | 54, 334, 326 | 2, 909, 804  | 802, 710    | 5, 229, 317 | 54, 109, 374                | 118. 00        |
| 194. 00 07950 MARKETI NG/COMMUNI CATI ON 94, 173 5, 690 1, 158 14, 880 115, 901 194. 00 194. 01 07951 AUXI LI ARY 52, 489 16, 383 0 12, 844 81, 716 194. 01 194. 02 07952 FOUNDATI ON 55, 262 0 0 0 55, 262 194. 02 200. 00 Cross Foot Adjustments 0 Negative Cost Centers 0 0 0 0 0 0 201. 00   |   |              |              |             |             |                             |                |
| 194. 01 07951 AUXILIARY 52, 489 16, 383 0 12, 844 81, 716 194. 01 194. 02 07952 FOUNDATION 55, 262 0 0 0 55, 262 194. 02 200. 00 Cross Foot Adjustments 0 Negative Cost Centers 0 0 0 0 0 0 201. 00  |   | 1            |              |             |             |                             | 1              |
| 194. 02 07952     FOUNDATION     55, 262     0     0     55, 262 194. 02       200. 00     Cross Foot Adjustments     0     0     0     0     200. 00       201. 00     Negative Cost Centers     0     0     0     0     0     201. 00  |   |              |              |             |             |                             |                |
| 200.00       Cross Foot Adjustments       0 200.00         201.00       Negative Cost Centers       0 0 0  |   |              |              |             |             |                             |                |
| 201.00   Negative Cost Centers   0 0 0 0 201.00  | 1 1   | 55, 262      | 0            | 0           | O           |                             |                |
|  | 1 1   |              | _            | _           | 0           |                             |                |
|  |   | 54, 891, 119 | 3, 027, 332  |             | -1          |                             |                |
|  | , , , , , , , , , , , , , , , , , , ,         | 1            | , .,, 302    | , _00       | .,, .00     | , ,                         |                |

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0210

Peri od: Worksheet B From 04/01/2022 Part I To 03/31/2023 Date/Time Prepared:

9/11/2023 9:16 am Cost Center Description ADMINISTRATIVE OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY & GENERAL PLANT LINEN SERVICE 9.00 10.00 5.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 1.00 00100 CAP REL COSTS-BLDG & FLXT 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 13, 815, 087 5 00 5 00 7.00 00700 OPERATION OF PLANT 506, 667 2, 013, 124 7.00 00800 LAUNDRY & LINEN SERVICE 33, 297 8.00 3, 468 135, 767 8.00 9.00 00900 HOUSEKEEPI NG 353, 524 8, 669 1, 413, 315 9.00 0 01000 DI ETARY 1, 522, 522 10.00 372, 507 42, 450 0 10.00 01100 CAFETERI A 314, 240 11.00 11.00 13 00 01300 NURSING ADMINISTRATION 146, 781 9,636 0 13, 467 Ω 13.00 01400 CENTRAL SERVICES & SUPPLY 207, 750 93, 570 0 14.00 14 00 0 15.00 01500 PHARMACY 55, 618 15, 257 0 16, 833 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 221, 353 12,027 0 0 16.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 1, 742, 159 171, 699 29, 721 355, 518 779, 343 30.00 04000 SUBPROVIDER - IPF 1, 724, 975 40.00 264, 083 18, 701 222, 871 325, 872 40.00 ANCILLARY SERVICE COST CENTERS 50.00 50.00 05000 OPERATING ROOM 572,076 127, 333 12.170 86.859 0 05300 ANESTHESI OLOGY 36, 925 53.00 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 436, 867 39, 676 11, 874 0 0 54.00 05401 ULTRASOUND 54.01 136,000 9, 107 0 0 0 54.01 03440 MAMMOGRAPHY 54.02 67, 953 5, 621 0 0 0 54.02 34, 092 56, 00 05600 RADI OI SOTOPE 90, 105 0 0 0 56.00 05700 CT SCAN 172, 477 9, 600 0 57.00 57.00 0 0 05800 MAGNETIC RESONANCE I MAGING (MRI) 249, 994 58 00 275, 651 0 0 Λ 58 00 60.00 06000 LABORATORY 1, 157, 825 52, 452 0 41, 073 0 60.00 06400 INTRAVENOUS THERAPY 64.00 C 0 64.00 06500 RESPIRATORY THERAPY 392.314 6.011 32, 320 65.00 24, 182 0 65.00 06600 PHYSI CAL THERAPY 209.413 66.00 61,011 5, 195 30, 300 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 90, 452 3, 504 0 0 0 67.00 06800 SPEECH PATHOLOGY 68.00 6,488 0 0 0 68.00 0 69 00 06900 ELECTROCARDI OLOGY 70 478 30.004 O 0 69 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 430, 941 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72.00 72.00 C 73.00 07300 DRUGS CHARGED TO PATIENTS 889. 259 0 0 73.00 0 07500 ASC (NON-DISTINCT PART) 75.00 448,032 100, 468 14, 990 117, 832 0 75.00 03950 FAITH CENTER CHEMOTHERAPY 76.00 60, 562 20, 386 C 0 76.00 07697 CARDIAC REHABILITATION 76. 97 46,040 0 0 0 76.97 77 00 07700 ALLOGENEIC HSCT ACQUISITION O 0 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 696, 715 213, 511 98, 979 0 88.00 17,810 88. 01 08801 RURAL HEALTH CLINIC II 608, 384 175, 879 7, 421 98, 979 0 88.01 09100 EMERGENCY 91 00 91 00 1 318 231 119, 321 11.874 298 284 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 102. 00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 102. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 13, 552, 162 1, 922, 657 135, 767 1, 413, 315 1, 419, 455 118. 00 118.00 NONREI MBURSABLE COST CENTERS

192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 177, 874 73. 476 0 0 103, 067 192. 00 194. 00 07950 MARKETI NG/COMMUNI CATI ON 38, 981 4, 380 0 0 0 194. 00 194. 01 07951 AUXI LI ARY 27, 484 12, 611 0 0 0 194. 01 194. 02 07952 FOUNDATI ON 0 194, 02 18.586 0 0 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 0 201.00 202.00 TOTAL (sum lines 118 through 201) 13, 815, 087 2, 013, 124 135, 767 1, 413, 315 1, 522, 522 202. 00

Provider CCN: 14-0210

In Lieu of Form CMS-2552-10

| Period: | Worksheet B |
| From 04/01/2022 | Part |
| To 03/31/2023 | Date/Time Prepared: | 9/11/2023 9:16 am |

|         |  |            |                   |            | 03/31/2023 | 9/11/2023 9: 1 |         |
|---------|--|------------|-------------------|------------|------------|----------------|---------|
|         | Cost Center Description                    | CAFETERI A | NURSI NG          | CENTRAL    | PHARMACY   | MEDI CAL       |         |
|         | '  |            | ADMI NI STRATI ON | SERVICES & |            | RECORDS &      |         |
|         |  |            |                   | SUPPLY     |            | LI BRARY       |         |
|         |  | 11. 00     | 13. 00            | 14.00      | 15. 00     | 16. 00         |         |
|         | GENERAL SERVICE COST CENTERS               |            |                   |            |            |                |         |
| 1.00    | 00100 CAP REL COSTS-BLDG & FIXT            |            |                   |            |            |                | 1.00    |
| 2.00    | 00200 CAP REL COSTS-MVBLE EQUIP            |            |                   |            |            |                | 2. 00   |
| 4.00    | 00400 EMPLOYEE BENEFITS DEPARTMENT         |            |                   |            |            |                | 4.00    |
| 5.00    | 00500 ADMINISTRATIVE & GENERAL             |            |                   |            |            |                | 5. 00   |
| 7.00    | 00700 OPERATION OF PLANT                   |            |                   |            |            |                | 7. 00   |
| 8.00    | 00800 LAUNDRY & LINEN SERVICE              |            |                   |            |            |                | 8. 00   |
| 9.00    | 00900 HOUSEKEEPI NG                        |            |                   |            |            |                | 9. 00   |
| 10.00   | 01000 DI ETARY                             |            |                   |            |            |                | 10.00   |
| 11. 00  | 01100 CAFETERI A                           | 314, 240   |                   |            |            |                | 11. 00  |
| 13.00   | 01300 NURSING ADMINISTRATION               | 3, 955     | 610, 258          |            |            |                | 13. 00  |
| 14.00   | 01400 CENTRAL SERVICES & SUPPLY            | 9, 564     |                   | 928, 582   |            |                | 14.00   |
| 15.00   | 01500 PHARMACY                             | 8, 398     | l ol              | 22, 078    | 283, 552   |                | 15. 00  |
| 16.00   | 01600 MEDICAL RECORDS & LIBRARY            | 14, 116    |                   | 2, 627     | 0          | 908, 265       | 16. 00  |
| 19.00   | 01900 NONPHYSICIAN ANESTHETISTS            | 0          |                   | 0          | o          | 0              | 19. 00  |
|         | INPATIENT ROUTINE SERVICE COST CENTERS     |            |                   |            | '          |                |         |
| 30.00   | 03000 ADULTS & PEDIATRICS                  | 51, 631    | 154, 869          | 209, 924   | 0          | 50, 158        | 30.00   |
| 40.00   | 04000 SUBPROVI DER - I PF                  | 76, 734    |                   | 49, 680    | o          | 58, 333        | 40.00   |
|         | ANCILLARY SERVICE COST CENTERS             | ,          | ,                 | ,          | -1         |                |         |
| 50.00   | 05000 OPERATI NG ROOM                      | 14, 002    | 41, 998           | 93, 844    | 0          | 53, 640        | 50.00   |
| 53. 00  | 05300 ANESTHESI OLOGY                      | 0          |                   | 18, 444    | o          | 16, 063        | 53.00   |
| 54.00   | 05400 RADI OLOGY-DI AGNOSTI C              | 17, 876    | l ol              | 7, 544     | o          | 31, 464        | 54.00   |
| 54. 01  | 05401 ULTRASOUND                           | 4, 037     | l ol              | 19, 803    | o          | 34, 861        | 54. 01  |
| 54. 02  | 03440 MAMMOGRAPHY                          | 1, 355     | l ol              | 2, 246     | o          | 4, 000         | 54. 02  |
| 56. 00  | 05600 RADI 0I S0T0PE                       | 1, 429     |                   | 3, 843     | o          | 15, 317        | 56. 00  |
| 57. 00  | 05700 CT SCAN                              | 4, 747     | l ol              | 17, 786    | o          | 150, 195       | 57. 00  |
| 58. 00  | 05800 MAGNETIC RESONANCE IMAGING (MRI)     | 1, 471     | l ol              | 3, 056     | o          | 33, 747        | 58. 00  |
| 60.00   | 06000 LABORATORY                           | 26, 956    | l ol              | 35, 875    | o          | 144, 574       | 1       |
| 64. 00  | 06400 I NTRAVENOUS THERAPY                 | 0          | l ol              | 0          | 0          | 0              | 64. 00  |
| 65. 00  | 06500 RESPI RATORY THERAPY                 | 11, 307    | ا                 | 29, 878    | 0          | 20, 280        | 65. 00  |
| 66. 00  | 06600 PHYSI CAL THERAPY                    | 11, 834    |                   | 6, 370     | 0          | 13, 761        | 66. 00  |
| 67. 00  | 06700 OCCUPATI ONAL THERAPY                | 3, 898     |                   | 596        | 0          | 6, 759         | 67. 00  |
| 68. 00  | 06800 SPEECH PATHOLOGY                     | 284        |                   | 15         | 0          | 493            | 68. 00  |
| 69. 00  | 06900 ELECTROCARDI OLOGY                   | 2, 114     |                   | 3, 468     | 0          | 5, 636         | 69. 00  |
| 71. 00  | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 2,         | ا                 | 0, 130     | 0          | 25, 721        | 71. 00  |
| 72. 00  | 07200 I MPL. DEV. CHARGED TO PATIENTS      | 0          | ا                 | 0          | 0          | 0              | 72. 00  |
| 73. 00  | 07300 DRUGS CHARGED TO PATIENTS            | 0          | ا                 | 0          | 283, 552   | 69, 691        | 73. 00  |
| 75. 00  | 07500 ASC (NON-DISTINCT PART)              | 14, 729    | 44, 180           | 106, 757   | 0          | 35, 192        | 75. 00  |
| 76. 00  | 03950 FAITH CENTER CHEMOTHERAPY            | 2, 166     |                   | 11, 947    | 0          | 2, 248         | 76. 00  |
| 76. 97  | 07697 CARDI AC REHABI LI TATI ON           | 1, 277     | 3, 830            | 3, 236     | o          | 3, 566         | 76. 97  |
| 77. 00  | 07700 ALLOGENEIC HSCT ACQUISITION          | 0          |                   | 0,230      | o          | 0,000          | 77. 00  |
|         | OUTPATIENT SERVICE COST CENTERS            | -          | -1                | -          | -1         |                |         |
| 88. 00  | 08800 RURAL HEALTH CLINIC                  | 0          | 51, 740           | 18, 946    | 0          | 15, 830        | 88. 00  |
| 88. 01  | 08801 RURAL HEALTH CLINIC II               | 0          | o                 | 12, 991    | o          | 15, 422        | 88. 01  |
| 91.00   | 09100 EMERGENCY                            | 25, 945    | 77, 824           |            | o          | 101, 314       | 91.00   |
| 92.00   | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | ,          | , ,               | , ,        |            |                | 92.00   |
|         | OTHER REIMBURSABLE COST CENTERS            |            |                   |            |            |                |         |
| 102.00  | 10200 OPI OI D TREATMENT PROGRAM           | 0          | 0                 | 0          | 0          | 0              | 102.00  |
|         | SPECIAL PURPOSE COST CENTERS               |            |                   |            | -,         |                |         |
| 113. 00 | 11300 I NTEREST EXPENSE                    |            |                   |            |            |                | 113. 00 |
| 118.00  | 1 1  | 309, 825   | 610, 258          | 923, 695   | 283, 552   | 908, 265       |         |
|         | NONREI MBURSABLE COST CENTERS              |            | 2.0, 200          | 1=27 2.12  |            | ,              |         |
| 192.00  | 19200 PHYSI CLANS' PRI VATE OFFI CES       | 1, 393     | O                 | 3, 315     | 0          | 0              | 192. 00 |
|         | 07950 MARKETI NG/COMMUNI CATI ON           | 1, 120     |                   | 1, 367     | 0          |                | 194. 00 |
|         | 07951 AUXI LI ARY                          | 1, 902     |                   | 205        | o o        |                | 194. 01 |
|         | 07952 FOUNDATION                           | 0          |                   | 0          | o o        |                | 194. 02 |
| 200.00  |  |            |                   |            | ٩          | · ·            | 200. 00 |
| 201.00  |  | 0          | ol                | О          | o          | 0              | 201. 00 |
| 202.00  |  | 314, 240   | 610, 258          | 928, 582   | 283, 552   | 908, 265       |         |
|         |  |            |                   |            |            |                |         |

| CATION - GENERAL SERVICE COSTS  Cost Center Description  | NONPHYSI CI AN<br>ANESTHETI STS  | Provi der C<br>Subtotal   | Fr  | ri od:<br>om 04/01/2022<br>03/31/2023  | Worksheet B<br>Part I<br>Date/Time Prep<br>9/11/2023 9:10  |  |
|--|--|---|---|--|--|--|
| Cost Center Description  |  | Subtotal  |   |  |  | J alli   |
|  | 10.00  |   | Intern & Residents Cost & Post Stepdown Adjustments | Total  |  |  |
| NERAL SERVICE COST CENTERS   | 19. 00   | 24. 00  | 25. 00  | 26. 00   |  |  |
| 100 CAP REL COSTS-BLDG & FIXT 200 CAP REL COSTS-MVBLE EQUIP 400 EMPLOYEE BENEFITS DEPARTMENT 500 ADMINISTRATIVE & GENERAL 700 OPERATION OF PLANT 800 LAUNDRY & LINEN SERVICE 900 DIETARY 100 CAFETERIA 800 NURSING ADMINISTRATION 400 CENTRAL SERVICES & SUPPLY 500 PHARMACY 500 MEDICAL RECORDS & LIBRARY 900 NONPHYSICIAN ANESTHETISTS   | 0  |   |   |  |  | 1. 00<br>2. 00<br>4. 00<br>5. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00<br>13. 00<br>14. 00<br>15. 00<br>16. 00<br>19. 00  |
|  |  | 0.704.000   | 4 477 005   | 7 540 (05  |  | 20.00  |
|  | l l  |   |   |  |  | 30. 00<br>40. 00   |
| CILLARY SERVICE COST CENTERS   | <u> </u>   | 0,077,000   | ,,  | 0, 077, 000  |  | 10.00  |
| OOO OPERATING ROOM OOO OPERATING ROOM OOO ANESTHESIOLOGY OO RADIOLOGY-DIAGNOSTIC OOO RADIOLOGY-DIAGNOSTIC OOO RADIOLOGY-DIAGNOSTIC OOO RADIOLOGY-DIAGNOSTIC OOO RAMMOGRAPHY OOO CT SCAN OOO MAGNETIC RESONANCE IMAGING (MRI) OOO LABORATORY OOO INTRAVENOUS THERAPY OOO INTRAVENOUS THERAPY OOO OCCUPATIONAL THERAPY OOO SPEECH PATHOLOGY OOO SPEECH PATHOLOGY OOO BELECTROCARDIOLOGY OOO MEDICAL SUPPLIES CHARGED TO PATIENTS OOO DRUGS CHARGED TO PATIENTS OOO DRUGS CHARGED TO PATIENTS OOO DRUGS CHARGED TO PATIENTS OOO ASC (NON-DISTINCT PART) OOO ALLOGENEIC HSCT ACQUISITION OOO ALLOGENEIC HSCT ACQUISITION | 0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0  | 181, 219 1, 844, 224 608, 174 283, 218 412, 693 867, 625 1, 307, 218 4, 901, 283 0 1, 682, 747 960, 524 374, 148 26, 571 321, 250 1, 737, 966 0 3, 886, 508 2, 214, 299 283, 873 194, 838 | 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0               | 2, 702, 860<br>181, 219<br>1, 844, 224<br>608, 174<br>283, 218<br>412, 693<br>867, 625<br>1, 307, 218<br>4, 901, 283<br>1, 176, 295<br>1, 682, 747<br>960, 524<br>374, 148<br>26, 571<br>321, 250<br>1, 737, 966<br>0<br>3, 886, 508<br>2, 214, 299<br>283, 873<br>194, 838<br>0 |  | 50. 00<br>53. 00<br>54. 00<br>54. 01<br>54. 02<br>56. 00<br>57. 00<br>58. 00<br>60. 00<br>64. 00<br>65. 00<br>66. 00<br>67. 00<br>68. 00<br>69. 00<br>71. 00<br>72. 00<br>73. 00<br>75. 00<br>76. 97<br>77. 00 |
| BOO RURAL HEALTH CLINIC  | 0  |   |   | 3, 185, 052  |  | 88. 00   |
| 100 EMERGENCY<br>200 OBSERVATION BEDS (NON-DISTINCT PART)  | 0 0  |   |   | 2, 727, 966<br>6, 114, 992   |  | 88. 01<br>91. 00<br>92. 00   |
| 200 OPI OI D TREATMENT PROGRAM ECIAL PURPOSE COST CENTERS  | 0  | C   | 0   | 0  |  | 102. 00  |
| SUBTOTALS (SUM OF LINES 1 through 117)<br>  SUBTOTALS (SUM OF LINES 1 through 117)<br>  SPELMBURSABLE COST CENTERS   | 0  | 53, 643, 613  | 0   | 53, 643, 613   |  | 113. 00<br>118. 00   |
| 2000 PHYSICIANS' PRIVATE OFFICES 2500 MARKETING/COMMUNICATION 251 AUXILIARY 252 FOUNDATION Cross Foot Adjustments Negative Cost Centers TOTAL (sum lines 118 through 201)  | 0<br>0<br>0<br>0<br>0<br>0   | 161, 749<br>123, 918<br>73, 848<br>0  | 0<br>0<br>0<br>0<br>0<br>0                          | 887, 991<br>161, 749<br>123, 918<br>73, 848<br>0<br>0<br>54, 891, 119  |  | 192. 00<br>194. 00<br>194. 01<br>194. 02<br>200. 00<br>201. 00<br>202. 00  |
|  | ADMINISTRATIVE & GENERAL OO OPERATION OF PLANT ACOUNTY & LINEN SERVICE OOO HOUSEKEEPING OOO DIETARY IOO CAFETERIA OOO NURSING ADMINISTRATION OO CENTRAL SERVICES & SUPPLY OOO MURSING ADMINISTRATION OOO PHARMACY OOO MODICAL RECORDS & LIBRARY OOO NONPHYSICIAN ANESTHETISTS OOO NONPHYSICIAN ANESTHETISTS OOO ADULTS & PEDIATRICS OOO SUBPROVIDER - IPF CILLARY SERVICE COST CENTERS OOO OPERATING ROOM OOO ANESTHESIOLOGY OOO RADIOLOGY-DIAGNOSTIC OOO RESPIRATORY THERAPY OOO RESPIRATORY THERAPY OOO CESCAN OOO RESPIRATORY THERAPY OOO CUPATIONAL THERAPY OOO PHYSICAL THERAPY OOO SPEECH PATHOLOGY OOO ACCUPATIONAL THERAPY OOO COUPATIONAL THERAPY OOO ACCUPATIONAL THERAPY OOO OOOON THE OOON THE O | STOP   ADMIN STRATIVE & GENERAL   | 1000 ADMIN IN STRATI VE & GENERAL                   | 300   ADMIN ISTRATI VE & GENERAL   | 1000 ADM INISTRATIVE & GENERAL   1000 OPERATION OF PLANT   1000 LAUNDRY & LINEN SERVICE   1000 OPERATION OF PLANT   1000 LAUNDRY & LINEN SERVICE   1000 OPERATION OF PLANT   1000 OPERATION OPERAT | SOO ADMINISTRATIVE & GENERAL (700 OPERATION OF PLANT   |

| Peri od: | Worksheet B | From 04/01/2022 | Part | I | To 03/31/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-0210

|                  |   |               |                   | То          | 03/31/2023        | Date/Time Pre 9/11/2023 9:1 |                  |
|------------------|---|---------------|-------------------|-------------|-------------------|-----------------------------|------------------|
|                  |   |               | CAPI TAL REI      | LATED COSTS |                   | 77 117 2023 7. 1            | O alli           |
|                  |   |               |                   |             |                   |                             |                  |
|                  | Cost Center Description                                       | Di rectl y    | BLDG & FIXT       | MVBLE EQUIP | Subtotal          | EMPLOYEE                    |                  |
|                  |   | Assigned New  |                   |             |                   | BENEFI TS                   |                  |
|                  |   | Capi tal      |                   |             |                   | DEPARTMENT                  |                  |
|                  |   | Related Costs |                   |             |                   |                             |                  |
|                  | CENEDAL CEDALCE COCT CENTERS                                  | 0             | 1. 00             | 2. 00       | 2A                | 4. 00                       |                  |
| 1 00             | GENERAL SERVICE COST CENTERS  OO100 CAP REL COSTS-BLDG & FIXT |               |                   |             |                   |                             | 1 1 00           |
| 1. 00<br>2. 00   | 00200 CAP REL COSTS-BLDG & FIXT                               |               |                   |             |                   |                             | 1. 00<br>2. 00   |
| 4. 00            | 00400 EMPLOYEE BENEFITS DEPARTMENT                            | 0             | 38, 386           | 207         | 38, 593           | 38, 593                     | 4. 00            |
| 5. 00            | 00500 ADMI NI STRATI VE & GENERAL                             | 2, 518        | 311, 356          |             | 486, 018          | 6, 919                      | 5. 00            |
| 7. 00            | 00700 OPERATION OF PLANT                                      | 2,310         | 62, 262           |             | 67, 335           | 701                         | 7. 00            |
| 8. 00            | 00800 LAUNDRY & LINEN SERVICE                                 | 0             | 4, 505            |             | 8, 604            | 0                           | 8. 00            |
| 9. 00            | 00900 HOUSEKEEPI NG   | 0             | 11, 262           |             | 11, 938           |                             | 9. 00            |
| 10. 00           | 01000 DI ETARY  | 0             | 55, 149           |             | 55, 149           | 1, 222                      | 10.00            |
| 11. 00           | 01100 CAFETERI A  | 0             | 0                 |             | 0                 | . 0                         | 11. 00           |
| 13.00            | 01300 NURSING ADMINISTRATION                                  | 0             | 12, 519           | 978         | 13, 497           | 590                         | 13. 00           |
| 14.00            | 01400 CENTRAL SERVICES & SUPPLY                               | 1, 522        | 121, 560          | 11, 897     | 134, 979          | 520                         | 14. 00           |
| 15.00            | 01500 PHARMACY  | 0             | 19, 821           | 61, 756     | 81, 577           | 0                           | 15. 00           |
| 16.00            | 01600 MEDICAL RECORDS & LIBRARY                               | 0             | 15, 625           | 1, 065      | 16, 690           | 751                         | 16. 00           |
| 19. 00           | 01900 NONPHYSICIAN ANESTHETISTS                               | 0             | 0                 | 0           | 0                 | 0                           | 19. 00           |
|                  | INPATIENT ROUTINE SERVICE COST CENTERS                        |               |                   |             |                   |                             |                  |
| 30. 00           | 03000 ADULTS & PEDIATRICS                                     | 5, 466        |                   |             | 294, 213          |                             | 30. 00           |
| 40. 00           | 04000 SUBPROVI DER - I PF                                     | 0             | 343, 080          | 12, 698     | 355, 778          | 5, 370                      | 40. 00           |
|                  | ANCILLARY SERVICE COST CENTERS                                | 05. (10       | 4/5 400           | 101 010     | 504 440           | 4 005                       |                  |
| 50.00            | 05000 OPERATING ROOM  | 254, 640      | · ·               |             | 521, 112          | 1, 395                      | 50.00            |
| 53. 00           | 05300 ANESTHESI OLOGY   | 3, 478        | 0                 | -,          | 6, 777            | 0                           | 53.00            |
| 54. 00<br>54. 01 | 05400 RADI OLOGY-DI AGNOSTI C                                 | 0             | 51, 545           |             | 65, 095           | 1, 471                      | 54.00            |
| 54. 01           | 05401   ULTRASOUND<br>  03440   MAMMOGRAPHY                   | 0             | 11, 831<br>7, 303 | 12, 499     | 24, 330<br>7, 303 | 406<br>173                  | 54. 01<br>54. 02 |
| 56. 00           | 05600 RADI OI SOTOPE  | 0             | 7, 303<br>44, 290 |             | 7, 303<br>44, 750 | 164                         | 56. 00           |
| 57. 00           | 05700 CT SCAN   | 0             | 12, 471           |             | 13, 902           | 482                         | 57.00            |
| 58. 00           | 05800 MAGNETIC RESONANCE IMAGING (MRI)                        | 0             | 358, 114          |             | 497, 480          | 196                         | ł                |
| 60.00            | 06000 LABORATORY  | 0             | 68, 142           |             | 144, 603          | 1, 706                      | 60.00            |
| 64. 00           | 06400 I NTRAVENOUS THERAPY                                    | 0             | 00, 1.12          |             | 0                 | 0                           | 64. 00           |
| 65.00            | 06500 RESPI RATORY THERAPY                                    | 24, 576       | 31, 415           | 16, 739     | 72, 730           | 1, 010                      | 65. 00           |
| 66.00            | 06600 PHYSI CAL THERAPY                                       | 0             | 79, 262           |             | 84, 264           | 764                         | 66. 00           |
| 67.00            | 06700 OCCUPATI ONAL THERAPY                                   | 0             | 4, 552            |             | 4, 552            | 375                         | 67. 00           |
| 68.00            | 06800 SPEECH PATHOLOGY  | 0             | 0                 | 0           | 0                 | 27                          | 68. 00           |
| 69.00            | 06900 ELECTROCARDI OLOGY                                      | 27, 290       | 38, 979           | 6, 615      | 72, 884           | 159                         | 69. 00           |
| 71. 00           | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS                    | 0             | 0                 | 0           | 0                 | 0                           | 71. 00           |
| 72. 00           | 07200 IMPL. DEV. CHARGED TO PATIENTS                          | 0             | 0                 | 0           | 0                 | 0                           | 72. 00           |
| 73. 00           | 07300 DRUGS CHARGED TO PATIENTS                               | 0             | 0                 | 0           | 0                 | 1, 085                      | 1                |
| 75. 00           | 07500 ASC (NON-DISTINCT PART)                                 | 0             | 130, 522          |             | 168, 889          | 1, 533                      | 1                |
| 76. 00           | 03950 FAITH CENTER CHEMOTHERAPY                               | 0             | 26, 484           |             | 33, 425           | 202                         | 76. 00           |
| 76. 97           | 07697 CARDI AC REHABI LI TATI ON                              | 0             | 0                 | , ,         | 7, 298            | 176                         | 76. 97           |
| 77. 00           | 07700 ALLOGENEI C HSCT ACQUI SI TI ON                         | 0             | 0                 | 0           | 0                 | 0                           | 77. 00           |
| 88. 00           | OUTPATIENT SERVICE COST CENTERS  08800 RURAL HEALTH CLINIC    | 444           | 277, 380          | 6, 660      | 284, 484          | 1 200                       | 88. 00           |
|                  | 08801 RURAL HEALTH CLINIC II                                  | 5, 400        |                   |             | 238, 020          |                             | 88. 00           |
|                  | 09100 EMERGENCY   | 0,400         |                   |             | 181, 579          |                             | 91. 00           |
|                  | 09200 OBSERVATION BEDS (NON-DISTINCT PART)                    |               | 155, 014          | 20, 303     | 101, 379          | 2, 130                      | 92.00            |
| 72.00            | OTHER REIMBURSABLE COST CENTERS                               |               |                   |             | <u> </u>          |                             | 72.00            |
| 102 00           | 10200 OPI OI D TREATMENT PROGRAM                              | 0             | 0                 | 0           | 0                 | 0                           | 102. 00          |
|                  | SPECIAL PURPOSE COST CENTERS                                  |               | -                 | -1          | -1                |                             |                  |
| 113.00           | 11300   NTEREST EXPENSE                                       |               |                   |             |                   |                             | 113. 00          |
| 118.00           | SUBTOTALS (SUM OF LINES 1 through 117)                        | 325, 334      | 2, 909, 804       | 802, 710    | 4, 037, 848       | 37, 934                     | 118. 00          |
|                  | NONREI MBURSABLE COST CENTERS                                 |               |                   |             |                   |                             |                  |
| 192.00           | 19200 PHYSICIANS' PRIVATE OFFICES                             | 7, 418        | 95, 455           | 15, 418     | 118, 291          |                             | 192. 00          |
|                  | 07950 MARKETI NG/COMMUNI CATI ON                              | 0             | 5, 690            |             | 6, 848            |                             | 194. 00          |
|                  | 07951 AUXI LI ARY   | 0             | 16, 383           | 0           | 16, 383           |                             | 194. 01          |
|                  | 07952 FOUNDATION  | 0             | 0                 | 0           | 0                 |                             | 194. 02          |
| 200.00           |   |               |                   |             | 0                 |                             | 200. 00          |
| 201.00           |   |               | 0                 | 0           | 0                 |                             | 201. 00          |
| 202.00           | TOTAL (sum lines 118 through 201)                             | 332, 752      | 3, 027, 332       | 819, 286    | 4, 179, 370       | 38, 593                     | 202. 00          |
|                  |   |               |                   |             |                   |                             |                  |

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0210

Peri od: Worksheet B From 04/01/2022 Part II To 03/31/2023 Date/Time Prepared:

9/11/2023 9:16 am Cost Center Description ADMINISTRATIVE OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY & GENERAL PLANT LINEN SERVICE 9.00 10.00 5.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 1.00 00100 CAP REL COSTS-BLDG & FLXT 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 492, 937 5 00 5 00 7.00 00700 OPERATION OF PLANT 18,079 86, 115 7.00 00800 LAUNDRY & LINEN SERVICE 1, 188 9, 940 8.00 148 8.00 9.00 00900 HOUSEKEEPI NG 12, 615 371 26, 034 9.00 0 01000 DI ETARY 0 71, 479 10.00 13, 292 1,816 10.00 11.00 01100 CAFETERI A 0 14, 753 11.00 13 00 01300 NURSING ADMINISTRATION 5, 237 412 0 248 0 13.00 01400 CENTRAL SERVICES & SUPPLY 7.413 4.003 0 14.00 14 00 0 0 15.00 01500 PHARMACY 1, 985 653 0 310 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 7,898 514 0 0 0 16.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 0 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 62, 147 7, 345 2, 177 6, 549 36, 588 30.00 04000 SUBPROVIDER - IPF 15, 299 40.00 61, 551 11, 297 1, 369 4, 105 40.00 ANCILLARY SERVICE COST CENTERS 50.00 20, 413 50.00 05000 OPERATING ROOM 5, 447 891 1,600 0 05300 ANESTHESI OLOGY 1, 318 53.00 53.00 o 54.00 05400 RADI OLOGY-DI AGNOSTI C 15, 588 1, 697 869 0 54.00 05401 ULTRASOUND 54.01 4.853 390 C 0 0 54.01 03440 MAMMOGRAPHY 54.02 2, 425 240 0 0 0 54.02 1, 458 56, 00 05600 RADI OI SOTOPE 3, 215 0 0 0 56.00 05700 CT SCAN 6, 154 0 57.00 57.00 411 0 0 05800 MAGNETIC RESONANCE I MAGING (MRI) 8, 920 58 00 11, 792 0 0 0 58 00 60.00 06000 LABORATORY 41, 314 2, 244 0 757 0 60.00 06400 I NTRAVENOUS THERAPY 64.00 0 0 0 64.00 06500 RESPIRATORY THERAPY 13, 999 1.034 595 0 65.00 440 65.00 06600 PHYSI CAL THERAPY 66.00 7.472 2,610 380 558 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 3, 228 150 C 0 0 67.00 06800 SPEECH PATHOLOGY 0 68.00 232 0 0 68.00 69 00 06900 ELECTROCARDI OLOGY 2 515 1, 283 O 0 0 69 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 15, 377 C 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72.00 72.00 C 73.00 07300 DRUGS CHARGED TO PATIENTS 31, 731 0 0 73.00 C 0 07500 ASC (NON-DISTINCT PART) 15, 987 75.00 4, 298 1, 098 2, 171 0 75.00 76.00 03950 FAITH CENTER CHEMOTHERAPY 2, 161 872 C 0 76.00 07697 CARDIAC REHABILITATION 76. 97 1,643 0 0 0 76.97 77 00 07700 ALLOGENEIC HSCT ACQUISITION O 0 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 24, 860 9, 133 1, 304 1, 823 0 88.00 88. 01 08801 RURAL HEALTH CLINIC II 21, 708 7, 524 543 1,823 0 88.01 09100 EMERGENCY 5, 495 91 00 91 00 47 037 5, 104 869 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 102. 00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 102. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 483, 555 9, 940 26, 034 66, 640 118. 00 118.00 82, 246 NONREI MBURSABLE COST CENTERS

192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 4, 839 192. 00 6.347 3.143 0 0 194. 00 07950 MARKETI NG/COMMUNI CATI ON 1, 391 187 0 0 0 194. 00 194. 01 07951 AUXI LI ARY 981 539 0 0 0 194. 01 194. 02 07952 FOUNDATI ON 0 194, 02 663 0 0 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 0 201.00 202.00 TOTAL (sum lines 118 through 201) 492, 937 86, 115 9, 940 26, 034 71, 479 202. 00

Provider CCN: 14-0210

| Peri od: | Worksheet B | From 04/01/2022 | Part | I | To 03/31/2023 | Date/Time Prepared:

|   |            |                   | То            | 03/31/2023 | Date/Time Pre 9/11/2023 9:1 |                  |
|---|------------|-------------------|---------------|------------|-----------------------------|------------------|
| Cost Center Description   | CAFETERI A | NURSI NG          | CENTRAL       | PHARMACY   | MEDI CAL                    | - Calli          |
| ·   |            | ADMI NI STRATI ON | SERVICES &    |            | RECORDS &                   |                  |
|   | 11.00      | 40.00             | SUPPLY        | 45.00      | LI BRARY                    |                  |
| CENEDAL CEDVICE COCT CENTEDS  | 11. 00     | 13. 00            | 14. 00        | 15. 00     | 16. 00                      |                  |
| GENERAL SERVICE COST CENTERS  1.00   O0100   CAP REL COSTS-BLDG & FIXT              |            |                   |               |            |                             | 1.00             |
| 2. 00   00200 CAP REL COSTS-MVBLE EQUIP   |            |                   |               |            |                             | 2.00             |
| 4. 00   00400 EMPLOYEE BENEFITS DEPARTMENT  |            |                   |               |            |                             | 4.00             |
| 5. 00 00500 ADMI NI STRATI VE & GENERAL   |            |                   |               |            |                             | 5. 00            |
| 7. 00 00700 OPERATION OF PLANT  |            |                   |               |            |                             | 7. 00            |
| 8.00 00800 LAUNDRY & LINEN SERVICE  |            |                   |               |            |                             | 8. 00            |
| 9. 00 00900 HOUSEKEEPI NG   |            |                   |               |            |                             | 9. 00            |
| 10. 00   01000   DI ETARY   |            |                   |               |            |                             | 10.00            |
| 11. 00  01100  CAFETERI A   | 14, 753    |                   |               |            |                             | 11. 00           |
| 13.00 O1300 NURSING ADMINISTRATION  | 186        |                   |               |            |                             | 13. 00           |
| 14. 00   01400   CENTRAL SERVI CES & SUPPLY   | 449        |                   | 147, 364      |            |                             | 14. 00           |
| 15. 00   01500   PHARMACY   | 394        |                   | 3, 504        | 88, 423    | 0, 000                      | 15.00            |
| 16. 00 01600 MEDI CAL RECORDS & LI BRARY  | 663        |                   | 417           | 0          | 26, 933                     | 16.00            |
| 19. 00 01900 NONPHYSI CLAN ANESTHETI STS I NPATI ENT ROUTI NE SERVI CE COST CENTERS | 0          | 0                 | 0             | 0          | 0                           | 19. 00           |
| 30. 00 03000 ADULTS & PEDIATRICS  | 2, 424     | 5, 119            | 33, 314       | 0          | 1, 489                      | 30.00            |
| 40. 00   04000 SUBPROVI DER - I PF  | 3, 602     |                   | 7, 884        | Ö          |                             | 40. 00           |
| ANCI LLARY SERVI CE COST CENTERS  | 0,002      | ,,,,,,            | 7,001         | <u> </u>   | 1,702                       | 10.00            |
| 50. 00 05000 OPERATI NG ROOM  | 657        | 1, 388            | 14, 893       | 0          | 1, 592                      | 50.00            |
| 53. 00 05300 ANESTHESI OLOGY  | 0          | o                 | 2, 927        | 0          | 477                         | 53. 00           |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C  | 839        | 0                 | 1, 197        | 0          | 934                         | 54.00            |
| 54. 01   05401   ULTRASOUND   | 190        | 0                 | 3, 143        | 0          | 1, 035                      | 54. 01           |
| 54. 02   03440   MAMMOGRAPHY  | 64         | 0                 | 356           | 0          | 119                         | 54. 02           |
| 56. 00   05600   RADI 01 SOTOPE   | 67         | 0                 | 610           | 0          | 455                         | 56. 00           |
| 57. 00   05700   CT   SCAN  | 223        | 0                 | 2, 823        | 0          | 4, 427                      | 57. 00           |
| 58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)                                      | 69         | 0                 | 485<br>5, 693 | 0          | 1, 002                      | 58.00            |
| 60.00   06000   LABORATORY<br>64.00   06400   INTRAVENOUS THERAPY                   | 1, 266     | 0                 | 5, 693        | 0          | 4, 292<br>0                 | 60. 00<br>64. 00 |
| 65. 00   06500   RESPI RATORY   THERAPY   | 531        |                   | 4, 742        | 0          | 602                         | 65.00            |
| 66. 00 06600 PHYSI CAL THERAPY  | 556        |                   | 1, 011        | 0          | 408                         | 66. 00           |
| 67. 00 06700 OCCUPATI ONAL THERAPY  | 183        |                   | 95            | Ö          | 201                         | 67. 00           |
| 68. 00 06800 SPEECH PATHOLOGY   | 13         |                   | 2             | Ö          | 15                          | 68. 00           |
| 69. 00 06900 ELECTROCARDI OLOGY   | 99         |                   | 550           | 0          | 167                         | 69.00            |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS                                    | 0          | o                 | 0             | 0          | 764                         | 71. 00           |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS  | 0          | o                 | 0             | 0          | 0                           | 72. 00           |
| 73.00 07300 DRUGS CHARGED TO PATIENTS   | 0          | 0                 | 0             | 88, 423    | 2, 069                      | 73. 00           |
| 75. 00 07500 ASC (NON-DISTINCT PART)  | 691        | 1, 460            | 16, 942       | 0          | 1, 045                      | 75. 00           |
| 76. 00 03950 FAI TH CENTER CHEMOTHERAPY   | 102        |                   | 1, 896        | 0          | 67                          | 76. 00           |
| 76. 97 07697 CARDI AC REHABI LI TATI ON   | 60         | l I               | 513           | 0          | 106                         | 76. 97           |
| 77. 00 O7700 ALLOGENEIC HSCT ACQUISITION OUTPATIENT SERVICE COST CENTERS            | 0          | 0                 | 0             | 0          | 0                           | 77. 00           |
| 88. 00 08800 RURAL HEALTH CLINIC  | 0          | 1, 710            | 3, 007        | 0          | 470                         | 88. 00           |
| 88. 01 08801 RURAL HEALTH CLINIC II   |            | 1,,10             | 2, 062        | Ö          | 458                         | 88. 01           |
| 91. 00   09100   EMERGENCY  | 1, 218     | 2, 572            | 38, 522       | 0          | 3, 007                      | 91.00            |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)                                    |            |                   |               |            |                             | 92. 00           |
| OTHER REIMBURSABLE COST CENTERS   |            |                   |               |            |                             |                  |
| 102.00 10200 OPIOLD TREATMENT PROGRAM   | 0          | 0                 | 0             | 0          | 0                           | 102. 00          |
| SPECIAL PURPOSE COST CENTERS  | T          | 1                 |               |            |                             |                  |
| 113. 00 11300   INTEREST EXPENSE  | 14 54/     | 20 170            | 14/ 500       | 00 400     | 27 022                      | 113.00           |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS         | 14, 546    | 20, 170           | 146, 588      | 88, 423    | 26, 933                     | 118. 00          |
| 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES  | 65         |                   | 526           | 0          | 0                           | 192. 00          |
| 194. 00 07950 MARKETI NG/COMMUNI CATI ON  | 53         |                   | 217           | 0          |                             | 194. 00          |
| 194. 01 07951 AUXI LI ARY   | 89         |                   | 33            | Ö          |                             | 194. 01          |
| 194. 02 07952 FOUNDATI ON   | 0          |                   | 0             | ő          |                             | 194. 02          |
| 200.00 Cross Foot Adjustments   | 1          | 1                 |               |            |                             | 200. 00          |
| 201.00 Negative Cost Centers  | 0          | o                 | 0             | o          |                             | 201. 00          |
| 202.00   TOTAL (sum lines 118 through 201)  | 14, 753    | 20, 170           | 147, 364      | 88, 423    | 26, 933                     | 202. 00          |
|   |            |                   |               |            |                             |                  |

| Heal th   | Financial Systems HA  | ARRISBURG MEDICA                | L CENTER, INC.       |  | In Lie                                      | u of Form CMS-2552-10   |
|---|---|---------------------------------|----------------------|--|---|---|
| ALLOCA  | TION OF CAPITAL RELATED COSTS   |                                 | Provider C           |  | Period:<br>From 04/01/2022<br>To 03/31/2023 | Worksheet B Part II Date/Time Prepared: 9/11/2023 9:16 am   |
|   | Cost Center Description   | NONPHYSI CI AN<br>ANESTHETI STS | Subtotal             | Intern & Residents Cos & Post Stepdown Adjustments |   |   |
|   | OFNEDAL CEDIUSE COCT OFNITEDO   | 19. 00                          | 24. 00               | 25. 00   | 26. 00                                      |   |
| 1 00  | GENERAL SERVICE COST CENTERS  | T                               |                      | T  |   | 1 00  |
| 1. 00<br>2. 00<br>4. 00<br>5. 00<br>7. 00<br>8. 00<br>9. 00<br>11. 00<br>13. 00<br>14. 00<br>15. 00<br>16. 00<br>19. 00 | 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY | 0                               |                      |  |   | 1. 00<br>2. 00<br>4. 00<br>5. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00<br>13. 00<br>14. 00<br>15. 00<br>16. 00 |
| 19.00   | 01900 NONPHYSI CLAN ANESTHETI STS   | l o                             |                      |  |   | 19.00   |
| 30. 00  | INPATI ENT ROUTI NE SERVI CE COST CENTERS   03000   ADULTS & PEDI ATRI CS   |                                 | 456, 097             | 7  | 0 456, 097                                  | 30.00   |
| 40. 00  | 04000 SUBPROVI DER - I PF   |                                 | 475, 566             | 1  | 0 475, 566                                  | 40.00   |
| 10.00   | ANCI LLARY SERVI CE COST CENTERS  |                                 | 1,70,7000            | 1  | 1,0,000                                     | 10.00   |
| 50.00   | 05000 OPERATI NG ROOM   |                                 | 569, 388             | 3  | 0 569, 388                                  | 50.00   |
| 53.00   | 05300 ANESTHESI OLOGY   |                                 | 11, 499              |  | 0 11, 499                                   | 53. 00  |
| 54. 00  | 05400 RADI OLOGY-DI AGNOSTI C   |                                 | 87, 690              | 1  | 0 87, 690                                   | 54. 00  |
| 54. 01  | 05401 ULTRASOUND  |                                 | 34, 347              | 1  | 0 34, 347                                   | 54. 01  |
| 54. 02  | 03440 MAMMOGRAPHY   |                                 | 10, 680              | 1  | 0 10, 680                                   | 54. 02  |
| 56. 00<br>57. 00  | 05600   |                                 | 50, 719<br>28, 422   | 1  | 0 50, 719<br>0 28, 422                      | 56. 00<br>57. 00  |
| 58. 00  | 05800 MAGNETIC RESONANCE IMAGING (MRI)  |                                 | 519, 944             |  | 0 519, 944                                  | 58.00   |
| 60.00   | 06000 LABORATORY  |                                 | 201, 875             | 1  | 0 201, 875                                  | 60.00   |
| 64. 00  | 06400 I NTRAVENOUS THERAPY  |                                 | C                    | 1  | 0 0   | 64. 00  |
| 65.00   | 06500 RESPI RATORY THERAPY  |                                 | 95, 683              | 3  | 0 95, 683                                   | 65. 00  |
| 66. 00  | 06600 PHYSI CAL THERAPY   |                                 | 98, 023              | 1  | 0 98, 023                                   | 66. 00  |
| 67. 00  | 06700 OCCUPATI ONAL THERAPY   |                                 | 8, 784               | 1  | 0 8, 784                                    | 67. 00  |
| 68. 00  | 06800 SPEECH PATHOLOGY  |                                 | 289                  | 1  | 0 289                                       | 68. 00  |
| 69. 00<br>71. 00  | 06900 ELECTROCARDI OLOGY  |                                 | 77, 657              | 1  | 0 77, 657<br>0 16, 141                      | 69. 00<br>71. 00  |
| 71.00   | 07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   07200   MPL. DEV. CHARGED TO PATIENTS  |                                 | 16, 141              | 1  | 0 16, 141<br>0 0                            | 71.00   |
| 73. 00  | 07300 DRUGS CHARGED TO PATIENTS   |                                 | 123, 308             | 1  | 0 123, 308                                  | 73. 00  |
| 75. 00  | 07500 ASC (NON-DISTINCT PART)   |                                 | 214, 114             | 1  | 0 214, 114                                  | 75. 00  |
| 76.00   | 03950 FAITH CENTER CHEMOTHERAPY   |                                 | 38, 940              |  | 0 38, 940                                   | 76. 00  |
| 76. 97  | 07697 CARDI AC REHABI LI TATI ON  |                                 | 9, 923               | 1  | 0 9, 923                                    | 76. 97  |
| 77. 00  | 07700 ALLOGENEIC HSCT ACQUISITION   |                                 | C                    | )  | 0 0   | 77. 00  |
| 00 00   | OUTPATIENT SERVICE COST CENTERS   |                                 | 220 170              | 1  | 0 220 170                                   | 88.00   |
| 88. 00<br>88. 01  | 08800  RURAL HEALTH CLINIC<br>  08801  RURAL HEALTH CLINIC II   |                                 | 328, 179<br>273, 307 |  | 0 328, 179<br>0 273, 307                    | 88. 00<br>88. 01  |
| 91. 00  | 09100 EMERGENCY   |                                 | 287, 541             |  | 0 287, 541                                  | 91.00   |
| 92. 00  | 09200 OBSERVATION BEDS (NON-DISTINCT PART)  |                                 | 207,011              | 1  | 0 207, 311                                  | 92.00   |
|   | OTHER REIMBURSABLE COST CENTERS   | · · · · · ·                     |                      | '  | - 1   |   |
| 102.00  | 10200 OPIOID TREATMENT PROGRAM  |                                 | C                    | )  | 0 0   | 102. 00   |
|   | SPECIAL PURPOSE COST CENTERS  |                                 |                      |  |   |   |
|   | 11300 I NTEREST EXPENSE   |                                 |                      |  |   | 113. 00   |
| 118.00  | 5 /   | 0                               | 4, 018, 116          | <u> </u>   | 0 4, 018, 116                               | 118. 00   |
| 102.00  | NONREI MBURSABLE COST CENTERS 19200 PHYSI CI ANS' PRI VATE OFFI CES   | T                               | 122 440              | J  | 0 133, 669                                  | 192. 00   |
|   | 07950 MARKETI NG/COMMUNI CATI ON  |                                 | 133, 669<br>8, 804   |  | 0 133, 669<br>0 8, 804                      | 194. 00   |
|   | 07951 AUXI LI ARY   |                                 | 18, 118              |  | 0 18, 118                                   | 194. 00   |
|   | 07952 FOUNDATION  |                                 | 663                  |  | 0 663                                       | 194. 02   |
| 200.00  |   | 0                               | C                    | 1  | 0 0   | 200. 00   |
| 201.00  | Negative Cost Centers   | 0                               | C                    | 1  | 0 0   | 201. 00   |
| 202.00  | TOTAL (sum lines 118 through 201)   | 0                               | 4, 179, 370          | )  | 0 4, 179, 370                               | 202. 00   |
|   |   |                                 |                      |  |   |   |

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 14-0210 Peri od: Worksheet B-1 From 04/01/2022 03/31/2023 Date/Time Prepared: 9/11/2023 9:16 am CAPITAL RELATED COSTS BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliation ADMINISTRATIVE Cost Center Description (SQUARE FEET) (DOLLAR VALUE) BENEFITS & GENERAL (ACCUM. COST) DEPARTMENT (GROSS SALARI ES) 1.00 2.00 5. 00 4.00 5A GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 127 683 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 806, 874 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 1,619 21, 303, 121 4.00 204 00500 ADMINISTRATIVE & GENERAL 3, 822, 873 5 00 169 536 -13, 815, 087 41, 076, 032 5 00 13 132 7.00 00700 OPERATION OF PLANT 2,626 4, 996 386, 872 1, 506, 457 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 190 4,037 99, 002 8.00 00900 HOUSEKEEPI NG 475 612, 453 0 1, 051, 122 9.00 9.00 666 0 01000 DI ETARY 1, 107, 565 10 00 10.00 2,326 C 674, 183 11.00 01100 CAFETERI A 0 11.00 01300 NURSING ADMINISTRATION 528 963 0 13.00 325, 435 436, 419 13.00 0 01400 CENTRAL SERVICES & SUPPLY 617, 698 14.00 11.717 286, 741 14.00 5.127 165, 368 15.00 01500 PHARMACY 836 60,820 C15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 659 1, 049 414, 620 0 658, 142 16.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 9, 408 64, 691 2, 611, 435 5, 179, 958 30.00 04000 SUBPROVIDER - IPF 5, 128, 816 40.00 14, 470 12, 506 2, 963, 781 40.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 6,977 99, 518 1, 700, 938 50.00 769, 928 0 53.00 05300 ANESTHESI OLOGY 3, 249 109, 787 53 00 13, 345 1, 298, 923 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 2, 174 811, 541 54.00 0 05401 ULTRASOUND 499 224, 313 404, 366 54.01 12, 310 54.01 54.02 03440 MAMMOGRAPHY 308 95. 590 202, 043 54.02 0 56.00 05600 RADI OI SOTOPE 1,868 453 90, 543 267, 907 56.00 265, 972 57.00 05700 CT SCAN 526 1, 409 0 512, 820 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 15.104 137, 255 108, 233 743, 299 58.00 60.00 06000 LABORATORY 2,874 75, 303 941, 452 3, 442, 528 60.00 06400 I NTRAVENOUS THERAPY 0 0 0 64.00 64.00 65.00 06500 RESPIRATORY THERAPY 1, 325 16, 485 557, 593 1, 166, 455 65.00 06600 PHYSI CAL THERAPY 622, 640 66,00 3, 343 4, 926 421, 622 66,00 67.00 06700 OCCUPATIONAL THERAPY 192 207, 108 268, 939 67.00 06800 SPEECH PATHOLOGY 68.00 15, 112 0 0 0 0 0 0 19, 291 68.00 06900 ELECTROCARDI OLOGY 6, 515 209, 550 69.00 87,671 69.00 1.644 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1, 281, 304 71.00 0  $\cap$ 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 C 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 598, 737 2, 644, 006 73.00 1, 332, 119 07500 ASC (NON-DISTINCT PART) 5.505 75 00 37 786 846, 174 75 00 03950 FAITH CENTER CHEMOTHERAPY 76.00 1, 117 6, 836 111, 317 180, 067 76.00 76. 97 07697 CARDIAC REHABILITATION 7, 187 97, 319 136, 889 76. 97 07700 ALLOGENEIC HSCT ACQUISITION 77.00 77.00 0 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 11, 699 6,559 765, 880 0 2, 071, 521 88.00 08801 RURAL HEALTH CLINIC II 0 1, 808, 890 88.01 88.01 9,637 4,066 645, 203 91.00 09100 EMERGENCY 6.538 26, 163 1, 179, 645 0 3, 919, 458 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 102. 00 0 0 0 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 122, 726 790, 550 20, 939, 346 -13, 815, 087 40, 294, 287 118. 00 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 252.764 528, 866 192, 00 4.026 15, 184 194. 00 07950 MARKETI NG/COMMUNI CATI ON 240 1, 140 59, 581 0 115, 901 194. 00 194. 01 07951 AUXI LI ARY 0 81, 716 194. 01 691 51, 430 55, 262 194. 02 194. 02 07952 FOUNDATION C 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 3, 027, 332 819, 286 5, 320, 165 13, 815, 087 202. 00 Part I) 203.00 0.249736 0. 336330 203. 00 Unit cost multiplier (Wkst. B, Part I) 23 709750 1 015383 204.00 Cost to be allocated (per Wkst. B, 38, 593 492, 937 204. 00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.001812 0. 012001 205. 00 II)206.00 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 Parts III and IV)

Health Financial Systems HARRISBURG MEDICAL CENTER, INC. In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 14-0210 Peri od: Worksheet B-1 From 04/01/2022 03/31/2023 Date/Time Prepared: 9/11/2023 9:16 am Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A (TIME SPENT) (MEALS SERVED) (ASSI GNED PLANT LINEN SERVICE (SQUARE FEET) (POUNDS OF TIME) LAUNDRY) 11.00 7.00 9.00 10.00 8.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 7.00 00700 OPERATION OF PLANT 110, 306 7.00 00800 LAUNDRY & LINEN SERVICE 36, 590 190 8.00 8.00 00900 HOUSEKEEPI NG 9.00 475 2,099 9.00 10.00 01000 DI ETARY 2.326 C 121, 205 10.00 01100 CAFETERI A 25, 016 444, 510 11.00 11.00 0 01300 NURSING ADMINISTRATION 5, 594 13.00 528 C 20 0 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 5, 127 C С 0 13, 529 14.00 15.00 01500 PHARMACY 836 25 0 11,879 15.00 01600 MEDICAL RECORDS & LIBRARY 0 19, 968 16.00 659 C 0 16.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 0 0 19.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 9, 408 8. 010 528 62, 042 73, 035 30.00 04000 SUBPROVIDER - IPF 25, 942 108, 544 40 00 14.470 5 040 331 40 00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 6, 977 3, 280 129 0 19, 806 50.00 0 53.00 05300 ANESTHESI OLOGY C 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 0 2 174 25, 287 54 00 3.200 54 00 54.01 05401 ULTRASOUND 499 C 0 0 5, 710 54.01 54.02 03440 MAMMOGRAPHY 308 0 0 0 0 0 0 0 1, 917 54.02 56 00 05600 RADI OI SOTOPE Ω 0 2, 022 56 00 1,868 0 57.00 05700 CT SCAN 526 C 6, 715 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 15, 104 0 2, 081 58.00 58.00 60.00 06000 LABORATORY 2,874 0 61 38, 131 60.00 06400 I NTRAVENOUS THERAPY 64 00 Ω 0 0 64 00 1,620 65.00 06500 RESPIRATORY THERAPY 1.325 48 15, 994 65.00 06600 PHYSI CAL THERAPY 1, 400 45 16, 740 66.00 3.343 0 0 0 0 0 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 192 C 5, 514 67.00 06800 SPEECH PATHOLOGY 0 402 68.00 0 Ω 68 00 69.00 06900 ELECTROCARDI OLOGY 1,644 C 0 2, 990 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 0 0 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0 C 0 73.00 75.00 07500 ASC (NON-DISTINCT PART) 5,505 4,040 175 20, 835 75.00 76.00 03950 FAITH CENTER CHEMOTHERAPY 1, 117 C 0 0 3,064 76.00 0 07697 CARDIAC REHABILITATION 76.97 0 1, 806 76.97 C 07700 ALLOGENEIC HSCT ACQUISITION O 77.00 0 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 11, 699 4, 800 147 88.00 08801 RURAL HEALTH CLINIC II 2,000 88.01 9,637 147 0 0 88.01 91.00 09100 EMERGENCY 6,538 3, 200 443 0 36, 701 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 0 0 102. 00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 102. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 2, 099 118.00 105, 349 36, 590 113,000 438, 264 118. 00 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 4,026 0 8, 205 1, 971 192. 00 194. 00 07950 MARKETI NG/COMMUNI CATI ON 0 1, 584 194. 00 240 0 194. 01 07951 AUXI LI ARY 2, 691 194. 01 691 Ω 0 0 194. 02 07952 FOUNDATION C 0 0 0 194. 02 200.00 Cross Foot Adjustments 200.00 Negative Cost Centers 201.00 201.00 202.00 Cost to be allocated (per Wkst. B, 2, 013, 124 135, 767 1, 413, 315 1, 522, 522 314, 240 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 18. 250358 3.710495 673. 327775 12.561544 0. 706936 203. 00 Cost to be allocated (per Wkst. B, 204.00 86.115 9, 940 26, 034 71.479 14, 753 204. 00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.780692 0.271659 12.403049 0.589736 0. 033189 205. 00 II)206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207. 00

Parts III and IV)

|                  | •  | IKKI SBUKG WEDI CA |                      |                     |                          | Warden D 1                  |                    |
|------------------|--|--------------------|----------------------|---------------------|--------------------------|-----------------------------|--------------------|
| COST A           | LLOCATION - STATISTICAL BASIS  |                    | Provi der Co         |                     | eriod:<br>rom 04/01/2022 | Worksheet B-1               |                    |
|                  |  |                    |                      |                     | o 03/31/2023             |                             |                    |
|                  | 0 1 0 1 0 1 1  | MILIDOLAIO         | OFNEDAL              | DUA DIA OV          | MEDICAL                  | 9/11/2023 9: 1              | 6 am               |
|                  | Cost Center Description  | NURSI NG           | CENTRAL              | PHARMACY            | MEDI CAL                 | NONPHYSI CI AN              |                    |
|                  |  | ADMI NI STRATI ON  | SERVICES &<br>SUPPLY | (COSTED<br>REQUIS.) | RECORDS &<br>LI BRARY    | ANESTHETI STS<br>(ASSI GNED |                    |
|                  |  | (DI RECT NURS.     | (COSTED              | KLQUI 3. )          | (GROSS                   | TIME)                       |                    |
|                  |  | HRS. )             | REQUIS.)             |                     | CHARGES)                 | 11 W.L.)                    |                    |
|                  |  | 13. 00             | 14. 00               | 15. 00              | 16.00                    | 19. 00                      |                    |
| -                | GENERAL SERVICE COST CENTERS   | '                  |                      | •                   | '                        |                             |                    |
| 1.00             | 00100 CAP REL COSTS-BLDG & FLXT  |                    |                      |                     |                          |                             | 1.00               |
| 2.00             | 00200 CAP REL COSTS-MVBLE EQUIP  |                    |                      |                     |                          |                             | 2. 00              |
| 4.00             | 00400 EMPLOYEE BENEFITS DEPARTMENT   |                    |                      |                     |                          |                             | 4. 00              |
| 5.00             | 00500 ADMI NI STRATI VE & GENERAL  |                    |                      |                     |                          |                             | 5. 00              |
| 7.00             | 00700 OPERATION OF PLANT   |                    |                      |                     |                          |                             | 7.00               |
| 8. 00<br>9. 00   | OO8OO  LAUNDRY & LINEN SERVICE<br>  OO9OO  HOUSEKEEPING                    |                    |                      |                     |                          |                             | 8. 00<br>9. 00     |
| 10.00            | 01000 DI ETARY   |                    |                      |                     |                          |                             | 10.00              |
| 11. 00           | 01100 CAFETERI A   |                    |                      |                     |                          |                             | 11. 00             |
| 13.00            | 01300 NURSING ADMINISTRATION   | 287, 793           |                      |                     |                          |                             | 13.00              |
| 14.00            | 01400 CENTRAL SERVICES & SUPPLY  | 0                  | 512, 273             |                     |                          |                             | 14. 00             |
| 15.00            | 01500 PHARMACY   | 0                  | 12, 180              | 1, 895, 743         |                          |                             | 15. 00             |
| 16.00            | 01600 MEDICAL RECORDS & LIBRARY  | 0                  | 1, 449               |                     | 1 1                      |                             | 16. 00             |
| 19. 00           | 01900 NONPHYSICIAN ANESTHETISTS  | 0                  | 0                    | C                   | 0                        | 0                           | 19. 00             |
|                  | I NPATI ENT ROUTI NE SERVI CE COST CENTERS                                 | 70.005             | 445.000              | 1                   |                          |                             |                    |
| 30.00            | 03000 ADULTS & PEDI ATRI CS  | 73, 035            | 115, 809             |                     |                          | 0                           |                    |
| 40. 00           | 04000 SUBPROVI DER - I PF<br>ANCI LLARY SERVI CE COST CENTERS              | 108, 146           | 27, 407              | C                   | 7, 730, 325              | 0                           | 40. 00             |
| 50. 00           | 05000 OPERATING ROOM   | 19, 806            | 51, 771              |                     | 7, 108, 459              | 0                           | 50.00              |
| 53. 00           | 05300 ANESTHESI OLOGY  | 17,000             | 10, 175              |                     | 1 1                      | 0                           | 1                  |
| 54. 00           | 05400 RADI OLOGY-DI AGNOSTI C  | o                  | 4, 162               |                     | _,,                      | 0                           |                    |
| 54. 01           | 05401 ULTRASOUND   | 0                  | 10, 925              |                     |                          | 0                           | 1                  |
| 54.02            | 03440 MAMMOGRAPHY  | 0                  | 1, 239               | C                   | 530, 069                 | 0                           | 54. 02             |
| 56.00            | 05600 RADI OI SOTOPE   | 0                  | 2, 120               |                     | _,,                      | 0                           | 56. 00             |
| 57. 00           | 05700 CT SCAN  | 0                  | 9, 812               | 1                   | ,,                       | 0                           |                    |
| 58. 00           | 05800 MAGNETIC RESONANCE IMAGING (MRI)                                     | 0                  | 1, 686               |                     | 1 1                      | 0                           |                    |
| 60. 00<br>64. 00 | 06000  LABORATORY<br> 06400  I NTRAVENOUS THERAPY                          | 0                  | 19, 791<br>0         |                     | 1 . , , , , , , , , , ,  | 0                           |                    |
| 65. 00           | 06500 RESPIRATORY THERAPY  | 0                  | 16, 483              | 1                   | -                        | 0                           | 1                  |
| 66. 00           | 06600 PHYSI CAL THERAPY  | 0                  | 3, 514               |                     |                          | 0                           | 1                  |
| 67. 00           | 06700 OCCUPATI ONAL THERAPY  | o                  | 329                  |                     | 895, 761                 | 0                           | 67. 00             |
| 68.00            | 06800 SPEECH PATHOLOGY   | O                  | 8                    | C                   | 65, 362                  | 0                           | 68. 00             |
| 69. 00           | 06900 ELECTROCARDI OLOGY   | 0                  | 1, 913               | C                   | 746, 832                 | 0                           | 69. 00             |
| 71. 00           | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS                                 | 0                  | 0                    |                     | 3, 408, 588              | 0                           |                    |
| 72. 00           | 07200 I MPL. DEV. CHARGED TO PATIENTS                                      | 0                  | 0                    |                     | 0                        | 0                           |                    |
| 73. 00<br>75. 00 | 07300 DRUGS CHARGED TO PATLENTS<br>07500 ASC (NON-DISTINCT PART)           | 20, 835            | 0<br>E0 00E          |                     |                          | 0                           |                    |
| 76. 00           | 03950 FAITH CENTER CHEMOTHERAPY  | 3, 064             | 58, 895<br>6, 591    |                     |                          | 0                           | 1                  |
| 76. 97           | 07697 CARDI AC REHABI LI TATI ON   | 1, 806             | 1, 785               |                     |                          | 0                           | 1                  |
| 77. 00           | 07700 ALLOGENEIC HSCT ACQUISITION  | 0                  | 0                    |                     |                          | 0                           | 1                  |
|                  | OUTPATIENT SERVICE COST CENTERS  |                    |                      |                     |                          |                             |                    |
|                  | 08800 RURAL HEALTH CLINIC  | 24, 400            | 10, 452              |                     | 1 1                      | 0                           | 1                  |
|                  | 08801 RURAL HEALTH CLINIC II   | 0                  | 7, 167               |                     |                          |                             |                    |
| 91.00            | 09100 EMERGENCY  | 36, 701            | 133, 914             | C                   | 13, 426, 189             | 0                           |                    |
| 92.00            | 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS |                    |                      |                     |                          |                             | 92.00              |
| 102.00           | 10200 OPI OI D TREATMENT PROGRAM   | l                  | 0                    | C                   | o                        | 0                           | 102. 00            |
| 102.00           | SPECIAL PURPOSE COST CENTERS   | ٩                  |                      |                     | <u> </u>                 | 0                           | 102.00             |
| 113.00           | 11300   INTEREST EXPENSE   |                    |                      |                     |                          |                             | 113. 00            |
| 118.00           | SUBTOTALS (SUM OF LINES 1 through 117)                                     | 287, 793           | 509, 577             | 1, 895, 743         | 120, 355, 889            | 0                           | 118. 00            |
|                  | NONREI MBURSABLE COST CENTERS  |                    |                      |                     |                          |                             |                    |
|                  | 19200 PHYSI CI ANS' PRI VATE OFFI CES                                      | 0                  | 1, 829               |                     | 1                        |                             | 192. 00            |
|                  | 07950 MARKETI NG/COMMUNI CATI ON   | 0                  | 754                  |                     |                          |                             | 194. 00            |
|                  | 07951   AUXI LI ARY<br>  07952   FOUNDATI ON                               | 0                  | 113                  | i e                 | ١                        |                             | 194. 01<br>194. 02 |
| 200.00           |  | U U                | 0                    | 1                   | 0                        | U                           | 200.00             |
| 200.00           |  |                    |                      |                     |                          |                             | 201. 00            |
| 202.00           | 3  | 610, 258           | 928, 582             | 283, 552            | 908, 265                 | 0                           | 202. 00            |
|                  | Part I)  |                    | ,                    |                     | 100, 200                 | _                           |                    |
| 203.00           | Unit cost multiplier (Wkst. B, Part I)                                     | 2. 120475          | 1. 812670            | 0. 149573           | 0. 007546                | 0. 000000                   | 203. 00            |
| 204.00           |  | 20, 170            | 147, 364             | 88, 423             | 26, 933                  | 0                           | 204. 00            |
|                  | Part II)   | 0.070005           | 0.007//7             |                     |                          |                             |                    |
| 205.00           |  | 0. 070085          | 0. 287667            | 0. 046643           | 0.000224                 | 0. 000000                   | 205. 00            |
| 206.00           |  |                    |                      |                     |                          |                             | 206. 00            |
| 200.00           | (per Wkst. B-2)  |                    |                      |                     |                          |                             | 200.00             |
| 207.00           |  |                    |                      |                     |                          |                             | 207. 00            |
|                  | Parts III and IV)  |                    |                      |                     |                          |                             |                    |
|                  |  |                    |                      |                     |                          |                             |                    |
|                  |  |                    |                      |                     |                          |                             |                    |

HARRISBURG MEDICAL CENTER, INC.

In Lieu of Form CMS-2552-10
Worksheet B-2

Health Financial Systems
POST STEPDOWN ADJUSTMENTS

| Provider CCN: 14-0210   Peri od: From 04/01/2022   To 03/31/2023   Peri od: From 04/01/2022   Date/Ti me Prepared: 9/11/2023 9:16 am  | Health Financial Systems F | ARRI SBURG MEDI CAL CENTER, INC. |            |              |               | u of Form CMS-2 | 2552-10 |
|--|----------------------------|----------------------------------|------------|--------------|---------------|-----------------|---------|
| To 03/31/2023   Date/Time Prepared: 9/11/2023 9: 16 am   | POST STEPDOWN ADJUSTMENTS  |                                  | Provider C | CCN: 14-0210 |               |                 |         |
| Description   CODE   |                            |                                  |            |              | To 03/31/2023 | Date/Time Pre   |         |
| 1.00   2.00   3.00   4.00   1.00      |                            |                                  |            | Wor          | ksheet        |                 |         |
| 1.00   |                            | Descri pt                        | on         | CODE         | Li ne No.     | Amount          |         |
| DI ALYSI S  ADJ FOR EPO COSTS IN HOME  1 94.00 0 2.00 PROGRAM  3.00 ADJ FOR ARANESP COSTS IN  4.00 ADJ FOR ARANESP COSTS IN  5.00 ADJ FOR ARANESP COSTS IN  DI ALYSI S  ADJ FOR ARANESP COSTS IN  ADJ FOR ESA COSTS IN RENAL  DI ALYSI S  ADJ FOR ESA COSTS IN RENAL  DI ALYSI S  ADJ FOR ESA COSTS IN HOME  PROGRAM  ADJ FOR ESA COSTS IN HOME  ADJ FOR ESA COSTS IN HOME  PROGRAM  ADJ FOR ESA COSTS IN HOME  |                            | 1. 00                            |            | 2. 00        | 3. 00         | 4. 00           |         |
| 2.00 ADJ FOR EPO COSTS IN HOME PROGRAM 3.00 ADJ FOR ARANESP COSTS IN 1 74.00 0 3.00  4.00 ADJ FOR ARANESP COSTS IN 1 94.00 0 4.00  ADJ FOR ARANESP COSTS IN 1 94.00 0 5.00  HOME PROGRAM 5.00 ADJ FOR ESA COSTS IN RENAL 1 74.00 0 5.00  DI ALYSI S 1 94.00 0 6.00  PROGRAM 7.00 ADJ FOR ESA COSTS IN HOME 1 94.00 0 6.00  ADJ FOR ESA COSTS IN HOME 1 94.00 0 6.00  ADJ FOR ESA COSTS IN HOME 1 94.00 0 6.00  | 1. 00                      | ADJ FOR EPO COSTS                | IN RENAL   |              | 1 74.00       | 0               | 1. 00   |
| PROGRAM  3. 00  ADJ FOR ARANESP COSTS IN  4. 00  ADJ FOR ARANESP COSTS IN  ADJ FOR ARANESP COSTS IN  ADJ FOR ARANESP COSTS IN  HOME PROGRAM  5. 00  ADJ FOR ESA COSTS IN RENAL  DI ALYSIS  ADJ FOR ESA COSTS IN HOME  PROGRAM  7. 00  ADJ FOR ESA COSTS IN HOME  ADJ FOR |                            |                                  |            |              |               |                 |         |
| 3.00 ADJ FOR ARANESP COSTS IN 1 74.00 0 3.00 RENAL DIALYSIS 4.00 ADJ FOR ARANESP COSTS IN 1 94.00 0 4.00 HOME PROGRAM 5.00 ADJ FOR ESA COSTS IN RENAL 1 74.00 0 5.00 DIALYSIS 6.00 ADJ FOR ESA COSTS IN HOME 1 94.00 0 6.00 PROGRAM 7.00 ADJ FOR ESA COSTS IN HOME 1 30.00 -1,176,295 7.00   | 2. 00                      | ADJ FOR EPO COSTS                | IN HOME    |              | 1 94.00       | 0               | 2. 00   |
| RENAL DI ALYSI S 4. 00 ADJ FOR ARANESP COSTS IN 1 94. 00 0 4. 00 HOME PROGRAM 5. 00 ADJ FOR ESA COSTS IN RENAL 1 74. 00 0 5. 00 DI ALYSI S ADJ FOR ESA COSTS IN HOME 1 94. 00 0 6. 00 PROGRAM 7. 00 ADULTS & PEDI ATRICS 1 30. 00 -1, 176, 295 7. 00   |                            | PROGRAM                          |            |              |               |                 |         |
| 4. 00 ADJ FOR ARANESP COSTS IN 1 94. 00 0 4. 00 HOME PROGRAM 5. 00 ADJ FOR ESA COSTS IN RENAL 1 74. 00 0 5. 00 DI ALYSI S 6. 00 ADJ FOR ESA COSTS IN HOME 1 94. 00 0 6. 00 PROGRAM 7. 00 ADULTS & PEDIATRICS 1 30. 00 -1, 176, 295 7. 00   | 3. 00                      |                                  | OSTS IN    |              | 1 74.00       | 0               | 3. 00   |
| HOME PROGRAM 5.00 ADJ FOR ESA COSTS IN RENAL 1 74.00 0 5.00 DI ALYSI S 6.00 ADJ FOR ESA COSTS IN HOME 1 94.00 0 6.00 PROGRAM 7.00 ADULTS & PEDIATRICS 1 30.00 -1,176,295 7.00  |                            |                                  |            |              |               |                 |         |
| 5.00 ADJ FOR ESA COSTS IN RENAL 1 74.00 0 5.00 DI ALYSI S 6.00 ADJ FOR ESA COSTS IN HOME 1 94.00 0 6.00 PROGRAM 7.00 ADULTS & PEDIATRICS 1 30.00 -1,176,295 7.00   | 4. 00                      |                                  | OSTS IN    |              | 1 94.00       | 0               | 4. 00   |
| DI ALYSI S 6. 00 ADJ FOR ESA COSTS IN HOME 1 94. 00 0 6. 00 PROGRAM 7. 00 ADULTS & PEDIATRICS 1 30. 00 -1, 176, 295 7. 00  |                            |                                  |            |              |               |                 |         |
| 6.00 ADJ FOR ESA COSTS IN HOME 1 94.00 0 6.00 PROGRAM 7.00 ADULTS & PEDIATRICS 1 30.00 -1,176,295 7.00   | 5. 00                      |                                  | IN RENAL   |              | 1 74.00       | 0               | 5. 00   |
| PROGRAM 7. 00 ADULTS & PEDIATRICS 1 30. 00 -1, 176, 295 7. 00  |                            |                                  |            |              |               |                 |         |
| 7. 00 ADULTS & PEDIATRICS 1 30. 00 -1, 176, 295 7. 00  | 6. 00                      |                                  | IN HOME    |              | 1 94.00       | 0               | 6. 00   |
|  |                            |                                  |            |              |               |                 |         |
| 0.00   |                            |                                  | CS         |              |               |                 |         |
| 8.00   I  64.00  1,176,295  8.00   | 8.00                       | I V THERAPY                      |            |              | 1 64.00       | 1, 176, 295     | 8. 00   |

| Health Financial Systems                 | HARRISBURG MEDICAL CENTER, INC. | In Lie   | u of Form CMS-2552-10 |
|--|---------------------------------|----------|-----------------------|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | Provi der CCN: 14-0210          | Peri od: | Worksheet C           |

Part I Date/Time Prepared: To 03/31/2023 9/11/2023 9:16 am Title XVIII Hospi tal PPS Costs Total Cost Therapy Limit Cost Center Description Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 4. 00 1.00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 30 00 03000 ADULTS & PEDIATRICS 7.548.685 7, 548, 685 7, 548, 685 40.00 04000 SUBPROVIDER - IPF 8,099,385 8, 099, 385 8, 099, 385 40.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 2, 702, 860 2, 702, 860 2, 702, 860 50.00 0 53.00 05300 ANESTHESI OLOGY 181, 219 181, 219 181, 219 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1,844,224 1, 844, 224 0 1, 844, 224 54.00 0 05401 ULTRASOUND 608, 174 608, 174 608, 174 54.01 54.01 03440 MAMMOGRAPHY 283, 218 54.02 283, 218 283, 218 54 02 0 56.00 05600 RADI OI SOTOPE 412, 693 412, 693 412, 693 56.00 57.00 05700 CT SCAN 867, 625 867, 625 0 0 0 0 0 0 0 0 0 0 0 0 867, 625 57.00 1, 307, 218 1, 307, 218 1, 307, 218 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 06000 LABORATORY 4, 901, 283 60.00 4, 901, 283 4, 901, 283 60.00 64.00 06400 I NTRAVENOUS THERAPY 1, 176, 295 1, 176, 295 1, 176, 295 64.00 06500 RESPIRATORY THERAPY 65.00 1, 682, 747 1, 682, 747 1, 682, 747 65.00 06600 PHYSI CAL THERAPY 66 00 960 524 960 524 960 524 66 00 06700 OCCUPATIONAL THERAPY 67.00 374, 148 374, 148 374, 148 67.00 68.00 06800 SPEECH PATHOLOGY 26, 571 26, 571 26, 571 68.00 69.00 06900 ELECTROCARDI OLOGY 321, 250 321, 250 321, 250 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71 00 1, 737, 966 1, 737, 966 1, 737, 966 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 07300 DRUGS CHARGED TO PATIENTS 3, 886, 508 73.00 3, 886, 508 3, 886, 508 73.00 2, 214, 299 75 00 07500 ASC (NON-DISTINCT PART) 2, 214, 299 2, 214, 299 75 00 03950 FAITH CENTER CHEMOTHERAPY 76.00 283, 873 283, 873 283, 873 76.00 76.97 07697 CARDIAC REHABILITATION 194, 838 194, 838 0 194, 838 76. 97 07700 ALLOGENEIC HSCT ACQUISITION 77.00 0 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 3, 185, 052 3, 185, 052 0 3, 185, 052 88.00 88. 01 08801 RURAL HEALTH CLINIC II 2, 727, 966 2, 727, 966 0 2, 727, 966 88.01 91.00 09100 EMERGENCY 6, 114, 992 6, 114, 992 o 6, 114, 992 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 3, 114, 149 3, 114, 149 3, 114, 149 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 102. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 56, 757, 762 56, 757, 762 0 56, 757, 762 200. 00 201.00 Less Observation Beds 3, 114, 149 3, 114, 149 3, 114, 149 201. 00 ol 53, 643, 613 202. 00 202.00 Total (see instructions) 53, 643, 613 53, 643, 613

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 14-0210 Peri od: Worksheet C From 04/01/2022 Part I 03/31/2023 Date/Time Prepared: 9/11/2023 9:16 am Title XVIII Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA + col . 7) Ratio I npati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 2, 062, 905 2, 062, 905 30.00 30.00 40.00 04000 SUBPROVIDER - IPF 7, 730, 325 7, 730, 325 40.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 278, 402 6, 830, 057 7, 108, 459 0. 380231 0.000000 50.00 05300 ANESTHESI OLOGY 53.290 2,075,445 2, 128, 735 0.085130 0.000000 53.00 53 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 105, 785 4, 063, 886 4, 169, 671 0.442295 0.000000 54.00 54.01 05401 ULTRASOUND 321, 582 4, 298, 171 4, 619, 753 0. 131646 0.000000 54.01 03440 MAMMOGRAPHY 530, 069 530, 069 0.534304 0.000000 54.02 54.02 05600 RADI OI SOTOPE 28 847 2, 029, 786 0. 203318 0.000000 56.00 2,000,939 56.00 57.00 05700 CT SCAN 936, 675 18, 959, 048 19, 895, 723 0.043609 0.000000 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 144, 729 4, 327, 485 4, 472, 214 0. 292298 0.000000 58.00 1, 702, 296 06000 LABORATORY 0.255821 0.000000 60.00 17, 456, 741 19, 159, 037 60.00 64.00 06400 I NTRAVENOUS THERAPY 443.542 1,087,188 1, 530, 730 0.768454 0.000000 64.00 06500 RESPIRATORY THERAPY 1, 436, 249 1, 251, 277 2, 687, 526 0.626132 0.000000 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 495, 329 1, 328, 226 1, 823, 555 0.526732 0.000000 66.00 06700 OCCUPATIONAL THERAPY 396, 682 499.079 895.761 0.417687 67.00 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 6,862 58, 500 65, 362 0.406521 0.000000 68.00 06900 ELECTROCARDI OLOGY 632, 592 0.430150 0.000000 69.00 114, 240 746, 832 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 379, 836 3, 408, 588 0.509879 0.000000 71.00 3, 028, 752 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 1,620,064 7, 615, 468 9, 235, 532 0.420821 0.000000 73.00 75.00 07500 ASC (NON-DISTINCT PART) 14, 428 4, 649, 235 4, 663, 663 0.474798 0.000000 75.00 297, 964 297, 964 76 00 03950 FAITH CENTER CHEMOTHERAPY 0 952709 0.000000 76 00 76.97 07697 CARDIAC REHABILITATION 278 472, 274 472, 552 0.412310 0.000000 76.97 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0.000000 0.000000 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 2, 097, 813 2, 097, 813 88.00 88. 01 08801 RURAL HEALTH CLINIC II 0 2,043,795 2, 043, 795 88.01 91.00 09100 EMERGENCY 790, 437 12, 635, 752 13, 426, 189 0. 455453 0.000000 91.00 92 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 702, 890 2, 350, 460 3, 053, 350 1.019912 0.000000 92 00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 102.00

19, 765, 673

19, 765, 673

100, 590, 216

100, 590, 216

120, 355, 889

120, 355, 889

113 00

200.00

201. 00

202.00

SPECIAL PURPOSE COST CENTERS

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

113. 00 11300 | I NTEREST | EXPENSE

200.00

201.00

202.00

|   |               |             | To 03/31/2023 | Date/Time Prepared: 9/11/2023 9:16 am |
|---|---------------|-------------|---------------|---------------------------------------|
| -   |               | Title XVIII | Hospi tal     | PPS                                   |
| Cost Center Description                           | PPS Inpatient |             | <u> </u>      |                                       |
|   | Ratio         |             |               |                                       |
|   | 11. 00        |             |               |                                       |
| INPATIENT ROUTINE SERVICE COST CENTERS            |               |             |               |                                       |
| 30. 00   03000   ADULTS & PEDI ATRI CS            |               |             |               | 30.00                                 |
| 40. 00 04000 SUBPROVI DER - I PF                  |               |             |               | 40. 00                                |
| ANCILLARY SERVICE COST CENTERS                    |               |             |               |                                       |
| 50.00   05000   OPERATING ROOM                    | 0. 380231     |             |               | 50. 00                                |
| 53. 00 05300 ANESTHESI OLOGY                      | 0. 085130     |             |               | 53. 00                                |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C          | 0. 442295     |             |               | 54. 00                                |
| 54. 01   05401   ULTRASOUND                       | 0. 131646     |             |               | 54. 01                                |
| 54. 02   03440   MAMMOGRAPHY                      | 0. 534304     |             |               | 54. 02                                |
| 56. 00   05600   RADI 0I SOTOPE                   | 0. 203318     |             |               | 56. 00                                |
| 57. 00   05700   CT   SCAN                        | 0. 043609     |             |               | 57. 00                                |
| 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)      | 0. 292298     |             |               | 58. 00                                |
| 60. 00   06000   LABORATORY                       | 0. 255821     |             |               | 60.00                                 |
| 64. 00 06400 I NTRAVENOUS THERAPY                 | 0. 768454     |             |               | 64. 00                                |
| 65. 00 06500 RESPI RATORY THERAPY                 | 0. 626132     |             |               | 65. 00                                |
| 66. 00 06600 PHYSI CAL THERAPY                    | 0. 526732     |             |               | 66. 00                                |
| 67. 00 06700 OCCUPATI ONAL THERAPY                | 0. 417687     |             |               | 67. 00                                |
| 68. 00 06800 SPEECH PATHOLOGY                     | 0. 406521     |             |               | 68. 00                                |
| 69. 00 06900 ELECTROCARDI OLOGY                   | 0. 430150     |             |               | 69. 00                                |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS  | 0. 509879     |             |               | 71. 00                                |
| 72.00 07200 I MPL. DEV. CHARGED TO PATIENTS       | 0. 000000     |             |               | 72. 00                                |
| 73.00 07300 DRUGS CHARGED TO PATIENTS             | 0. 420821     |             |               | 73. 00                                |
| 75. 00 07500 ASC (NON-DISTINCT PART)              | 0. 474798     |             |               | 75. 00                                |
| 76.00 03950 FAITH CENTER CHEMOTHERAPY             | 0. 952709     |             |               | 76. 00                                |
| 76. 97 07697 CARDI AC REHABI LI TATI ON           | 0. 412310     |             |               | 76. 97                                |
| 77. 00 07700 ALLOGENEIC HSCT ACQUISITION          | 0. 000000     |             |               | 77. 00                                |
| OUTPATIENT SERVICE COST CENTERS                   | 1             |             |               |                                       |
| 88. 00 08800 RURAL HEALTH CLINIC                  |               |             |               | 88.00                                 |
| 88. 01 08801 RURAL HEALTH CLINIC II               |               |             |               | 88. 01                                |
| 91. 00   09100   EMERGENCY                        | 0. 455453     |             |               | 91.00                                 |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 1. 019912     |             |               | 92. 00                                |
| OTHER REIMBURSABLE COST CENTERS                   |               |             |               |                                       |
| 102. 00 10200 OPI OI D TREATMENT PROGRAM          |               |             |               | 102. 00                               |
| SPECIAL PURPOSE COST CENTERS                      |               |             |               | 112 00                                |
| 113. 00 11300 I NTEREST EXPENSE                   |               |             |               | 113. 00                               |
| 200.00 Subtotal (see instructions)                |               |             |               | 200. 00                               |
| 201.00 Less Observation Beds                      |               |             |               | 201. 00                               |
| 202.00   Total (see instructions)                 | 1             |             |               | 202. 00                               |

| Health Financial Systems HA                        | RRISBURG MEDICA | AL CENTER, INC. |                | In Lie                                      | eu of Form CMS- | 2552-10 |
|--|-----------------|-----------------|----------------|---|-----------------|---------|
| APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL | COSTS           | Provi der C     |                | Period:<br>From 04/01/2022<br>To 03/31/2023 |                 |         |
|  |                 | Titl∈           | XVIII          | Hospi tal                                   | PPS             |         |
| Cost Center Description                            | Capi tal        | Swing Bed       | Reduced        | Total Patient                               | Per Diem (col.  |         |
|  | Related Cost    | Adjustment      | Capi tal       | Days  | 3 / col . 4)    |         |
|  | (from Wkst. B,  |                 | Related Cost   |   |                 |         |
|  | Part II, col.   |                 | (col . 1 - col |   |                 |         |
|  | 26)             |                 | 2)             |   |                 |         |
|  | 1.00            | 2.00            | 3.00           | 4. 00                                       | 5. 00           |         |
| INPATIENT ROUTINE SERVICE COST CENTERS             |                 |                 |                |   |                 |         |
| 30.00 ADULTS & PEDIATRICS                          | 456, 097        | 61              | 456, 03        | 6 3, 112                                    | 146. 54         | 30.00   |
| 40. 00   SUBPROVI DER - I PF                       | 475, 566        | 0               | 475, 56        | 6 5, 559                                    | 85. 55          | 40.00   |
| 200.00 Total (lines 30 through 199)                | 931, 663        |                 | 931, 60        | 2 8, 671                                    |                 | 200. 00 |
| Cost Center Description                            | I npati ent     | I npati ent     |                |   |                 |         |
|  | Program days    | Program         |                |   |                 |         |
|  |                 | Capital Cost    |                |   |                 |         |
|  |                 | (col. 5 x col.  |                |   |                 |         |
|  |                 | 6)              |                |   |                 |         |
|  | 6.00            | 7. 00           |                |   |                 |         |
| INPATIENT ROUTINE SERVICE COST CENTERS             |                 |                 |                |   |                 |         |
| 30. 00 ADULTS & PEDIATRICS                         | 829             | 121, 482        |                |   |                 | 30.00   |
| 40. 00 SUBPROVI DER - I PF                         | 620             | 53, 041         |                |   |                 | 40. 00  |
| 200.00 Total (lines 30 through 199)                | 1, 449          | 174, 523        |                |   |                 | 200. 00 |

| Heal th Financial | Systems   | HARRI SBURG MEDI CAL             | CENTER, INC.      | In Lie | u of Form CMS-2552-10 |
|-------------------|-----------|----------------------------------|-------------------|--------|-----------------------|
| ADDODTI ONMENT OF | LNDATLENT | ANOLILIADY CEDVICE CADITAL COCTO | D 1 1 00N 44 0040 | n      | W I I I D             |

| Heal th          | Health Financial Systems HARRISBURG MEDICAL CENTER, INC. In Lieu of Form CMS-2552-10 |                |                |              |                                  |                          |         |  |  |
|------------------|--|----------------|----------------|--------------|----------------------------------|--------------------------|---------|--|--|
| APPORT           | TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA                                       | L COSTS        | Provi der C    | CN: 14-0210  | Peri od:                         | Worksheet D              |         |  |  |
|                  |  |                |                |              | From 04/01/2022<br>To 03/31/2023 | Part II<br>Date/Time Pre | narod:  |  |  |
|                  |  |                |                |              | 10 03/31/2023                    | 9/11/2023 9:1            |         |  |  |
|                  |  |                | Title          | XVIII        | Hospi tal                        | PPS                      |         |  |  |
|                  | Cost Center Description  | Capi tal       | Total Charges  | Ratio of Cos | t Inpatient                      | Capital Costs            |         |  |  |
|                  |  |                | (from Wkst. C, |              | Program                          | (column 3 x              |         |  |  |
|                  |  | (from Wkst. B, | Part I, col.   |              | . Charges                        | column 4)                |         |  |  |
|                  |  | Part II, col.  | 8)             | 2)           |                                  |                          |         |  |  |
|                  |  | 26)            |                |              |                                  |                          |         |  |  |
|                  | I  | 1.00           | 2. 00          | 3. 00        | 4. 00                            | 5. 00                    |         |  |  |
|                  | ANCILLARY SERVICE COST CENTERS   |                | 7 400 450      |              | 154 ((0                          | 40.440                   |         |  |  |
| 50.00            | 05000 OPERATI NG ROOM  | 569, 388       |                | l .          |                                  | 12, 149                  |         |  |  |
| 53.00            | 05300 ANESTHESI OLOGY  | 11, 499        |                |              |                                  | 168                      |         |  |  |
| 54.00            | 05400 RADI OLOGY - DI AGNOSTI C  | 87, 690        |                | 1            |                                  | 2, 076                   |         |  |  |
| 54. 01           | 05401 ULTRASOUND   | 34, 347        |                |              |                                  | 1, 532                   |         |  |  |
| 54. 02           | 03440 MAMMOGRAPHY  | 10, 680        | · ·            |              |                                  | 0                        |         |  |  |
| 56.00            | 05600 RADI OI SOTOPE   | 50, 719        |                |              |                                  | 559                      |         |  |  |
| 57. 00           | 05700 CT SCAN  | 28, 422        |                |              |                                  | 1, 302                   |         |  |  |
| 58.00            | 05800 MAGNETIC RESONANCE I MAGING (MRI)  | 519, 944       |                |              |                                  |                          |         |  |  |
| 60.00            | 06000 LABORATORY   | 201, 875       |                |              |                                  | 11, 792                  |         |  |  |
| 64. 00           | 06400 I NTRAVENOUS THERAPY   | 0 05 (03       | 1,000,700      |              |                                  | 0                        | 64. 00  |  |  |
| 65. 00           | 06500 RESPIRATORY THERAPY  | 95, 683        |                |              |                                  | 25, 554                  | 65.00   |  |  |
| 66.00            | 06600 PHYSI CAL THERAPY  | 98, 023        |                |              |                                  | 12, 668                  |         |  |  |
| 67. 00           | 06700 OCCUPATI ONAL THERAPY  | 8, 784         | 1              | l .          |                                  | 1, 849                   |         |  |  |
| 68.00            | 06800 SPEECH PATHOLOGY   | 289            |                |              | · ·                              | 14                       |         |  |  |
| 69.00            | 06900 ELECTROCARDI OLOGY   | 77, 657        |                | l .          | · ·                              | 11, 002                  |         |  |  |
| 71.00            | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS   | 16, 141<br>0   | 3, 408, 588    |              |                                  | 1, 192<br>0              |         |  |  |
| 72. 00<br>73. 00 | 07200 IMPL. DEV. CHARGED TO PATIENTS<br>07300 DRUGS CHARGED TO PATIENTS              | 123, 308       | ı              |              |                                  | 6, 987                   |         |  |  |
| 75. 00           | 07500 ASC (NON-DISTINCT PART)  | 214, 114       |                |              |                                  | 289                      |         |  |  |
| 76. 00           | 03950 FAITH CENTER CHEMOTHERAPY  | 38, 940        |                |              |                                  | 289                      | 1       |  |  |
| 76. 00           | 07697 CARDI AC REHABI LI TATI ON   | 9, 923         |                |              |                                  | 6                        | 76. 00  |  |  |
| 77.00            | 07700 ALLOGENEIC HSCT ACQUISITION  | 9, 923         | l              | 1            |                                  | 0                        |         |  |  |
| 77.00            | OUTPATIENT SERVICE COST CENTERS  |                |                | 0.00000      | 0                                | U                        | 77.00   |  |  |
| 88. 00           | 08800 RURAL HEALTH CLINIC  | 328, 179       | 2, 097, 813    | 0. 15643     | 39 0                             | 0                        | 88. 00  |  |  |
| 88. 01           | 08801 RURAL HEALTH CLINIC II   | 273, 307       |                |              |                                  | 0                        | 1       |  |  |
| 91. 00           | 09100 EMERGENCY  | 287, 541       |                |              |                                  | 11, 760                  |         |  |  |
| 92.00            | 09200 OBSERVATION BEDS (NON-DISTINCT PART)   | 188, 160       | 1              | 1            |                                  | 19, 372                  |         |  |  |
| 200.00           |  | 3, 274, 613    |                | 1            | 5, 756, 140                      |                          |         |  |  |
| 200.00           | Total (Tilles 50 till ough 177)  | 3,214,013      | 1 10, 302, 037 | I            | 5, 750, 140                      | 155,044                  | 1200.00 |  |  |

| Health Financial Systems Hu                         | ARRI SBURG MEDI C <i>A</i>   | AL CENTER, INC.     |                                | In Lie                                      | eu of Form CMS-2            | 2552-10        |
|---|------------------------------|---------------------|--------------------------------|---|-----------------------------|----------------|
| APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA | ASS THROUGH COST             |                     | <u> </u>                       | Period:<br>From 04/01/2022<br>Fo 03/31/2023 | Date/Time Pre 9/11/2023 9:1 | pared:<br>6 am |
|   |                              | Title               | XVIII                          | Hospi tal                                   | PPS                         |                |
| Cost Center Description                             | Nursi ng<br>Program          | Nursi ng<br>Program | Allied Health<br>Post-Stepdown | Allied Health<br>Cost                       | All Other<br>Medical        |                |
|   | Post-Stepdown<br>Adjustments | 3                   | Adjustments                    |   | Education Cost              |                |
|   | 1A                           | 1. 00               | 2A                             | 2. 00                                       | 3. 00                       |                |
| INPATIENT ROUTINE SERVICE COST CENTERS              | 171                          | 1.00                |                                | 2.00  | 0.00                        |                |
| 30. 00 03000 ADULTS & PEDIATRICS                    | 0                            | 0                   |                                | 0   | 0                           | 30.00          |
| 40. 00   04000   SUBPROVI DER -   1 PF              | 0                            | 0                   |                                |   | 0                           |                |
| 200.00 Total (lines 30 through 199)                 | 0                            | 0                   |                                |   |                             | 200.00         |
| Cost Center Description                             | Swi ng-Bed                   | Total Costs         | Total Patient                  | Per Diem (col.                              | Inpatient                   |                |
|   | Adjustment                   | (sum of cols.       | Days                           | 5 ÷ col . 6)                                | Program Days                |                |
|   | Amount (see                  | 1 through 3,        |                                | ,   |                             |                |
|   |                              | minus col. 4)       |                                |   |                             |                |
|   | 4.00                         | 5.00                | 6. 00                          | 7. 00                                       | 8. 00                       |                |
| INPATIENT ROUTINE SERVICE COST CENTERS              |                              |                     |                                |   |                             |                |
| 30. 00 03000 ADULTS & PEDIATRICS                    | 0                            | 0                   | 3, 11:                         | 0.00  | 829                         | 30.00          |
| 40. 00   04000   SUBPROVI DER - 1 PF                | o                            | 0                   | 5, 55                          | 0.00  | 620                         | 40.00          |
| 200.00 Total (lines 30 through 199)                 |                              | 0                   | 8, 67 <sup>-</sup>             | 1   | 1, 449                      | 200. 00        |
| Cost Center Description                             | I npati ent                  |                     |                                |   |                             |                |
|   | Program                      |                     |                                |   |                             |                |
|   | Pass-Through                 |                     |                                |   |                             |                |
|   | Cost (col. 7 x               |                     |                                |   |                             |                |
|   | col. 8)                      |                     |                                |   |                             |                |
|   | 9. 00                        |                     |                                |   |                             |                |
| INPATIENT ROUTINE SERVICE COST CENTERS              |                              |                     |                                |   |                             |                |
| 30. 00   03000   ADULTS & PEDI ATRI CS              | 0                            |                     |                                |   |                             | 30. 00         |
| 40. 00   04000   SUBPROVI DER -   PF                | 0                            |                     |                                |   |                             | 40. 00         |
| 200.00   Total (lines 30 through 199)               | 0                            |                     |                                |   |                             | 200. 00        |

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet D | From 04/01/2022 | Part IV | To 03/31/2023 | Date/Time Prepared: Provider CCN: 14-0210 THROUGH COSTS

|        |  |               |               |          | 10 00/01/2020 | 9/11/2023 9: 1 |         |
|--------|--|---------------|---------------|----------|---------------|----------------|---------|
|        |  |               | Title         | XVIII    | Hospi tal     | PPS            |         |
|        | Cost Center Description                    | Non Physician | Nursi ng      | Nursi ng | Allied Health | Allied Health  |         |
|        |  | Anestheti st  | Program       | Program  | Post-Stepdown |                |         |
|        |  | Cost          | Post-Stepdown |          | Adjustments   |                |         |
|        |  |               | Adjustments   |          |               |                |         |
|        |  | 1.00          | 2A            | 2. 00    | 3A            | 3. 00          |         |
|        | ANCILLARY SERVICE COST CENTERS             |               |               |          |               |                |         |
| 50. 00 | 05000 OPERATI NG ROOM                      | 0             | 0             |          | 0             | 0              | 50.00   |
| 53.00  | 05300 ANESTHESI OLOGY                      | 0             | 0             |          | 0             | 0              | 53. 00  |
| 54.00  | 05400 RADI OLOGY-DI AGNOSTI C              | 0             | 0             |          | 0             | 0              | 54. 00  |
| 54. 01 | 05401 ULTRASOUND                           | 0             | 0             |          | 0             | 0              | 54. 01  |
| 54. 02 | 03440 MAMMOGRAPHY                          | 0             | 0             |          | 0             | 0              | 54. 02  |
| 56. 00 | 05600  RADI OI SOTOPE                      | 0             | 0             |          | 0             | 0              | 56. 00  |
| 57.00  | 05700 CT SCAN                              | 0             | 0             |          | 0             | 0              | 57. 00  |
| 58. 00 | 05800 MAGNETIC RESONANCE IMAGING (MRI)     | 0             | 0             |          | 0             | 0              | 58. 00  |
| 60.00  | 06000 LABORATORY                           | 0             | 0             |          | 0             | 0              | 60. 00  |
| 64.00  | 06400 I NTRAVENOUS THERAPY                 | 0             | 0             |          | 0             | 0              | 64. 00  |
| 65. 00 | 06500 RESPI RATORY THERAPY                 | 0             | 0             |          | 0             | 0              | 65. 00  |
| 66. 00 | 06600 PHYSI CAL THERAPY                    | 0             | 0             |          | 0             | 0              | 66. 00  |
| 67.00  | 06700 OCCUPATI ONAL THERAPY                | 0             | 0             |          | 0 0           | 0              | 67. 00  |
| 68. 00 | 06800 SPEECH PATHOLOGY                     | 0             | 0             |          | 0 0           | 0              | 68. 00  |
| 69. 00 | 06900 ELECTROCARDI OLOGY                   | 0             | 0             |          | 0 0           | 0              | 69. 00  |
| 71.00  | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0             | 0             |          | 0 0           | 0              | 71. 00  |
| 72.00  | 07200 I MPL. DEV. CHARGED TO PATIENTS      | 0             | 0             |          | 0 0           | 0              | 72. 00  |
| 73.00  | 07300 DRUGS CHARGED TO PATIENTS            | 0             | 0             |          | 0 0           | 0              | 73. 00  |
| 75.00  | 07500 ASC (NON-DISTINCT PART)              | 0             | 0             |          | 0 0           | 0              | 75. 00  |
| 76.00  | 03950 FAITH CENTER CHEMOTHERAPY            | 0             | 0             |          | 0 0           | 0              | 76. 00  |
| 76. 97 | 07697 CARDI AC REHABI LI TATI ON           | 0             | 0             |          | 0 0           | 0              | 76. 97  |
| 77. 00 | 07700 ALLOGENEIC HSCT ACQUISITION          | 0             | 0             |          | 0 0           | 0              | 77. 00  |
|        | OUTPATIENT SERVICE COST CENTERS            |               |               |          |               |                |         |
| 88. 00 | 08800 RURAL HEALTH CLINIC                  | 0             | 0             |          | 0 0           | 0              | 88. 00  |
| 88. 01 | 08801 RURAL HEALTH CLINIC II               | 0             | 0             |          | 0 0           | 0              | 88. 01  |
| 91.00  | 09100 EMERGENCY                            | 0             | 0             |          | 0             | 0              | 91.00   |
| 92.00  | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0             |               |          | 0             | 0              | 92.00   |
| 200.00 | Total (lines 50 through 199)               | 0             | 0             |          | 0 0           | 0              | 200. 00 |
|        |  |               |               |          |               |                |         |

| Health Financial Systems                            | HARRI SBURG MEDI CAL         | CENTER, INC.           | In Lie          | In Lieu of Form CMS-2552-10  |  |  |
|---|------------------------------|------------------------|-----------------|--|--|--|
| APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS | ANCILLARY SERVICE OTHER PASS | Provi der CCN: 14-0210 | From 04/01/2022 | Worksheet D<br>Part IV<br>Date/Time Prepared:<br>9/11/2023 9:16 am |  |  |
|   |                              | Title XVIII            | Hospi tal       | PPS  |  |  |

| THROUG | H COSTS                                    |                |               |              | To 03/31/2023                                 |                |          |
|--------|--|----------------|---------------|--------------|---|----------------|----------|
|        |  |                | Title         | XVIII        | Hospi tal                                     | PPS            |          |
|        | Cost Center Description                    | All Other      | Total Cost    | Total        |   | Ratio of Cost  |          |
|        |  | Medi cal       | (sum of cols. | Outpati ent  | (from Wkst. C,                                |                |          |
|        |  | Education Cost | 1, 2, 3, and  | Cost (sum of | Part I, col.                                  | (col. 5 ÷ col. |          |
|        |  |                | 4)            | col s. 2, 3, | 8)  | 7)             |          |
|        |  |                |               | and 4)       |   | (see           |          |
|        |  |                |               |              |   | instructions)  |          |
|        |  | 4. 00          | 5. 00         | 6. 00        | 7. 00   | 8. 00          |          |
|        | ANCILLARY SERVICE COST CENTERS             | ,              |               |              |   |                |          |
| 50.00  | O5000  OPERATI NG ROOM                     | 0              | 0             | (            | 7, 108, 459                                   | l .            |          |
| 53.00  | 05300 ANESTHESI OLOGY                      | 0              | 0             | (            | 2, 128, 735                                   | 0.000000       | 53.00    |
| 54.00  | 05400   RADI OLOGY-DI AGNOSTI C            | 0              | 0             | (            | 4, 169, 671                                   |                |          |
| 54. 01 | 05401 ULTRASOUND                           | 0              | 0             | (            | 4, 619, 753                                   | 0.000000       | 54. 01   |
| 54. 02 | 03440 MAMMOGRAPHY                          | 0              | 0             | (            | 530, 069                                      | 0.000000       | 54. 02   |
| 56.00  | 05600 RADI OI SOTOPE                       | 0              | 0             | (            | 2, 029, 786                                   | 0.000000       | 56. 00   |
| 57.00  | 05700 CT SCAN                              | o              | 0             |              | 19, 895, 723                                  | 0.000000       | 57. 00   |
| 58.00  | 05800 MAGNETIC RESONANCE IMAGING (MRI)     | o              | 0             |              | 4, 472, 214                                   | 0.000000       | 58. 00   |
| 60.00  | 06000 LABORATORY                           | o              | 0             |              | 19, 159, 037                                  | 0.000000       | 60.00    |
| 64.00  | 06400 I NTRAVENOUS THERAPY                 | o              | 0             |              | 1, 530, 730                                   | 0.000000       | 64. 00   |
| 65.00  | 06500 RESPI RATORY THERAPY                 | o              | 0             |              | 2, 687, 526                                   | 0.000000       | 65. 00   |
| 66.00  | 06600 PHYSI CAL THERAPY                    | o              | 0             |              | 1, 823, 555                                   | 0.000000       | 66. 00   |
| 67.00  | 06700 OCCUPATI ONAL THERAPY                | o              | 0             |              | 895, 761                                      | 0.000000       | 67. 00   |
| 68.00  | 06800 SPEECH PATHOLOGY                     | l ol           | 0             |              | 65, 362                                       | 0.000000       | 68. 00   |
| 69.00  | 06900 ELECTROCARDI OLOGY                   | l ol           | 0             |              | 746, 832                                      | 0.000000       | 69.00    |
| 71. 00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | o              | 0             |              | 3, 408, 588                                   | l .            | 1        |
| 72. 00 | 07200 IMPL. DEV. CHARGED TO PATIENTS       | o              | 0             |              | 0   | 0.000000       | 1        |
| 73. 00 | 07300 DRUGS CHARGED TO PATIENTS            | o              | 0             |              | 9, 235, 532                                   | l .            | 1        |
|        | 07500 ASC (NON-DISTINCT PART)              | o              | 0             |              | 4, 663, 663                                   | l .            |          |
|        | 03950 FAI TH CENTER CHEMOTHERAPY           | o              | 0             |              | 297, 964                                      |                |          |
|        | 07697 CARDI AC REHABI LI TATI ON           | أم             | 0             | ĺ            | 472, 552                                      |                |          |
|        | 07700 ALLOGENEI C HSCT ACQUISITION         |                | 0             |              | 0 .72,002                                     |                |          |
| ,,,,,, | OUTPATIENT SERVICE COST CENTERS            | <u> </u>       |               |              | <u>,                                     </u> | 0.00000        | 1 55     |
| 88 00  | 08800 RURAL HEALTH CLINIC                  | 0              | 0             |              | 2, 097, 813                                   | 0.000000       | 88. 00   |
|        | 08801 RURAL HEALTH CLINIC II               |                | 0             |              | 2, 043, 795                                   | l .            | 1        |
| 91. 00 | 09100 EMERGENCY                            |                | 0             | 1            | 13, 426, 189                                  |                | 1        |
|        | 09200 OBSERVATION BEDS (NON-DISTINCT PART) |                | 0             |              | 3, 053, 350                                   | l .            | 1        |
| 200.00 |  |                | 0             |              | 110, 562, 659                                 | l .            | 200. 00  |
| 200.00 | 1 1.0ta. (Tries so thi sagir 177)          | ١              | O             | '            | 110,002,007                                   | I              | 1-30. 00 |

| Health Financial Systems                            | CENTER, INC.                 | u of Form CMS-2552-10  |  |  |
|---|------------------------------|------------------------|--|--|
| APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS | ANCILLARY SERVICE OTHER PASS | Provi der CCN: 14-0210 | Peri od:<br>From 04/01/2022<br>To 03/31/2023 | Worksheet D<br>Part IV<br>Date/Time Prepared:<br>9/11/2023 9:16 am |

|   |                |             | 10            | 03/31/2023   | 9/11/2023 9:1 |         |
|---|----------------|-------------|---------------|--------------|---------------|---------|
| -   |                | Title       | XVIII         | Hospi tal    | PPS           | o am    |
| Cost Center Description                           | Outpati ent    | I npati ent | Inpati ent    | Outpati ent  | Outpati ent   |         |
|   | Ratio of Cost  | Program     | Program       | Program      | Program       |         |
|   | to Charges     | Charges     | Pass-Through  | Charges      | Pass-Through  |         |
|   | (col. 6 ÷ col. |             | Costs (col. 8 |              | Costs (col. 9 |         |
|   | 7)             |             | x col. 10)    |              | x col. 12)    |         |
|   | 9. 00          | 10.00       | 11. 00        | 12.00        | 13. 00        |         |
| ANCILLARY SERVICE COST CENTERS                    | ,              |             | ,             |              |               |         |
| 50. 00   05000   OPERATI NG ROOM                  | 0. 000000      | 151, 669    | 0             | 2, 014, 575  | 0             | 00.00   |
| 53. 00   05300   ANESTHESI OLOGY                  | 0. 000000      | 31, 191     | 0             | 593, 203     | 0             | 53. 00  |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C          | 0. 000000      | 98, 739     | 0             | 1, 079, 186  | 0             | 54.00   |
| 54. 01  05401  ULTRASOUND                         | 0. 000000      | 206, 049    | 0             | 1, 523, 494  | 0             | 54. 01  |
| 54. 02   03440   MAMMOGRAPHY                      | 0. 000000      | 0           | 0             | 0            | 0             | 54. 02  |
| 56. 00   05600   RADI 0I SOTOPE                   | 0. 000000      | 22, 362     | 0             | 800, 231     | 0             | 56. 00  |
| 57. 00  05700   CT   SCAN                         | 0. 000000      | 910, 994    | 0             | 5, 355, 464  | 0             | 57. 00  |
| 58.00   05800   MAGNETIC RESONANCE I MAGING (MRI) | 0. 000000      | 116, 748    | 0             | 1, 311, 936  | 0             | 58. 00  |
| 60. 00   06000   LABORATORY                       | 0. 000000      | 1, 119, 073 | 0             | 2, 212, 275  | 0             | 60.00   |
| 64.00 06400 INTRAVENOUS THERAPY                   | 0. 000000      | 203, 303    | 0             | 397, 763     | 0             | 64. 00  |
| 65. 00 06500 RESPIRATORY THERAPY                  | 0. 000000      | 717, 762    | 0             | 310, 933     | 0             | 65. 00  |
| 66. 00 06600 PHYSI CAL THERAPY                    | 0. 000000      | 235, 675    | 0             | 36, 812      | 0             | 66. 00  |
| 67. 00 06700 OCCUPATI ONAL THERAPY                | 0. 000000      | 188, 526    | 0             | 27, 162      | 0             | 67. 00  |
| 68. 00 06800 SPEECH PATHOLOGY                     | 0. 000000      | 3, 114      | 0             | 893          | 0             | 68. 00  |
| 69. 00 06900 ELECTROCARDI OLOGY                   | 0. 000000      | 105, 804    | 0             | 530, 461     | 0             | 69. 00  |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS  | 0. 000000      | 251, 761    | 0             | 1, 241, 752  | 0             | 71. 00  |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS        | 0. 000000      | 0           | 0             | 0            | 0             | 72. 00  |
| 73.00 07300 DRUGS CHARGED TO PATIENTS             | 0. 000000      | 523, 296    | 0             | 4, 488, 924  | 0             | 73. 00  |
| 75.00 07500 ASC (NON-DISTINCT PART)               | 0. 000000      | 6, 296      | 0             | 1, 390, 198  | 0             | 75. 00  |
| 76.00 03950 FAITH CENTER CHEMOTHERAPY             | 0. 000000      | 0           | 0             | 151, 114     | 0             | 76. 00  |
| 76. 97 07697 CARDIAC REHABILITATION               | 0. 000000      | 278         | 0             | 204, 328     | 0             | 76. 97  |
| 77.00 07700 ALLOGENEIC HSCT ACQUISITION           | 0. 000000      | 0           | 0             | 0            | 0             | 77. 00  |
| OUTPATIENT SERVICE COST CENTERS                   | <u> </u>       |             |               |              |               |         |
| 88. 00 08800 RURAL HEALTH CLINIC                  | 0. 000000      | 0           | 0             | 0            | 0             | 88. 00  |
| 88.01 08801 RURAL HEALTH CLINIC II                | 0. 000000      | 0           | 0             | 0            | 0             | 88. 01  |
| 91. 00 09100 EMERGENCY                            | 0. 000000      | 549, 144    | 0             | 2, 547, 218  | 0             | 91. 00  |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)  | 0. 000000      | 314, 356    | 0             | 745, 686     | 0             | 92. 00  |
| 200.00   Total (lines 50 through 199)             |                | 5, 756, 140 | o             | 26, 963, 608 | 0             | 200. 00 |

| Heal th       | Financial Systems HA                              | ARRISBURG MEDICA | AL CENTER, INC. |               | In Lie             | eu of Form CMS-:                        | 2552-10 |
|---------------|---|------------------|-----------------|---------------|--------------------|---|---------|
| <b>APPORT</b> | IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND     | VACCINE COST     | Provi der C     | CN: 14-0210   | Peri od:           | Worksheet D                             |         |
|               |   |                  |                 |               | From 04/01/2022    |   |         |
|               |   |                  |                 |               | To 03/31/2023      | Date/Time Pre 9/11/2023 9:1             | parea:  |
|               |   |                  | Title           | xVIII         | Hospi tal          | PPS                                     | o alli  |
|               |   |                  | 11 11 0         | Charges       | поэрг саг          | Costs                                   |         |
|               | Cost Center Description                           | Cost to Charge   | PPS Reimbursed  |               | Cost               | PPS Services                            |         |
|               |   | Ratio From       | Services (see   |               | Rei mbursed        | (see inst.)                             |         |
|               |   | Worksheet C,     | inst.)          | Servi ces     | Services Not       | ( , , , , , , , , , , , , , , , , , , , |         |
|               |   | Part I, col. 9   | ĺ               | Subject To    | Subject To         |   |         |
|               |   |                  |                 | Ded. & Coins. | Ded. & Coins.      |   |         |
|               |   |                  |                 | (see inst.)   | (see inst.)        |   |         |
|               |   | 1.00             | 2. 00           | 3.00          | 4. 00              | 5. 00                                   |         |
|               | ANCILLARY SERVICE COST CENTERS                    |                  |                 |               |                    |   |         |
|               | 05000 OPERATING ROOM                              | 0. 380231        |                 |               | 0                  | 766, 004                                |         |
|               | 05300 ANESTHESI OLOGY                             | 0. 085130        |                 |               | 0                  | 50, 499                                 | 1       |
|               | 05400 RADI OLOGY-DI AGNOSTI C                     | 0. 442295        |                 |               | 0                  | 477, 319                                | 1       |
|               | 05401 ULTRASOUND                                  | 0. 131646        |                 |               | 0                  | 200, 562                                |         |
|               | 03440 MAMMOGRAPHY                                 | 0. 534304        |                 |               | 0                  | 0                                       | 54. 02  |
|               | 05600 RADI 0I S0T0PE                              | 0. 203318        |                 |               | 0                  | 162, 701                                | 1       |
|               | 05700 CT SCAN                                     | 0. 043609        |                 |               | 0                  | 233, 546                                | 1       |
|               | 05800 MAGNETIC RESONANCE IMAGING (MRI)            | 0. 292298        |                 |               | 0                  | 383, 476                                |         |
|               | 06000 LABORATORY                                  | 0. 255821        | 2, 212, 275     |               | 0                  | 565, 946                                | 60.00   |
|               | 06400 I NTRAVENOUS THERAPY                        | 0. 768454        |                 |               | 0                  | 305, 663                                |         |
|               | 06500 RESPI RATORY THERAPY                        | 0. 626132        |                 | •             | 0                  | 194, 685                                |         |
|               | 06600 PHYSI CAL THERAPY                           | 0. 526732        |                 |               | 0                  | 19, 390                                 | 1       |
|               | 06700 OCCUPATI ONAL THERAPY                       | 0. 417687        |                 |               | 0                  | 11, 345                                 | 1       |
|               | 06800 SPEECH PATHOLOGY                            | 0. 406521        | 893             |               | 0                  | 363                                     | 1       |
|               | 06900 ELECTROCARDI OLOGY                          | 0. 430150        |                 |               | 0                  | 228, 178                                |         |
|               | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS        | 0. 509879        |                 | 1             | 0                  | 633, 143                                | 1       |
|               | 07200 IMPL. DEV. CHARGED TO PATIENTS              | 0. 000000        |                 | 1             | 0                  | 0                                       |         |
|               | 07300 DRUGS CHARGED TO PATIENTS                   | 0. 420821        | 4, 488, 924     |               | 0 222              | 1, 889, 033                             |         |
|               | 07500 ASC (NON-DISTINCT PART)                     | 0. 474798        |                 |               | 0                  | 660, 063                                |         |
|               | 03950 FAITH CENTER CHEMOTHERAPY                   | 0. 952709        |                 |               | 0                  | 143, 968                                | 1       |
|               | 07697 CARDIAC REHABILITATION                      | 0. 412310        |                 |               | 0                  | 84, 246                                 | 1       |
|               | 07700 ALLOGENEIC HSCT ACQUISITION                 | 0. 000000        | 0               |               | 0 0                | 0                                       | 77. 00  |
|               | OUTPATIENT SERVICE COST CENTERS                   | T                | T               | T             |                    | T                                       |         |
|               | 08800 RURAL HEALTH CLINIC                         |                  |                 |               |                    |   | 88. 00  |
|               | 08801 RURAL HEALTH CLINIC II                      | 0 455450         | 0.547.040       |               |                    | 4 4 4 0 4 0 0                           | 88. 01  |
|               | 09100 EMERGENCY                                   | 0. 455453        |                 |               | 0 110              |   |         |
|               | 09200 OBSERVATION BEDS (NON-DISTINCT PART)        | 1. 019912        |                 |               | 0 0                | 760, 534                                |         |
| 200.00        |   |                  | 26, 963, 608    |               | 0 332              | 8, 930, 802                             |         |
| 201. 00       |   |                  |                 |               |                    |   | 201. 00 |
| 202. 00       | Only Charges<br>Net Charges (line 200 - line 201) |                  | 26, 963, 608    |               | 0 332              | 8, 930, 802                             | 202 00  |
| 202.00        | I liver charges (Title 200 - Title 201)           | I                | 20, 703, 000    | I             | o <sub>l</sub> 332 | 0, 730, 602                             | 1202.00 |

| APPORTIC | JNMENT OF MEDICAL, OTHER HEALTH SERVICES AND        | VACCINE COST  | Provider C    | CN: 14-0210 | From 04/01/2022<br>To 03/31/2023 | Part V Date/Time Pr 9/11/2023 9: | epared:<br>16 am |
|----------|---|---------------|---------------|-------------|----------------------------------|----------------------------------|------------------|
|          |   |               | Titl∈         | e XVIII     | Hospi tal                        | PPS                              |                  |
|          |   | Cos           |               |             |                                  |                                  |                  |
|          | Cost Center Description                             | Cost          | Cost          |             |                                  |                                  |                  |
|          |   | Rei mbursed   | Reimbursed    |             |                                  |                                  |                  |
|          |   | Servi ces     | Servi ces Not |             |                                  |                                  |                  |
|          |   | Subject To    | Subject To    |             |                                  |                                  |                  |
|          |   | Ded. & Coins. | Ded. & Coins. |             |                                  |                                  |                  |
|          |   | (see inst.)   | (see inst.)   | -           |                                  |                                  |                  |
|          | NOLLI ADV. CEDVI OF COCT. CENTEDO                   | 6. 00         | 7. 00         |             |                                  |                                  |                  |
|          | NCI LLARY SERVI CE COST CENTERS                     |               |               | <u></u>     |                                  |                                  |                  |
| 1        | 5000 OPERATI NG ROOM                                | 0             | C             | 1           |                                  |                                  | 50.00            |
|          | 5300 ANESTHESI OLOGY                                | 0             | C             |             |                                  |                                  | 53. 00           |
|          | 5400 RADI OLOGY - DI AGNOSTI C                      | 0             | C             |             |                                  |                                  | 54.00            |
|          | 5401 ULTRASOUND                                     | 0             |               |             |                                  |                                  | 54. 01           |
|          | 3440 MAMMOGRAPHY                                    | 0             |               |             |                                  |                                  | 54. 02           |
|          | 5600 RADI OI SOTOPE                                 | 0             | C             |             |                                  |                                  | 56.00            |
|          | 5700 CT SCAN  | 0             |               |             |                                  |                                  | 57. 00           |
|          | 5800 MAGNETIC RESONANCE I MAGING (MRI)              | 0             | C             | 1           |                                  |                                  | 58. 00           |
|          | 6000 LABORATORY                                     | 0             | C             | 1           |                                  |                                  | 60.00            |
|          | 6400 I NTRAVENOUS THERAPY                           | 0             | C             |             |                                  |                                  | 64.00            |
|          | 6500 RESPI RATORY THERAPY<br>6600 PHYSI CAL THERAPY | 0             |               |             |                                  |                                  | 65. 00<br>66. 00 |
|          | 6700 OCCUPATI ONAL THERAPY                          | 0             |               | 1           |                                  |                                  | 67.00            |
|          | 6800 SPEECH PATHOLOGY                               | 0             |               | 1           |                                  |                                  | 68. 00           |
|          | 6900 ELECTROCARDI OLOGY                             | 0             |               | 1           |                                  |                                  | 69.00            |
|          | 7100 MEDICAL SUPPLIES CHARGED TO PATIENTS           | 0             |               | 1           |                                  |                                  | 71. 00           |
|          | 7200 IMPL. DEV. CHARGED TO PATIENTS                 | 0             |               |             |                                  |                                  | 72.00            |
|          | 7300 DRUGS CHARGED TO PATIENTS                      | 0             | 93            | 1           |                                  |                                  | 73. 00           |
|          | 7500 ASC (NON-DISTINCT PART)                        | 0             | 75            |             |                                  |                                  | 75. 00           |
|          | 3950 FAITH CENTER CHEMOTHERAPY                      | 0             |               | 1           |                                  |                                  | 76.00            |
|          | 7697 CARDI AC REHABI LI TATI ON                     | 0             | Ċ             | 1           |                                  |                                  | 76. 97           |
|          | 7700 ALLOGENEIC HSCT ACQUISITION                    | 0             |               | 1           |                                  |                                  | 77. 00           |
|          | UTPATIENT SERVICE COST CENTERS                      |               |               | 21          |                                  |                                  | 77.00            |
|          | 8800 RURAL HEALTH CLINIC                            |               |               |             |                                  |                                  | 88. 00           |
|          | 8801 RURAL HEALTH CLINIC II                         |               |               |             |                                  |                                  | 88. 01           |
|          | 9100 EMERGENCY                                      | 0             | 50            |             |                                  |                                  | 91. 00           |
|          | 9200 OBSERVATION BEDS (NON-DISTINCT PART)           | 0             | C             | •           |                                  |                                  | 92. 00           |
| 200.00   | Subtotal (see instructions)                         | 0             | 143           | 3           |                                  |                                  | 200.00           |
| 201.00   | Less PBP Clinic Lab. Services-Program               | 0             |               |             |                                  |                                  | 201. 00          |
|          | Only Charges  |               |               |             |                                  |                                  |                  |
| 202.00   | Net Charges (line 200 - line 201)                   | 0             | 143           | 3           |                                  |                                  | 202. 00          |

|        |   | DDI ODUDO MEDI O  |                |              |                 | 6.5                             | 0550 40     |
|--------|---|-------------------|----------------|--------------|-----------------|---------------------------------|-------------|
|        | Financial Systems HA TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA | RRI SBURG MEDI CA |                |              | Period:         | eu of Form CMS-2<br>Worksheet D | 2552-10     |
| APPURI | TUNMENT OF INPATIENT ANCILLARY SERVICE CAPITA                       | IL CUSTS          | Provi der C    | CN: 14-0210  | From 04/01/2022 |                                 |             |
|        |   |                   | Component      | CCN: 14-S210 | To 03/31/2023   |                                 | pared:      |
|        |   |                   | '              |              |                 | 9/11/2023 9:1                   | <u>6 am</u> |
|        |   |                   | Title          | XVIII        | Subprovi der -  | PPS                             |             |
|        |   |                   |                |              | I PF            |                                 |             |
|        | Cost Center Description   | Capi tal          | Total Charges  |              |                 | Capital Costs                   |             |
|        |   |                   | (from Wkst. C, |              | Program         | (column 3 x                     |             |
|        |   | (from Wkst. B,    | Part I, col.   |              | . Charges       | column 4)                       |             |
|        |   | Part II, col.     | 8)             | 2)           |                 |                                 |             |
|        |   | 26)               | 0.00           | 2.00         | 4.00            | F 00                            |             |
|        | ANCILLARY CERVICE COCT CENTERS                                      | 1.00              | 2. 00          | 3.00         | 4. 00           | 5. 00                           |             |
| FO 00  | ANCI LLARY SERVI CE COST CENTERS                                    | F(0, 200          | 7 100 450      | 0.0001       | 20 0            |                                 | F0 00       |
| 50.00  | 05000 OPERATING ROOM  | 569, 388          |                |              |                 | 1                               |             |
| 53.00  | 05300 ANESTHESI OLOGY   | 11, 499           |                |              |                 | _                               |             |
| 54.00  | 05400 RADI OLOGY-DI AGNOSTI C                                       | 87, 690           |                | 1            |                 |                                 |             |
| 54. 01 | 05401 ULTRASOUND  | 34, 347           | 4, 619, 753    |              |                 |                                 |             |
| 54. 02 | 03440 MAMMOGRAPHY   | 10, 680           |                |              |                 | _                               |             |
| 56. 00 | 05600 RADI OI SOTOPE  | 50, 719           |                |              |                 |                                 | 56. 00      |
| 57. 00 | 05700 CT SCAN   | 28, 422           |                |              |                 |                                 | 57. 00      |
| 58. 00 | 05800 MAGNETIC RESONANCE I MAGING (MRI)                             | 519, 944          |                |              |                 | _                               | 58. 00      |
| 60.00  | 06000 LABORATORY  | 201, 875          |                |              |                 |                                 | 1           |
| 64. 00 | 06400 I NTRAVENOUS THERAPY  | 0                 | ,              |              |                 |                                 |             |
| 65. 00 | 06500 RESPI RATORY THERAPY  | 95, 683           |                |              |                 |                                 | 65. 00      |
| 66. 00 | 06600 PHYSI CAL THERAPY   | 98, 023           |                |              |                 |                                 |             |
| 67. 00 | 06700 OCCUPATI ONAL THERAPY   | 8, 784            | · ·            | 1            |                 |                                 |             |
| 68. 00 | 06800 SPEECH PATHOLOGY  | 289               |                |              |                 | _                               | 68. 00      |
| 69. 00 | 06900 ELECTROCARDI OLOGY  | 77, 657           |                |              |                 |                                 |             |
| 71.00  | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS                          | 16, 141           |                |              |                 |                                 |             |
| 72.00  | 07200 I MPL. DEV. CHARGED TO PATIENTS                               | 0                 | 1              | 1 0.0000     |                 |                                 |             |
| 73.00  | 07300 DRUGS CHARGED TO PATIENTS                                     | 123, 308          |                |              |                 |                                 | 1           |
| 75. 00 | 07500 ASC (NON-DISTINCT PART)                                       | 214, 114          |                |              |                 | 0                               | 1           |
| 76. 00 | 03950 FAITH CENTER CHEMOTHERAPY                                     | 38, 940           |                |              |                 | 0                               |             |
| 76. 97 | 07697 CARDI AC REHABI LI TATI ON                                    | 9, 923            | 1              |              |                 | 0                               | 76. 97      |
| 77. 00 | 07700 ALLOGENEIC HSCT ACQUISITION                                   | 0                 | 0              | 0.0000       | 00 0            | 0                               | 77. 00      |
|        | OUTPATIENT SERVICE COST CENTERS                                     |                   |                | 1            | 1               | _                               |             |
| 88. 00 | 08800 RURAL HEALTH CLINIC   | 328, 179          |                |              |                 |                                 |             |
| 88. 01 | 08801 RURAL HEALTH CLINIC II  | 273, 307          |                |              |                 | 0                               |             |
| 91.00  | 09100 EMERGENCY   | 287, 541          |                |              | ·               |                                 |             |
| 92.00  | 09200 OBSERVATION BEDS (NON-DISTINCT PART)                          | 0                 | -,,            | 1            |                 | 0                               |             |
| 200.00 | Total (lines 50 through 199)  | 3, 086, 453       | 110, 562, 659  | Ί            | 334, 167        | 5, 843                          | 200. 00     |
|        |   |                   |                |              |                 |                                 |             |

|   | ARRISBURG MEDICA |               |              |    |                        | u of Form CMS-2                  | 2552-10 |
|---|------------------|---------------|--------------|----|------------------------|----------------------------------|---------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF | RVICE OTHER PASS | S Provider Co | CN: 14-0210  |    | riod:<br>om 04/01/2022 | Worksheet D<br>Part IV           |         |
| THROUGH COSTS                                       |                  | Component     | CCN: 14-S210 | То |                        | Date/Time Prep<br>9/11/2023 9:10 |         |
|   |                  | Title         | : XVIII      | S  | Subprovider -<br>IPF   | PPS                              |         |
| Cost Center Description                             | Non Physician    | Nursi ng      | Nursi ng     |    |                        | Allied Health                    |         |
|   | Anestheti st     | Program       | Program      |    | Post-Stepdown          |                                  |         |
|   | Cost             | Post-Stepdown |              |    | Adjustments            |                                  |         |
|   |                  | Adjustments   |              |    |                        |                                  |         |
|   | 1.00             | 2A            | 2. 00        |    | 3A                     | 3. 00                            |         |
| ANCILLARY SERVICE COST CENTERS                      | _                | _             | 1            |    | _                      | _                                |         |
| 50. 00   05000   OPERATI NG ROOM                    | 0                | 1             |              | 0  | 0                      | 0                                | 50.00   |
| 53. 00   05300   ANESTHESI OLOGY                    | 0                | 0             |              | 0  | 0                      | 0                                | 53.00   |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C            | 0                | 0             |              | 0  | 0                      | 0                                | 54.00   |
| 54. 01   05401   ULTRASOUND                         | 0                | 0             |              | 0  | 0                      | 0                                | 54. 01  |
| 54. 02   03440   MAMMOGRAPHY                        | 0                | 0             |              | 0  | 0                      | 0                                | 54. 02  |
| 56. 00   05600   RADI OI SOTOPE                     | 0                | 0             |              | 0  | 0                      | 0                                | 56. 00  |
| 57. 00  05700   CT   SCAN                           | 0                | 0             |              | 0  | 0                      | 0                                | 57. 00  |
| 58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)      | 0                | 0             |              | 0  | 0                      | 0                                | 58. 00  |
| 60. 00   06000   LABORATORY                         | 0                | 0             |              | 0  | 0                      | 0                                | 60.00   |
| 64. 00 06400 I NTRAVENOUS THERAPY                   | 0                | 0             |              | 0  | 0                      | 0                                | 64. 00  |
| 65. 00 06500 RESPI RATORY THERAPY                   | 0                | 0             |              | 0  | 0                      | 0                                | 65. 00  |
| 66. 00   06600   PHYSI CAL THERAPY                  | 0                | 0             |              | 0  | 0                      | 0                                | 66. 00  |
| 67. 00 06700 OCCUPATI ONAL THERAPY                  | 0                | 0             |              | 0  | 0                      | 0                                | 67. 00  |
| 68. 00 06800 SPEECH PATHOLOGY                       | 0                | 0             |              | 0  | 0                      | 0                                | 68. 00  |
| 69. 00 06900 ELECTROCARDI OLOGY                     | 0                | 0             |              | 0  | 0                      | 0                                | 69. 00  |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS    | 0                | 0             |              | 0  | 0                      | 0                                | 71.00   |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS          | 0                | 0             |              | 0  | 0                      | 0                                | 72. 00  |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS              | 0                | 0             |              | 0  | 0                      | 0                                | 73. 00  |
| 75. 00   07500   ASC (NON-DISTINCT PART)            | 0                | 0             |              | 0  | 0                      | 0                                | 75. 00  |
| 76. 00 03950 FAITH CENTER CHEMOTHERAPY              | 0                | 0             |              | 0  | 0                      | 0                                | 76. 00  |
| 76. 97 07697 CARDI AC REHABI LI TATI ON             | 0                | -             |              | 0  | 0                      | 0                                |         |
| 77. 00 07700 ALLOGENEIC HSCT ACQUISITION            | 0                | 0             |              | 0  | 0                      | 0                                | 77. 00  |
| OUTPATIENT SERVICE COST CENTERS                     |                  |               |              |    |                        |                                  |         |
| 88. 00 08800 RURAL HEALTH CLINIC                    | 0                |               | •            | 0  | 0                      | 0                                |         |
| 88. 01 08801 RURAL HEALTH CLINIC II                 | 0                | 0             |              | 0  | 0                      | 0                                |         |
| 91. 00   09100   EMERGENCY                          | 0                | 0             |              | 0  | 0                      | 0                                | 91.00   |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)    | 0                |               |              | 0  |                        | 0                                | 92.00   |
| 200.00 Total (lines 50 through 199)                 | 0                | 1 0           |              | 0  | 0                      | 0                                | 200. 00 |

| Health Financial Systems H  | ARRISBURG MEDICA | AL CENTER, INC. |              | In Li∈                           | eu of Form CMS-2       | 2552-10 |
|---|------------------|-----------------|--------------|----------------------------------|------------------------|---------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS                    | RVICE OTHER PASS | S Provider C    | CN: 14-0210  | Peri od:<br>From 04/01/2022      | Worksheet D<br>Part IV |         |
| Tikobali 60313  |                  | Component       | CCN: 14-S210 | To 03/31/2023                    |                        |         |
|   |                  | Titl∈           | : XVIII      | Subprovi der –<br>I PF           | PPS                    |         |
| Cost Center Description   | All Other        | Total Cost      | Total        |                                  | Ratio of Cost          |         |
|   | Medi cal         | (sum of cols.   | Outpati ent  | (from Wkst. C,                   |                        |         |
|   | Education Cost   |                 | Cost (sum of |                                  | (col. 5 ÷ col.         |         |
|   |                  | 4)              | col s. 2, 3, | 8)                               | 7)                     |         |
|   |                  |                 | and 4)       |                                  | (see<br>instructions)  |         |
|   | 4, 00            | 5.00            | 6. 00        | 7. 00                            | 8. 00                  |         |
| ANCILLARY SERVICE COST CENTERS  | 4.00             | 3.00            | 0.00         | 7.00                             | 0.00                   |         |
| 50. 00 05000 OPERATING ROOM   | 0                | О               | )            | 0 7, 108, 459                    | 0.000000               | 50. 00  |
| 53. 00 05300 ANESTHESI OLOGY  | 0                | l c             | ,            | 0 2, 128, 735                    | 0.000000               | 53. 00  |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C  | 0                | 0               | )            | 0 4, 169, 671                    | 0.000000               | 54.00   |
| 54. 01   05401   ULTRASOUND   | 0                | 0               | )            | 0 4, 619, 753                    | 0.000000               | 54. 01  |
| 54. 02   03440   MAMMOGRAPHY  | 0                | 0               | )            | 0 530, 069                       |                        |         |
| 56. 00   05600   RADI 0I SOTOPE   | 0                | 0               | )            | 0 2, 029, 786                    |                        |         |
| 57. 00   05700   CT   SCAN  | 0                | 0               | )            | 0 19, 895, 723                   |                        |         |
| 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)                                       | 0                | 0               | 1            | 0 4, 472, 214                    |                        |         |
| 60. 00   06000   LABORATORY   | 0                | 0               | 1            | 0 19, 159, 037                   |                        |         |
| 64. 00   06400   I NTRAVENOUS THERAPY<br>65. 00   06500   RESPIRATORY THERAPY       | 0                | 0               |              | 0 1, 530, 730                    |                        |         |
| 65. 00   06500   RESPI RATORY   THERAPY<br>66. 00   06600   PHYSI CAL   THERAPY     | 0                |                 |              | 0 2, 687, 526<br>0 1, 823, 555   |                        |         |
| 67. 00   06700   OCCUPATI ONAL THERAPY  | 0                |                 |              | 0 895, 761                       |                        |         |
| 68. 00   06800   SPEECH PATHOLOGY   |                  |                 |              | 0 65, 362                        |                        |         |
| 69. 00   06900   ELECTROCARDI OLOGY   |                  |                 |              | 0 746, 832                       |                        |         |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS                                   | 0                |                 |              | 0 3, 408, 588                    |                        |         |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS  | 0                | O               | )            | 0 0                              | 0.000000               |         |
| 73.00 07300 DRUGS CHARGED TO PATIENTS   | 0                | O               | 1            | 0 9, 235, 532                    | 0.000000               |         |
| 75.00 07500 ASC (NON-DISTINCT PART)   | 0                | 0               | )            | 0 4, 663, 663                    | 0.000000               | 75. 00  |
| 76.00 03950 FAITH CENTER CHEMOTHERAPY   | 0                | 0               | )            | 0 297, 964                       | 0.000000               | 76. 00  |
| 76. 97 07697 CARDIAC REHABILITATION   | 0                | 0               | )            | 0 472, 552                       | 0.000000               | 76. 97  |
| 77.00 07700 ALLOGENEIC HSCT ACQUISITION   | 0                | 0               |              | 0 0                              | 0.000000               | 77. 00  |
| OUTPATIENT SERVICE COST CENTERS   |                  |                 | 1            |                                  |                        |         |
| 88. 00 08800 RURAL HEALTH CLINIC  | 0                |                 | 1            | 0 2, 097, 813                    |                        |         |
| 88. 01   08801 RURAL HEALTH CLINIC II   | 0                | · -             |              | 0 2, 043, 795                    |                        |         |
| 91. 00   09100   EMERGENCY<br>92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART) |                  |                 | 1            | 0 13, 426, 189<br>0 3, 053, 350  |                        |         |
| 200.00 Total (lines 50 through 199)   | 0                | 1               | 1            | 0 3, 053, 350<br>0 110, 562, 659 |                        | 200.00  |
| 200.00   Total (Tries 30 till ough 177)   | 1                | 1               | 1            | 0  110, 302, 039                 |                        | 1200.00 |

|   |                       | ************************************** | 0511750 1110 |              |                                  | 6.5                             |                  |
|---|-----------------------|--|--------------|--------------|----------------------------------|---------------------------------|------------------|
| Health Financial Systems APPORTIONMENT OF INPATIENT/OUT                   |                       | ARRI SBURG MEDI CAL                    | Provider C   | N. 14 0210   | Period:                          | eu of Form CMS-2<br>Worksheet D | 2552-10          |
| THROUGH COSTS   | PATTENT ANCILLARY SER | RVICE UTHER PASS                       |              | CCN: 14-0210 | From 04/01/2022<br>To 03/31/2023 | Part IV                         | pared:<br>6 am   |
|   |                       |  | Title        | XVIII        | Subprovi der –<br>I PF           | PPS                             |                  |
| Cost Center Descri  | ption                 | Outpati ent                            | I npati ent  | Inpati ent   | Outpati ent                      | Outpati ent                     |                  |
|   |                       | Ratio of Cost                          | Program      | Program      | Program                          | Program                         |                  |
|   |                       | to Charges                             | Charges      | Pass-Through |                                  | Pass-Through                    |                  |
|   |                       | (col. 6 ÷ col.                         |              | Costs (col.  | 8                                | Costs (col. 9                   |                  |
|   |                       | 7)                                     |              | x col. 10)   |                                  | x col. 12)                      |                  |
|   |                       | 9. 00                                  | 10. 00       | 11. 00       | 12. 00                           | 13. 00                          |                  |
| ANCILLARY SERVICE COST (  | CENTERS               |  |              |              |                                  |                                 |                  |
| 50. 00   05000   OPERATI NG ROOM  |                       | 0. 000000                              | 0            |              | 0 0                              |                                 | 50.00            |
| 53. 00   05300   ANESTHESI OLOGY  |                       | 0. 000000                              | 0            |              | 0 0                              | 0                               | 53.00            |
| 54. 00 05400 RADI OLOGY - DI AGNOST                                       | .TC                   | 0. 000000                              | 6, 632       |              | 0 212                            | 0                               | 54. 00           |
| 54. 01   05401   ULTRASOUND   |                       | 0. 000000                              | 8, 084       |              | 0 0                              | 0                               | 54. 01           |
| 54. 02   03440   MAMMOGRAPHY  |                       | 0. 000000                              | 0            |              | 0                                | 0                               | 54. 02           |
| 56. 00   05600   RADI OI SOTOPE   |                       | 0. 000000                              | 1, 247       |              | 0 0                              | 0                               | 56. 00           |
| 57. 00   05700   CT   SCAN  |                       | 0. 000000                              | 25, 681      |              | 0                                | 0                               | 57. 00           |
| 58. 00 05800 MAGNETI C RESONANCE  | : IMAGING (MRI)       | 0. 000000                              | 0            |              | 0 0                              | 0                               | 58. 00           |
| 60. 00   06000   LABORATORY   | 21.6                  | 0. 000000                              | 98, 660      |              | 0 121                            | 0                               | 60.00            |
| 64. 00 06400 I NTRAVENOUS THERAF  |                       | 0. 000000                              | 5, 404       |              | 0 0                              | 0                               | 64.00            |
| 65. 00 06500 RESPIRATORY THERAF   | Y .                   | 0. 000000                              | 13, 575      |              | 0 0                              | 0                               | 65.00            |
| 66. 00 06600 PHYSI CAL THERAPY  | A DV                  | 0.000000                               | 16, 972      |              | 0 0                              | 0                               | 66.00            |
| 67. 00 06700 OCCUPATI ONAL THERA  | APY .                 | 0. 000000                              | 11, 689      |              | 0 0                              | 0                               | 67. 00           |
| 68. 00 06800 SPEECH PATHOLOGY   |                       | 0. 000000                              | 0            |              | 0 0                              | 0                               | 68. 00           |
| 69. 00 06900 ELECTROCARDI OLOGY   | NIADOED TO DATI ENTO  | 0. 000000                              | 8, 436       |              | 0 380                            | 0                               | 69.00            |
| 71. 00 07100 MEDICAL SUPPLIES (   |                       | 0. 000000                              | 202          |              | 0 0                              | 0                               | 71.00            |
| 72. 00   07200   IMPL. DEV. CHARGEE                                       |                       | 0.000000                               | 0            |              | 0                                | 0                               | 72.00            |
| 73. 00 07300 DRUGS CHARGED TO F   |                       | 0.000000                               | 98, 964      |              | 0 0                              | 0                               | 73.00            |
| 75. 00   07500   ASC (NON-DISTINCT<br>76. 00   03950   FAITH CENTER CHEMO |                       | 0. 000000<br>0. 000000                 | 0            |              | 0                                | 0                               | 75. 00<br>76. 00 |
| 76. 00   03950  FAITH CENTER CHEMC  |                       | 0. 000000                              | 0            |              | 0 0                              | 0                               | 76.00            |
|   |                       | 0. 000000                              | 0            |              | 0 0                              | 0                               |                  |
| 77. 00 07700 ALLOGENEIC HSCT AC   |                       | 0.000000                               | 0            |              | 0 0                              | . 0                             | 77. 00           |
| 88. 00 08800 RURAL HEALTH CLINI   |                       | 0. 000000                              | 0            |              | 0 0                              | 0                               | 88. 00           |
| 88. 01   08800   RURAL HEALTH CLINI                                       |                       | 0. 000000                              | 0            |              | 0 0                              | 0                               | 88. 00           |
| 91. 00   09100   EMERGENCY  | CII                   | 0. 000000                              | 38, 621      |              | 0 0                              | 0                               | 91.00            |
| 92. 00   09200   OBSERVATION BEDS (                                       | (NON DISTINCT DART)   | 0. 000000                              | 38, 62 I     |              | 0 0                              |                                 |                  |
| 200.00 Total (lines 50 th   |                       | 0.000000                               | 334, 167     |              | 0 713                            | 0                               | 200.00           |
| 200.00   Total (Titles 50 ti  | ii ougir 177)         | 1                                      | 334, 107     | I            | ο <sub> </sub> /13               | , 0                             | 1200.00          |

|        |   | ARRISBURG MEDICA |                    |                             |  | u of Form CMS-  | <u> 2552-10</u> |
|--------|---|------------------|--------------------|-----------------------------|--|---|-----------------|
| APPORT | IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND | ) VACCINE COST   | Provider Component | CN: 14-0210<br>CCN: 14-S210 | Peri od:<br>From 04/01/2022<br>To 03/31/2023 | Worksheet D<br>Part V<br>Date/Time Pre<br>9/11/2023 9:1 | pared:<br>6 am  |
|        |   | _                | Title              | · XVIII                     | Subprovi der –<br>I PF                       | PPS   |                 |
|        |   |                  |                    | Charges                     |  | Costs   |                 |
|        | Cost Center Description                       | Cost to Charge   |                    |                             | Cost   | PPS Services  |                 |
|        |   |                  | Services (see      | Reimbursed                  | Rei mbursed                                  | (see inst.)   |                 |
|        |   | Worksheet C,     | inst.)             | Servi ces                   | Services Not                                 |   |                 |
|        |   | Part I, col. 9   |                    | Subject To                  | Subj ect To                                  |   |                 |
|        |   |                  |                    | Ded. & Coins                |  |   |                 |
|        |   |                  |                    | (see inst.)                 | (see inst.)                                  |   |                 |
|        |   | 1.00             | 2. 00              | 3. 00                       | 4. 00  | 5. 00   |                 |
|        | ANCILLARY SERVICE COST CENTERS                |                  | 1                  |                             |  |   |                 |
| 50. 00 | 05000 OPERATI NG ROOM                         | 0. 380231        | 0                  |                             | 0  | 0   |                 |
| 53. 00 | 05300  ANESTHESI OLOGY                        | 0. 085130        |                    |                             | 0  | 0   |                 |
| 54.00  | 05400  RADI OLOGY-DI AGNOSTI C                | 0. 442295        |                    | •                           | 0  | 94  |                 |
| 54. 01 | 05401 ULTRASOUND                              | 0. 131646        |                    | •                           | 0  | 0   |                 |
| 54. 02 | 03440 MAMMOGRAPHY                             | 0. 534304        |                    |                             | 0  | 0   | 54. 02          |
| 56.00  | 05600  RADI 0I SOTOPE                         | 0. 203318        |                    |                             | 0  | 0   |                 |
| 57.00  | 05700  CT SCAN                                | 0. 043609        |                    | 1                           | 0  | 0   |                 |
| 58. 00 | 05800 MAGNETIC RESONANCE IMAGING (MRI)        | 0. 292298        |                    | 1                           | 0  | 0   |                 |
| 60.00  | 06000 LABORATORY                              | 0. 255821        | 121                | •                           | 0  | 31  | 60.00           |
| 64. 00 | 06400 I NTRAVENOUS THERAPY                    | 0. 768454        |                    | •                           | 0  | 0   | 1               |
| 65. 00 | 06500 RESPI RATORY THERAPY                    | 0. 626132        |                    |                             | 0  | 0   |                 |
| 66. 00 | 06600 PHYSI CAL THERAPY                       | 0. 526732        | l .                |                             | 0  | 0   | 66. 00          |
| 67. 00 | 06700 OCCUPATI ONAL THERAPY                   | 0. 417687        | 0                  |                             | 0  | 0   |                 |
| 68. 00 | 06800 SPEECH PATHOLOGY                        | 0. 406521        | 0                  |                             | 0  | 0   |                 |
| 69. 00 | 06900 ELECTROCARDI OLOGY                      | 0. 430150        | l .                |                             | 0  | 163   |                 |
| 71. 00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS    | 0. 509879        |                    |                             | 0  | 0   |                 |
| 72.00  | 07200 I MPL. DEV. CHARGED TO PATIENTS         | 0. 000000        | 0                  |                             | 0  | 0   | 72. 00          |
| 73.00  | 07300 DRUGS CHARGED TO PATIENTS               | 0. 420821        | 0                  |                             | 0  | 0   |                 |
| 75.00  | 07500 ASC (NON-DISTINCT PART)                 | 0. 474798        | 0                  |                             | 0 0  | 0   | 75. 00          |
| 76. 00 | 03950 FAITH CENTER CHEMOTHERAPY               | 0. 952709        |                    |                             | 0 0  | 0   |                 |
| 76. 97 | 07697 CARDI AC REHABI LI TATI ON              | 0. 412310        |                    |                             | 0 0  | 0   | 76. 97          |
| 77. 00 | 07700 ALLOGENEIC HSCT ACQUISITION             | 0. 000000        | 0                  |                             | 0 0  | 0   | 77. 00          |
|        | OUTPATIENT SERVICE COST CENTERS               |                  |                    |                             |  |   |                 |
| 88.00  | 08800 RURAL HEALTH CLINIC                     |                  |                    |                             |  |   | 88. 00          |
| 88. 01 | 08801 RURAL HEALTH CLINIC II                  |                  |                    |                             |  |   | 88. 01          |
| 91 00  | 09100 EMERGENCY                               | 0 455453         | l o                | 1                           | 0 0  | 0   | 91 00           |

0. 455453

1. 019912

0 91.00

0 92.00 288 200.00 201.00

288 202. 00

0 0 0

713

713

91. 00 09100 EMERGENCY

92.00 09700 EMERGENCY
92.00 09700 OBSERVATION BEDS (NON-DISTINCT PART)
200.00 Subtotal (see instructions)
Less PBP Clinic Lab. Services-Program
Only Charges
202.00 Net Charges (line 200 - line 201)

|   | ARRISBURG MEDICA |               |              |                             | u of Form CMS-        | 2552-10  |
|---|------------------|---------------|--------------|-----------------------------|-----------------------|----------|
| APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND | O VACCINE COST   | Provi der Co  | CN: 14-0210  | Peri od:<br>From 04/01/2022 | Worksheet D<br>Part V |          |
|   |                  | Component (   | CCN: 14-S210 | To 03/31/2023               | Date/Time Pre         | enared:  |
|   |                  | oomponone.    |              |                             | 9/11/2023 9:1         | 16 am    |
|   |                  | Title         | XVIII        | Subprovi der -              | PPS                   |          |
|   | Cos              | ts            |              | I PF                        |                       |          |
| Cost Center Description                             | Cost             | Cost          |              |                             |                       |          |
|   | Rei mbursed      | Rei mbursed   |              |                             |                       |          |
|   | Servi ces        | Services Not  |              |                             |                       |          |
|   | Subject To       | Subject To    |              |                             |                       |          |
|   |                  | Ded. & Coins. |              |                             |                       |          |
|   | (see inst.)      | (see inst.)   |              |                             |                       |          |
|   | 6.00             | 7.00          |              |                             |                       |          |
| ANCILLARY SERVICE COST CENTERS                      |                  |               |              |                             |                       |          |
| 50.00 05000 OPERATING ROOM                          | 0                | 0             |              |                             |                       | 50.00    |
| 53. 00   05300   ANESTHESI OLOGY                    | 0                | 0             |              |                             |                       | 53.00    |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C            | 0                | 0             |              |                             |                       | 54.00    |
| 54. 01   05401   ULTRASOUND                         | 0                | 0             |              |                             |                       | 54.0     |
| 54. 02 03440 MAMMOGRAPHY                            | 0                | 0             |              |                             |                       | 54. 0    |
| 56. 00   05600   RADI 0I SOTOPE                     | 0                | 0             |              |                             |                       | 56.00    |
| 57. 00   05700   CT   SCAN                          | 0                | 0             |              |                             |                       | 57.00    |
| 58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)   | 0                | 0             |              |                             |                       | 58.00    |
| 50. 00  06000 LABORATORY                            | 0                | 0             |              |                             |                       | 60.00    |
| 54. 00 06400 INTRAVENOUS THERAPY                    | 0                | 0             |              |                             |                       | 64. 00   |
| 55. 00 06500 RESPIRATORY THERAPY                    | 0                | 0             |              |                             |                       | 65. 0    |
| 66. 00 06600 PHYSI CAL THERAPY                      | 0                | 0             |              |                             |                       | 66. 0    |
| 57. 00 06700 OCCUPATI ONAL THERAPY                  | 0                | 0             |              |                             |                       | 67. 0    |
| 58.00 06800 SPEECH PATHOLOGY                        | 0                | 0             |              |                             |                       | 68. 0    |
| 59. 00  06900 ELECTROCARDI OLOGY                    | 0                | 0             |              |                             |                       | 69. 0    |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS    | 0                | 0             |              |                             |                       | 71.0     |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS          | 0                | 0             |              |                             |                       | 72. 0    |
| 73.00 07300 DRUGS CHARGED TO PATIENTS               | 0                | 0             |              |                             |                       | 73. 0    |
| 75.00   07500   ASC (NON-DISTINCT PART)             | 0                | 0             |              |                             |                       | 75. 0    |
| 76.00 03950 FAITH CENTER CHEMOTHERAPY               | 0                | 0             |              |                             |                       | 76. 0    |
| 76. 97 07697 CARDI AC REHABI LI TATI ON             | 0                | 0             |              |                             |                       | 76. 9    |
| 77.00 07700 ALLOGENEIC HSCT ACQUISITION             | 0                | 0             |              |                             |                       | <u> </u> |
| OUTPATIENT SERVICE COST CENTERS                     |                  |               |              |                             |                       | 4        |
| 38. OO  08800 RURAL HEALTH CLINIC                   |                  |               |              |                             |                       | 88. 0    |
| 38.01 08801 RURAL HEALTH CLINIC II                  |                  |               |              |                             |                       | 88. 0    |
| 91. 00   09100   EMERGENCY                          | 0                | 0             |              |                             |                       | 91.00    |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)    | 0                | 0             |              |                             |                       | 92. 0    |
| Subtotal (see instructions)                         | 0                | 0             |              |                             |                       | 200. 0   |
| Less PBP Clinic Lab. Services-Program               | 0                |               |              |                             |                       | 201.00   |
| Only Charges  | _                | _             |              |                             |                       |          |
| 202.00   Net Charges (line 200 - line 201)          | 0                | 0             |              |                             |                       | 202.00   |

| Health Financial Systems                | HARRISBURG MEDICAL CENTER, INC. | In Lie                                      | u of Form CMS-2                             | 2552-10 |
|---|---------------------------------|---|---|---------|
| COMPUTATION OF INPATIENT OPERATING COST | Provi der CCN: 14-0210          | Period:<br>From 04/01/2022<br>To 03/31/2023 | Worksheet D-1 Date/Time Prep 9/11/2023 9:16 |         |
|   | Title XVIII                     | Hospi tal                                   | PPS   |         |

| -      |  | Ti +1 o V/////            | Haani tal        | 9/11/2023 9: 1 | <u>6 am</u> |
|--------|--|---------------------------|------------------|----------------|-------------|
|        | Cost Center Description  | Title XVIII               | Hospi tal        | PPS            |             |
|        | Cost Center Description  |                           |                  | 1. 00          |             |
|        | PART I - ALL PROVIDER COMPONENTS   |                           |                  |                |             |
|        | I NPATI ENT DAYS   |                           |                  |                |             |
| 1.00   | Inpatient days (including private room days and swing-bed days   |                           |                  | 3, 227         | 1. 00       |
| 2.00   | Inpatient days (including private room days, excluding swing-l   |                           |                  | 3, 112         |             |
| 3.00   | Private room days (excluding swing-bed and observation bed day do not complete this line.                                | ys). If you have only pri | vate room days,  | 0              | 3. 00       |
| 4.00   | Semi-private room days (excluding swing-bed and observation be   | ed days)                  |                  | 1, 828         | 4. 00       |
| 5. 00  | Total swing-bed SNF type inpatient days (including private room  |                           | 31 of the cost   | 76             | 5. 00       |
|        | reporting period   | , .,                      |                  |                |             |
| 6.00   | Total swing-bed SNF type inpatient days (including private roof  | om days) after December : | 31 of the cost   | 34             | 6. 00       |
|        | reporting period (if calendar year, enter 0 on this line)  |                           |                  |                |             |
| 7. 00  | Total swing-bed NF type inpatient days (including private roor   | m days) through December  | 31 of the cost   | 2              | 7. 00       |
| 0.00   | reporting period   |                           |                  |                | 0.00        |
| 8. 00  | Total swing-bed NF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line) | m days) after becember 3  | or the cost      | 3              | 8. 00       |
| 9. 00  | Total inpatient days including private room days applicable to   | the Program (evoluding    | swing-had and    | 829            | 9. 00       |
| 7.00   | newborn days) (see instructions)   | o the frogram (excruding  | swifig-bed and   | 027            | 7.00        |
| 10.00  | Swing-bed SNF type inpatient days applicable to title XVIII or   | nly (including private r  | oom days)        | 70             | 10. 00      |
|        | through December 31 of the cost reporting period (see instruc-   | ti ons)                   | ,                |                |             |
| 11. 00 | Swing-bed SNF type inpatient days applicable to title XVIII or   |                           | oom days) after  | 0              | 11.00       |
|        | December 31 of the cost reporting period (if calendar year, er   |                           |                  |                |             |
| 12. 00 | Swing-bed NF type inpatient days applicable to titles V or XI)   | only (including private   | e room days)     | 0              | 12. 00      |
| 13. 00 | through December 31 of the cost reporting period<br>Swing-bed NF type inpatient days applicable to titles V or XI)       | / anly (including private | a maam daysa)    | 0              | 13. 00      |
| 13.00  | after December 31 of the cost reporting period (if calendar ye   |                           |                  | U              | 13.00       |
| 14. 00 | Medically necessary private room days applicable to the Progra   |                           |                  | 0              | 14. 00      |
| 15. 00 | Total nursery days (title V or XIX only)   | am (ana aan ng am ng aaa  |                  | 0              | 15. 00      |
| 16.00  | Nursery days (title V or XIX only)   |                           |                  | 0              | 16. 00      |
|        | SWING BED ADJUSTMENT   |                           |                  |                |             |
| 17. 00 | Medicare rate for swing-bed SNF services applicable to service   | es through December 31 o  | f the cost       | 0.00           | 17. 00      |
| 40.00  | reporting period   | C. D. I. O. C.            |                  |                | 40.00       |
| 18. 00 | Medicare rate for swing-bed SNF services applicable to service   | es after December 31 of   | the cost         | 0.00           | 18. 00      |
| 19. 00 | reporting period Medicaid rate for swing-bed NF services applicable to services  | through December 31 of    | the cost         | 188. 44        | 19. 00      |
| 17.00  | reporting period   | s through becember 31 of  | the cost         | 100. 44        | 17.00       |
| 20. 00 | Medicaid rate for swing-bed NF services applicable to services   | s after December 31 of th | ne cost          | 208. 70        | 20. 00      |
|        | reporting period   |                           |                  |                |             |
| 21. 00 | Total general inpatient routine service cost (see instructions   |                           |                  | 7, 548, 685    |             |
| 22. 00 | Swing-bed cost applicable to SNF type services through December  | er 31 of the cost reporti | ng period (line  | 0              | 22. 00      |
| 22 00  | 5 x line 17)   | 21 of the cost reporting  | a ported (line 4 | 0              | 22 00       |
| 23. 00 | Swing-bed cost applicable to SNF type services after December   x line 18)   | 31 of the cost reporting  | g period (iine o | 0              | 23. 00      |
| 24. 00 | Swing-bed cost applicable to NF type services through December   | 31 of the cost reportion  | na period (line  | 377            | 24. 00      |
| 2 00   | 7 x line 19)   | 0. 0. t coot rope. t      | .g po ou (       | 0              | 2 00        |
| 25.00  | Swing-bed cost applicable to NF type services after December 3   | 31 of the cost reporting  | period (line 8   | 626            | 25.00       |
|        | x line 20)   |                           |                  |                |             |
| 26. 00 | Total swing-bed cost (see instructions)  |                           |                  | 1, 003         |             |
| 27. 00 | General inpatient routine service cost net of swing-bed cost   | (line 21 minus line 26)   |                  | 7, 547, 682    | 27. 00      |
| 28. 00 | PRIVATE ROOM DIFFERENTIAL ADJUSTMENT   | d and observation had abo | argos)           | 0              | 20 00       |
| 29. 00 | Private room charges (excluding swing-bed charges)   | a and observation bed cha | gi yes)          | 0              |             |
| 30. 00 | Semi - pri vate room charges (excluding swing-bed charges)   |                           |                  | Ö              | 30. 00      |
| 31. 00 | General inpatient routine service cost/charge ratio (line 27 -   | : line 28)                |                  | 0. 000000      |             |
| 32. 00 | Average private room per diem charge (line 29 ÷ line 3)  |                           |                  | 0.00           |             |
| 33.00  | Average semi-private room per diem charge (line 30 ÷ line 4)   |                           |                  | 0.00           |             |
| 34.00  | Average per diem private room charge differential (line 32 mir   | nus line 33)(see instruc  | tions)           | 0.00           | 34.00       |
| 35.00  | Average per diem private room cost differential (line 34 x line  | ne 31)                    |                  | 0. 00          | 35. 00      |
| 36. 00 | Private room cost differential adjustment (line 3 x line 35)   |                           |                  | 0              | 36.00       |
| 37. 00 | General inpatient routine service cost net of swing-bed cost a   | and private room cost di  | fferential (line | 7, 547, 682    | 37. 00      |
|        | 27 minus line 36)  |                           |                  |                |             |
|        | PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU                  | ISTMENTS                  |                  |                |             |
| 38. 00 | Adjusted general inpatient routine service cost per diem (see  |                           |                  | 2, 425. 35     | 38. 00      |
| 39. 00 | Program general inpatient routine service cost per dreim (see  | *                         |                  | 2, 423. 33     |             |
| 40. 00 | Medically necessary private room cost applicable to the Progra   | -                         |                  | 2,010,013      |             |
|        | Total Program general inpatient routine service cost (line 39  | ,                         |                  | 2, 010, 615    |             |
|        |  |                           | '                |                |             |

| OMPUI          | ATION OF INPATIENT OPERATING COST  |                 | Provi der (    | CN: 14-0210            | Peri od:                         | Worksheet D-1                  |                |
|----------------|--|-----------------|----------------|------------------------|----------------------------------|--------------------------------|----------------|
|                |  |                 |                |                        | From 04/01/2022<br>To 03/31/2023 | Date/Time Pre<br>9/11/2023 9:1 |                |
|                | Cost Center Description  | Total           | Ti tl<br>Total | e XVIII<br>Average Pei | Hospital r Program Days          | PPS<br>Program Cost            |                |
|                | oost denter beschiption  | Inpatient Cost  |                | Diem (col. 1           |                                  | (col. 3 x col.                 |                |
|                |  | 1.00            | 2.00           | 3.00                   | 4. 00                            | 4)<br>5. 00                    |                |
| 2. 00          | NURSERY (title V & XIX only)   |                 | <u> </u>       |                        |                                  |                                | 42. 0          |
| 3. 00          | Intensive Care Type Inpatient Hospital Units<br>INTENSIVE CARE UNIT  |                 |                | T                      |                                  | I                              | 43.0           |
| 4. 00          | CORONARY CARE UNIT   |                 |                |                        |                                  |                                | 44. 0          |
| 5.00           | BURN INTENSIVE CARE UNIT<br>SURGICAL INTENSIVE CARE UNIT   |                 |                |                        |                                  |                                | 45. 0<br>46. 0 |
|                | OTHER SPECIAL CARE (SPECIFY)   |                 |                |                        |                                  |                                | 47. 0          |
|                | Cost Center Description  |                 |                |                        |                                  | 1.00                           |                |
| 8. 00          | Program inpatient ancillary service cost (Wk:  | st. D-3, col. 3 | , line 200)    |                        |                                  | 1. 00<br>2, 273, 518           | 48. 0          |
| 3. 01          | Program inpatient cellular therapy acquisiti   | on cost (Worksh | eet D-6, Part  |                        | , column 1)                      | 0                              |                |
| 9. 00          | Total Program inpatient costs (sum of lines - PASS THROUGH COST ADJUSTMENTS  | 41 through 48.0 | 1)(see instru  | ctions)                |                                  | 4, 284, 133                    | 49. 0          |
| 0. 00          | Pass through costs applicable to Program inp   | atient routine  | servi ces (fro | m Wkst. D, su          | m of Parts I and                 | 121, 482                       | 50.0           |
| 1. 00          |  | atient ancillar | v services (f  | rom Wkst D             | sum of Parts II                  | 133. 844                       | 51.0           |
|                | and IV)  |                 | , (.           |                        |                                  |                                |                |
| 2. 00<br>3. 00 | Total Program excludable cost (sum of lines !<br>Total Program inpatient operating cost exclu  | ,               | lated non-nh   | vsician anest          | hetist and                       | 255, 326<br>4, 028, 807        |                |
| 3. 00          | medical education costs (line 49 minus line  |                 | ratea, non pri | ysi ci aii aiicst      | Tietr St, and                    | 4, 020, 007                    | ] 55. 0        |
| 1 00           | TARGET AMOUNT AND LIMIT COMPUTATION Program discharges   |                 |                |                        |                                  | 0                              | ]<br>  54.0    |
| 5. 00          | Target amount per discharge  |                 |                |                        |                                  |                                | 55. 0          |
| 5. 01          | Permanent adjustment amount per discharge  |                 |                |                        |                                  | 0.00                           | 1              |
| 5. 02<br>5. 00 | Adjustment amount per discharge (contractor of Target amount (line 54 x sum of lines 55, 55  |                 |                |                        |                                  | 0.00                           | 1              |
| 7. 00          | Difference between adjusted inpatient operat   |                 | rget amount (  | line 56 minus          | line 53)                         | 0                              | 57.0           |
| 3. 00<br>9. 00 | Bonus payment (see instructions)<br>Trended costs (lesser of line 53 ÷ line 54,  | or line 55 from | the cost ren   | orting period          | endina 1996                      | 0.00                           |                |
|                | updated and compounded by the market basket)   |                 | ·              | 0.                     |                                  |                                |                |
| 0. 00          | Expected costs (lesser of line 53 ÷ line 54, market basket)  | or line 55 fro  | m prior year   | cost report,           | updated by the                   | 0.00                           | 60.0           |
| . 00           | Continuous improvement bonus payment (if line  |                 |                |                        |                                  | 0                              | 61. 0          |
|                | 55.01, or line 59, or line 60, enter the less $(53)$ are less than expected costs (lines $(54)$ x  |                 | ,              | •                      | •                                |                                |                |
|                | enter zero. (see instructions)   | 00), 0 % 0.     | tilo tal got a |                        | o,, o                            |                                |                |
|                | Relief payment (see instructions) Allowable Inpatient cost plus incentive paym   | ent (see instru | ctions)        |                        |                                  | 0 0                            |                |
| . 00           | PROGRAM INPATIENT ROUTINE SWING BED COST   | cht (3cc fhatru | eti olis)      |                        |                                  |                                | 05. 0          |
| . 00           | Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)  | ts through Dece | mber 31 of th  | e cost report          | ing period (See                  | 0                              | 64.0           |
| 5. 00          | Medicare swing-bed SNF inpatient routine cos   | ts after Decemb | er 31 of the   | cost reportin          | g period (See                    | 0                              | 65.0           |
| . 00           | instructions)(title XVIII only)<br>Total Medicare swing-bed SNF inpatient routi  | no costs (lino  | 64 plus lino   | 45) (+i +l o VVI       | II only): for                    | 0                              | 66.0           |
| . 00           | CAH, see instructions  | ne costs (Title | 04 prus rrne   | bb)(title xvi          | 11 Om y), 101                    |                                | 00.0           |
| . 00           | Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)  | e costs through | December 31    | of the cost r          | eporting period                  | 0                              | 67. 0          |
| 3. 00          | Title V or XIX swing-bed NF inpatient routing  | e costs after D | ecember 31 of  | the cost rep           | orting period                    | 0                              | 68.0           |
| 00             | (line 13 x line 20)<br> Total title V or XIX swing-bed NF inpatient  | routine costs ( | line 67 + lin  | - 68)                  |                                  | 0                              | 69. (          |
|                | PART III - SKILLED NURSING FACILITY, OTHER NU  | JRSING FACILITY | , AND ICF/IID  | ONLY                   |                                  |                                |                |
| . 00           | Skilled nursing facility/other nursing facili<br>Adjusted general inpatient routine service of   |                 |                |                        | )                                |                                | 70. (          |
| 00             | Program routine service cost (line 9 x line  | ,               | THE 70 - THE   | 2)                     |                                  |                                | 72. (          |
| 00             | Medically necessary private room cost applications and program control in the cost applications are program as a second cost application and program are program as a second cost application and program are program as a second cost application and program are program as a second cost application and program are program as a second cost application and program are program as a second cost application and program are program as a second cost application and program are program as a second cost application and program are program as a second cost application and program are program as a second cost application and program are program as a second cost application and program are program as a second cost application and program are program as a second cost application and program are program as a second cost application and program are program as a second cost and program are program as a se |                 | •              |                        |                                  |                                | 73. (          |
| . 00<br>. 00   | Total Program general inpatient routine serv<br>Capital-related cost allocated to inpatient  | •               |                |                        | Part II, column                  |                                | 74. (<br>75. ( |
| 00             | 26, line 45)   | 0)              |                |                        |                                  |                                | 7, ,           |
| . 00<br>. 00   | Per diem capital-related costs (line 75 ÷ li<br>Program capital-related costs (line 9 x line   |                 |                |                        |                                  |                                | 76. (<br>77. ( |
| . 00           | Inpatient routine service cost (line 74 minus  | s line 77)      |                |                        |                                  |                                | 78. (          |
| . 00           | Aggregate charges to beneficiaries for excess<br>Total Program routine service costs for compa   |                 |                | *.                     | nus line 79)                     |                                | 79.<br>80.     |
| . 00           | Inpatient routine service costs for compa  |                 | SSC TIME LATEO | . (1110 /0 1111        | 177)                             |                                | 81.            |
| . 00           | Inpatient routine service cost limitation (I   |                 | •              |                        |                                  |                                | 82.            |
| . 00           | Reasonable inpatient routine service costs (<br>Program inpatient ancillary services (see in:  |                 | 3)             |                        |                                  |                                | 83. (<br>84. ( |
| . 00           | Utilization review - physician compensation  | (see instructio |                |                        |                                  |                                | 85. (          |
| . 00           | Total Program inpatient operating costs (sum<br>PART IV - COMPUTATION OF OBSERVATION BED PASS  |                 | rough 85)      |                        |                                  |                                | 86.            |
|                | The state of the s | )               |                |                        |                                  |                                | 4              |

1, 284 87. 00 2, 425. 35 88. 00 3, 114, 149 89. 00

87.00 Total observation bed days (see instructions)
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)
89.00 Observation bed cost (line 87 x line 88) (see instructions)

| Health Financial Systems HA                   | RRISBURG MEDICA | AL CENTER, INC. |            | In Lie                     | u of Form CMS-2                  | 2552-10 |
|---|-----------------|-----------------|------------|----------------------------|----------------------------------|---------|
| COMPUTATION OF INPATIENT OPERATING COST       |                 | Provi der CC    |            | Period:<br>From 04/01/2022 | Worksheet D-1                    |         |
|   |                 |                 |            | To 03/31/2023              | Date/Time Prep<br>9/11/2023 9:10 |         |
|   |                 | Title           | XVIII      | Hospi tal                  | PPS                              |         |
| Cost Center Description                       | Cost            | Routine Cost    | column 1 ÷ | Total                      | Observati on                     |         |
|   |                 | (from line 21)  | column 2   | Observati on               | Bed Pass                         |         |
|   |                 |                 |            | Bed Cost (from             | Through Cost                     |         |
|   |                 |                 |            | line 89)                   | (col. 3 x col.                   |         |
|   |                 |                 |            |                            | 4) (see                          |         |
|   |                 |                 |            |                            | instructions)                    |         |
|   | 1.00            | 2.00            | 3.00       | 4. 00                      | 5. 00                            |         |
| COMPUTATION OF OBSERVATION BED PASS THROUGH ( | COST            |                 |            |                            |                                  |         |
| 90.00 Capital -related cost                   | 456, 097        | 7, 548, 685     | 0. 06042   | 3, 114, 149                | 188, 160                         | 90.00   |
| 91.00 Nursing Program cost                    | 0               | 7, 548, 685     | 0.00000    | 3, 114, 149                | 0                                | 91.00   |
| 92.00 Allied health cost                      | 0               | 7, 548, 685     | 0.00000    | 3, 114, 149                | 0                                | 92.00   |
| 93.00 All other Medical Education             | 0               | 7, 548, 685     | 0. 000000  | 3, 114, 149                | 0                                | 93. 00  |

| Health Financial Systems                | HARRISBURG MEDICAL CENTER, INC. | In Lie                      | u of Form CMS-2552-10                 |
|---|---------------------------------|-----------------------------|---------------------------------------|
| COMPUTATION OF INPATIENT OPERATING COST | Provi der CCN: 14-0210          | Peri od:<br>From 04/01/2022 | Worksheet D-1                         |
|   | Component CCN: 14-S210          | To 03/31/2023               | Date/Time Prepared: 9/11/2023 9:16 am |
|   | Title XVIII                     | Subprovi der -              | PPS                                   |

|                  |  | II the Aviii                          | I PF             | FF3         |                  |
|------------------|--|---------------------------------------|------------------|-------------|------------------|
|                  | Cost Center Description  |                                       |                  |             |                  |
|                  | PART I - ALL PROVIDER COMPONENTS   |                                       |                  | 1. 00       |                  |
|                  | I NPATI ENT DAYS   |                                       |                  |             |                  |
| 1.00             | Inpatient days (including private room days and swing-bed days   |                                       |                  | 5, 559      | 1. 00            |
| 2.00             | Inpatient days (including private room days, excluding swing-l<br>Private room days (excluding swing-bed and observation bed day |                                       |                  | 5, 559      | 2.00             |
| 3. 00            | do not complete this line.   | (S). If you have only pri             | vate room days,  | 0           | 3. 00            |
| 4.00             | Semi-private room days (excluding swing-bed and observation be   | ed days)                              |                  | 5, 559      | 4. 00            |
| 5.00             | Total swing-bed SNF type inpatient days (including private roo   | om days) through December             | 31 of the cost   | 0           | 5. 00            |
| 6. 00            | reporting period Total swing-bed SNF type inpatient days (including private roo  | om days) after December 3             | 1 of the cost    | 0           | 6. 00            |
| 0.00             | reporting period (if calendar year, enter 0 on this line)  | om days) arter becember a             | in or the cost   | O           | 0.00             |
| 7.00             | Total swing-bed NF type inpatient days (including private room   | n days) through December              | 31 of the cost   | 0           | 7. 00            |
| 8. 00            | reporting period Total swing-bed NF type inpatient days (including private roor  | n days) after December 21             | of the cost      | 0           | 8. 00            |
| 8.00             | reporting period (if calendar year, enter 0 on this line)  | ii days) ai tei beceilibei 31         | or the cost      | U           | 8.00             |
| 9.00             | Total inpatient days including private room days applicable to   | the Program (excluding                | swing-bed and    | 620         | 9. 00            |
| 10. 00           | newborn days) (see instructions)<br>Swing-bed SNF type inpatient days applicable to title XVIII or                               | alv (i neludi na privato re           | nom dave)        | 0           | 10. 00           |
| 10.00            | through December 31 of the cost reporting period (see instructions)  |                                       | ioiii days)      | U           | 10.00            |
| 11. 00           | Swing-bed SNF type inpatient days applicable to title XVIII or   | nly (including private ro             | oom days) after  | 0           | 11. 00           |
| 12. 00           | December 31 of the cost reporting period (if calendar year, en<br>Swing-bed NF type inpatient days applicable to titles V or XI) |                                       | room days)       | 0           | 12. 00           |
| 12.00            | through December 31 of the cost reporting period   | Comy (frictualing private             | ( 1 00 lii days) | U           | 12.00            |
| 13.00            | Swing-bed NF type inpatient days applicable to titles V or XIX   |                                       |                  | 0           | 13. 00           |
| 14. 00           | after December 31 of the cost reporting period (if calendar ye   |                                       | ,                | 0           | 14. 00           |
| 15. 00           | Medically necessary private room days applicable to the Progra<br>Total nursery days (title V or XIX only)                       | dii (excidding swing-bed o            | lays)            | 0           | 15. 00           |
| 16. 00           | Nursery days (title V or XIX only)   |                                       |                  | 0           | 16. 00           |
| 47.00            | SWING BED ADJUSTMENT   |                                       | S 11 1           | 0.00        | 47.00            |
| 17. 00           | Medicare rate for swing-bed SNF services applicable to service reporting period  | es through December 31 of             | tne cost         | 0.00        | 17. 00           |
| 18. 00           | Medicare rate for swing-bed SNF services applicable to service   | es after December 31 of t             | he cost          | 0.00        | 18. 00           |
| 19. 00           | reporting period   | through December 21 of                | the cost         | 0.00        | 19. 00           |
| 19.00            | Medicaid rate for swing-bed NF services applicable to services reporting period  | s through becember 31 or              | the cost         | 0.00        | 19.00            |
| 20. 00           | Medicaid rate for swing-bed NF services applicable to services   | s after December 31 of th             | e cost           | 0. 00       | 20. 00           |
| 21. 00           | reporting period Total general inpatient routine service cost (see instructions  | (2)                                   |                  | 8, 099, 385 | 21. 00           |
| 22. 00           | Swing-bed cost applicable to SNF type services through December  |                                       | ng period (line  | 0, 0,7, 000 | 22. 00           |
|                  | 5 x line 17)   |                                       |                  |             |                  |
| 23. 00           | Swing-bed cost applicable to SNF type services after December x line 18)   | 31 of the cost reporting              | period (line 6   | 0           | 23. 00           |
| 24. 00           | Swing-bed cost applicable to NF type services through December   | 31 of the cost reportin               | g period (line   | 0           | 24. 00           |
| 25 00            | 7 x line 19)   | 24 -                                  |                  | 0           | 25 00            |
| 25. 00           | Swing-bed cost applicable to NF type services after December 3 x line 20)  | or the cost reporting                 | period (line 8   | 0           | 25. 00           |
| 26. 00           | Total swing-bed cost (see instructions)  |                                       |                  | 0           |                  |
| 27. 00           | General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT                                | (line 21 minus line 26)               |                  | 8, 099, 385 | 27. 00           |
| 28. 00           | General inpatient routine service charges (excluding swing-bed   | d and observation bed cha             | irges)           | 0           | 28. 00           |
| 29. 00           | Private room charges (excluding swing-bed charges)   |                                       |                  | 0           |                  |
| 30.00            | Semi-private room charges (excluding swing-bed charges)  | Line 20)                              |                  | 0. 000000   | 30.00            |
| 31. 00<br>32. 00 | General inpatient routine service cost/charge ratio (line 27 - Average private room per diem charge (line 29 ÷ line 3)           | - ITTIE 26)                           |                  | 0.00000     |                  |
| 33. 00           | Average semi-private room per diem charge (line 30 ÷ line 4)   |                                       |                  | 0. 00       |                  |
| 34.00            | Average per diem private room charge differential (line 32 mir   |                                       | i ons)           | 0.00        |                  |
| 35. 00<br>36. 00 | Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)     | ne зі)                                |                  | 0.00        | 35. 00<br>36. 00 |
| 37. 00           | General inpatient routine service cost net of swing-bed cost a   | and private room cost dif             | ferential (line  | 8, 099, 385 |                  |
|                  | 27 minus line 36)  | · · · · · · · · · · · · · · · · · · · |                  |             |                  |
|                  | PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU                          | ISTMENTS                              |                  |             |                  |
| 38. 00           | Adjusted general inpatient routine service cost per diem (see  |                                       |                  | 1, 456. 99  | 38. 00           |
| 39. 00           | Program general inpatient routine service cost (line 9 x line  | 38)                                   |                  | 903, 334    | 39. 00           |
| 40.00            | Medically necessary private room cost applicable to the Program general inputions routing service cost (Line 20)                 | •                                     |                  | 002 224     | 40.00            |
| 41. 00           | Total Program general inpatient routine service cost (line 39  | + ITHE 40)                            | ļ                | 903, 334    | 41.00            |

| COMPLIT                    | Financial Systems HARRISBURG MEDICAL ATION OF INPATIENT OPERATING COST   | Provider Co           |  | Peri od:                         | worksheet D-1                        |                  |
|----------------------------|--|-----------------------|--|----------------------------------|--------------------------------------|------------------|
| COMPUT                     | ATTON OF INFAITENT OFERATING COST  |                       | CCN: 14-S210                           | From 04/01/2022<br>To 03/31/2023 | Date/Time Pre                        | epared:          |
|                            |  | Title                 | XVIII                                  | Subprovi der -                   | 9/11/2023 9: 1<br>PPS                | <u>6 am</u>      |
|                            | Cost Center Description Total Inpatient Cost In  | Total<br>patient Days | Average Per<br>Diem (col. 1<br>col. 2) | Program Days                     | Program Cost<br>(col. 3 x col.<br>4) |                  |
|                            | 1.00   | 2. 00                 | 3.00                                   | 4. 00                            | 5. 00                                | <b></b>          |
| 42. 00                     | NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units  |                       |  |                                  | <u> </u>                             | 42.00            |
| 43. 00                     | INTENSIVE CARE UNIT  |                       |  |                                  |                                      | 43.00            |
| 44. 00                     | CORONARY CARE UNIT   |                       |  |                                  |                                      | 44.00            |
| 45. 00<br>46. 00           | BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT  |                       |  |                                  |                                      | 45. 00<br>46. 00 |
|                            | OTHER SPECIAL CARE (SPECIFY)   |                       |  |                                  |                                      | 47. 00           |
|                            | Cost Center Description  |                       |  |                                  |                                      |                  |
| 48. 00                     | Program inpatient ancillary service cost (Wkst. D-3, col. 3,   | Lino 200)             |  |                                  | 1. 00<br>120, 053                    | 48.00            |
| 48. 01                     | Program inpatient cellular therapy acquisition cost (Workshee  |                       | III, line 10                           | , column 1)                      | 120, 033                             |                  |
| 49. 00                     | Total Program inpatient costs (sum of lines 41 through 48.01)  |                       |  |                                  | 1, 023, 387                          |                  |
| 50. 00                     | PASS THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program inpatient routine se                                   | mulaca (fram          | Wka+ D au                              | m of Donto L and                 | F2 041                               | 50.00            |
| 30.00                      | Flass through costs appricable to Program impatrent routine se<br>   | ivices (iron          | WKSt. D, Su                            | III OI PAILS I AIIU              | 53, 041                              | 30.00            |
| 51. 00                     | Pass through costs applicable to Program inpatient ancillary   | services (fr          | om Wkst. D,                            | sum of Parts II                  | 5, 843                               | 51.00            |
| 52. 00                     | and IV) Total Program excludable cost (sum of lines 50 and 51)   |                       |  |                                  | 58, 884                              | 52.00            |
| 53. 00                     | Total Program inpatient operating cost excluding capital rela  | ited, non-phy         | sician anest                           | hetist, and                      | 964, 503                             |                  |
|                            | medical education costs (line 49 minus line 52)  |                       |  |                                  |                                      | 1                |
| 54 00                      | TARGET AMOUNT AND LIMIT COMPUTATION Program discharges   |                       |  |                                  | 0                                    | 54.00            |
| 55. 00                     | Target amount per discharge  |                       |  |                                  | 0.00                                 |                  |
| 55. 01                     | Permanent adjustment amount per discharge  |                       |  |                                  | 0.00                                 |                  |
| 55. 02<br>56. 00           | Adjustment amount per discharge (contractor use only) Target amount (line 54 x sum of lines 55, 55.01, and 55.02)              |                       |  |                                  | 0.00                                 | 1                |
| 57. 00                     | Difference between adjusted inpatient operating cost and targ  | et amount (I          | ine 56 minus                           | line 53)                         | 0                                    |                  |
| 58. 00                     | Bonus payment (see instructions)   | •                     |  | •                                | 0                                    |                  |
| 59. 00                     | Trended costs (lesser of line 53 ÷ line 54, or line 55 from t  | he cost repo          | rting period                           | endi ng 1996,                    | 0.00                                 | 59.0             |
| 60. 00                     | updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54, or line 55 from                      | prior year c          | ost report,                            | updated by the                   | 0.00                                 | 60.0             |
| 61. 00                     | market basket) Continuous improvement bonus payment (if line 53 $\div$ line 54 is  |                       |  |                                  | 0                                    | 61.0             |
|                            | 55.01, or line 59, or line 60, enter the lesser of 50% of the 53) are less than expected costs (lines 54 x 60), or 1 % of t    |                       |  |                                  |                                      |                  |
|                            | enter zero. (see instructions)   | ne target am          | odire (rine o                          | 0), 0ther wi 30                  |                                      |                  |
| 62.00                      | Relief payment (see instructions)  | d ana)                |  |                                  | 0 0                                  |                  |
| 63. 00                     | Allowable Inpatient cost plus incentive payment (see instruct PROGRAM INPATIENT ROUTINE SWING BED COST                         | 10115)                |  |                                  | 0                                    | ] 63.00          |
| 64. 00                     | Medicare swing-bed SNF inpatient routine costs through Decemb  | er 31 of the          | cost report                            | ing period (See                  | 0                                    | 64.00            |
| 65. 00                     | <pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine costs after December</pre>                       | 31 of the c           | ost renortin                           | a neriod (See                    | 0                                    | 65. 0            |
| 00.00                      | instructions)(title XVIII only)  | or or the c           | ost reportin                           | g perrou (see                    | ĺ                                    | 05.0             |
| 66. 00                     | Total Medicare swing-bed SNF inpatient routine costs (line 64 CAH, see instructions  | plus line 6           | 5)(title XVI                           | <pre>II only); for</pre>         | 0                                    | 66. 0            |
| 67. 00                     | Title V or XIX swing-bed NF inpatient routine costs through D  | ecember 31 o          | f the cost r                           | eporting period                  | О                                    | 67. 00           |
| 68. 00                     | (line 12 x line 19)<br>Title V or XIX swing-bed NF inpatient routine costs after Dec   | ember 31 of           | the cost rep                           | orting period                    | 0                                    | 68. 00           |
| 69. 00                     | (line 13 x line 20)<br>Total title V or XIX swing-bed NF inpatient routine costs (li   |                       |  |                                  | 0                                    | 69.00            |
| 70 00                      | PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY,   |                       |  | `                                |                                      | 70.0             |
| 70. 00<br>71. 00           | Skilled nursing facility/other nursing facility/ICF/IID routi<br>Adjusted general inpatient routine service cost per diem (lin |                       | •                                      | )                                |                                      | 70.00            |
| 72. 00                     | Program routine service cost (line 9 x line 71)  |                       | ŕ                                      |                                  |                                      | 72. 0            |
| 73. 00<br>74. 00           | Medically necessary private room cost applicable to Program (  |                       | ne 35)                                 |                                  |                                      | 73. 0            |
| 74. 00<br>75. 00           | Total Program general inpatient routine service costs (line 7 Capital-related cost allocated to inpatient routine service c    |                       | orksheet B.                            | Part II. column                  |                                      | 75. 0            |
|                            | 26, line 45)   | (                     |  | , _5. a                          |                                      |                  |
| 76. 00<br>77. 00           | Per diem capital-related costs (line 75 ÷ line 2)  |                       |  |                                  |                                      | 76. 00<br>77. 00 |
|                            | Program capital-related costs (line 9 x line 76) Inpatient routine service cost (line 74 minus line 77)                        |                       |  |                                  |                                      | 78. 0            |
| 79. 00                     | Aggregate charges to beneficiaries for excess costs (from pro  |                       |  |                                  |                                      | 79. 0            |
|                            | Total Program routine service costs for comparison to the cos  | t limitation          | (line 78 mi                            | nus line 79)                     |                                      | 80.0             |
| 31. 00<br>32. 00           | Inpatient routine service cost per diem limitation Inpatient routine service cost limitation (line 9 x line 81)                |                       |  |                                  |                                      | 81. 0            |
| 33. 00                     | Reasonable inpatient routine service costs (see instructions)  |                       |  |                                  |                                      | 83. 0            |
|                            | Program inpatient ancillary services (see instructions)  |                       |  |                                  |                                      | 84. 0            |
|                            | cition rowcow. Induction componention (coo inctructions  | . J                   |  |                                  | 1                                    | 85. 0            |
| 85. 00                     | Utilization review - physician compensation (see instructions  |                       |  |                                  |                                      | 86 0             |
| 84. 00<br>85. 00<br>86. 00 | Total Program inpatient operating costs (sum of lines 83 thropart IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST        |                       |  |                                  |                                      | 86. 0            |

| Health Financial Systems HA                        | RRISBURG MEDICA | AL CENTER, INC. |              | In Lie                           | u of Form CMS-2 | 2552-10 |
|--|-----------------|-----------------|--------------|----------------------------------|-----------------|---------|
| COMPUTATION OF INPATIENT OPERATING COST            |                 | Provi der CC    |              | Peri od:                         | Worksheet D-1   |         |
|  |                 | Component (     | CCN: 14-S210 | From 04/01/2022<br>To 03/31/2023 |                 |         |
|  |                 | Title           | XVIII        | Subprovi der -                   | PPS             |         |
|  |                 |                 |              | I PF                             |                 |         |
| Cost Center Description                            |                 |                 |              |                                  |                 |         |
|  |                 |                 |              |                                  | 1. 00           |         |
| 89.00 Observation bed cost (line 87 x line 88) (se | e instructions) |                 |              |                                  | 0               | 89. 00  |
| Cost Center Description                            | Cost            | Routine Cost    | column 1 ÷   | Total                            | Observati on    |         |
|  |                 | (from line 21)  | column 2     | Observati on                     | Bed Pass        |         |
|  |                 |                 |              | Bed Cost (from                   | Through Cost    |         |
|  |                 |                 |              | line 89)                         | (col. 3 x col.  |         |
|  |                 |                 |              |                                  | 4) (see         |         |
|  |                 |                 |              |                                  | instructions)   |         |
|  | 1.00            | 2.00            | 3.00         | 4. 00                            | 5. 00           |         |
| COMPUTATION OF OBSERVATION BED PASS THROUGH (      | COST            |                 |              |                                  |                 |         |
| 90.00 Capital -related cost                        | 475, 566        | 8, 099, 385     | 0. 05871     | 6 0                              | 0               | 90. 00  |
| 91.00 Nursing Program cost                         | 0               | 8, 099, 385     | 0. 00000     | 0                                | 0               | 91. 00  |
| 92.00 Allied health cost                           | 0               | 8, 099, 385     | 0. 00000     | 0                                | 0               | 92.00   |
| 93.00 All other Medical Education                  | 0               | 8, 099, 385     | 0. 00000     | 0                                | 0               | 93. 00  |

| Handah Firensial Contons  | CRUPS MEDICAL CENTER LING             |                      | 1 1:-                            | £ [ CMC :                        | 2552 10 |
|---|---------------------------------------|----------------------|----------------------------------|----------------------------------|---------|
| Health Financial Systems HARRI INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | SBURG MEDICAL CENTER, INC. Provider C |                      | Period:                          | u of Form CMS-2<br>Worksheet D-3 |         |
| THE ATTENT AND LEARN SERVICE GOST ATTORTION MENT                              | Trovider c                            | ON. 14 0210          | From 04/01/2022<br>To 03/31/2023 | Date/Time Pre                    |         |
|   |                                       |                      | 10 03/31/2023                    | 9/11/2023 9:1                    |         |
|   | Titl∈                                 | XVIII                | Hospi tal                        | PPS                              |         |
| Cost Center Description   |                                       | Ratio of Cos         |                                  | Inpati ent                       |         |
|   |                                       | To Charges           | Program                          | Program Costs                    |         |
|   |                                       |                      | Charges                          | (col. 1 x col.                   |         |
|   |                                       | 1.00                 | 2.00                             | 2)                               |         |
| INPATIENT ROUTINE SERVICE COST CENTERS  |                                       | 1.00                 | 2. 00                            | 3. 00                            |         |
| 30. 00 03000 ADULTS & PEDIATRICS  |                                       |                      | 918, 682                         |                                  | 30.00   |
| 40. 00   04000   SUBPROVI DER - 1 PF  |                                       |                      | 910,002                          |                                  | 40.00   |
| ANCI LLARY SERVI CE COST CENTERS  |                                       |                      |                                  |                                  | 10.00   |
| 50. 00 05000 OPERATI NG ROOM  |                                       | 0. 38023             | 31 151, 669                      | 57, 669                          | 50. 00  |
| 53. 00   05300   ANESTHESI OLOGY  |                                       | 0. 08513             |                                  | 2, 655                           | 1       |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C  |                                       | 0. 44229             | 98, 739                          | 43, 672                          | 54. 00  |
| 54. 01   05401   ULTRASOUND   |                                       | 0. 13164             |                                  | 27, 126                          | 54. 01  |
| 54. 02   03440   MAMMOGRAPHY  |                                       | 0. 53430             | 04 0                             | 0                                | 54. 02  |
| 56. 00   05600   RADI 0I SOTOPE   |                                       | 0. 20331             |                                  | 4, 547                           | 56. 00  |
| 57. 00  05700 CT SCAN   |                                       | 0. 04360             |                                  | 39, 728                          |         |
| 58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)                             |                                       | 0. 29229             |                                  |                                  |         |
| 60. 00   06000   LABORATORY   |                                       | 0. 25582             |                                  |                                  | 60. 00  |
| 64.00 06400 INTRAVENOUS THERAPY   |                                       | 0. 76845             |                                  | 156, 229                         |         |
| 65. 00 06500 RESPI RATORY THERAPY   |                                       | 0. 62613             |                                  | 449, 414                         |         |
| 66. 00 06600 PHYSI CAL THERAPY  |                                       | 0. 52673             |                                  | 124, 138                         |         |
| 67. 00   06700   0CCUPATI ONAL THERAPY<br>68. 00   06800   SPEECH PATHOLOGY   |                                       | 0. 41768             | · ·                              | 78, 745                          | 1       |
| 68. 00   06800   SPEECH PATHOLOGY<br>69. 00   06900   ELECTROCARDI OLOGY      |                                       | 0. 40652<br>0. 43015 |                                  | 1, 266<br>45, 512                |         |
| 71. 00  07100 MEDICAL SUPPLIES CHARGED TO PATIENTS                            |                                       | 0. 50987             |                                  | 128, 368                         | 1       |
| 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS                                   |                                       | 0.00000              |                                  | 120, 300                         | 1       |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS  |                                       | 0. 42082             |                                  | 220, 214                         |         |
| 75. 00   07500   ASC (NON-DISTINCT PART)                                      |                                       | 0. 47479             | · ·                              | 2, 989                           | 75. 00  |
| 76. 00 03950 FAI TH CENTER CHEMOTHERAPY                                       |                                       | 0. 95270             |                                  | 0                                | 1       |
| 76. 97 07697 CARDI AC REHABI LI TATI ON                                       |                                       | 0. 41231             |                                  | 115                              | 1       |
| 77. 00 07700 ALLOGENEIC HSCT ACQUISITION                                      |                                       | 0.00000              |                                  | 0                                |         |
| OUTPATIENT SERVICE COST CENTERS   |                                       | •                    |                                  |                                  |         |
| 88. 00 08800 RURAL HEALTH CLINIC  |                                       | 0.00000              | 00                               | 0                                | 88. 00  |
| 88.01 08801 RURAL HEALTH CLINIC II  |                                       | 0. 00000             |                                  | 0                                |         |
| 91. 00   09100   EMERGENCY  |                                       | 0. 45545             |                                  | · ·                              | 91. 00  |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)                              |                                       | 1. 01991             |                                  |                                  |         |
| 200.00 Total (sum of lines 50 through 94 and 96 t                             |                                       |                      | 5, 756, 140                      | 2, 273, 518                      | 1       |
| 201.00 Less PBP Clinic Laboratory Services-Progra                             | am only charges (line 61)             |                      | 0                                |                                  | 201. 00 |
| 202.00 Net charges (line 200 minus line 201)                                  |                                       | I                    | 5, 756, 140                      |                                  | 202. 00 |

|         | Financial Systems HARRISBURG MEDICAL                              |             |                            |                            | u of Form CMS-                            |         |
|---------|---|-------------|----------------------------|----------------------------|---|---------|
| INPATIE | NT ANCILLARY SERVICE COST APPORTIONMENT                           | Provi der C | CN: 14-0210                | Period:<br>From 04/01/2022 | Worksheet D-3                             |         |
|         |   | Component   | CCN: 14-S210               | To 03/31/2023              | Date/Time Pre<br>9/11/2023 9:1            |         |
|         |   | Titl€       | e XVIII                    | Subprovider -<br>IPF       | PPS                                       |         |
|         | Cost Center Description   |             | Ratio of Cos<br>To Charges | •                          | Inpatient Program Costs (col. 1 x col. 2) |         |
|         |   |             | 1.00                       | 2. 00                      | 3. 00                                     |         |
|         | NPATIENT ROUTINE SERVICE COST CENTERS                             |             |                            |                            | Г   | 4       |
|         | 03000 ADULTS & PEDI ATRI CS                                       |             |                            | 050 070                    |   | 30.00   |
|         | 14000 SUBPROVIDER - IPF<br>NCILLARY SERVICE COST CENTERS          |             |                            | 859, 978                   |   | 40. 00  |
| _       | DSOOO OPERATING ROOM  |             | 0. 3802                    | 31 0                       | 0   | 50.00   |
|         | 05300 ANESTHESI OLOGY   |             | 0. 0851                    |                            |   |         |
|         | 05400 RADI OLOGY-DI AGNOSTI C                                     |             | 0. 4422                    |                            | 2, 933                                    |         |
| 54. 01  | 05401 ULTRASOUND  |             | 0. 1316                    | 46 8, 084                  | 1, 064                                    | 54. 01  |
| 54.02   | 03440 MAMMOGRAPHY   |             | 0. 5343                    | 04 0                       | 0   | 54. 02  |
|         | D5600 RADI OI SOTOPE  |             | 0. 2033                    |                            | 254                                       |         |
|         | 05700 CT SCAN   |             | 0. 0436                    |                            | 1, 120                                    |         |
|         | 05800 MAGNETIC RESONANCE IMAGING (MRI)                            |             | 0. 2922                    |                            |   |         |
|         | 06000 LABORATORY  |             | 0. 2558                    |                            |   | 1       |
| - 1     | 16400   I NTRAVENOUS THERAPY<br>16500   RESPI RATORY THERAPY      |             | 0. 7684<br>0. 6261         |                            | 4, 153<br>8, 500                          | 1       |
|         | 06600 PHYSI CAL THERAPY   |             | 0. 5267                    |                            |   | 1       |
|         | 06700 OCCUPATI ONAL THERAPY                                       |             | 0. 4176                    |                            |   |         |
|         | 06800 SPEECH PATHOLOGY  |             | 0. 4065                    |                            | 0   |         |
|         | 06900 ELECTROCARDI OLOGY  |             | 0. 4301                    |                            | 3, 629                                    | 69.00   |
| 71.00   | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS                        |             | 0. 5098                    | 79 202                     | 103                                       | 71.00   |
|         | 07200 IMPL. DEV. CHARGED TO PATIENTS                              |             | 0.0000                     |                            |   |         |
|         | 07300 DRUGS CHARGED TO PATIENTS                                   |             | 0. 4208                    |                            |   |         |
|         | 07500 ASC (NON-DISTINCT PART)                                     |             | 0. 4747                    |                            | 0   |         |
|         | 03950 FAITH CENTER CHEMOTHERAPY                                   |             | 0. 9527                    |                            | 0   |         |
|         | 17697 CARDIAC REHABILITATION<br>17700 ALLOGENEIC HSCT ACQUISITION |             | 0. 4123<br>0. 0000         |                            | 0   |         |
|         | UTPATIENT SERVICE COST CENTERS                                    |             | 0.0000                     | 00  0                      | 0   | 177.00  |
|         | 08800 RURAL HEALTH CLINIC   |             | 0.0000                     | 00                         | 0   | 88. 00  |
|         | 18801 RURAL HEALTH CLINIC II                                      |             | 0.0000                     |                            | Ö   |         |
| 91.00   | 99100 EMERGENCY   |             | 0. 4554                    | 53 38, 621                 | 17, 590                                   | 91.00   |
| 92.00   | 9200 OBSERVATION BEDS (NON-DISTINCT PART)                         |             | 1. 0199                    | 12 0                       | 0   | 1       |
| 200. 00 | Total (sum of lines 50 through 94 and 96 through 98)              |             |                            | 334, 167                   | 120, 053                                  | 1       |
| 201.00  | Less PBP Clinic Laboratory Services-Program only charge:          | s (line 61) |                            | 0                          |   | 201. 00 |
| 202.00  | Net charges (line 200 minus line 201)                             |             |                            | 334, 167                   |   | 202. 00 |

| Health Financial Systems HARRISBURG MEDICAL (  | CENTED INC |                     | In Lie                           | eu of Form CMS-:                      | 2552 10  |
|--|------------|---------------------|----------------------------------|---------------------------------------|----------|
| INPATIENT ANCILLARY SERVICE COST APPORTIONMENT   |            | CN: 14-0210         | Peri od:                         | Worksheet D-3                         |          |
|  |            | CCN: 14-U210        | From 04/01/2022<br>To 03/31/2023 |                                       | pared:   |
|  | Ti tl e    | e XVIII             | Swing Beds - SNF                 | PPS                                   | <u> </u> |
| Cost Center Description  |            | Ratio of Cos        | t Inpatient                      | Inpati ent                            |          |
|  |            | To Charges          | Program<br>Charges               | Program Costs<br>(col. 1 x col.<br>2) |          |
|  |            | 1.00                | 2. 00                            | 3. 00                                 |          |
| INPATIENT ROUTINE SERVICE COST CENTERS   |            |                     |                                  |                                       |          |
| 30. 00 03000 ADULTS & PEDIATRICS   |            |                     |                                  |                                       | 30. 00   |
| 40. 00   04000   SUBPROVI DER - 1 PF   |            |                     |                                  |                                       | 40. 00   |
| ANCI LLARY SERVI CE COST CENTERS   |            |                     |                                  | 1                                     |          |
| 50. 00   05000   OPERATI NG ROOM   |            | 0. 38023            |                                  | -                                     |          |
| 53. 00   05300   ANESTHESI OLOGY   |            | 0. 08513            |                                  | -                                     |          |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C<br>54. 01   05401   ULTRASOUND                  |            | 0.44229             |                                  |                                       |          |
| 54. 01   05401   ULTRASOUND<br>54. 02   03440   MAMMOGRAPHY                              |            | 0. 1316<br>0. 53430 |                                  | 75                                    | 1        |
| 56. 00   05600  RADI 0I SOTOPE   |            | 0. 2033             |                                  | 0                                     |          |
| 57. 00   05700   CT   SCAN   |            | 0. 04360            |                                  | 0                                     |          |
| 58. 00   05800   MAGNETIC RESONANCE   MAGING (MRI)                                       |            | 0. 2922             |                                  | 0                                     | 1        |
| 60. 00   06000   LABORATORY  |            | 0. 2558             |                                  | _                                     |          |
| 64.00 06400 INTRAVENOUS THERAPY  |            | 0. 7684             |                                  | 0                                     | 1        |
| 65. 00 06500 RESPI RATORY THERAPY  |            | 0. 6261:            | 32 20, 756                       | 12, 996                               | 65. 00   |
| 66. 00 06600 PHYSI CAL THERAPY   |            | 0. 5267             | 32 42, 619                       | 22, 449                               | 66. 00   |
| 67. 00 06700 OCCUPATI ONAL THERAPY   |            | 0. 4176             | 36, 351                          | 15, 183                               | 67. 00   |
| 68. 00   06800   SPEECH PATHOLOGY  |            | 0. 40652            |                                  | 0                                     | 68. 00   |
| 69. 00 06900 ELECTROCARDI OLOGY  |            | 0. 4301!            |                                  | 0                                     |          |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS  |            | 0. 5098             |                                  |                                       | 1        |
| 72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS  |            | 0. 00000            |                                  |                                       |          |
| 73. 00 O7300 DRUGS CHARGED TO PATIENTS   |            | 0. 4208:            |                                  |                                       | 1        |
| 75.00 O7500 ASC (NON-DISTINCT PART) 76.00 O3950 FAITH CENTER CHEMOTHERAPY                |            | 0. 4747<br>0. 9527  |                                  | 290                                   | 1        |
| 76. 00   03950  FAITH CENTER CHEMOTHERAPY  76. 97   07697   CARDI AC   REHABI LI TATI ON |            | 0. 95270            |                                  | 0                                     | 1        |
| 77. 00 07700 ALLOGENEI C HSCT ACQUISITION  |            | 0. 4123             |                                  |                                       |          |
| OUTPATIENT SERVICE COST CENTERS  |            | 0.0000              | 50  0                            | <u> </u>                              | 77.00    |
| 88. 00 08800 RURAL HEALTH CLINIC   |            | 0.0000              | 00                               | 0                                     | 88. 00   |
| 88. 01   08801   RURAL HEALTH CLINIC II  |            | 0.0000              |                                  | 0                                     |          |
| 91. 00 09100 EMERGENCY   |            | 0. 4554             | 53 0                             | 0                                     | 91. 00   |
| 92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)   |            | 1. 0199             | 12 0                             | 0                                     | 92.00    |
| 200.00 Total (sum of lines 50 through 94 and 96 through 98)                              |            |                     | 147, 734                         | 68, 836                               | 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)   |            | I                   | 147, 734                         | I                                     | 202. 00  |

| Health Financial Systems                | HARRISBURG MEDICAL CENTER, INC. | In Lie                                       | u of Form CMS-2552-10   |
|---|---------------------------------|--|---|
| CALCULATION OF REIMBURSEMENT SETTLEMENT | Provi der CCN: 14-0210          | Peri od:<br>From 04/01/2022<br>To 03/31/2023 | Worksheet E<br>Part A<br>Date/Time Prepared:<br>9/11/2023 9:16 am |

|                  |  |                        |                   | 9/11/2023 9:1    |        |
|------------------|--|------------------------|-------------------|------------------|--------|
|                  |  | Title XVIII            | Hospi tal         | PPS              |        |
|                  |  |                        |                   | 1 00             |        |
|                  | PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS  |                        |                   | 1. 00            |        |
| 1. 00            | DRG Amounts Other than Outlier Payments  |                        |                   | 0                | 1.00   |
| 1. 01            | DRG amounts other than outlier payments for discharges occurring   | prior to October 1 (s  | see               | 1, 183, 581      | 1. 01  |
|                  | instructions)  | p. 10. 10 001020. 1 (  | ,,,,              | .,,              |        |
| 1.02             | DRG amounts other than outlier payments for discharges occurring   | on or after October    | l (see            | 926, 731         | 1. 02  |
|                  | instructions)  |                        |                   |                  |        |
| 1. 03            | DRG for federal specific operating payment for Model 4 BPCI for d  | ischarges occurring p  | orior to October  | 0                | 1. 03  |
| 1. 04            | 1 (see instructions)   | i cohorgos, occurri na | on or ofter       | 0                | 1. 04  |
| 1.04             | DRG for federal specific operating payment for Model 4 BPCI for d<br>October 1 (see instructions)                                      | rscharges occurring to | on or arter       | U                | 1.04   |
| 2. 00            | Outlier payments for discharges. (see instructions)  |                        |                   |                  | 2. 00  |
| 2. 01            | Outlier reconciliation amount  |                        |                   | 0                | 2. 01  |
| 2.02             | Outlier payment for discharges for Model 4 BPCI (see instructions  | )                      |                   | 0                | 2. 02  |
| 2.03             | Outlier payments for discharges occurring prior to October 1 (see  | instructions)          |                   | 0                | 2. 03  |
| 2.04             | Outlier payments for discharges occurring on or after October 1 (  | see instructions)      |                   | 19, 899          | 2. 04  |
| 3. 00            | Managed Care Simulated Payments  |                        |                   | 797, 205         | 3. 00  |
| 4. 00            | Bed days available divided by number of days in the cost reportin  | g period (see instru   | ctions)           | 36. 17           | 4. 00  |
| 5. 00            | Indirect Medical Education Adjustment  FTE count for allopathic and osteopathic programs for the most re                               | cont cost reporting    | port od onding on | 0.00             | 5. 00  |
| 5.00             | or before 12/31/1996. (see instructions)   | cent cost reporting p  | berroa enaring on | 0.00             | 3.00   |
| 5. 01            | FTE cap adjustment for qualifing hospitals under §131 of the CAA   | 2021 (see instruction  | ns)               | 0.00             | 5. 01  |
| 6. 00            | FTE count for allopathic and osteopathic programs that meet the c  |                        |                   | 0.00             | 6. 00  |
|                  | new programs in accordance with 42 CFR 413.79(e)   |                        |                   |                  |        |
| 6. 26            | Rural track program FTE cap limitation adjustment after the cap-b  | uilding window closed  | d under §127 of   | 0.00             | 6. 26  |
|                  | the CAA 2021 (see instructions)  |                        |                   |                  |        |
| 7. 00            | MMA Section 422 reduction amount to the IME cap as specified unde  |                        |                   | 0. 00            | 7. 00  |
| 7. 01            | ACA § 5503 reduction amount to the IME cap as specified under 42   | CFR §412.105(f)(1)(i   | /)(B)(2) If the   | 0. 00            | 7. 01  |
| 7. 02            | cost report straddles July 1, 2011 then see instructions.  | rogram ETE limitation  | (c) for rural     | 0.00             | 7. 02  |
| 7.02             | Adjustment (increase or decrease) to the hospital's rural track p<br>track programs with a rural track for Medicare GME affiliated pro |                        |                   | 0.00             | 7.02   |
|                  | and 87 FR 49075 (August 10, 2022) (see instructions)   | grails in accordance t | W til 413. 73(b)  |                  |        |
| 8. 00            | Adjustment (increase or decrease) to the FTE count for allopathic  | and osteopathic prod   | arams for         | 0.00             | 8. 00  |
|                  | affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c  |                        |                   |                  |        |
|                  | 1998), and 67 FR 50069 (August 1, 2002).   |                        |                   |                  |        |
| 8. 01            | The amount of increase if the hospital was awarded FTE cap slots   | under § 5503 of the A  | ACA. If the cost  | 0.00             | 8. 01  |
|                  | report straddles July 1, 2011, see instructions.   |                        |                   |                  |        |
| 8. 02            | The amount of increase if the hospital was awarded FTE cap slots   | from a closed teachi   | ng hospital       | 0.00             | 8. 02  |
| 8. 21            | under § 5506 of ACA. (see instructions) The amount of increase if the hospital was awarded FTE cap slots                               | under 8126 of the CA   | 1 2021 (500       | 0.00             | 8. 21  |
| 0. 21            | instructions)  | under 9126 of the CA   | 4 2021 (See       | 0.00             | 0. 21  |
| 9. 00            | Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.4  | 9 minus lines 7 and    | 7 01 plus or      | 0.00             | 9. 00  |
| 7. 00            | minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27   |                        | 7. 0.7 p. 0.5 0.  | 0.00             | 7.00   |
| 10.00            | FTE count for allopathic and osteopathic programs in the current   | year from your record  | ds                | 0.00             | 10.00  |
| 11. 00           | FTE count for residents in dental and podiatric programs.  |                        |                   |                  | 11. 00 |
| 12. 00           | Current year allowable FTE (see instructions)  |                        |                   |                  | 12.00  |
| 13. 00           | Total allowable FTE count for the prior year.  |                        |                   |                  | 13. 00 |
| 14. 00           | Total allowable FTE count for the penultimate year if that year e  | nded on or after Sep   | tember 30, 1997,  | 0.00             | 14. 00 |
| 15. 00           | otherwise enter zero. Sum of lines 12 through 14 divided by 3.   |                        |                   | 0.00             | 15. 00 |
| 16. 00           | Adjustment for residents in initial years of the program (see ins  | tructions)             |                   |                  | 16. 00 |
| 17. 00           | Adjustment for residents displaced by program or hospital closure  |                        |                   | 0.00             |        |
| 18. 00           | Adjusted rolling average FTE count   |                        |                   | 0.00             | 18. 00 |
| 19. 00           | Current year resident to bed ratio (line 18 divided by line 4).  |                        |                   | 0. 000000        | 19. 00 |
| 20. 00           | Prior year resident to bed ratio (see instructions)  |                        |                   | 0.000000         | 20. 00 |
| 21. 00           | Enter the lesser of lines 19 or 20 (see instructions)  |                        |                   | 0.000000         | 21. 00 |
| 22.00            | IME payment adjustment (see instructions)  |                        |                   | 0                | 22. 00 |
| 22. 01           | IME payment adjustment - Managed Care (see instructions)   |                        |                   | 0                | 22. 01 |
|                  | Indirect Medical Education Adjustment for the Add-on for § 422 of  |                        |                   |                  |        |
| 23. 00           | Number of additional allopathic and osteopathic IME FTE resident   | cap slots under 42 Cl  | FR 412. 105       | 0. 00            | 23. 00 |
| 24.00            | (f)(1)(iv)(C).   |                        |                   | 0.00             | 24.00  |
| 24. 00<br>25. 00 | IME FTE Resident Count Over Cap (see instructions)   | r of line 22 or line   | 24 (600           | 0.00             | 24.00  |
| 23.00            | If the amount on line 24 is greater than -0-, then enter the lowe instructions)  | I OI IIIIe 23 OI IIIIe | 24 (See           | 0.00             | 25. 00 |
| 26. 00           | Resident to bed ratio (divide line 25 by line 4)   |                        |                   | 0. 000000        | 26. 00 |
| 27. 00           | IME payments adjustment factor. (see instructions)   |                        |                   | 0. 000000        | 27. 00 |
| 28. 00           | IME add-on adjustment amount (see instructions)  |                        |                   | 0                | 28. 00 |
| 28. 01           | IME add-on adjustment amount - Managed Care (see instructions)   |                        |                   | 0                | 28. 01 |
| 29. 00           | Total IME payment ( sum of lines 22 and 28)  |                        |                   | 0                | 29. 00 |
| 29. 01           | Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  |                        |                   | 0                | 29. 01 |
|                  | Di sproporti onate Share Adjustment  |                        |                   |                  |        |
| 30.00            | Percentage of SSI recipient patient days to Medicare Part A patie  | nt days (see instruc   | tions)            | 8. 72            | 30.00  |
| 31.00            | Percentage of Medicaid patient days (see instructions)   |                        |                   | 13. 29           | 31.00  |
| 32.00            | Sum of lines 30 and 31   |                        |                   | 22. 01           |        |
| 33.00            | Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions)                    |                        |                   | 7. 37<br>38, 883 | 33.00  |
| J4. UU           | The sproportionate share adjustillent (see HISH UCH 0115)  |                        | l                 | 30,003           | 34.00  |

|                  | Fig. 1. L. G L   | OFNITED LING              |  | 6 E 0M6 (                        | 2550 40          |
|------------------|--|---------------------------|--|----------------------------------|------------------|
|                  | Financial Systems HARRISBURG MEDICAL ATION OF REIMBURSEMENT SETTLEMENT   | Provider CCN: 14-0210     | Peri od:<br>From 04/01/2022<br>To 03/31/2023 | Worksheet E Part A Date/Time Pre | pared:           |
|                  |  | Title XVIII               | Hospi tal                                    | 9/11/2023 9: 1<br>PPS            | <u>6 am</u>      |
|                  |  |                           | Prior to 10/1                                |                                  |                  |
|                  | Uncompensated Care Payment Adjustment  |                           | 1. 00  | 2. 00                            |                  |
| 35. 00           | Total uncompensated care amount (see instructions)   |                           | 7, 192, 008, 710                             | 6, 874, 403, 459                 | 35. 00           |
| 35. 01           | Factor 3 (see instructions)  |                           | 0. 000070417                                 | 0. 000068161                     | 35. 01           |
| 35. 02           |  | enter zero on this line   | 506, 440                                     | 468, 566                         | 35. 02           |
| 35. 03           | (see instructions) Pro rata share of the hospital UCP, including supplemental UCP  | CP (see instructions)     | 253, 914                                     | 233, 641                         | 35. 03           |
|                  | Total UCP adjustment (sum of columns 1 and 2 on line 35.03)  | •                         | 487, 555                                     | 200,011                          | 36. 00           |
|                  | Additional payment for high percentage of ESRD beneficiary di  | scharges (lines 40 throu  |  |                                  |                  |
| 40. 00           | Total Medicare discharges (see instructions)   |                           | Before 1/1                                   | On/After 1/1                     | 40. 00           |
|                  |  |                           | 1. 00  | 1. 01                            |                  |
| 41. 00           | Total ESRD Medicare discharges (see instructions)  |                           | 0  | 0                                | 41. 00           |
| 41. 01           | Total ESRD Medicare covered and paid discharges (see instruct  |                           | 0  | 0                                |                  |
| 42.00            | Divide line 41 by line 40 (if less than 10%, you do not quali  | fy for adjustment)        | 0.00   |                                  | 42. 00           |
| 43. 00<br>44. 00 | Total Medicare ESRD inpatient days (see instructions) Ratio of average length of stay to one week (line 43 divided             | by line 41 divided by 7   | 0. 000000                                    |                                  | 43. 00<br>44. 00 |
| 11.00            | days)  | by Time II di vi ded by 7 | 0.00000                                      |                                  | 11.00            |
| 45. 00           | Average weekly cost for dialysis treatments (see instructions  |                           | 0.00   | 0.00                             |                  |
| 46. 00<br>47. 00 | Total additional payment (line 45 times line 44 times line 41 Subtotal (see instructions)                                      | . 01)                     | 2, 656, 649                                  |                                  | 46. 00<br>47. 00 |
| 48. 00           | Hospital specific payments (to be completed by SCH and MDH, s  | small rural hospitals     | 2, 528, 455                                  |                                  | 48.00            |
|                  | only. (see instructions)   | mar. Tarar neep. tare     | 27 0207 100                                  |                                  | .0.00            |
|                  |  |                           |  | Amount                           |                  |
| 49. 00           | Total payment for inpatient operating costs (see instructions  | .)                        |  | 1. 00<br>2, 656, 649             | 49. 00           |
| 50. 00           | Payment for inpatient program capital (from Wkst. L, Pt. I an  |                           |  | 160, 283                         | •                |
| 51.00            | Exception payment for inpatient program capital (Wkst. L, Pt.  |                           |  | 0                                |                  |
| 52. 00           | Direct graduate medical education payment (from Wkst. E-4, li  | ne 49 see instructions).  |  | 0                                | 52. 00           |
| 53. 00<br>54. 00 | Nursing and Allied Health Managed Care payment Special add-on payments for new technologies                                    |                           |  | 0<br>11, 642                     | 53. 00<br>54. 00 |
| 54. 00           |  |                           |  | 11, 042                          | 54. 00           |
| 55. 00           | Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6  | 9)                        |  | 0                                | 55. 00           |
| 55. 01           | Cellular therapy acquisition cost (see instructions)   |                           |  | 0                                | 55. 01           |
| 56. 00<br>57. 00 | Cost of physicians' services in a teaching hospital (see intr<br>Routine service other pass through costs (from Wkst. D, Pt. I | •                         | hrough 35)                                   | 0                                | 56. 00<br>57. 00 |
| 58. 00           | Ancillary service other pass through costs from Wkst. D, Pt.   |                           | ili ougii 33).                               | 0                                |                  |
| 59. 00           | Total (sum of amounts on lines 49 through 58)  | •                         |  | 2, 828, 574                      | 59. 00           |
| 60.00            | Primary payer payments   |                           |  | 13, 607                          | 1                |
| 61. 00<br>62. 00 | Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries                      | s line 60)                |  | 2, 814, 967<br>343, 992          |                  |
| 63. 00           | Coinsurance billed to program beneficiaries  |                           |  | 343, 442                         | 63.00            |
| 64. 00           |  |                           |  | 124, 873                         | 64. 00           |
|                  | Adjusted reimbursable bad debts (see instructions)   |                           |  | 81, 167                          | •                |
| 66. 00<br>67. 00 | Allowable bad debts for dual eligible beneficiaries (see inst<br>Subtotal (line 61 plus line 65 minus lines 62 and 63)         | ructions)                 |  | 106, 137<br>2, 552, 142          | 66. 00<br>67. 00 |
| 68. 00           | Credits received from manufacturers for replaced devices for   | applicable to MS-DRGs (s  | ee instructions)                             | 2, 332, 142                      | 68. 00           |
| 69. 00           | Outlier payments reconciliation (sum of lines 93, 95 and 96).  |                           |  | 0                                | 69. 00           |
| 70.00            | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   | >                         |  | 0                                | 70.00            |
| 70. 50<br>70. 75 | Rural Community Hospital Demonstration Project (§410A Demonst N95 respirator payment adjustment amount (see instructions)      | tration) adjustment (see  | instructions)                                | 0                                | 70. 50<br>70. 75 |
| 70. 73           | Demonstration payment adjustment amount (see instructions)   |                           |  | 0                                | 70. 73           |
| 70. 88           | SCH or MDH volume decrease adjustment (contractor use only)  |                           |  | 0                                | 70. 88           |
| 70. 89           | Pioneer ACO demonstration payment adjustment amount (see inst  | ructions)                 |  | _                                | 70. 89           |
| 70. 90<br>70. 91 | HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)         |                           |  | 0                                | 70. 90<br>70. 91 |
| 70. 91           |  |                           |  | 0                                | 70. 91           |
| 70. 93           | HVBP payment adjustment amount (see instructions)  |                           |  | 0                                | 70. 93           |
|                  | HRR adjustment amount (see instructions)   |                           |  | -712                             |                  |
| 10. 95           | Recovery of accelerated depreciation   |                           |  | 0                                | 70. 95           |

| Health Financial Systems                | HARRISBURG MEDICAL CENTER, IN | C            | In Lieu                     | u of Form CMS-2552-10 |
|---|-------------------------------|--------------|-----------------------------|-----------------------|
| CALCULATION OF REIMBURSEMENT SETTLEMENT | Provi der                     | CCN: 14-0210 | Peri od:<br>From 04/01/2022 | Worksheet E<br>Part A |

To 03/31/2023 Date/Time Prepared: 9/11/2023 9:16 am Title XVIII Hospi tal PPS FFY (yyyy) Amount 1.00 70.96 Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 2022 323, 985 70.96 the corresponding federal year for the period prior to 10/1) Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 2023 70.97 311, 414 70.97 the corresponding federal year for the period ending on or after 10/1) 70.98 0 Low Volume Payment-3 70.98 0 18, 745 70 99 HAC adjustment amount (see instructions) 70 99 Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70) 3, 168, 084 71.00 71.00 71. 01 Sequestration adjustment (see instructions) 55, 441 71.01 Demonstration payment adjustment amount after sequestration 71.0271. 02 71.03 Sequestration adjustment-PARHM pass-throughs 71.03 3, 011, 779 72.00 Interim payments 72.00 72. 01 Interim payments-PARHM 72.01 73.00 Tentative settlement (for contractor use only) Ω 73.00 73.01 Tentative settlement-PARHM (for contractor use only) 73.01 74.00 Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 100, 864 74.00 73) Balance due provider/program-PARHM (see instructions) 74 01 74 01 75.00 Protested amounts (nonallowable cost report items) in accordance with 0 75.00 CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR (lines 90 through 96) Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 90.00 0 90.00 plus 2.04 (see instructions) Capital outlier from Wkst. L, Pt. I, line 2 91.00 0 91.00 92.00 Operating outlier reconciliation adjustment amount (see instructions) 0 92.00 93.00 Capital outlier reconciliation adjustment amount (see instructions) 93.00 0 94 00 The rate used to calculate the time value of money (see instructions) 0 00 94 00 95.00 Time value of money for operating expenses (see instructions) 0 95.00 96.00 Time value of money for capital related expenses (see instructions) 96.00 0 Prior to 10/1 On/After 10/1 2 00 1 00 HSP Bonus Payment Amount 0 100. 00 100.00 HSP bonus amount (see instructions) 0 HVBP Adjustment for HSP Bonus Payment 0.0000000000101.00 0.0000000000 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instructions) 0 102.00 HRR Adjustment for HSP Bonus Payment 0.0000 103.00 0.0000 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions) 0 104.00 Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. 200.00 Cost Reimbursement 201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) 201.00 202.00 Medicare discharges (see instructions) 202. 00 203.00 Case-mix adjustment factor (see instructions) 203.00 Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration peri od) 204.00 Medicare target amount 204.00 205.00 Case-mix adjusted target amount (line 203 times line 204) 205. 00 206.00 Medicare inpatient routine cost cap (line 202 times line 205) 206. 00 Adjustment to Medicare Part A Inpatient Reimbursement 207.00 Program reimbursement under the §410A Demonstration (see instructions) 207.00 208. 00 208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) 209.00 Adjustment to Medicare IPPS payments (see instructions) 209. 00 210.00 Reserved for future use 210. 00 211.00 Total adjustment to Medicare IPPS payments (see instructions) 211. 00 Comparision of PPS versus Cost Reimbursement 212.00 Total adjustment to Medicare Part A IPPS payments (from line 211) 212 00 213. 00 218. 00 213.00 Low-volume adjustment (see instructions) 218.00 Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)

Provider CCN: 14-0210

|                  |   |                          |                             | T: +1 -                     | V() (1 1 1         | 11: 4-1              | 9/11/2023 9:1       | <u>6 am</u> |
|------------------|---|--------------------------|-----------------------------|-----------------------------|--------------------|----------------------|---------------------|-------------|
|                  |   | W/S F Part A             | Amounts (from               | Pre/Post                    | XVIII Period Prior | Hospi tal<br>Peri od | PPS<br>Total (Col 2 |             |
|                  |   | line                     | E, Part A)                  | Entitlement                 | to 10/01           | On/After 10/01       |                     |             |
|                  |   | 0                        | 1.00                        | 2.00                        | 3. 00              | 4. 00                | 5. 00               |             |
| 1. 00            | DRG amounts other than outlier  | 1. 00                    | 0                           | 0                           | C                  | 0                    | 0                   | 1. 00       |
| 1. 01            | payments<br>DRG amounts other than outlier<br>payments for discharges   | 1. 01                    | 1, 183, 581                 | O                           | 1, 183, 581        |                      | 1, 183, 581         | 1. 01       |
| 1. 02            | occurring prior to October 1<br>DRG amounts other than outlier<br>payments for discharges<br>occurring on or after October        | 1. 02                    | 926, 731                    | 0                           |                    | 926, 731             | 926, 731            | 1. 02       |
| 1. 03            | 1<br>DRG for Federal specific<br>operating payment for Model 4<br>BPCI occurring prior to   | 1. 03                    | 0                           | O O                         | C                  |                      | 0                   | 1. 03       |
| 1.04             | October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1                             | 1. 04                    | 0                           | O                           |                    | 0                    | 0                   | 1. 04       |
| 2. 00            | Outlier payments for discharges (see instructions)  | 2. 00                    |                             |                             |                    |                      |                     | 2. 00       |
| 2. 01            | Outlier payments for discharges for Model 4 BPCI  | 2. 02                    | 0                           | 0                           | C                  | 0                    | 0                   | 2. 01       |
| 2. 02            | Outlier payments for<br>discharges occurring prior to<br>October 1 (see instructions)   | 2. 03                    | O                           | O                           | C                  |                      | 0                   | 2. 02       |
| 2. 03            | Outlier payments for<br>discharges occurring on or<br>after October 1 (see  | 2. 04                    | 19, 899                     | O                           |                    | 19, 899              | 19, 899             | 2. 03       |
| 3. 00            | instructions) Operating outlier reconciliation  | 2. 01                    | 0                           | 0                           | С                  | 0                    | 0                   | 3. 00       |
| 4. 00            | Managed care simulated payments   | 3. 00                    | 797, 205                    | 0                           | 428, 528           | 368, 677             | 797, 205            | 4.00        |
| Г 00             | Indirect Medical Education Adju   |                          | 0.000000                    | 0.00000                     | 0.00000            | 0.000000             |                     |             |
| 5. 00            | Amount from Worksheet E, Part A, line 21 (see instructions)   | 21. 00                   | 0. 000000                   | 0. 000000                   | 0. 000000          | 0. 000000            |                     | 5. 00       |
| 6. 00            | IME payment adjustment (see instructions)   | 22. 00                   | 0                           | 0                           | С                  | 0                    | 0                   | 6. 00       |
| 6. 01            | IME payment adjustment for managed care (see instructions)  | 22. 01                   | O                           | O                           | С                  | 0                    | 0                   | 6. 01       |
| 7. 00            | Indirect Medical Education Adju<br>IME payment adjustment factor<br>(see instructions)  | ustment for the<br>27.00 | e Add-on for Se<br>0.000000 | otion 422 of to<br>0.000000 |                    | 0. 000000            |                     | 7. 00       |
| 8. 00            | IME adjustment (see instructions)   | 28. 00                   | 0                           | 0                           | C                  | 0                    | 0                   | 8. 00       |
| 8. 01            | IME payment adjustment add on for managed care (see instructions)   | 28. 01                   | O                           | O                           | C                  | 0                    | 0                   | 8. 01       |
| 9. 00            | Total IME payment (sum of lines 6 and 8)  | 29. 00                   | 0                           | 0                           | C                  | 0                    | 0                   | 9. 00       |
| 9. 01            | Total IME payment for managed care (sum of lines 6.01 and 8.01)   | 29. 01                   | 0                           | 0                           | C                  | 0                    | 0                   | 9.0         |
| 10.00            | Disproportionate Share Adjustme<br>Allowable disproportionate   |                          | 0.0707                      | 0.0707                      | 0.0707             | 0.0727               |                     | 10.00       |
| 10. 00           | share percentage (see instructions)   | 33. 00                   | 0. 0737                     | 0. 0737                     | 0. 0737            | 0. 0737              |                     | 10.00       |
| 11. 00           | Disproportionate share adjustment (see instructions)  | 34. 00                   | 38, 883                     | 0                           | 21, 808            |                      |                     |             |
| 11. 01           | Uncompensated care payments<br>Additional payment for high per  |                          | 487, 555<br>RD beneficiary  |                             |                    | 233, 641             | 487, 555            |             |
| 12. 00           | Total ESRD additional payment   | 46. 00                   | 0                           | 0                           | C                  | 0                    | 0                   | 12. 00      |
| 13. 00<br>14. 00 | (see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) | 47. 00<br>48. 00         | 2, 656, 649<br>0            | 0                           | 1, 459, 303<br>C   | 1, 197, 346<br>0     | 2, 656, 649<br>0    | 1           |
| 15. 00           | (see instructions) Total payment for inpatient operating costs (see   | 49. 00                   | 2, 656, 649                 | O                           | 1, 459, 303        | 1, 197, 346          | 2, 656, 649         | 15. 00      |
| 16. 00           | <pre>instructions) Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)</pre>                               | 50. 00                   | 160, 283                    | 0                           | 89, 193            | 71, 090              | 160, 283            | 16. 00      |

LOW VOLUME CALCULATION EXHIBIT 4 Provi der CCN: 14-0210 Peri od: Worksheet E From 04/01/2022 Part A Exhibit 4 03/31/2023 Date/Time Prepared: 9/11/2023 9:16 am Title XVIII Hospi tal W/S E, Part A Amounts (from Pre/Post Period Prior Total (Col 2 Peri od to 10/01 Part A) On/After 10/01 line Entitlement through 4) 4 00 0 1 00 2 00 3 00 5 00 17.00 Special add-on payments for 54.00 11,642 2,681 8, 961 11, 642 17.00 new technologies 17.01 Net organ aquisition cost 17.01 17.02 Credits received from 68.00 17.02 0 0 0 manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation 93.00 0 0 0 18.00 adjustment amount (see instructions) 19.00 SUBTOTAL 1, 551, 177 1, 277, 397 2, 828, 574 19.00 W/S L, line (Amounts from 0 1.00 2.00 3.00 4. 00 5. 00 Capital DRG other than outlier 20.00 1.00 158, 931 89, 193 158, 931 20.00 69,738 Model 4 BPCI Capital DRG other 20.01 1 01 0 20 01 than outlier 21.00 Capital DRG outlier payments 2.00 1, 352 0 1, 352 1, 352 21.00 Model 4 BPCI Capital DRG 21.01 2.01 21.01 outlier payments Indirect medical education 22.00 5.00 0.0000 0.0000 0.0000 0.0000 22.00 percentage (see instructions) 23.00 Indirect medical education 6.00 C 0 23.00 adjustment (see instructions) 24.00 Allowable disproportionate 10.00 0.0000 0.0000 0.0000 0.0000 24.00 share percentage (see instructions) 25.00 Di sproporti onate share 11.00 0 C 0 25.00 0 adjustment (see instructions) 26.00 Total prospective capital 12.00 160, 283 89, 193 71,090 160, 283 26.00 payments (see instructions) W/S E, Part A (Amounts to E, line Part A) 1.00 2.00 3.00 4.00 5.00 0 27.00 Low volume adjustment factor 0.208864 0. 243788 27.00 28.00 Low volume adjustment 70.96 323, 985 323, 985 28.00 (transfer amount to Wkst. E, Pt. A. line) 70. 97 29.00 Low volume adjustment 311, 414 29.00 311, 414 (transfer amount to Wkst. E, Pt. A, line) 100.00 Transfer low volume 100.00

adjustments to Wkst. E, Pt. A.

Provider CCN: 14-0210

Peri od:

From 04/01/2022

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Part A Exhibit 5

03/31/2023 Date/Time Prepared: 9/11/2023 9:16 am Hospi tal Title XVIII Period to Total (cols. 2 Wkst. E, Pt. Amt. from Peri od on 10/01 A. line Wkst. E, Pt. after 10/01 and 3) A) 2.00 3. 00 0 4.00 1.00 1.00 DRG amounts other than outlier payments 1.00 1. 00 DRG amounts other than outlier payments for 1.01 1.01 1, 183, 581 1, 183, 581 1, 183, 581 1.01 discharges occurring prior to October 1 DRG amounts other than outlier payments for 1.02 1.02 926, 731 926, 731 926, 731 1.02 discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment 1.03 С 0 1.03 for Model 4 BPCI occurring prior to October DRG for Federal specific operating payment 1.04 1.04 0 1.04 for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 2.00 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 O 2.01 **BPCI** 2 02 Outlier payments for discharges occurring 2 03 0 2 02 prior to October 1 (see instructions) Outlier payments for discharges occurring on 2.03 2.04 19, 899 19, 899 19,899 2.03 or after October 1 (see instructions) 3.00 Operating outlier reconciliation 2.01 3.00 Managed care simulated payments 797, 205 428. 528 368.677 797, 205 4.00 3.00 4.00 Indirect Medical Education Adjustment 5.00 Amount from Worksheet E, Part A, line 21 21.00 0.000000 0.000000 0.000000 5.00 (see instructions) IME payment adjustment (see instructions) 6.00 22.00 0 0 0 6.00 IME payment adjustment for managed care (see 0 6.01 22.01 0 0 6.01 instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 IME payment adjustment factor (see 27. 00 0.000000 0.000000 0.000000 7.00 instructions) 8 00 IME adjustment (see instructions) 28 00 8 00 0 0 0 0 8.01 IME payment adjustment add on for managed 28.01 0 0 8.01 care (see instructions) Total IME payment (sum of lines 6 and 8) 29.00 9.00 0 0 9.00 Total IME payment for managed care (sum of 9.01 29.01 C 0 9.01 lines 6.01 and 8.01) Disproportionate Share Adjustment 0.0737 10.00 Allowable disproportionate share percentage 33.00 0.0737 0.0737 10.00 (see instructions) 11.00 Disproportionate share adjustment (see 34.00 38, 883 21, 808 17.075 38.883 11.00 instructions) 487, 555 11.01 253, 914 487, 555 Uncompensated care payments 36, 00 233, 641 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment (see 46. 00 12.00 instructions) 47.00 13 00 1, 459, 303 1, 197, 346 Subtotal (see instructions) 2, 656, 649 2, 656, 649 13 00 14.00 Hospital specific payments (completed by SCH 48.00 14.00 and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs 49.00 2, 656, 649 1, 459, 303 1, 197, 346 2, 656, 649 15.00 15.00 (see instructions) 16.00 Payment for inpatient program capital (from 50 00 160, 283 89, 193 71, 090 160, 283 16.00 Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 54.00 2,681 8, 961 11, 642 11,642 17.00 17.01 Net organ acquisition cost 17.01 Credits received from manufacturers for 68.00 0 17.02 17.02 0 replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment 93.00 0 18.00 amount (see instructions) 19.00 **SUBTOTAL** 1, 551, 177 1, 277, 397 2, 828, 574 19.00

| Financial Systems | HARRISBURG MEDICAL CI | ENTER, INC. | In Lie | u of Form CMS-2552-10 |
|-------------------|-----------------------|-------------|--------|-----------------------|
|                   |                       |             |        |                       |

| Heal th | Financial Systems HA                          | RRISBURG MEDICA | AL CENTER, INC.        |        | In Li€                                      | eu of Form CMS-2 | 2552-10 |
|---------|---|-----------------|------------------------|--------|---|------------------|---------|
| HOSPI T | AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA | TION EXHIBIT 5  | Provi der C            |        | Period:<br>From 04/01/2022<br>To 03/31/2023 |                  | pared:  |
|         |   |                 |                        | XVIII  | Hospi tal                                   | PPS              |         |
|         |   | Wkst. L, line   | (Amt. from<br>Wkst. L) |        |   |                  |         |
|         |   | 0               | 1.00                   | 2.00   | 3. 00                                       | 4.00             |         |
| 20. 00  | Capital DRG other than outlier                | 1.00            | 158, 931               | 89, 19 | 3 69, 738                                   | 158, 931         | 20. 00  |
| 20. 01  | Model 4 BPCI Capital DRG other than outlier   | 1.01            | 0                      |        | 0   | 0                | 20. 01  |
| 21.00   | Capital DRG outlier payments                  | 2.00            | 1, 352                 |        | 0 1, 352                                    | 1, 352           | 21. 00  |
| 21. 01  | Model 4 BPCI Capital DRG outlier payments     | 2. 01           | 0                      |        | o o   | 0                | 21. 01  |
| 22. 00  | Indirect medical education percentage (see    | 5. 00           | 0.0000                 | 0.000  | 0.0000                                      |                  | 22. 00  |
|         | instructions)                                 |                 |                        |        |   |                  |         |
| 23.00   | Indirect medical education adjustment (see    | 6.00            | 0                      |        | 0 0   | 0                | 23. 00  |
|         | instructions)                                 |                 |                        |        |   |                  |         |
| 24.00   | Allowable disproportionate share percentage   | 10.00           | 0.0000                 | 0.000  | 0.0000                                      |                  | 24. 00  |
|         | (see instructions)                            |                 |                        |        |   |                  |         |
| 25.00   | Di sproporti onate share adjustment (see      | 11. 00          | 0                      |        | 0   | 0                | 25. 00  |
|         | instructions)                                 |                 |                        |        |   |                  |         |
| 26.00   | Total prospective capital payments (see       | 12.00           | 160, 283               | 89, 19 | 3 71, 090                                   | 160, 283         | 26. 00  |
|         | instructions)                                 |                 |                        |        |   |                  |         |
|         |   | Wkst. E, Pt.    | (Amt. from             |        |   |                  |         |
|         |   | A, line         | Wkst. E, Pt.           |        |   |                  |         |
|         |   |                 | A)                     |        |   |                  |         |
|         |   | 0               | 1.00                   | 2.00   | 3. 00                                       | 4. 00            |         |
| 27. 00  |   |                 |                        |        |   |                  | 27. 00  |
| 28. 00  | Low volume adjustment prior to October 1      | 70. 96          | 323, 985               |        |   | 323, 985         |         |
| 29. 00  | Low volume adjustment on or after October 1   | 70. 97          | 311, 414               |        | 311, 414                                    | 311, 414         |         |
| 30.00   | HVBP payment adjustment (see instructions)    | 70. 93          | 0                      |        | 0   | 0                | 30. 00  |
| 30. 01  | HVBP payment adjustment for HSP bonus         | 70. 90          | 0                      |        | 0   | 0                | 30. 01  |
|         | payment (see instructions)                    |                 |                        |        |   |                  |         |
| 31.00   | HRR adjustment (see instructions)             | 70. 94          | -712                   | -71    | 2 0   | -712             |         |
| 31. 01  | HRR adjustment for HSP bonus payment (see     | 70. 91          | 0                      |        | 0   | 0                | 31. 01  |
|         | instructions)                                 |                 |                        |        |   |                  |         |
|         |   |                 |                        |        |   | (Amt. to Wkst.   |         |
|         |   | _               |                        |        |   | E, Pt. A)        |         |
| 00.07   | luo a lui a                                   | 0               | 1.00                   | 2.00   | 3.00  | 4. 00            | 00.05   |
| 32. 00  | HAC Reduction Program adjustment (see         | 70. 99          |                        | 18, 74 | 5 0   | 18, 745          | 32. 00  |
| 100.00  | instructions)                                 |                 |                        |        |   |                  | 100.00  |
| 100.00  | Transfer HAC Reduction Program adjustment to  |                 | Y                      |        |   |                  | 100. 00 |
|         | Wkst. E, Pt. A.                               |                 | I                      | l      | T.  | I                | I       |

| Health Financial Systems                | HARRISBURG MEDICAL CENTER, INC. | In Lie                                       | u of Form CMS-2552-10                  |
|---|---------------------------------|--|--|
| CALCULATION OF REIMBURSEMENT SETTLEMENT | Provi der CCN: 14-0210          | Peri od:<br>From 04/01/2022<br>To 03/31/2023 | Worksheet E Part B Date/Time Prepared: |

| MART 6   |        | Title XVIII Hospital                         |        | PPS         | o aiii |
|--|--------|--|--------|-------------|--------|
| Next 1   |        |  |        |             |        |
| 1.00   Medical and other services (see instructions)   1.43   1.00   1   |        | PART R - MEDICAL AND OTHER HEALTH SERVICES   |        | 1.00        |        |
| O'PS or Rith payment (see Instructions)   3.00   0.00      | 1.00   |  | $\neg$ | 143         | 1. 00  |
| Quiller payent (see Instructions)  |        | · · · · · · · · · · · · · · · · · · ·        |        |             |        |
| Dutile reconstitation amount (see instructions)  |        |  |        |             |        |
| Enter the hospital specific payment to cast ratio (see instructions)   |        |  |        |             |        |
| Line 2 times   line 5   0   0   0   0   0   0   0   0   0  |        |  |        |             |        |
| Translit floral corridor payment (see Instructions)  |        |  |        | 0           |        |
| Ancil lary service other pass through costs from Wist. D. Pt. IV, col. 13, line 200  |        |  |        |             |        |
| 0   10   10   10   10   10   10   10   |        |  |        |             |        |
| 10.0   Total cost Cyan of Tines 1 and 10) (see instructions)   143   11.00   |        |  |        |             |        |
| Reasonable Charges   332   12.00   Ancil Tary Service Charges   332   12.00   Ancil Tary Service Charges   332   13.00   Organ acquist It ion charges (from 8kst. 0-4, Pt. III. col. 4, Iline 69)   332   14.00   Total reasonable charges (sum of lines 12 and 13)   332   14.00   Total reasonable charges (sum of lines 12 and 13)   332   14.00   332   14   |        |  |        |             |        |
| 12.00   Ancil lary service charges   331   2.00   12.00   13.00   0rgan acquist it on charges (From West. D-4, Pt. III. col. 4, line 69)   332   14.00   13.00   0rgan acquist it on charges (seem of lines 12 and 13)   332   14.00   332   1   |        |  |        |             |        |
| 13.00   Organ acquist from charges (from Wist, D.4. Pt. III, col. 4, line 69)   0.13.00   0   | 12.00  |  |        | 222         | 12.00  |
| 14.00  |        |  |        |             |        |
| 15.00   Aggregate amount actually collected from patients  |        |  |        |             |        |
| 16.00   Amounts that would have been realized from patients   lable for payment for services on a chargebasis   0   16.00   had souch payment been made in accordance with 14 2 CFR \$413.13(e)   0.000000   17.00   0.000000   17.00   0.000000   17.00   0.000000   17.00   0.000000   17.00   0.000000   17.00   0.000000   17.00   0.000000   17.00   0.000000   17.00   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000   |        |  |        |             |        |
| 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)   0.0000000   17.00   0.0000000   17.00   0.0000000   17.00   0.0000000   17.00   0.0000000   17.00   0.0000000   17.00   0.0000000   17.00   0.000000   17.00   0.000000   0.000000   0.00000   0.000000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.00000   0.000000   0.00000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.00000000  | 16.00  | · · · · · · · · · · · · · · · · · · ·        | SIS    | 0           | 16.00  |
| 18.00   Total customary charges (see instructions)   332   18.00   19.00   Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see 189   19.00   1.0   | 17. 00 |  |        | 0. 000000   | 17. 00 |
| instructions   | 18. 00 |  |        |             |        |
| 20.00   Excess of reasonable cost over customary charges (complete only If line 11 exceeds line 18) (see instructions)   143   21.00   | 19. 00 |  |        | 189         | 19. 00 |
| Instructions    143   21   0   10   10   10   10   10   10   | 20.00  |  |        | 0           | 20.00  |
| 22.00   Interns and residents (see instructions)   0.22.00   0.23.00   0.23.00   0.24.00   0.24.00   0.25.00   0.25.00   0.23.00   0.25.00   0.2   | 20.00  |  |        | O           | 20.00  |
| 23.00   Cost of physicians' services in a teaching hospital (see instructions)   5.362,476   24.00   Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)   5.362,476   24.00   25.0   | 21. 00 | Lesser of cost or charges (see instructions) |        | 143         | 21. 00 |
| 24. 00   Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)   5, 362, 476   24. 00   |        | , ,  |        |             | •      |
| COMPUTATION OF RELIMBURSEMENT SETTLEMENT   |        |  |        | -           |        |
| 25.00   Deductibles and coinsurance amounts (for CAH, see instructions)   843,624 26.00  | 24.00  |  |        | 5, 302, 470 | 24.00  |
| 27. 00   Subtotal [(Ilnes 21 and 24 minus the sum of Ilnes 25 and 26) plus the sum of Ilnes 22 and 23] (see   4,518,995   27. 00   1   | 25. 00 |  |        | 0           | 25. 00 |
| Instructions   |        |  |        |             |        |
| 28. 00   Direct graduate medical education payments (from Wkst. E-4, line 50)   28. 00   28   | 27. 00 |  | е      | 4, 518, 995 | 27. 00 |
| 28.50   REH FacI II ty payment amount   28.50   29.00   ESRD direct medical education costs (from Wkst. E-4, line 36)   0.29, 00   0.   | 28 00  |  |        | 0           | 28 00  |
| Subtotal (sum of lines 27, 28, 28.50 and 29)   |        |  |        |             |        |
| 31.00   Subtotal (line 30 minus line 31)   4,518,995   32.00   ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI CES)   33.00   Composite rate ESRD (from Wkst. I5, line 11)   0.33.00   33.00   33.00   33.00   33.00   33.00   33.00   33.00   34.00   All owable bad debts (see instructions)   175,667   34.00   34.00   All owable bad debts (see instructions)   114,184   35.00   35.00   All owable bad debts (see instructions)   145,807   36.00   All owable bad debts for dual eligible beneficiaries (see instructions)   145,807   36.00   37.00   Subtotal (see instructions)   4,633,179   37.00   38.00   MSP-LCC reconciliation amount from PS&R   0.38.00   39.50   99.00   THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0.39.00   99.50     |        |  |        |             |        |
| Subtotal (ine 30 minus line 31)   ALDWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33.00   |        |  |        |             | •      |
| ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   0   0   0   0   0   0   0   0   0  |        |  |        |             |        |
| 34.00  | 02.00  |  |        | 1, 010, 770 | 02.00  |
| 35.00  |        |  |        |             | •      |
| 36. 00   |        |  |        |             |        |
| 37.00   Subtotal (see instructions)   4,633,179   37.00   38.00   MSP-LCC reconciliation amount from PS&R   0   39.00   39.00   39.50   39.50   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.00   39.50   39.50   Pioneer ACO demonstration payment adjustment (see instructions)   0   39.55   39.75   N95 respirator payment adjustment amount before sequestration   0   39.97   39.98   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39.98   39.99   RECOVERY OF ACCELERATED DEPRECIATION   0   39.99   39.99   RECOVERY OF ACCELERATED DEPRECIATION   0   39.99   39.99   39.90   |        | ,      |        |             |        |
| 38. 00   MSP-LCC reconciliation amount from PS&R   0   38. 00   39. 00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39. 00   39. 00   39. 00   39. 00   39. 00   39. 50   39. 50   39. 50   39. 55   39. 57   59. 77   Demonstration payment adjustment amount (see instructions)   0   39. 75   39. 97   Demonstration payment adjustment amount before sequestration   0   39. 97   39. 98   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39. 98   39. 99   RECOVERY OF ACCELERATED DEPRECIATION   0   39. 99   40. 00   Subtotal (see instructions)   4,633,179   40. 00   40. 01   40. 02   Demonstration payment adjustment sequestration   81. 081   40. 01   40. 02   Demonstration payment adjustment amount after sequestration   40. 02   Demonstration payment adjustment amount after sequestration   40. 02   40. 03   40. 03   40. 04   40. 04   40. 05    |        |  |        |             |        |
| 39.50   Pi oneer ACO demonstrati on payment adjustment (see instructions)   39.50  |        |  |        |             |        |
| 39. 75       N95 respirator payment adjustment amount (see instructions)       0       39. 75         39. 97       Demonstrati on payment adjustment amount before sequestration       0       39. 98         39. 98       Partial or full credits received from manufacturers for replaced devices (see instructions)       0       39. 98         39. 99       RECOVERY OF ACCELERATED DEPRECIATION       0       39. 99         40. 00       Subtotal (see instructions)       4, 633, 179       40. 00         40. 01       Demonstration payment adjustment amount after sequestration       81, 081       40. 01         40. 02       Sequestration adjustment amount after sequestration       0       40. 02         40. 03       Sequestration payments adjustment amount after sequestration       40. 02         41. 00       Interim payments-PARHM payments-PARHM       40. 00         41. 01       Interim payments-PARHM       4, 616, 815       41. 00         42. 01       Tentative settlement (for contractors use only)       0       42. 00         42. 01       Tentative settlement-PARHM (for contractor use only)       42. 01         43. 00       Balance due provider/program (see instructions)       -64, 717       43. 00         44. 00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,       0 </td <td></td> <td></td> <td></td> <td>0</td> <td></td>  |        |  |        | 0           |        |
| 39.97   Demonstration payment adjustment amount before sequestration   39.97   39.98   39.98   39.99   |        |  |        | 0           |        |
| 39. 98       Partial or full credits received from manufacturers for replaced devices (see instructions)       0       39. 98         39. 99       RECOVERY OF ACCELERATED DEPRECIATION       0       39. 99         40. 00       Subtotal (see instructions)       4, 633, 179       40. 00         40. 01       Sequestration adjustment (see instructions)       81, 081       40. 01         40. 02       Demonstration payment adjustment amount after sequestration       0       40. 02         40. 03       Sequestration adjustment-PARHM pass-throughs       40. 03         41. 01       Interim payments       4, 616, 815       41. 00         42. 00       Tentative settlement (for contractors use only)       0       42. 00         42. 01       Tentative settlement -PARHM (for contractor use only)       42. 01         43. 00       Bal ance due provider/program (see instructions)       -64, 717       43. 00         44. 00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,       0       44. 00         90. 00       Original outlier amount (see instructions)       0       90. 00         91. 00       Outlier reconciliation adjustment amount (see instructions)       0       90. 00         92. 00       The rate used to calculate the Time Value of Money (see instructions)       0   |        | ,      |        |             |        |
| 40.00 Subtotal (see instructions) 40.01 Sequestration adj ustment (see instructions) 40.02 Demonstration payment adj ustment amount after sequestration 40.03 Sequestration adj ustment-PARHM pass-throughs 41.00 Interim payments 41.01 Interim payments 4.616,815 41.00 41.01 Tentative settlement (for contractors use only) 42.00 Tentative settlement (for contractor use only) 43.00 Bal ance due provider/program (see instructions) 43.01 Bal ance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 70 BE COMPLETED BY CONTRACTOR 90.00 Outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Ogano Advance instructions 95.00 Time Value of Money (see instructions) 96.00 Ogano Advance instructions 97.00 Time Value of Money (see instructions) 97.00 Ogano Advance instructions 97.00 Time Value of Money (see instructions) 98.00 Time Value of Money (see instructions) 99.00 Ogano Advance instructions 99.00 Ogano Advance instructions 90.00 Time Value of Money (see instructions) 90.00 Ogano Advance instructions 90.00 Time Value of Money (see instructions) 90.00 Ogano Advance instructions 90.00 Ogano Advance inst |        |  |        |             |        |
| 40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 5 Sequestration adjustment-PARHM pass-throughs 6 Sequestration adjustment-PARHM pass-throughs 7 Sequestration adjustment-PARHM pass-throughs 7 Sequestration adjustment-PARHM pass-throughs 8 Sequestration adjustment amount after sequestration 9 Sequestratio |        | RECOVERY OF ACCELERATED DEPRECIATION         |        | 0           | 39. 99 |
| 40. 02 Demonstration payment adjustment amount after sequestration  40. 03 Sequestration adjustment-PARHM pass-throughs  41. 00 Interim payments  41. 01 Interim payments-PARHM  42. 00 Tentative settlement (for contractors use only)  42. 01 Tentative settlement-PARHM (for contractor use only)  43. 00 Balance due provider/program (see instructions)  43. 01 Balance due provider/program-PARHM (see instructions)  44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  50 Protested amounts (nonallowable cost report items)  90. 00 Original outlier amount (see instructions)  91. 00 Outlier reconciliation adjustment amount (see instructions)  92. 00 The rate used to calculate the Time Value of Money  93. 00 Time Value of Money (see instructions)  94. 00 93. 00  95. 00 Time Value of Money (see instructions)  96. 00 97. 00  97. 00 Time Value of Money (see instructions)  98. 00 99. 00  99. 00  99. 00  99. 00  99. 00  99. 00  99. 00  99. 00  99. 00  99. 00  99. 00  99. 00  99. 00  99. 00  99. 00  99. 00  99. 00  99. 00  |        |  |        |             | •      |
| 40. 03 Sequestration adjustment-PARHM pass-throughs 41. 00 Interim payments 41. 01 Interim payments-PARHM 42. 00 Tentative settlement (for contractors use only) 42. 01 Tentative settlement-PARHM (for contractor use only) 43. 00 Balance due provider/program (see instructions) 43. 01 Balance due provider/program-PARHM (see instructions) 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 44. 00 Original outlier amount (see instructions)  90. 00 Outlier reconciliation adjustment amount (see instructions) 91. 00 Outlier reconciliation adjustment amount (see instructions) 92. 00 The rate used to calculate the Time Value of Money 93. 00 Time Value of Money (see instructions) 0 93. 00   |        |  |        |             | •      |
| 41.00 Interim payments 41.01 Interim payments-PARHM 42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 44.00 Original outlier amount (see instructions)  90.00 Outlier reconciliation adjustment amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions)   |        | ,      |        | U           |        |
| 42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 70 BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 42.00 42.01 43.00 42.01 42.01 42.01 43.00 42.01 43.00 42.01 43.00 43.01 44.00 91.00 90.00 91.00 91.00 92.00 93.00   |        |  |        | 4, 616, 815 |        |
| 42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 \$\frac{115.2}{5115.2}\$  TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 93.00   |        | Interim payments-PARHM                       |        |             |        |
| 43.00 Balance due provider/program (see instructions)  43.01 Balance due provider/program-PARHM (see instructions)  44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00    91.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  93.00 O 93.00  |        |  |        | 0           |        |
| 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00    90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions) 98.00 Outlier reconciliation adjustment amount (see instructions) 99.00 Outlier reconciliation adjustment amount (see instructions)   |        |  |        | -64 717     |        |
| 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 \$115.2 TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 0 91.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 The rate used to calculate the Time Value of Money 0.00 92.00 Time Value of Money (see instructions) 0 93.00   |        | ,  |        | -04, 717    | •      |
| TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  94.00 Outlier reconciliation adjustment amount (see instructions)  95.00 Outlier reconciliation adjustment amount (see instructions)  97.00 Outlier reconciliation adjustment amount (see instructions)  98.00 Outlier reconciliation adjustment amount (see instructions)  99.00 Outlier reconciliation adjustment amount (see instructions)  |        | ,      |        | 0           | •      |
| 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Original outlier amount (see instructions) 94.00 Original outlier amount (see instructions) 95.00 Original outlier amount (see instructions) 97.00 Original outlier amount (see instructions)   |        |  |        |             |        |
| 91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  0 91.00  92.00  93.00   | 90 00  |  |        | 0           | 00.00  |
| 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0.00 92.00 0 93.00   |        |  |        |             |        |
| 93.00 Time Value of Money (see instructions) 0 93.00   |        |  |        |             |        |
| 94.00   Total (sum of lines 91 and 93)   0   94.00   |        |  |        |             |        |
|  | 94. 00 | lotal (sum of lines 91 and 93)               |        | 0           | 94. 00 |

| Health Financial Systems                | HARRI SBURG MEDI CAL | CENTER, INC.          | In Lie          | u of Form CMS | -2552-10      |
|---|----------------------|-----------------------|-----------------|---------------|---------------|
| CALCULATION OF REIMBURSEMENT SETTLEMENT |                      | Provider CCN: 14-0210 | Peri od:        | Worksheet E   |               |
|   |                      |                       | From 04/01/2022 |               |               |
|   |                      |                       | To 03/31/2023   |               |               |
|   |                      |                       |                 | 9/11/2023 9:  | <u>16 am </u> |
|   |                      | Title XVIII           | Hospi tal       | PPS           |               |
|   |                      |                       |                 |               |               |
|   |                      |                       |                 | 1. 00         |               |
| MEDICARE PART B ANCILLARY COSTS         |                      |                       |                 |               |               |
| 200.00 Part B Combined Billed Days      |                      |                       |                 | (             | 0 200. 00     |

| Health Financial Systems                | HARRISBURG MEDICAL CENTER, INC.                  | In Lie                                       | u of Form CMS-2552-10    |
|---|--|--|--------------------------|
| CALCULATION OF REIMBURSEMENT SETTLEMENT | Provi der CCN: 14-0210<br>Component CCN: 14-S210 | Peri od:<br>From 04/01/2022<br>To 03/31/2023 | Date/Time Prepared:      |
|   | Title XVIII                                      | Subprovi der -<br>I PF                       | 9/11/2023 9:16 am<br>PPS |
|   |  |  |                          |

|          | I PF  | 110       |     |
|----------|---|-----------|-----|
|          |   | 1 00      |     |
|          | PART B - MEDICAL AND OTHER HEALTH SERVICES  | 1.00      |     |
| 00       | Medical and other services (see instructions)   | 0         | 1.  |
| 00       | Medical and other services reimbursed under OPPS (see instructions)   | 288       |     |
| 00       | OPPS or REH payments  | 153       |     |
| 00       | Outlier payment (see instructions)  | 0         |     |
| 01<br>00 | Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instructions)   | 0.000     |     |
| 0C       | Line 2 times line 5   | 0.000     | 1   |
| 00       | Sum of lines 3, 4, and 4.01, divided by line 6  | 0.00      |     |
| 00       | Transitional corridor payment (see instructions)  | 0         | 8   |
| 00       | Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200  | 0         | 1 . |
| 00       | Organ acqui si ti ons   | 0         |     |
| 00       | Total cost (sum of lines 1 and 10) (see instructions)  COMPUTATION OF LESSER OF COST OR CHARGES   | 0         | 11  |
|          | Reasonable charges  |           | 1   |
| 00       | Ancillary service charges   | 0         | 12  |
| 00       | Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)  | 0         | 13  |
| 00       | Total reasonable charges (sum of lines 12 and 13)   | 0         | 14  |
| 00       | Customary charges   | 1         | ١,, |
| 00       | Aggregate amount actually collected from patients liable for payment for services on a charge basis  Amounts that would have been realized from patients liable for payment for services on a chargebasis | 0         | 1 . |
| 00       | had such payment been made in accordance with 42 CFR §413.13(e)   |           | '   |
| 00       | Ratio of line 15 to line 16 (not to exceed 1.000000)  | 0. 000000 | 17  |
| 00       | Total customary charges (see instructions)  | 0         | 18  |
| 00       | Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see  | 0         | 19  |
| 00       | instructions) Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see  | o         | 20  |
| 00       | instructions)   |           | 20  |
| 00       | Lesser of cost or charges (see instructions)  | 0         | 2   |
| 00       | Interns and residents (see instructions)  | 0         | 22  |
|          | Cost of physicians' services in a teaching hospital (see instructions)  | 0         | 1 - |
| 00       | Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)  | 153       | 24  |
| 00       | COMPUTATION OF REIMBURSEMENT SETTLEMENT  Deductibles and coinsurance amounts (for CAH, see instructions)  | 0         | 25  |
| . 00     | Deductibles and Coinsurance amounts (for CAH, see instructions)   | 30        |     |
|          | Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see  | 123       | 1   |
|          | instructions)   |           |     |
|          | Direct graduate medical education payments (from Wkst. E-4, line 50)  | 0         | 1   |
|          | REH facility payment amount   |           | 28  |
| 00       | ESRD direct medical education costs (from Wkst. E-4, line 36)<br>Subtotal (sum of lines 27, 28, 28.50 and 29)   | 0<br>123  |     |
| 00       | Primary payer payments  | 0         | 1   |
| 00       | Subtotal (line 30 minus line 31)  | 123       | 32  |
|          | ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   | _         | ļ . |
|          | Composite rate ESRD (from Wkst. I-5, line 11)   | 0         |     |
|          | Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)   | 0         |     |
|          | Allowable bad debts for dual eligible beneficiaries (see instructions)  |           |     |
|          | Subtotal (see instructions)   | 123       |     |
| 00       | MSP-LCC reconciliation amount from PS&R   | 0         | 38  |
| 00       | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  | 0         |     |
| 50       | Pioneer ACO demonstration payment adjustment (see instructions)   |           | 39  |
| 75<br>97 | N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestration  | 0         | 1   |
| 98       | Partial or full credits received from manufacturers for replaced devices (see instructions)   |           | 1   |
| 99       | RECOVERY OF ACCELERATED DEPRECIATION  | l o       |     |
| 00       | Subtotal (see instructions)   | 123       |     |
| 01       | Sequestration adjustment (see instructions)   | 2         |     |
| 02       | Demonstration payment adjustment amount after sequestration   | 0         | 1 . |
| 03       | Sequestration adjustment-PARHM pass-throughs  | 101       | 4   |
|          | Interim payments Interim payments-PARHM   | 121       | 4   |
| 00       | Tentative settlement (for contractors use only)   | o         |     |
| 01       | 3,  |           | 4:  |
| 00       | Balance due provider/program (see instructions)   | 0         | 4:  |
| . 01     | Balance due provider/program-PARHM (see instructions)   |           | 43  |
| . 00     | Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,   | 0         | 44  |
|          | §115.2 TO BE COMPLETED BY CONTRACTOR  |           | 1   |
| 00       | Original outlier amount (see instructions)  | 0         | 90  |
|          | Outlier reconciliation adjustment amount (see instructions)   | Ö         |     |
|          | The rate used to calculate the Time Value of Money  | 0.00      |     |
|          | Time Value of Money (see instructions)  |           | 9:  |

| Health Financial Systems                | HARRI SBURG MEDI CAL | CENTER, INC.           | In Lie          | u of Form CMS- | 2552-10 |
|---|----------------------|------------------------|-----------------|----------------|---------|
| CALCULATION OF REIMBURSEMENT SETTLEMENT |                      | Provider CCN: 14-0210  | Peri od:        | Worksheet E    |         |
|   |                      |                        | From 04/01/2022 |                |         |
|   |                      | Component CCN: 14-S210 | To 03/31/2023   | Date/Time Pre  | pared:  |
|   |                      | •                      |                 | 9/11/2023 9:1  | 6 am    |
|   |                      | Title XVIII            | Subprovi der -  | PPS            |         |
|   |                      |                        | I PF            |                |         |
|   |                      |                        |                 |                |         |
|   |                      |                        |                 | 1. 00          |         |
| 94.00 Total (sum of lines 91 and 93)    |                      |                        | ·               | 0              | 94. 00  |
|   |                      |                        |                 |                |         |
|   |                      |                        |                 | 1. 00          |         |
| MEDICARE PART B ANCILLARY COSTS         |                      |                        |                 |                |         |
| 200.00 Part B Combined Billed Days      |                      |                        |                 |                | 200. 00 |

 
 Heal th
 Financial
 Systems
 HARRISB

 ANALYSIS
 OF
 PAYMENTS
 TO
 PROVIDERS
 FOR
 SERVICES
 RENDERED
 | Peri od: | Worksheet E-1 | From 04/01/2022 | Part I | To 03/31/2023 | Date/Time Prepared: Provider CCN: 14-0210

|                |   |            | '           | 0 03/31/2023 | 9/11/2023 9: 10 |                |
|----------------|---|------------|-------------|--------------|-----------------|----------------|
|                |   | Title      | XVIII       | Hospi tal    | PPS             |                |
|                |   | I npati en | t Part A    | Par          | t B             |                |
|                |   | mm/dd/yyyy | Amount      | mm/dd/yyyy   | Amount          |                |
|                |   | 1. 00      | 2, 00       | 3. 00        | 4. 00           |                |
| 1.00           | Total interim payments paid to provider   |            | 3, 011, 779 |              | 4, 616, 815     | 1. 00          |
| 2. 00          | Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,  |            | 0           |              | 0               | 2. 00          |
| 3.00           | write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider |            |             |              |                 | 3. 00          |
| 3. 01          | ADJUSTMENTS TO PROVIDER   |            | 0           |              | 0               | 3. 01          |
| 3. 02          | ADSOSTMENTS TO TROVIDER   |            | 0           |              | 0               | 3. 02          |
| 3. 03          |   |            | 0           |              | 0               | 3. 03          |
| 3. 04          |   |            | Ö           |              | 0               | 3. 04          |
| 3. 05          |   |            | 0           |              | 0               | 3. 05          |
|                | Provider to Program   |            |             |              |                 |                |
| 3.50           | ADJUSTMENTS TO PROGRAM  |            | 0           |              | 0               | 3. 50          |
| 3.51           |   |            | 0           |              | 0               | 3. 51          |
| 3.52           |   |            | 0           |              | 0               | 3. 52          |
| 3. 53          |   |            | 0           |              | 0               | 3. 53          |
| 3.54           |   |            | 0           |              | 0               | 3. 54          |
| 3. 99          | Subtotal (sum of lines 3.01-3.49 minus sum of lines   |            | 0           |              | 0               | 3. 99          |
| 4. 00          | 3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)   |            | 3, 011, 779 |              | 4, 616, 815     | 4. 00          |
|                | (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)  |            |             |              |                 |                |
|                | TO BE COMPLETED BY CONTRACTOR   |            |             |              |                 |                |
| 5.00           | List separately each tentative settlement payment after desk review. Also show date of each payment. If none,   |            |             |              |                 | 5. 00          |
|                | write "NONE" or enter a zero. (1)   |            |             |              |                 |                |
|                | Program to Provider   |            |             |              |                 |                |
| 5.01           | TENTATI VE TO PROVI DER   |            | 0           |              | 0               | 5. 01          |
| 5.02           |   |            | 0           |              | 0               | 5. 02          |
| 5.03           |   |            | 0           |              | 0               | 5. 03          |
| _              | Provi der to Program  |            |             |              |                 |                |
| 5. 50          | TENTATI VE TO PROGRAM   |            | 0           |              | 0               | 5. 50          |
| 5. 51          |   |            | 0           |              | 0               | 5. 51          |
| 5. 52<br>5. 99 | Subtotal (sum of lines 5.01-5.49 minus sum of lines   |            | 0           |              | 0               | 5. 52<br>5. 99 |
| 5. 99          | 5. 50-5. 98)  |            | 0           |              | U               | 5. 99          |
| 6.00           | Determined net settlement amount (balance due) based on   |            |             |              |                 | 6. 00          |
| 6. 01          | the cost report. (1) SETTLEMENT TO PROVIDER   |            | 100, 864    |              | 0               | 6. 01          |
| 6. 01          | SETTLEMENT TO PROVIDER  |            | 100, 864    |              | 64, 717         | 6. 01          |
| 7. 00          | Total Medicare program liability (see instructions)   |            | 3, 112, 643 |              | 4, 552, 098     | 7. 00          |
| 7.00           | Total modicale program trability (see Histructions)   |            | 5, 112, 043 | Contractor   | NPR Date        | 7.00           |
|                |   |            |             | Number       | (Mo/Day/Yr)     |                |
|                |   | (          | )           | 1. 00        | 2.00            |                |
| 8. 00          | Name of Contractor  |            |             |              |                 | 8. 00          |
|                |   | •          |             | '            |                 | •              |

Provider CCN: 14-0210 Component CCN: 14-S210

| Inpatient Part A  |       |  | Title      | XVIII    | Subprovider - | PPS    |       |
|---|-------|--|------------|----------|---------------|--------|-------|
| 1.00   10tal Interim payments paid to provider   1.00   2.00   3.00   4.00   1.00     |       |  | Inpatien   | t Part A | Par           | t B    |       |
| Total interim payments paid to provider   1   |       |  | mm/dd/yyyy | Amount   | mm/dd/yyyy    | Amount |       |
| Interlin payments payable on Individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero.   |       |  | 1.00       |          |               |        |       |
| 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)   |       | 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,                       |            |          |               | l .    |       |
| 3. 02   0   | 3. 00 | amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider |            |          |               |        | 3. 00 |
| 3. 03 3. 04 3. 05 3. 04 3. 05 3. 04 3. 05 3. 05 3. 07 3. 08 3. 08 3. 09 3. 00 | 3. 01 | ADJUSTMENTS TO PROVIDER  |            |          |               |        | 3. 01 |
| 3.04   0   0   0   3.04     3.05   0   0   0   0   3.05     2.00   0   0   0   3.05     3.01   0   0   0   0   3.05     3.02   0   0   0   3.51     3.03   0   0   0   3.51     3.04   0   0   0   3.51     3.05   0   0   0   3.51     3.05   0   0   0   3.51     3.06   0   0   3.52     3.07   0   0   0   3.52     3.08   0   0   0   3.53     3.09   3.50-3.98   0   0   0   3.54     3.09   3.50-3.98   0   0   0   3.54     3.09   3.50-3.98   0   0   0   3.54     3.09   0   0   0   0     1.00   0   0   0   0     1.00   0   0   0     1.00   0   0   0     1.00   0   0     1.00   0   0     1.00   0   0     1.00   0   0     1.00   0   0     1.00   0   0     1.00   0   0     1.00   0   0     1.00   0   0     1.00   0   0     1.00   0   0     1.00   0   0     1.00   0   0     1.00   0   0     1.00   0   0     1.00   0   0     1.00   0   0     1.00   0   0     1.00   0   0     3.04   3.05     3.50   0   0   0     3.06   0   0     3.06   0   0   0     3.07   0   0     3.08   0   0   0     3.08   0   0   0     3.51   0   0     3.51   0   0     3.52   0   0     3.52   0   0     3.53   0   0     3.54   0   0     3.59   0   0     3.51   0     3.50   0   0     3.51   0     3.52   0   0     3.52   0     3.53   0     3.54   0   0     4.00   0     5.01   0     5.01   0     6.01   0     6.02   0     6.02   0     6.03   0     6.04   0     6.05   0     6.06   0     6.07   0     7.00     |       |  |            |          |               |        |       |
| 3.05  |       |  |            |          |               |        |       |
| Provider to Program   ADJUSTMENTS TO PROGRAM   0   0   3.50   |       |  |            |          |               |        |       |
| 3. 50   ADJUSTMENTS TO PROGRAM  | 3.05  | Provider to Program  |            |          | U             | 0      | 3. 05 |
| 3.51   3.52   3.53   3.54   3.55   3.55   3.55   3.55   3.56   3.57   3.59   3.50-3.98    | 3 50  |  |            |          | 0             | 0      | 3 50  |
| 3.53   3.54   3.54   3.54   3.54   3.54   3.54   3.54   3.54   3.55     |       | 7.5000 TIME.TITO TO THOUSEN IN   |            |          |               |        |       |
| 3.54   3.99   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   3.50-3.98)   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   622,585   121   4.00   (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)   TO BE COMPLETED BY CONTRACTOR   | 3.52  |  |            |          | О             | 0      | 3. 52 |
| Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)  | 3.53  |  |            |          | 0             | 0      | 3. 53 |
| 3.50-3.98   Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)   TO BE COMPLETED BY CONTRACTOR   |       |  |            |          | ~             | - 1    |       |
| 121   4.00  | 3. 99 |  |            |          | 0             | 0      | 3. 99 |
| appropriate   TO BE COMPLETED BY CONTRACTOR   | 4. 00 | Total interim payments (sum of lines 1, 2, and 3.99)   |            | 622, 58  | 5             | 121    | 4. 00 |
| TO BE COMPLETED BY CONTRACTOR   |       |  |            |          |               |        |       |
| Solid   |       |  |            |          |               |        |       |
| desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider   | 5 00  | list senarately each tentative settlement navment after  |            |          |               |        | 5 00  |
| TENTATI VE TO PROVI DER   | 3.00  | desk review. Also show date of each payment. If none,  |            |          |               |        | 3. 00 |
| Solition   |       | Program to Provider  |            |          |               |        |       |
| Solution   |       | TENTATI VE TO PROVI DER  |            |          |               |        |       |
| Provider to Program   |       |  |            |          |               |        |       |
| TENTATI VE TO PROGRAM   | 5.03  | Describer to Describe  |            |          | 0             | 0      | 5. 03 |
| 5.51   5.52   5.52   5.53   5.55   5.55   5.55   5.55   5.55   5.55   5.50     | 5 50  |  |            |          |               |        | 5 50  |
| 5.52   5.99   Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)   6.00   Determined net settlement amount (balance due) based on the cost report. (1)   6.01   SETTLEMENT TO PROVIDER   0   0   0   6.01   6.02   SETTLEMENT TO PROGRAM   50,110   0   6.02   7.00   Total Medicare program liability (see instructions)   572,475   121   7.00  |       | TENTATI VE TO TROCKAW  |            |          |               |        |       |
| 5. 99 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 0 0 6. 01 6. 02 SETTLEMENT TO PROGRAM 50, 110 7. 00 Total Medicare program liability (see instructions) 572, 475 121 7. 00  Contractor NPR Date (Mo/Day/Yr) 0 1. 00 2. 00  |       |  |            |          |               |        |       |
| 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  Contractor Number (Mo/Day/Yr)  0 1.00 2.00   |       | Subtotal (sum of lines 5.01-5.49 minus sum of lines  |            |          | Ö             | 0      |       |
| 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  Contractor Number (Mo/Day/Yr)  0 1.00 2.00   | 6. 00 |  |            |          |               |        | 6. 00 |
| 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  50, 110 572, 475  Contractor Number (Mo/Day/Yr) 0 1.00 2.00  |       |  |            |          |               |        |       |
| 7.00 Total Medicare program liability (see instructions) 572,475 121 7.00  Contractor NPR Date (Mo/Day/Yr)  0 1.00 2.00   |       |  |            |          |               |        |       |
| Contractor         NPR Date           Number         (Mo/Day/Yr)           0         1.00         2.00  |       |  |            |          |               | - 1    |       |
| Number         (Mo/Day/Yr)           0         1.00         2.00  | 7.00  | iotal medicare program frability (see instructions)  |            | 5/2, 4/  |               |        | 7.00  |
| 0 1.00 2.00   |       |  |            |          |               |        |       |
|   |       |  | (          | )        |               |        |       |
|   | 8.00  | Name of Contractor   |            |          |               |        | 8. 00 |

 
 CENTER, INC.
 In Lieu of Form CMS-2552-10

 Provider CCN: 14-0210
 Period: From 04/01/2022 Part I To 03/31/2023
 Worksheet E-1 Part I Date/Time Prepared: 9/11/2023 9:16 am
 HARRI SB ANALYSI S OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

|                |  |            |           |                 | 9/11/2023 9:1 | 6 am           |
|----------------|--|------------|-----------|-----------------|---------------|----------------|
|                |  |            |           | wing Beds - SNF |               |                |
|                |  | Inpatien   | it Part A | Par             | rt B          |                |
|                |  | mm/dd/yyyy | Amount    | mm/dd/yyyy      | Amount        |                |
|                |  | 1. 00      | 2.00      | 3. 00           | 4. 00         |                |
| 1.00           | Total interim payments paid to provider                                      |            | 56, 661   |                 | 0             | 1. 00          |
| 2.00           | Interim payments payable on individual bills, either                         |            | 0         |                 | 0             | 2. 00          |
|                | submitted or to be submitted to the contractor for                           |            |           |                 |               |                |
|                | services rendered in the cost reporting period. If none,                     |            |           |                 |               |                |
|                | write "NONE" or enter a zero   |            |           |                 |               |                |
| 3.00           | List separately each retroactive lump sum adjustment                         |            |           |                 |               | 3.00           |
|                | amount based on subsequent revision of the interim rate                      |            |           |                 |               |                |
|                | for the cost reporting period. Also show date of each                        |            |           |                 |               |                |
|                | payment. If none, write "NONE" or enter a zero. (1)                          |            |           |                 |               |                |
|                | Program to Provider  |            |           |                 |               |                |
| 3.01           | ADJUSTMENTS TO PROVIDER  |            | C         |                 | 0             | 3. 01          |
| 3.02           |  |            | C         |                 | 0             | 3. 02          |
| 3.03           |  |            | 0         |                 | 0             | 3. 03          |
| 3.04           |  |            | 0         |                 | 0             | 3. 04          |
| 3.05           |  |            | C         |                 | 0             | 3. 05          |
|                | Provider to Program  |            |           |                 |               |                |
| 3.50           | ADJUSTMENTS TO PROGRAM   |            | 0         |                 | 0             | 3. 50          |
| 3. 51          |  |            | 0         |                 | 0             |                |
| 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                          |            | C         |                 | 0             | 3. 99          |
|                | 3. 50-3. 98)   |            |           |                 |               |                |
| 4.00           | Total interim payments (sum of lines 1, 2, and 3.99)                         |            | 56, 661   |                 | 0             | 4.00           |
|                | (transfer to Wkst. E or Wkst. E-3, line and column as                        |            |           |                 |               |                |
|                | appropri ate)  |            |           |                 |               |                |
|                | TO BE COMPLETED BY CONTRACTOR  |            |           |                 |               |                |
| 5.00           | List separately each tentative settlement payment after                      |            |           |                 |               | 5. 00          |
|                | desk review. Also show date of each payment. If none,                        |            |           |                 |               |                |
|                | write "NONE" or enter a zero. (1)  |            |           |                 |               |                |
| E 04           | Program to Provider  |            | 1 0       | I               |               | - 04           |
| 5. 01          | TENTATI VE TO PROVI DER  |            | C         |                 | 0             |                |
| 5. 02          |  |            | C         |                 | 0             |                |
| 5. 03          | Describer to Describe  |            | C         |                 | 0             | 5. 03          |
| E E0           | Provider to Program TENTATIVE TO PROGRAM                                     |            | 1 0       |                 | 0             | 5. 50          |
| 5. 50          | TENTATIVE TO PROGRAM   |            | 0         |                 | 0             |                |
| 5. 51          |  |            |           |                 | 0             |                |
| 5. 52<br>5. 99 | Subtotal (sum of lines 5.01-5.49 minus sum of lines                          |            | 0         |                 | 0             | 5. 52<br>5. 99 |
| 5. 99          | 5. 50-5. 98)   |            |           |                 | 0             | 5.99           |
| 4 00           |  |            |           |                 |               | 4 00           |
| 6. 00          | Determined net settlement amount (balance due) based on the cost report. (1) |            |           |                 |               | 6. 00          |
| 6. 01          | SETTLEMENT TO PROVIDER   |            |           |                 | 0             | 6. 01          |
| 6. 02          | SETTLEMENT TO PROVIDER   |            |           |                 | 0             |                |
| 7. 00          |  |            | 56, 661   |                 | 0             |                |
| 7.00           | Total Medicare program liability (see instructions)                          |            | 30, 001   | Contractor      | NPR Date      | 7.00           |
|                |  |            |           | Number          | (Mo/Day/Yr)   |                |
|                |  |            | )         | 1. 00           | 2. 00         |                |
| 8. 00          | Name of Contractor   |            | -         |                 | 2.00          | 8. 00          |
| 3. 00          | 1  | 1          |           | (               | I .           | , 0.00         |

| Heal th | Financial Systems HARRISBURG MEDICAL                          | CENTER, INC.             | In Lie                      | u of Form CMS-                 | 2552-10 |
|---------|---|--------------------------|-----------------------------|--------------------------------|---------|
| CALCUL  | ATION OF REIMBURSEMENT SETTLEMENT FOR HIT                     | Provider CCN: 14-0210    | Peri od:<br>From 04/01/2022 | Worksheet E-1<br>Part II       | I       |
|         |   |                          | To 03/31/2023               | Date/Time Pro<br>9/11/2023 9:1 |         |
|         |   | Title XVIII              | Hospi tal                   | PPS                            |         |
|         |   |                          |                             |                                |         |
|         |   |                          |                             | 1. 00                          |         |
|         | TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS    |                          |                             |                                | _       |
|         | HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION |                          |                             |                                | _       |
| 1.00    | Total hospital discharges as defined in AARA §4102 from Wkst. | S-3, Pt. I col. 15 line  | 9 14                        |                                | 1. 00   |
| 2.00    | Medicare days (see instructions)                              |                          |                             |                                | 2. 00   |
| 3.00    | Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2       |                          |                             |                                | 3. 00   |
| 4.00    | Total inpatient days (see instructions)                       |                          |                             |                                | 4. 00   |
| 5.00    | Total hospital charges from Wkst C, Pt. I, col. 8 line 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 c | certified HIT technology | Wkst. S-2, Pt. I            |                                | 7. 00   |
|         | line 168  |                          |                             |                                |         |
| 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              |                          |                             |                                |         |
|         | Initial/interim HIT payment adjustment (see instructions)     |                          |                             |                                | 30. 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                  | HARRI SBURG MEDI CAL | CENTER, INC.           | In Lie          | u of Form CMS-2552-10 |
|---|----------------------|------------------------|-----------------|-----------------------|
| CALCULATION OF REIMBURSEMENT SETTLEMENT - | SWING BEDS           | Provider CCN: 14-0210  | Peri od:        | Worksheet E-2         |
|   |                      |                        | From 04/01/2022 |                       |
|   |                      | Component CCN: 14-U210 | To 03/31/2023   | Date/Time Prepared:   |
|   |                      | ·                      |                 | 9/11/2023 9 16 am     |

|                  |  | Component CCN: 14-U210                  | To 03/31/2023     | Date/Time Pre 9/11/2023 9:1 |         |
|------------------|--|---|-------------------|-----------------------------|---------|
|                  |  | Title XVIII                             | Swing Beds - SNF  |                             |         |
|                  |  |   | Part A            | Part B                      |         |
|                  | COMPUTATION OF MET COOT OF COMPTED OFFINA OF   |   | 1. 00             | 2. 00                       |         |
| 1. 00            | COMPUTATION OF NET COST OF COVERED SERVICES  Inpatient routine services - swing bed-SNF (see instructions)         |   | 41 244            | 0                           | 1.00    |
| 2.00             | Inpatient routine services - swing bed-NF (see instructions)   |   | 61, 264           | U                           | 2.00    |
| 3.00             | Ancillary services (from Wkst. D-3, col. 3, line 200, for Part   | A and sum of Wkst D                     | 0                 | 0                           | 1       |
| 0.00             | Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swin   | · · ·                                   | _                 | Ŭ                           | 0.00    |
|                  | instructions)  | 3 · · · ·                               |                   |                             |         |
| 3. 01            | Nursing and allied health payment-PARHM (see instructions)   |   |                   |                             | 3. 01   |
| 4.00             | Per diem cost for interns and residents not in approved teachi   | ng program (see                         |                   | 0.00                        | 4. 00   |
| г оо             | instructions)  |   | 70                | 0                           | F 00    |
| 5. 00<br>6. 00   | Program days Interns and residents not in approved teaching program (see in  | structions)                             | 70                | 0                           | 1       |
| 7. 00            | Utilization review - physician compensation - SNF optional met   | hod only                                | 0                 | U                           | 7. 00   |
| 8. 00            | Subtotal (sum of lines 1 through 3 plus lines 6 and 7)   | nod om y                                | 61, 264           | 0                           |         |
| 9.00             | Primary payer payments (see instructions)  |   | 0                 | 0                           | 1       |
| 10.00            | Subtotal (line 8 minus line 9)   |   | 61, 264           | 0                           | 10.00   |
| 11. 00           | Deductibles billed to program patients (exclude amounts applic   | able to physician                       | 0                 | 0                           | 11. 00  |
| 40.00            | professional services)   |   |                   |                             | 1       |
| 12. 00<br>13. 00 | Subtotal (line 10 minus line 11)   | (avaluda asi naunanaa                   | 61, 264           | 0                           |         |
| 13.00            | Coinsurance billed to program patients (from provider records) for physician professional services)                | (exclude collisurance                   | 3, 501            | 0                           | 13. 00  |
| 14. 00           | 80% of Part B costs (line 12 x 80%)  |   |                   | 0                           | 14.00   |
| 15. 00           | Subtotal (see instructions)  |   | 57, 763           | 0                           |         |
| 16. 00           | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   |   | 0                 | 0                           | 16. 00  |
| 16. 50           | Pioneer ACO demonstration payment adjustment (see instructions   | )                                       |                   |                             | 16. 50  |
| 16. 55           | Rural community hospital demonstration project (§410A Demonstr   | ation) payment                          | 0                 |                             | 16. 55  |
| 1/ 00            | adjustment (see instructions)  |   |                   | 0                           | 1/ 00   |
| 16. 99<br>17. 00 | Demonstration payment adjustment amount before sequestration Allowable bad debts (see instructions)                |   | 0                 | 0                           |         |
|                  | Adjusted reimbursable bad debts (see instructions)   |   | 0                 | 0                           |         |
| 18. 00           | Allowable bad debts for dual eligible beneficiaries (see instr   | uctions)                                | 0                 | 0                           | 1       |
|                  | Total (see instructions)   | ,                                       | 57, 763           | 0                           | 1       |
| 19. 01           | Sequestration adjustment (see instructions)  |   | 1, 102            | 0                           | 19. 01  |
| 19. 02           | Demonstration payment adjustment amount after sequestration)   |   | 0                 | 0                           | 19. 02  |
| 19. 03           | Sequestration adjustment-PARHM pass-throughs   |   |                   |                             | 19. 03  |
| 19. 25           | Sequestration for non-claims based amounts (see instructions)  |   | 0                 | 0                           |         |
|                  | Interim payments   |   | 56, 661           | 0                           |         |
| 20. 01           | Interim payments-PARHM Tentative settlement (for contractor use only)  |   | 0                 | 0                           | 20. 01  |
|                  | Tentative settlement (for contractor use only)   |   | J                 | U                           | 21.00   |
| 22. 00           | Balance due provider/program (line 19 minus lines 19.01, 19.02   | . 19. 25. 20. and 21)                   | 0                 | 0                           | 1       |
| 22. 01           | Balance due provider/program-PARHM (see instructions)  | ,,,,                                    |                   |                             | 22. 01  |
| 23.00            | Protested amounts (nonallowable cost report items) in accordan   | ce with CMS Pub. 15-2,                  | 0                 | 0                           | 23. 00  |
|                  | chapter 1, §115.2  |   |                   |                             |         |
| 200 00           | Rural Community Hospital Demonstration Project (§410A Demonstr   |   |                   |                             | 200 00  |
| 200.00           | Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. | rod under the 21st                      |                   |                             | 200. 00 |
|                  | Cost Reimbursement   |   |                   |                             | 1       |
| 201.00           | Medicare swing-bed SNF inpatient routine service costs (from W   | kst. D-1. Pt. II. line                  |                   |                             | 201. 00 |
|                  | 66 (title XVIII hospital))   |   |                   |                             |         |
| 202.00           | Medicare swing-bed SNF inpatient ancillary service costs (from   | Wkst. D-3, col. 3, lin                  | е                 |                             | 202. 00 |
|                  | 200 (title XVIII swing-bed SNF))   |   |                   |                             |         |
|                  | Total (sum of lines 201 and 202)   |   |                   |                             | 203. 00 |
| 204.00           | Medicare swing-bed SNF discharges (see instructions)   | £! £ +b                                 |                   |                             | 204. 00 |
|                  | Computation of Demonstration Target Amount Limitation (N/A in period)  | rinst year or the curre                 | nt 5-year demonst | ration                      |         |
| 205 00           | Medicare swing-bed SNF target amount   |   |                   |                             | 205. 00 |
|                  | Medicare swing-bed SNF inpatient routine cost cap (line 205 ti   | mes line 204)                           |                   |                             | 206. 00 |
|                  | Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs   |   |                   |                             |         |
| 207.00           | Program reimbursement under the §410A Demonstration (see instr   | uctions)                                |                   |                             | 207. 00 |
| 208.00           | Medicare swing-bed SNF inpatient service costs (from Wkst. E-2   | , col. 1, sum of lines                  | 1                 |                             | 208. 00 |
| 000 5            | and 3)   |   |                   |                             | 000 05  |
|                  | Adjustment to Medicare swing-bed SNF PPS payments (see instruc   | tions)                                  |                   |                             | 209. 00 |
| ∠10.00           | Reserved for future use Comparision of PPS versus Cost Reimbursement   |   |                   |                             | 210. 00 |
| 215 00           | Total adjustment to Medicare swing-bed SNF PPS payment (line 2   | 09 plus line 210) (see                  |                   |                             | 215. 00 |
| 5 . 50           | instructions)  | , |                   |                             |         |
|                  |  |   | . '               |                             | -       |

| Health Financial Systems                | HARRISBURG MEDICAL CENTER, INC. | In Lie                      | u of Form CMS-2552-10 |
|---|---------------------------------|-----------------------------|-----------------------|
| CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-0210           | Peri od:<br>From 04/01/2022 | Worksheet E-3         |
|   | Component CCN: 14-S210          |                             |                       |
|   | Title XVIII                     | Subprovi der -              | PPS                   |
|   |                                 | 111                         |                       |

|        | I PF   |            |        |
|--------|--|------------|--------|
|        |  | 1.00       |        |
|        | PART II - MEDICARE PART A SERVICES - IPF PPS   |            |        |
| 1.00   | Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)                | 619, 222   | 1.00   |
| 2.00   | Net IPF PPS Outlier Payments   | 1, 336     | 2.00   |
| 3.00   | Net IPF PPS ECT Payments   | 0          | 3.00   |
| 4.00   | Unweighted intern and resident FTE count in the most recent cost report filed on or before November  | 0.00       | 4.00   |
| 00     | 15, 2004. (see instructions)   | 0.00       |        |
| 4. 01  | Cap increases for the unweighted intern and resident FTE count for residents that were displaced by  | 0.00       | 4. 01  |
|        | program or hospital closure, that would not be counted without a temporary cap adjustment under 42   | 0.00       |        |
|        | GFR \$412.424(d)(1)(iii)(F)(1) or (2) (see instructions)   |            |        |
| 5.00   | New Teaching program adjustment. (see instructions)  | 0.00       | 5.00   |
| 6. 00  | Current year's unweighted FTE count of 1&R excluding FTEs in the new program growth period of a "new |            | 6. 00  |
| 0.00   | teaching program" (see instuctions)  | 0.00       | 0.00   |
| 7. 00  | Current year's unweighted L&R FTE count for residents within the new program growth period of a "new | 0.00       | 7. 00  |
| 7.00   | teaching program" (see instuctions)  | 0.00       | 7.00   |
| 8.00   | Intern and resident count for IPF PPS medical education adjustment (see instructions)                | 0.00       | 8.00   |
| 9. 00  | Average Daily Census (see instructions)  | 15. 230137 | 9. 00  |
| 10.00  | Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.                 | 0. 000000  |        |
| 11. 00 | 1 7  | 0.000000   | 11.00  |
|        | Teaching Adjustment (line 1 multiplied by line 10).  |            |        |
| 12.00  | Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)  | 620, 558   |        |
| 13.00  | Nursing and Allied Health Managed Care payment (see instruction)                                     | 0          | 13.00  |
| 14. 00 | Organ acquisition (DO NOT USE THIS LINE)   |            | 14.00  |
| 15. 00 | Cost of physicians' services in a teaching hospital (see instructions)                               | 0          | 15. 00 |
| 16. 00 | Subtotal (see instructions)  | 620, 558   |        |
| 17. 00 | Primary payer payments   | 0          | 17. 00 |
| 18. 00 | Subtotal (line 16 less line 17).   | 620, 558   | 18.00  |
| 19.00  | Deducti bl es  | 67, 304    | 19.00  |
| 20.00  | Subtotal (line 18 minus line 19)   | 553, 254   | 20.00  |
| 21.00  | Coi nsurance   | 13, 226    | 21.00  |
| 22.00  | Subtotal (line 20 minus line 21)   | 540, 028   | 22.00  |
| 23.00  | Allowable bad debts (exclude bad debts for professional services) (see instructions)                 | 65, 606    | 23.00  |
| 24.00  | Adjusted reimbursable bad debts (see instructions)   | 42, 644    | 24.00  |
| 25.00  | Allowable bad debts for dual eligible beneficiaries (see instructions)                               | 50, 774    | 25. 00 |
| 26. 00 | Subtotal (sum of lines 22 and 24)  | 582, 672   | 26. 00 |
| 27. 00 | Direct graduate medical education payments (see instructions)  | 0          | 27. 00 |
| 28. 00 | Other pass through costs (see instructions)  | Ö          | 28. 00 |
| 29. 00 | Outlier payments reconciliation  | 0          | 29.00  |
| 30.00  | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   | 0          | 30.00  |
| 30. 50 | Pioneer ACO demonstration payment adjustment (see instructions)                                      | Ö          | 30. 50 |
| 30. 98 | Recovery of accelerated depreciation.  | 0          | 30. 98 |
| 30. 99 | Demonstration payment adjustment amount before sequestration   | 0          | 30. 99 |
| 31. 00 | Total amount payable to the provider (see instructions)  | 582, 672   |        |
|        | 1  | 10, 197    |        |
| 31. 01 | Sequestration adjustment (see instructions)  | 1          |        |
| 31. 02 | Demonstration payment adjustment amount after sequestration  | (22 505    | 31. 02 |
| 32.00  | Interim payments   | 622, 585   |        |
| 33. 00 | Tentative settlement (for contractor use only)   | 0          | 33.00  |
| 34. 00 | Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)                           | -50, 110   |        |
| 35. 00 | Protested amounts (nonallowable cost report items) in accordance 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  | 1, 336     | 50.00  |
| 51.00  | Outlier reconciliation adjustment amount (see instructions)  | 0          | 51.00  |
| 52.00  | The rate used to calculate the Time Value of Money   | 0.00       | 52.00  |
| 53.00  | Time Value of Money (see instructions)   | 0          | 53.00  |
|        | FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (T | HE END OF  |        |
|        | THE COVID-19 PHE)  |            |        |
| 99.00  | Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.    | 0.000000   | 99.00  |
|        | Calculated Teaching Adjustment Factor for the current year. (see instructions)                       | 0.000000   |        |
|        |  | ,          | •      |

| Heal th  | Financial Systems                         | HARRI SBURG MEDI CAL  | CENTER, INC.          | In Lie                           | u of Form CMS-2 | 552-10 |
|--|---|-----------------------|-----------------------|----------------------------------|-----------------|--------|
| OUTLI E  | R RECONCILIATION AT TENTATIVE SETTLEMENT  |                       | Provider CCN: 14-0210 | Peri od:                         | Worksheet E-5   |        |
|  |   |                       |                       | From 04/01/2022<br>To 03/31/2023 | Date/Time Prep  | pared: |
|  |   |                       |                       |                                  | 9/11/2023 9: 18 | am     |
|  |   |                       | Title XVIII           |                                  | PPS             |        |
|  | ·   |                       |                       |                                  |                 |        |
|  |   |                       |                       |                                  | 1. 00           |        |
|  | TO BE COMPLETED BY CONTRACTOR             |                       |                       |                                  |                 |        |
| 1.00 Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions) |   |                       |                       | nstructions)                     | 0               | 1.00   |
| 2.00   | Capital outlier from Wkst. L, Pt. I, line | 2                     |                       |                                  | 0               | 2.00   |
| 3.00   | Operating outlier reconciliation adjustme | ent amount (see instr | ucti ons)             |                                  | 0               | 3.00   |
| 4.00 Capital outlier reconciliation adjustment amount (see instructions)                               |   |                       |                       | 0                                | 4.00            |        |
| 5.00 The rate used to calculate the time value of money (see instructions)                             |   |                       |                       | 0.00                             | 5.00            |        |
| 6.00 Time value of money for operating expenses (see instructions)                                     |   |                       |                       |                                  | 0               | 6.00   |
| 7.00   | Time value of money for capital related e | expenses (see instruc | tions)                |                                  | 0               | 7.00   |

Health Financial Systems

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

Provider CCN: 14-0210

Peri od: Worksheet G From 04/01/2022 To 03/31/2023 Date/Time Prepared:

| onl y)           |  |                        | '                        | 0 03/31/2023   | 9/11/2023 9: 1 |                  |
|------------------|--|------------------------|--------------------------|----------------|----------------|------------------|
|                  |  | General Fund           | Specific<br>Purpose Fund | Endowment Fund |                |                  |
|                  |  | 1.00                   | 2. 00                    | 3. 00          | 4. 00          |                  |
| 1 00             | CURRENT ASSETS   | 4 (52 204              |                          |                | 0              | 1 00             |
| 1. 00<br>2. 00   | Cash on hand in banks Temporary investments                | 4, 652, 284<br>33, 569 |                          | _              | 0              | 1. 00<br>2. 00   |
| 3.00             | Notes receivable   | 33, 309                |                          | _              | 0              | 3.00             |
| 4. 00            | Accounts receivable  | 15, 570, 971           | 7                        | 0              | 0              | 4.00             |
| 5. 00            | Other recei vabl e   | 102, 344               |                          | o o            | 0              | 5. 00            |
| 6. 00            | Allowances for uncollectible notes and accounts receivable | -10, 353, 376          | 1                        | 0              | 0              | 6. 00            |
| 7.00             | Inventory  | 1, 373, 336            |                          | 0              | 0              | 7. 00            |
| 8.00             | Prepai d expenses  | 313, 680               | ) c                      | 0              | 0              | 8. 00            |
| 9.00             | Other current assets                                       | 18, 064                | · C                      | 0              | 0              | 9. 00            |
| 10.00            | Due from other funds                                       | 0                      | ) C                      | 0              | 0              | 10.00            |
| 11. 00           | Total current assets (sum of lines 1-10)                   | 11, 710, 872           | 2  C                     | 0              | 0              | 11. 00           |
| 40.00            | FI XED ASSETS  | 770 440                |                          |                |                | 10.00            |
| 12.00            | Land   | 772, 443               | 1                        | _              | 0              | 12.00            |
| 13. 00<br>14. 00 | Land improvements  | 154, 334<br>-49, 787   |                          |                | 0              | 13. 00<br>14. 00 |
| 15. 00           | Accumulated depreciation Buildings                         | 20, 813, 541           |                          |                | 0              | 15.00            |
| 16. 00           | Accumulated depreciation                                   | -2, 132, 238           | 1                        | ή              | 0              | 16.00            |
| 17. 00           | Leasehold improvements                                     | 2, 132, 230            |                          | 0              | 0              | 17. 00           |
| 18. 00           | Accumulated depreciation                                   | Ö                      |                          | o o            | 0              | 18. 00           |
| 19.00            | Fi xed equipment   | 43, 061                |                          | 0              | 0              | 19. 00           |
| 20.00            | Accumul ated depreciation                                  | -1, 492                |                          | 0              | 0              | 20.00            |
| 21.00            | Automobiles and trucks                                     | 0                      | ) c                      | 0              | 0              | 21. 00           |
| 22. 00           | Accumulated depreciation                                   | 0                      | ) c                      | 0              | 0              | 22. 00           |
| 23.00            | Major movable equipment                                    | 5, 049, 815            | 1                        | 0              | 0              | 23. 00           |
| 24. 00           | Accumulated depreciation                                   | -1, 977, 158           | 1                        | 0              | 0              | 24. 00           |
| 25. 00           | Mi nor equi pment depreci abl e                            | 0                      | ) C                      |                | 0              | 25. 00           |
| 26. 00           | Accumulated depreciation                                   | 0                      |                          |                | 0              | 26. 00           |
| 27. 00<br>28. 00 | HIT designated Assets                                      | 0                      |                          |                | 0              | 27. 00<br>28. 00 |
| 29. 00           | Accumulated depreciation Minor equipment-nondepreciable    | 372, 013               |                          |                | 0              | 29.00            |
| 30.00            | Total fixed assets (sum of lines 12-29)                    | 23, 044, 532           | 1                        |                | 0              | 30.00            |
| 30. 00           | OTHER ASSETS   | 23, 044, 332           |                          | ,              | <u> </u>       | 30.00            |
| 31.00            | Investments  | 0                      | ) C                      | 0              | 0              | 31.00            |
| 32.00            | Deposits on Leases   | 0                      | ) c                      | 0              | 0              | 32. 00           |
| 33.00            | Due from owners/officers                                   | 0                      | ) c                      | 0              | 0              | 33. 00           |
| 34.00            | Other assets   | 336, 190               | ) c                      | 0              | 0              | 34. 00           |
| 35.00            | Total other assets (sum of lines 31-34)                    | 336, 190               | 1                        |                | 0              | 35. 00           |
| 36. 00           | Total assets (sum of lines 11, 30, and 35)                 | 35, 091, 594           | . C                      | 0              | 0              | 36. 00           |
| 07.00            | CURRENT LI ABI LI TI ES                                    | 000 007                |                          |                |                | 07.00            |
| 37. 00           | Accounts payable   | 890, 397               |                          |                | 0              | 37.00            |
| 38. 00<br>39. 00 | Salaries, wages, and fees payable Payroll taxes payable    | 2, 786, 730            |                          | <u> </u>       | 0              | 38. 00<br>39. 00 |
| 40.00            | Notes and Loans payable (short term)                       | 957, 907               | 1                        |                | 0              | 40.00            |
| 41. 00           | Deferred income  | 737, 707               |                          |                | 0              | 41.00            |
| 42. 00           | Accel erated payments                                      | 486, 891               | ,                        |                | O              | 42. 00           |
| 43. 00           | Due to other funds   | 1, 759, 780            |                          | 0              | 0              |                  |
| 44.00            | Other current liabilities                                  | 805, 209               | 1                        | 0              | 0              |                  |
| 45.00            | Total current liabilities (sum of lines 37 thru 44)        | 7, 686, 914            |                          | 0              | 0              |                  |
|                  | LONG TERM LIABILITIES                                      |                        |                          |                |                |                  |
| 46.00            | Mortgage payable   | 0                      | ) C                      | 0              | 0              |                  |
| 47.00            | Notes payable  | 17, 131, 379           | ) c                      | 0              | 0              |                  |
| 48. 00           | Unsecured Loans  | 0                      | ) C                      |                | 0              |                  |
| 49. 00           | Other long term liabilities                                | 207, 136               |                          |                | 0              | 49. 00           |
| 50.00            | Total long term liabilities (sum of lines 46 thru 49)      | 17, 338, 515           |                          |                | 0              | 50.00            |
| 51. 00           | Total liabilities (sum of lines 45 and 50)                 | 25, 025, 429           | <u> </u>                 | 0              | 0              | 51.00            |
| 52. 00           | CAPITAL ACCOUNTS  General fund balance                     | 10, 066, 165           |                          |                |                | 52. 00           |
| 53. 00           | Specific purpose fund                                      | 10,000,100             | 'l c                     | 1              |                | 53.00            |
| 54. 00           | Donor created - endowment fund balance - restricted        |                        |                          | <u></u>        |                | 54.00            |
| 55. 00           | Donor created - endowment fund balance - unrestricted      |                        |                          |                |                | 55.00            |
| 56. 00           | Governing body created - endowment fund balance            |                        |                          | 0              |                | 56.00            |
| 57. 00           | Plant fund balance - invested in plant                     |                        | 1                        |                | 0              |                  |
| 58. 00           | Plant fund balance - reserve for plant improvement,        |                        |                          |                | 0              | 58.00            |
|                  | repl acement, and expansi on                               |                        |                          |                |                |                  |
| 59. 00           | Total fund balances (sum of lines 52 thru 58)              | 10, 066, 165           | i c                      | 0              | 0              |                  |
| 60.00            | Total liabilities and fund balances (sum of lines 51 and   | 35, 091, 594           | ·  C                     | 0              | 0              | 60.00            |
|                  | [59]   |                        | [                        |                |                |                  |
|                  |  |                        |                          |                |                |                  |

Provider CCN: 14-0210

|                |  |                |              |           | To 03/31/2023 | B Date/Time Pre<br>9/11/2023 9:1 |                |
|----------------|--|----------------|--------------|-----------|---------------|----------------------------------|----------------|
|                |  | General        | Fund         | Special P | urpose Fund   | Endowment Fund                   | Jani           |
|                |  |                |              |           | ,             |                                  |                |
|                |  |                |              |           |               |                                  |                |
| 1.00           |  | 1.00           | 2.00         | 3. 00     | 4. 00         | 5. 00                            | 4 00           |
| 1.00           | Fund balances at beginning of period                     |                | 16, 235, 269 |           |               |                                  | 1.00           |
| 2.00           | Net income (loss) (from Wkst. G-3, line 29)              |                | -6, 276, 255 |           |               |                                  | 2.00           |
| 3. 00<br>4. 00 | Total (sum of line 1 and line 2) PRIOR PERIOD ADJUSTMENT | 107 151        | 9, 959, 014  | ,         |               | 0                                | 3. 00<br>4. 00 |
| 4. 00<br>5. 00 | PRIOR PERIOD ADJUSTMENT                                  | 107, 151       |              |           | )             | 0                                | 5. 00          |
| 6. 00          |  | 0              |              |           |               | 0                                | 6. 00          |
| 7. 00          |  |                |              |           | )             | 0                                | 7. 00          |
| 8.00           |  |                |              |           | )             | 0                                | 8. 00          |
| 9. 00          |  |                |              |           |               | 0                                | 9. 00          |
| 10. 00         | Total additions (sum of line 4-9)                        |                | 107, 151     | ,         |               |                                  | 10. 00         |
| 11. 00         | Subtotal (line 3 plus line 10)                           |                | 10, 066, 165 |           |               |                                  | 11. 00         |
| 12. 00         | Deductions (debit adjustments) (specify)                 | 0              | 10, 000, 103 | (         | n `           | J 0                              | 12. 00         |
| 13. 00         | beddetrons (debrt day detinonts) (specify)               |                |              |           | Ď             | 0                                | 13. 00         |
| 14. 00         |  | 0              |              |           | 0             | 0                                | 14. 00         |
| 15. 00         |  | o              |              |           |               | 0                                | 15. 00         |
| 16. 00         |  | o              |              |           |               | 0                                | 16. 00         |
| 17. 00         |  | 0              |              | (         | o o           | 0                                | 17. 00         |
| 18.00          | Total deductions (sum of lines 12-17)                    |                | o            |           |               | ol                               | 18. 00         |
| 19.00          | Fund balance at end of period per balance                |                | 10, 066, 165 |           |               |                                  | 19. 00         |
|                | sheet (line 11 minus line 18)                            |                |              |           |               |                                  |                |
|                |  | Endowment Fund | PI ant       | Fund      |               |                                  |                |
|                |  |                | 7.00         | 0.00      |               |                                  |                |
| 1 00           |  | 6. 00          | 7. 00        | 8. 00     |               |                                  | 1 00           |
| 1.00           | Fund balances at beginning of period                     | 0              |              | (         | O             |                                  | 1.00           |
| 2.00           | Net income (loss) (from Wkst. G-3, line 29)              |                |              |           |               |                                  | 2.00           |
| 3.00           | Total (sum of line 1 and line 2) PRIOR PERIOD ADJUSTMENT | 0              |              | (         | O             |                                  | 3. 00          |
| 4. 00<br>5. 00 | PRIOR PERIOD ADJUSTMENT                                  |                | 0            |           |               |                                  | 4. 00<br>5. 00 |
| 6.00           |  |                | 0            |           |               |                                  | 6. 00          |
| 7. 00          |  |                | 0            |           |               |                                  | 7. 00          |
| 8.00           |  |                | 0            |           |               |                                  | 7. 00<br>8. 00 |
| 9. 00          |  |                | 0            |           |               |                                  | 9. 00          |
| 10. 00         | Total additions (sum of line 4-9)                        | 0              | ď            | ,         | 0             |                                  | 10. 00         |
| 11. 00         | Subtotal (line 3 plus line 10)                           |                |              |           |               |                                  | 11. 00         |
| 12. 00         | Deductions (debit adjustments) (specify)                 |                | 0            | ,         |               |                                  | 12. 00         |
| 13. 00         | Security (Specify)                                       |                | Ö            |           |               |                                  | 13. 00         |
| 14. 00         |  |                | Ö            |           |               |                                  | 14. 00         |
| 15. 00         |  |                | 0            |           |               |                                  | 15. 00         |
| 16. 00         |  |                | Ö            |           |               |                                  | 16. 00         |
| 17. 00         |  |                | o            |           |               |                                  | 17. 00         |
| 18. 00         | Total deductions (sum of lines 12-17)                    | o              | Ĭ            | (         | O             |                                  | 18. 00         |
| 19. 00         | Fund balance at end of period per balance                |                | İ            |           | o<br>O        |                                  | 19. 00         |
|                | sheet (line 11 minus line 18)                            | ]              |              |           |               |                                  |                |
|                |  | •              |              |           | •             |                                  |                |

 
 Heal th Financial Systems
 HARR

 STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES
 Provider CCN: 14-0210

|                  |   |             | То  | 03/31/2023    | Date/Time Prep<br>9/11/2023 9:10 |                  |
|------------------|---|-------------|-----|---------------|----------------------------------|------------------|
|                  | Cost Center Description   | I npati ent |     | Outpati ent   | Total                            | J dill           |
|                  | oust defiter bescription  | 1.00        |     | 2. 00         | 3. 00                            |                  |
|                  | PART I - PATIENT REVENUES   | 1.00        |     | 2.00          | 0.00                             |                  |
|                  | General Inpatient Routine Services                                      |             |     |               |                                  |                  |
| 1.00             | Hospi tal   | 1, 997, 7   | 700 |               | 1, 997, 700                      | 1. 00            |
| 2.00             | SUBPROVI DER - I PF   | 7, 730, 3   |     |               | 7, 730, 325                      | 2. 00            |
| 3.00             | SUBPROVI DER - I RF   | ,           |     |               | ,,                               | 3. 00            |
| 4.00             | SUBPROVI DER  |             |     |               |                                  | 4. 00            |
| 5.00             | Swing bed - SNF   | 62, 3       | 370 |               | 62, 370                          | 5. 00            |
| 6.00             | Swing bed - NF  | 2, 8        | 335 |               | 2, 835                           | 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)                | 9, 793, 2   | 230 |               | 9, 793, 230                      | 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 INTENSIVE CARE UNIT   |             |     |               |                                  | 14.00            |
| 15.00            | OTHER SPECIAL CARE (SPECIFY)  |             |     |               |                                  | 15.00            |
| 16.00            | Total intensive care type inpatient hospital services (sum of lines     |             | 0   |               | 0                                | 16.00            |
|                  | 11-15)  |             |     |               |                                  |                  |
| 17. 00           | Total inpatient routine care services (sum of lines 10 and 16)          | 9, 793, 2   |     |               | 9, 793, 230                      |                  |
| 18. 00           | Ancillary services  | 8, 479, 1   |     | 81, 462, 396  | 89, 941, 512                     |                  |
| 19. 00           | Outpati ent servi ces   | 1, 493, 3   |     | 14, 986, 212  | 16, 479, 539                     | 19. 00           |
| 20. 00           | RURAL HEALTH CLINIC   |             | 0   | 2, 097, 813   | 2, 097, 813                      |                  |
| 20. 01           | RURAL HEALTH CLINIC II  |             | 0   | 2, 043, 795   | 2, 043, 795                      |                  |
| 21. 00           | FEDERALLY QUALIFIED HEALTH CENTER                                       |             | 0   | 0             | 0                                | 21. 00           |
| 22. 00           | HOME HEALTH AGENCY  |             |     |               |                                  | 22. 00           |
| 23. 00           | AMBULANCE SERVICES  |             |     |               |                                  | 23. 00           |
| 24. 00           | CMHC  |             |     |               |                                  | 24. 00           |
| 25. 00           | AMBULATORY SURGICAL CENTER (D. P. )                                     |             |     |               |                                  | 25. 00           |
| 26. 00           | HOSPI CE  |             |     |               | 0.040.070                        | 26. 00           |
| 27. 00           | PHYSICIAN PROFESSIONAL FEE CHARGES                                      | 921, 3      |     | 2, 019, 044   | 2, 940, 378                      |                  |
| 28. 00           | Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.  | 20, 687, 0  | 007 | 102, 609, 260 | 123, 296, 267                    | 28. 00           |
|                  | G-3, line 1) PART II - OPERATING EXPENSES                               |             |     |               |                                  |                  |
| 20.00            | Operating expenses (per Wkst. A, column 3, line 200)                    |             | -   | E/ 00/ 22/    |                                  | 20.00            |
| 29. 00<br>30. 00 | ADD (SPECIFY)   |             | 0   | 56, 086, 224  |                                  | 29. 00<br>30. 00 |
| 31.00            | ADD (SPECIFF)   |             | 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)                                    |             | ۷   | o             |                                  | 36. 00           |
| 37. 00           | DEDUCT (SPECIFY)  |             | 0   | Ĭ             |                                  | 37. 00           |
| 38. 00           |   |             | Ö   |               |                                  | 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)                                   |             |     | o             |                                  | 42. 00           |
| 43.00            | Total operating expenses (sum of lines 29 and 36 minus line 42)(transfe | er          |     | 56, 086, 224  |                                  | 43.00            |
|                  | to Wkst. G-3, line 4)   |             |     |               |                                  |                  |
|                  |   |             |     |               |                                  |                  |

|        | Financial Systems HARRISBURG MEDICAL                          |                       |                                  | u of Form CMS-2  | 2552-10 |
|--------|---|-----------------------|----------------------------------|------------------|---------|
| STATE  | ENT OF REVENUES AND EXPENSES                                  | Provider CCN: 14-0210 | Peri od:                         | Worksheet G-3    |         |
|        |   |                       | From 04/01/2022<br>To 03/31/2023 | Date/Time Pre    | aanad.  |
|        |   |                       | To 03/31/2023                    | 9/11/2023 9: 10  |         |
|        |   |                       |                                  | 77 117 2023 7. 1 | J dill  |
|        |   |                       |                                  | 1. 00            |         |
| 1.00   | Total patient revenues (from Wkst. G-2, Part I, column 3, li  | ne 28)                |                                  | 123, 296, 267    | 1. 00   |
| 2.00   | Less contractual allowances and discounts on patients' accou  |                       |                                  | 74, 007, 862     | 2. 00   |
| 3.00   | Net patient revenues (line 1 minus line 2)                    |                       |                                  | 49, 288, 405     | 3. 00   |
| 4.00   | Less total operating expenses (from Wkst. G-2, Part II, line  | 43)                   |                                  | 56, 086, 224     | 4. 00   |
| 5.00   | Net income from service to patients (line 3 minus line 4)     |                       |                                  | -6, 797, 819     | 5. 00   |
|        | OTHER I NCOME   |                       |                                  |                  |         |
| 6.00   | Contributions, donations, bequests, etc                       |                       |                                  | 283, 088         | 6. 00   |
| 7. 00  | Income from investments                                       |                       |                                  | -93, 173         |         |
| 8.00   | Revenues from telephone and other miscellaneous communication | n servi ces           |                                  | 0                | 8. 00   |
| 9.00   | Revenue from television and radio service                     |                       |                                  | 0                | 9. 00   |
| 10.00  | Purchase di scounts   |                       |                                  | 897              | 10. 00  |
| 11. 00 | Rebates and refunds of expenses                               |                       |                                  | 0                | 11. 00  |
| 12. 00 | Parking Lot receipts  |                       |                                  | 0                | 12. 00  |
| 13. 00 | Revenue from Laundry and Linen service                        |                       |                                  | 0                | 13. 00  |
| 14. 00 | Revenue from meals sold to employees and guests               |                       |                                  | 67, 140          | 14. 00  |
| 15. 00 | Revenue from rental of living quarters                        |                       |                                  | 0                |         |
| 16. 00 | Revenue from sale of medical and surgical supplies to other   | than patients         |                                  | 0                | 16. 00  |
|        | Revenue from sale of drugs to other than patients             |                       |                                  | 0                | 17. 00  |
|        | Revenue from sale of medical records and abstracts            |                       |                                  | 24, 539          | 18. 00  |
|        | Tuition (fees, sale of textbooks, uniforms, etc.)             |                       |                                  | 0                | 19. 00  |
| 20. 00 | Revenue from gifts, flowers, coffee shops, and canteen        |                       |                                  | 0                | 20. 00  |
| 21. 00 | Rental of vending machines                                    |                       |                                  | 5. 157           |         |
| 22. 00 | Rental of hospital space                                      |                       |                                  | 151, 225         | 22. 00  |
| 23. 00 | Governmental appropriations                                   |                       |                                  | 0                | 23. 00  |
|        | MI SCELLANEOUS I NCOME  |                       |                                  | 34, 584          |         |
| 24. 01 | FOUNDATION INCOME   |                       |                                  | 76, 051          |         |
|        | COVI D-19 PHE Fundi ng  |                       |                                  | 0                |         |
|        | Total other income (sum of lines 6.24)                        |                       |                                  | 540 500          |         |

549, 508

27, 944 27. 00 27, 944 28. 00 -6, 276, 255 29. 00

-6, 248, 311

25.00

26.00

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 LOSS ON DISPOSAL OF ASSETS
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)

|                | Financial Systems HARRISBURG MEDICAL   |                           |  | u of Form CMS-2   | 2552-10        |
|----------------|--|---------------------------|--|---|----------------|
| CALCUL         | ATION OF CAPITAL PAYMENT   | Provi der CCN: 14-0210    | Peri od:<br>From 04/01/2022<br>To 03/31/2023 | Worksheet L<br>Parts I-III<br>Date/Time Pre<br>9/11/2023 9:10 |                |
|                |  | Title XVIII               | Hospi tal                                    | PPS   |                |
|                |  |                           |  | 1.00  |                |
|                | PART I - FULLY PROSPECTIVE METHOD  |                           |  | 1. 00   |                |
|                | CAPITAL FEDERAL AMOUNT   |                           |  |   |                |
| 1.00           | Capital DRG other than outlier   |                           |  | 158, 931  | 1.00           |
| 1. 01          | Model 4 BPCI Capital DRG other than outlier  |                           |  | 0   | 1. 01          |
| 2.00           | Capital DRG outlier payments   |                           |  | 1, 352  | 2. 00          |
| 2.01           | Model 4 BPCI Capital DRG outlier payments  |                           |  | 0   | 2. 01          |
| 3.00           | Total inpatient days divided by number of days in the cost re  | eporting period (see inst | ructions)                                    | 5. 01   | 3. 00          |
| 4.00           | Number of interns & residents (see instructions)   |                           |  | 0.00  |                |
| 5.00           | Indirect medical education percentage (see instructions)   |                           |  | 0. 00   |                |
| 6. 00          | Indirect medical education adjustment (multiply line 5 by the 1.01) (see instructions)                           |                           |  | 0   |                |
| 7. 00          | Percentage of SSI recipient patient days to Medicare Part A   30) (see instructions)                             | 3 1                       | , part A line                                | 0. 00   | 7. 00          |
| 8.00           | Percentage of Medicaid patient days to total days (see instru  | uctions)                  |  | 0.00  |                |
| 9.00           | Sum of lines 7 and 8   |                           |  | 0.00  |                |
| 10.00          | Allowable disproportionate share percentage (see instructions  | s)                        |  |   | 10.00          |
| 11.00          | Disproporti onate share adjustment (see instructions)  |                           |  | 1(0, 202  |                |
| 12. 00         | Total prospective capital payments (see instructions)  |                           |  | 160, 283  | 12. 00         |
|                |  |                           |  | 1. 00   |                |
|                | PART II - PAYMENT UNDER REASONABLE COST  |                           |  |   |                |
| 1.00           | Program inpatient routine capital cost (see instructions)  |                           |  | 0   |                |
| 2.00           | Program inpatient ancillary capital cost (see instructions)  |                           |  | 0   |                |
| 3.00           | Total inpatient program capital cost (line 1 plus line 2)  |                           |  | 0   |                |
| 4.00           | Capital cost payment factor (see instructions)   |                           |  | 0   |                |
| 5. 00          | Total inpatient program capital cost (line 3 x line 4)   |                           |  | 0   | 5. 00          |
|                |  |                           |  | 1. 00   |                |
|                | PART III - COMPUTATION OF EXCEPTION PAYMENTS   |                           |  |   |                |
| 1.00           | Program inpatient capital costs (see instructions)   |                           |  | 0   | 1. 00          |
| 2. 00          | Program inpatient capital costs for extraordinary circumstan   | ces (see instructions)    |  | 0   | 2. 00          |
| 3. 00          | Net program inpatient capital costs (line 1 minus line 2)  |                           |  | 0   | 3. 00          |
| 4.00           | Applicable exception percentage (see instructions)   |                           |  | 0.00  |                |
| 5.00           | Capital cost for comparison to payments (line 3 x line 4)  | +                         |  | 0   | 5.00           |
| 6. 00<br>7. 00 | Percentage adjustment for extraordinary circumstances (see in  |                           | lino 4)                                      | 0.00  |                |
| 7. 00<br>8. 00 | Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) | y cricumstances (rine 2 ) | . Title o)                                   | 0   | 7. 00<br>8. 00 |
| 9.00           | Current year capital payments (from Part I, line 12, as appl)  | i cahl e)                 |  | 0   | 9.00           |
| 10.00          | Current year comparison of capital minimum payment level to  |                           | less line 9)                                 | 0   | 10.00          |
| 11. 00         | Carryover of accumulated capital minimum payment level over  |                           |  | 0   | 11.00          |
|                | Worksheet I Part III line 14)  |                           | . <i>J</i>                                   | Ĭ   | 55             |

Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)

Current year exception payment (if line 12 is positive, enter the amount on this line)

Carryover of accumulated capital minimum payment level over capital payment for the following period

0 12.00

0 13.00 14.00

0

0 15.00

0 16.00

0 17.00

Worksheet L, Part III, line 14)

(if line 12 is negative, enter the amount on this line)

17.00 Current year exception offset amount (see instructions)

15.00 Current year allowable operating and capital payment (see instructions)

16.00 Current year operating and capital costs (see instructions)

13.00

14.00

| Health Financial Systems                        | HADDI SDIIDO MEDI O  | NI CENTED INC  |              | ln lie                      | eu of Form CMS-2                 | 2552 10 |
|---|----------------------|--|--------------|-----------------------------|----------------------------------|---------|
| ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS       | TIARRE SDORG WEDI CA | HARRISBURG MEDICAL CENTER, INC.  Provider CCN: 14-0210 |              |                             | Worksheet M-1                    |         |
| ANW LETS TO STEE HOST TIME BROLD KNOT WHO SOUTS |                      |  |              | Peri od:<br>From 04/01/2022 |                                  |         |
|   |                      | Component  | CCN: 14-3473 | To 03/31/2023               | Date/Time Prep<br>9/11/2023 9:10 |         |
|   |                      |  |              | RHC I                       | 9/11/2023 9.10<br>Cost           | o alli  |
|   | Compensation         | Other Costs  | Total (col.  | 1 Reclassi fi cati          | Reclassi fied                    |         |
|   |                      |  | + col . 2)   | ons                         | Trial Balance                    |         |
|   |                      |  |              |                             | (col. 3 + col.                   |         |
|   |                      |  |              |                             | 4)                               |         |
|   | 1.00                 | 2.00   | 3.00         | 4. 00                       | 5. 00                            |         |

|        |  | Compensation | Other Costs       |             | Reclassi fi cati | Recl assi fi ed |        |
|--------|--|--------------|-------------------|-------------|------------------|-----------------|--------|
|        |  |              |                   | + col . 2)  | ons              | Trial Balance   |        |
|        |  |              |                   |             |                  | (col. 3 + col.  |        |
|        |  | 1.00         | 2. 00             | 3.00        | 4. 00            | 4)<br>5. 00     |        |
|        | FACILITY HEALTH CARE STAFF COSTS   | 1.00         | 2.00              | 0.00        | 1. 00            | 0.00            |        |
| 1.00   | Physi ci an  | 575, 786     | 0                 | 575, 786    | -51, 766         | 524, 020        | 1. 00  |
| 2.00   | Physician Assistant  | 0            | 0                 | 0           | 0                | 0               | 2. 00  |
| 3.00   | Nurse Practitioner   | 240, 741     | 0                 | 240, 741    | -4, 849          | 235, 892        | 3. 00  |
| 4.00   | Visiting Nurse   | 0            | 0                 | 0           | 0                | 0               | 4.00   |
| 5.00   | Other Nurse  | 252, 468     | 0                 | 252, 468    | 0                | 252, 468        | 5.00   |
| 6.00   | Clinical Psychologist  | 0            | 0                 | 0           | 0                | 0               | 6.00   |
| 7.00   | Clinical Social Worker   | 0            | 0                 | 0           | 0                | 0               | 7. 00  |
| 8.00   | Laboratory Techni ci an  | 0            | 0                 | 0           | 0                | 0               | 8. 00  |
| 9.00   | Other Facility Health Care Staff Costs   | 0            | 0                 | 0           | 0                | 0               | 9. 00  |
| 10.00  | Subtotal (sum of lines 1 through 9)  | 1, 068, 995  | 0                 | 1, 068, 995 |                  |                 |        |
| 11. 00 | Physician Services Under Agreement   | 0            | 47, 789           | 47, 789     | -5               | 47, 784         | 11. 00 |
| 12. 00 | Physician Supervision Under Agreement  | 0            | 0                 | 0           | 0                | 0               | 12. 00 |
| 13. 00 | Other Costs Under Agreement  | 0            | 0                 | 0           | 0                | 0               | 13. 00 |
| 14. 00 | Subtotal (sum of lines 11 through 13)  | 0            | 47, 789           |             |                  | 47, 784         | 14. 00 |
| 15. 00 | Medical Supplies   | 0            | 1, 521            | 1, 521      | 35, 184          |                 | 15. 00 |
| 16.00  | Transportation (Health Care Staff)   | 0            | 0                 | 0           | 0                | 0               | 16. 00 |
| 17. 00 | Depreciation-Medical Equipment   | 0            | 0                 | 0           | 0                | 0               | 17. 00 |
| 18. 00 | Professional Liability Insurance   | 0            | 0                 | 0           | 0                | 0               | 18.00  |
| 19. 00 | Other Health Care Costs  | 0            | 0                 | 0           | 0                | 0               | 19. 00 |
| 20.00  | Allowable GME Costs  |              | 1 501             | 1 501       | 25 104           | 27 705          | 20.00  |
| 21. 00 | Subtotal (sum of lines 15 through 20) Total Cost of Health Care Services (sum of | 1, 068, 995  | 1, 521<br>49, 310 |             |                  | · ·             | 21. 00 |
| 22. 00 | lines 10, 14, and 21)  | 1, 068, 995  | 49, 310           | 1, 118, 305 | -21, 436         | 1, 096, 869     | 22. 00 |
|        | COSTS OTHER THAN RHC/FQHC SERVICES   |              |                   |             |                  |                 |        |
| 23. 00 | Pharmacy   | 0            | 35, 398           | 35, 398     | -35, 184         | 214             | 23. 00 |
| 24. 00 | Dental   | Ö            | 00, 070           | 00,070      | 00, 101          | 0               | 24. 00 |
| 25. 00 | Optometry  | 0            | 0                 | 0           | 0                | 0               | 25. 00 |
| 25. 01 | Tel eheal th   | o            | 0                 | Ö           | 56, 620          | 56, 620         |        |
| 25. 02 | Chronic Care Management  | 0            | 0                 | 0           | 0                | 0               | 25. 02 |
| 26.00  | All other nonreimbursable costs  | 0            | 0                 | 0           | 0                | 0               | 26. 00 |
| 27.00  | Nonallowable GME costs   |              |                   |             |                  |                 | 27. 00 |
| 28.00  | Total Nonreimbursable Costs (sum of lines 23                                     | 0            | 35, 398           | 35, 398     | 21, 436          | 56, 834         | 28. 00 |
|        | through 27)  |              |                   |             |                  |                 |        |
|        | FACILITY OVERHEAD  |              |                   |             |                  |                 |        |
| 29. 00 | Facility Costs   | 0            | 77, 790           |             |                  |                 | 29. 00 |
| 30.00  | Administrative Costs   | 328, 639     | 96, 097           |             |                  |                 | 30. 00 |
| 31. 00 | Total Facility Overhead (sum of lines 29 and 30)                                 | 328, 639     | 173, 887          | 502, 526    | -60, 016         | 442, 510        | 31. 00 |
| 32. 00 | Total facility costs (sum of lines 22, 28  | 1, 397, 634  | 258, 595          | 1, 656, 229 | -60, 016         | 1, 596, 213     | 32. 00 |
| 32. 30 | and 31)  | ., 3,,, 001  | 200,070           | ., 555, 22, | 33,010           | ., 5, 5, 210    | 22.00  |
|        | ,  | '            |                   | •           | '                | '               |        |

| Health Financial Systems                  | HARRISBURG MEDICAL CENTER, INC. | In Lieu of Form CMS-2552-10           |
|---|---------------------------------|---------------------------------------|
| ANALYSIS OF HOSPITAL-BASED RHC/FOHC COSTS | Provi der CCN: 14-0210          | Period: Worksheet M-1 From 04/01/2022 |
|   | Component CCN: 14-3473          | To 03/31/2023 Date/Time Prepared:     |

|        |  |             |                |    | RHC I | 9/11/2023 9:<br>Cost |        |
|--------|--|-------------|----------------|----|-------|----------------------|--------|
|        |  | Adjustments | Net Expenses   | S  |       |                      |        |
|        |  |             | for Allocation | on |       |                      |        |
|        |  |             | (col . 5 + col |    |       |                      |        |
|        |  |             | 6)             |    |       |                      |        |
|        |  | 6. 00       | 7. 00          |    |       |                      |        |
|        | FACILITY HEALTH CARE STAFF COSTS             |             |                |    |       |                      |        |
| 1.00   | Physi ci an                                  | 0           | 524, 02        | 20 |       |                      | 1.00   |
| 2.00   | Physi ci an Assi stant                       | 0           |                | 0  |       |                      | 2. 00  |
| 3.00   | Nurse Practitioner                           | 0           | 235, 89        | 92 |       |                      | 3. 00  |
| 4.00   | Visiting Nurse                               | 0           |                | 0  |       |                      | 4. 00  |
| 5.00   | Other Nurse                                  | 0           | 252, 46        | 8  |       |                      | 5. 00  |
| 6.00   | Clinical Psychologist                        | 0           |                | 0  |       |                      | 6.00   |
| 7.00   | Clinical Social Worker                       | 0           |                | 0  |       |                      | 7.00   |
| 8.00   | Laboratory Techni ci an                      | 0           |                | 0  |       |                      | 8.00   |
| 9.00   | Other Facility Health Care Staff Costs       | 0           |                | o  |       |                      | 9.00   |
| 10. 00 | Subtotal (sum of lines 1 through 9)          | 0           | 1, 012, 38     | 30 |       |                      | 10.00  |
| 11. 00 | Physician Services Under Agreement           | 0           | 47, 78         | 34 |       |                      | 11. 00 |
|        | Physician Supervision Under Agreement        | 0           |                | О  |       |                      | 12.00  |
|        | Other Costs Under Agreement                  | 0           |                | 0  |       |                      | 13.00  |
|        | Subtotal (sum of lines 11 through 13)        | 0           | 47, 78         | 34 |       |                      | 14.00  |
|        | Medical Supplies                             | 0           | 36, 70         |    |       |                      | 15. 00 |
|        | Transportation (Health Care Staff)           | 0           |                | 0  |       |                      | 16. 00 |
|        | Depreciation-Medical Equipment               | 0           |                | O  |       |                      | 17. 00 |
|        | Professional Liability Insurance             | 0           |                | 0  |       |                      | 18. 00 |
|        | Other Health Care Costs                      | 0           |                | 0  |       |                      | 19. 00 |
|        | Allowable GME Costs                          |             |                |    |       |                      | 20.00  |
|        | Subtotal (sum of lines 15 through 20)        | 0           | 36, 70         | )5 |       |                      | 21. 00 |
|        | Total Cost of Health Care Services (sum of   | 0           | 1              |    |       |                      | 22. 00 |
| 22.00  | lines 10, 14, and 21)                        | ŭ           | 1,0,0,0        |    |       |                      | 22.00  |
|        | COSTS OTHER THAN RHC/FQHC SERVICES           |             |                | _  |       |                      |        |
|        | Pharmacy                                     | 0           | 2              | 14 |       |                      | 23.00  |
|        | Dental                                       | 0           |                | 0  |       |                      | 24. 00 |
|        | Optometry                                    | 0           |                | o  |       |                      | 25. 00 |
|        | Tel eheal th                                 | 0           | 56, 62         | 20 |       |                      | 25. 01 |
|        | Chronic Care Management                      | 0           |                | o  |       |                      | 25. 02 |
|        | All other nonreimbursable costs              | 0           |                | O  |       |                      | 26, 00 |
| 27. 00 | Nonallowable GME costs                       |             |                |    |       |                      | 27. 00 |
|        | Total Nonreimbursable Costs (sum of lines 23 | 0           | 56, 83         | 34 |       |                      | 28. 00 |
|        | through 27)                                  |             |                |    |       |                      |        |
|        | FACILITY OVERHEAD                            |             |                | _  |       |                      |        |
|        | Facility Costs                               | 0           | 40, 54         | 14 |       |                      | 29. 00 |
|        | Administrative Costs                         | 0           | 1              |    |       |                      | 30.00  |
|        | Total Facility Overhead (sum of lines 29 and | 0           | 442, 5         | •  |       |                      | 31.00  |
|        | 30)  | _           |                |    |       |                      |        |
| 32. 00 | Total facility costs (sum of lines 22, 28    | 0           | 1, 596, 2°     | 3  |       |                      | 32. 00 |
|        | and 31)                                      |             | ' ' ' ' ' ' '  |    |       |                      |        |

| Health Financial Systems                  | HARRISBURG MEDICAL CENTER, INC. | In Lieu of Form CMS-2552-10 |
|---|---------------------------------|-----------------------------|
| ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provi der CCN: 14-0210          | Period: Worksheet M-1       |

| ANALYS           | SIS OF HOSPITAL-BASED RHC/FQHC COSTS                                 |              | Provi der Co |               | Peri od:                         | Worksheet M-1   |        |
|------------------|--|--------------|--------------|---------------|----------------------------------|-----------------|--------|
|                  |  |              | Component (  |               | From 04/01/2022<br>To 03/31/2023 |                 | nared: |
|                  |  |              | Component    | 0011. 14 0070 | 10 03/31/2023                    | 9/11/2023 9: 1  |        |
|                  |  |              |              |               | RHC II                           | Cost            |        |
|                  |  | Compensation | Other Costs  | Total (col.   | 1 Reclassi fi cati               | Recl assi fi ed |        |
|                  |  | ·            |              | + col . 2)    | ons                              | Trial Balance   |        |
|                  |  |              |              |               |                                  | (col. 3 + col.  |        |
|                  |  |              |              |               |                                  | 4)              |        |
|                  |  | 1.00         | 2. 00        | 3. 00         | 4. 00                            | 5. 00           |        |
|                  | FACILITY HEALTH CARE STAFF COSTS                                     |              |              |               |                                  |                 |        |
| 1.00             | Physi ci an  | 321, 069     | 0            |               |                                  |                 | 1. 00  |
| 2.00             | Physician Assistant  | 74, 310      | 0            | ,             |                                  |                 | 2. 00  |
| 3.00             | Nurse Practitioner   | 202, 705     | 0            | 202, 70       | -33, 887                         |                 | 3. 00  |
| 4.00             | Visiting Nurse   | 0            | 0            |               | 0                                | 0               | 4. 00  |
| 5.00             | Other Nurse  | 158, 182     | 0            | 158, 18       | 32 0                             | 158, 182        | 5. 00  |
| 6.00             | Clinical Psychologist  | 0            | 0            |               | 0                                | 0               | 6. 00  |
| 7.00             | Clinical Social Worker   | 0            | 0            |               | 0                                | 0               | 7. 00  |
| 8.00             | Laboratory Techni ci an  | 0            | 0            |               | 0                                | 0               | 8. 00  |
| 9.00             | Other Facility Health Care Staff Costs                               | 0            | 0            |               | 0                                | 0               | 9. 00  |
| 10.00            | Subtotal (sum of lines 1 through 9)                                  | 756, 266     | 0            | 756, 26       | -64, 898                         | 691, 368        | 10.00  |
| 11. 00           | Physician Services Under Agreement                                   | 0            | 157, 576     | 157, 57       | -6, 459                          | 151, 117        | 11. 00 |
| 12.00            | Physician Supervision Under Agreement                                | 0            | 0            |               | 0                                | 0               | 12.00  |
| 13.00            | Other Costs Under Agreement  | 0            | 0            |               | 0                                | 0               | 13.00  |
| 14.00            | Subtotal (sum of lines 11 through 13)                                | 0            | 157, 576     | 157, 57       | -6, 459                          | 151, 117        | 14. 00 |
| 15. 00           | Medi cal Supplies  | 0            | 331          | 33            | 18, 033                          | 18, 364         | 15. 00 |
| 16. 00           | Transportation (Health Care Staff)                                   | 0            | 0            |               | 0                                | 0               | 16. 00 |
| 17. 00           | Depreciation-Medical Equipment                                       | 0            | 0            |               | 0                                | 0               |        |
| 18. 00           | Professional Liability Insurance                                     | 0            | 0            |               | 0                                | 0               | 18. 00 |
| 19. 00           | Other Health Care Costs  | 0            | 0            |               | 0                                | 0               | 19. 00 |
| 20.00            | Allowable GME Costs  |              |              |               |                                  |                 | 20. 00 |
| 21. 00           | Subtotal (sum of lines 15 through 20)                                | 0            | 331          |               |                                  |                 |        |
| 22. 00           | Total Cost of Health Care Services (sum of                           | 756, 266     | 157, 907     | 914, 17       | -53, 324                         | 860, 849        | 22. 00 |
|                  | lines 10, 14, and 21)  |              |              |               |                                  |                 |        |
|                  | COSTS OTHER THAN RHC/FQHC SERVICES                                   |              |              | 1             |                                  | T               |        |
| 23. 00           | Pharmacy   | 0            | 21, 540      | 21, 54        | · ·                              |                 | 23. 00 |
| 24. 00           | Dental   | 0            | 0            |               | 0                                | 0               | 24. 00 |
| 25. 00           | Optometry  | 0            | 0            |               | 0                                | 0               | 25. 00 |
| 25. 01           | Tel eheal th   | 0            | 0            |               | 0 71, 357                        |                 |        |
| 25. 02           | Chronic Care Management  | 0            | 0            |               | 0                                | 0               | 25. 02 |
| 26.00            | All other nonreimbursable costs                                      | U            | 0            |               | 0                                | 0               | 26. 00 |
| 27. 00           | Nonallowable GME costs   |              | 04 540       | 04 5          | 50.004                           | 74.044          | 27. 00 |
| 28. 00           | Total Nonreimbursable Costs (sum of lines 23                         | 0            | 21, 540      | 21, 54        | 53, 324                          | 74, 864         | 28. 00 |
|                  | through 27)  |              |              |               |                                  |                 |        |
| 20.00            | FACILITY OVERHEAD Facility Costs                                     | ٥            | 257, 018     | 257, 01       | -223, 241                        | 22 777          | 29. 00 |
| 29. 00<br>30. 00 |  | 277, 095     |              |               | · ·                              |                 |        |
|                  | Administrative Costs<br>Total Facility Overhead (sum of lines 29 and |              | 188, 030     |               |                                  |                 | 30.00  |
| 31. 00           | 30)  | 277, 095     | 445, 048     | 722, 14       | -242, 716                        | 479, 427        | 31.00  |
| 32. 00           | Total facility costs (sum of lines 22, 28                            | 1, 033, 361  | 624, 495     | 1, 657, 85    | -242, 716                        | 1, 415, 140     | 32. 00 |
| 32.00            | and 31)  | 1,033,301    | 024, 470     | 1,037,00      | -242,710                         | 1, 413, 140     | 32.00  |
|                  | /  | 1            |              | 1             | T .                              | 1               | 1      |

| Health Financial Systems                  | HARRISBURG MEDICAL CENTER, INC. | In Lieu of Form CMS-2552-10              |
|---|---------------------------------|--|
| ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 14-0210           | Period: Worksheet M-1<br>From 04/01/2022 |
|   | Component CCN: 14-8590          | To 03/31/2023 Date/Time Prepared:        |

|        |  |             |                |   |        | 9/11/2023 9:1 | 6 am   |
|--------|--|-------------|----------------|---|--------|---------------|--------|
|        |  |             |                |   | RHC II | Cost          |        |
|        |  | Adjustments | Net Expenses   |   |        |               |        |
|        |  |             | for Allocation |   |        |               |        |
|        |  |             | (col. 5 + col. |   |        |               |        |
|        |  |             | 6)             |   |        |               |        |
|        |  | 6.00        | 7. 00          |   |        |               |        |
|        | FACILITY HEALTH CARE STAFF COSTS             |             |                |   |        |               |        |
| 1.00   | Physi ci an                                  | 0           | 321, 069       | 9 |        |               | 1. 00  |
| 2.00   | Physician Assistant                          | 0           | 43, 299        | 9 |        |               | 2. 00  |
| 3.00   | Nurse Practitioner                           | 0           | 168, 818       | 3 |        |               | 3. 00  |
| 4.00   | Visiting Nurse                               | 0           | (              |   |        |               | 4.00   |
| 5.00   | Other Nurse                                  | 0           | 158, 182       | 2 |        |               | 5. 00  |
| 6.00   | Clinical Psychologist                        | 0           | (              |   |        |               | 6. 00  |
| 7.00   | Clinical Social Worker                       | 0           | (              |   |        |               | 7. 00  |
| 8.00   | Laboratory Techni ci an                      | 0           | (              |   |        |               | 8. 00  |
| 9.00   | Other Facility Health Care Staff Costs       | o           | (              |   |        |               | 9. 00  |
| 10.00  | Subtotal (sum of lines 1 through 9)          | o           | 691, 368       | 3 |        |               | 10.00  |
| 11.00  | Physician Services Under Agreement           | o           | 151, 117       | 7 |        |               | 11. 00 |
| 12.00  | Physician Supervision Under Agreement        | ol          | (              |   |        |               | 12. 00 |
| 13.00  | Other Costs Under Agreement                  | ol          | (              |   |        |               | 13.00  |
| 14.00  | Subtotal (sum of lines 11 through 13)        | o           | 151, 117       | 7 |        |               | 14. 00 |
| 15.00  | Medical Supplies                             | ol          | 18, 364        | 1 |        |               | 15. 00 |
| 16.00  | Transportation (Health Care Staff)           | o           | (              | 1 |        |               | 16. 00 |
| 17. 00 | Depreciation-Medical Equipment               | o           | (              |   |        |               | 17. 00 |
| 18. 00 | Professional Liability Insurance             | ol          | (              |   |        |               | 18. 00 |
| 19. 00 | Other Health Care Costs                      | ol          | (              |   |        |               | 19.00  |
| 20. 00 | Allowable GME Costs                          | آ ا         |                |   |        |               | 20.00  |
| 21. 00 | Subtotal (sum of lines 15 through 20)        | 0           | 18, 364        | 1 |        |               | 21. 00 |
| 22. 00 | Total Cost of Health Care Services (sum of   | 0           | 860, 849       |   |        |               | 22. 00 |
| 22.00  | lines 10, 14, and 21)                        | Ĭ           | 000,011        |   |        |               | 22.00  |
|        | COSTS OTHER THAN RHC/FQHC SERVICES           |             |                |   |        |               |        |
| 23. 00 | Pharmacy                                     | 0           | 3, 507         | 7 |        |               | 23. 00 |
| 24. 00 | Dental                                       | ol          | (              | 1 |        |               | 24. 00 |
| 25. 00 | Optometry                                    | ol          | (              |   |        |               | 25. 00 |
| 25. 01 | Tel eheal th                                 | ol          | 71, 357        | 7 |        |               | 25. 01 |
| 25. 02 | Chronic Care Management                      | Ö           | (              | 1 |        |               | 25. 02 |
| 26. 00 | All other nonreimbursable costs              | Ö           | (              |   |        |               | 26. 00 |
| 27. 00 | Nonallowable GME costs                       | ٦           |                |   |        |               | 27. 00 |
| 28. 00 | Total Nonreimbursable Costs (sum of lines 23 | o           | 74, 864        | 1 |        |               | 28. 00 |
| 20.00  | through 27)                                  | Ĭ           | , ,, 00        | ] |        |               | 20.00  |
|        | FACILITY OVERHEAD                            |             |                |   |        |               |        |
| 29. 00 | Facility Costs                               | Ol          | 33, 777        | 7 |        |               | 29. 00 |
| 30. 00 | Administrative Costs                         | ol          | 445, 650       |   |        |               | 30.00  |
| 31. 00 | Total Facility Overhead (sum of lines 29 and | ol<br>O     | 479, 427       | 1 |        |               | 31.00  |
| 000    | 30)  | Ĭ           | , 121          |   |        |               | 355    |
| 32. 00 | Total facility costs (sum of lines 22, 28    | ol          | 1, 415, 140    |   |        |               | 32. 00 |
|        | and 31)                                      | آ           | .,,            |   |        |               |        |
|        | ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '        | '           |                | • |        |               | •      |

|                  | Financial Systems HA TION OF OVERHEAD TO HOSPITAL-BASED RHC/FOHC S      | ARRISBURG MEDICA<br>SERVICES | AL CENTER, INC. Provider C | CN: 14-0210  | In Lie<br>Period: | u of Form CMS-2<br>Worksheet M-2 |       |
|------------------|---|------------------------------|----------------------------|--------------|-------------------|----------------------------------|-------|
|                  |   |                              |                            |              | From 04/01/2022   |                                  |       |
|                  |   |                              | Component (                | CCN: 14-3473 | To 03/31/2023     | Date/Time Prep<br>9/11/2023 9:10 |       |
|                  |   |                              |                            |              | RHC I             | Cost                             |       |
|                  |   | Number of FTE                | Total Visits               |              | Minimum Visits    |                                  |       |
|                  |   | Personnel                    |                            | Standard (1) | (col. 1 x col.    |                                  |       |
|                  |   | 4.00                         | 0.00                       | 0.00         | 3)                | 4                                |       |
|                  | VICITO AND PRODUCTIVITY   | 1.00                         | 2.00                       | 3. 00        | 4. 00             | 5. 00                            |       |
|                  | VISITS AND PRODUCTIVITY   |                              |                            |              |                   |                                  | -     |
| 1 00             | Posi ti ons   | 0.50                         | 4 270                      | 4 20         | 0 2 42/           |                                  | 1.00  |
| 1.00             | Physician   | 0. 58<br>1. 29               |                            |              |                   |                                  | 2.00  |
| 2.00             | Physician Assistant<br>Nurse Practitioner                               | 0. 95                        |                            |              |                   |                                  | 3.00  |
| 4. 00            | Subtotal (sum of lines 1 through 3)                                     | 2. 82                        |                            |              | 7, 140            |                                  |       |
| 5. 00            | Visiting Nurse  | 0.00                         |                            |              | 7, 140            | 13, 142                          | 1     |
| 6. 00            | Clinical Psychologist   | 0.00                         | l e                        |              |                   | 0                                |       |
| 7. 00            | Clinical Social Worker  | 0.00                         | l e                        |              |                   | 0                                |       |
| 7. 01            | Medical Nutrition Therapist (FQHC only)                                 | 0.00                         | l e                        |              |                   | 0                                |       |
| 7. 02            | Di abetes Self Management Training (FQHC                                | 0.00                         |                            |              |                   | 0                                | 7. 02 |
| 7.02             | only)   | 0.00                         | Ĭ                          |              |                   | Ĭ                                | 7.02  |
| 8.00             | Total FTEs and Visits (sum of lines 4                                   | 2. 82                        | 13, 142                    |              |                   | 13, 142                          | 8.00  |
|                  | through 7)  |                              |                            |              |                   |                                  |       |
| 9.00             | Physician Services Under Agreements                                     |                              | 0                          |              |                   | 0                                | 9. 00 |
|                  |   |                              |                            |              |                   |                                  |       |
|                  |   |                              |                            |              |                   | 1. 00                            |       |
|                  | DETERMINATION OF ALLOWABLE COST APPLICABLE TO                           |                              |                            | VI CES       |                   |                                  |       |
|                  | Total costs of health care services (from Wk                            |                              |                            |              |                   | 1, 096, 869                      |       |
|                  |   |                              |                            |              |                   | 56, 834                          |       |
| 12.00            | Cost of all services (excluding overhead) (s                            |                              |                            |              |                   | 1, 153, 703                      |       |
| 13.00            | Ratio of hospital -based RHC/FQHC services (I                           |                              |                            | 0.43         |                   | 0. 950738                        |       |
| 14.00            | Total hospital-based RHC/FQHC overhead - (fr                            |                              |                            | ne 31)       |                   | 442, 510                         |       |
| 15. 00<br>16. 00 | Parent provider overhead allocated to facili                            | ty (see instruc              | ctions)                    |              |                   | 1, 588, 839                      |       |
| 17. 00           | Total overhead (sum of lines 14 and 15)                                 |                              |                            |              |                   | 2, 031, 349<br>0                 |       |
|                  | Allowable GME overhead (see instructions) Enter the amount from line 16 |                              |                            |              |                   | 2, 031, 349                      |       |
| 10.00            |   |                              |                            |              |                   |                                  |       |
| 19 00            | Overhead applicable to hospital-based RHC/FQ                            | HC services (li              | ne 13 y line 1             | 81           | Į.                | 1, 931, 281                      | 19.00 |

| Heal th          | Financial Systems HA  | ARRISBURG MEDICA | AL CENTER, INC.  |               | In Lie                     | eu of Form CMS-2            | 2552-10 |
|------------------|---|------------------|------------------|---------------|----------------------------|-----------------------------|---------|
|                  | TION OF OVERHEAD TO HOSPITAL-BASED RHC/FOHC S   |                  | Provi der C      | CN: 14-0210 F | Period:<br>From 04/01/2022 | Worksheet M-2               |         |
|                  |   |                  | Component        |               | To 03/31/2023              | Date/Time Pre 9/11/2023 9:1 |         |
|                  |   |                  |                  |               | RHC II                     | Cost                        |         |
|                  |   | Number of FTE    | Total Visits     |               | Minimum Visits             |                             |         |
|                  |   | Personnel        |                  | Standard (1)  | (col. 1 x col.             |                             |         |
|                  |   |                  |                  |               | 3)                         | 4                           |         |
|                  |   | 1. 00            | 2. 00            | 3. 00         | 4. 00                      | 5. 00                       |         |
|                  | VISITS AND PRODUCTIVITY   |                  |                  |               |                            |                             |         |
|                  | Posi ti ons   |                  |                  |               |                            |                             |         |
| 1.00             | Physi ci an   | 0. 62            |                  |               | · ·                        |                             | 1. 00   |
| 2.00             | Physi ci an Assi stant  | 0. 52            |                  |               |                            |                             | 2. 00   |
| 3.00             | Nurse Practitioner  | 0. 97            |                  |               | · ·                        |                             | 3. 00   |
| 4.00             | Subtotal (sum of lines 1 through 3)   | 2. 11            |                  |               | 5, 733                     |                             | 1       |
| 5.00             | Visiting Nurse  | 0.00             |                  |               |                            | 0                           |         |
| 6.00             | Clinical Psychologist   | 0.00             |                  |               |                            | 0                           |         |
| 7.00             | Clinical Social Worker  | 0.00             |                  |               |                            | 0                           | 7. 00   |
| 7. 01            | Medical Nutrition Therapist (FQHC only)   | 0.00             |                  |               |                            | 0                           | 7. 01   |
| 7.02             | Diabetes Self Management Training (FQHC   | 0.00             | 0                |               |                            | 0                           | 7. 02   |
|                  | onl y)  |                  |                  |               |                            |                             |         |
| 8.00             | Total FTEs and Visits (sum of lines 4   | 2. 11            | 10, 149          |               |                            | 10, 149                     | 8. 00   |
|                  | through 7)  |                  | _                |               |                            | _                           |         |
| 9.00             | Physician Services Under Agreements   |                  | 0                |               |                            | 0                           | 9. 00   |
|                  |   |                  |                  |               |                            | 4.00                        |         |
|                  | DETERMINATION OF ALLOWARIE COCT APPLICABLE TO   | O HOCDITAL BACE  | D DUC /FOUR CER  | VI CEC        |                            | 1. 00                       |         |
| 10. 00           | DETERMINATION OF ALLOWABLE COST APPLICABLE TO   |                  |                  | VICES         |                            | 860, 849                    | 10.00   |
| 11. 00           |   |                  |                  |               |                            | 74, 864                     | 1       |
|                  |   |                  |                  |               |                            |                             |         |
| 12.00            | Cost of all services (excluding overhead) (s  |                  |                  |               |                            | 935, 713<br>0. 919993       |         |
| 13.00            | Ratio of hospital -based RHC/FQHC services (I   |                  |                  | 21)           |                            |                             |         |
| 14.00            | Total hospital-based RHC/FQHC overhead - (fr  |                  |                  | ne 31)        |                            | 479, 427                    |         |
| 15. 00<br>16. 00 | Parent provider overhead allocated to facili<br>Total overhead (sum of lines 14 and 15) | ty (see instruc  | ctions)          |               |                            | 1, 312, 826                 |         |
| 17. 00           |   |                  |                  |               |                            | 1, 792, 253                 | 17. 00  |
| 17.00            | Allowable GME overhead (see instructions) Enter the amount from line 16                 |                  |                  |               |                            | 1 702 252                   |         |
|                  | Overhead applicable to hospital-based RHC/FQ  | UC convices (1)  | no 12 v lino 1   | 0)            |                            | 1, 792, 253                 | 1       |
|                  | Total allowable cost of hospital-based RHC/FU   |                  |                  |               |                            | 1, 648, 860<br>2, 509, 709  |         |
| 20.00            | Tiotal allowable cost of hospital-based RHC/F   | unc services (S  | sum of filles to | and 19)       |                            | 2, 309, 709                 | 20.00   |

|                  | Financial Systems HARRISBURG MEDICAL  ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC                          | Provider CCN: 14-0210    | Peri od:                         | u of Form CMS-2<br>Worksheet M-3 |                  |
|------------------|--|--------------------------|----------------------------------|----------------------------------|------------------|
| SERVI (          |  | Component CCN: 14-3473   | From 04/01/2022<br>To 03/31/2023 | Date/Time Pre                    | pared:           |
|                  |  | Title XVIII              | RHC I                            | 9/11/2023 9: 10<br>Cost          | o alli           |
|                  |  |                          |                                  |                                  |                  |
|                  | DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES   |                          |                                  | 1. 00                            |                  |
| 1. 00            | Total Allowable Cost of hospital-based RHC/FQHC Services (from   | m Wkst. M-2. line 20)    |                                  | 3, 028, 150                      | 1.00             |
| 2.00             | Cost of injections/infusions and their administration (from W  |                          |                                  | 107, 294                         |                  |
| 3.00             | Total allowable cost excluding injections/infusions (line 1 m  | inus line 2)             |                                  | 2, 920, 856                      | 3.00             |
| 4.00             | Total Visits (from Wkst. M-2, column 5, line 8)  | >                        |                                  | 13, 142                          |                  |
| 5.00             | Physicians visits under agreement (from Wkst. M-2, column 5,   | line 9)                  |                                  | 0                                | 5.00             |
| 6. 00<br>7. 00   | Total adjusted visits (line 4 plus line 5) Adjusted cost per visit (line 3 divided by line 6)                                |                          |                                  | 13, 142<br>222. 25               |                  |
| 7.00             | Adjusted cost per visit (Title 3 divided by Title 0)   |                          | Cal cul ati on                   |                                  | 7.00             |
|                  |  |                          |                                  |                                  |                  |
|                  |  |                          | Rate Period 1                    |                                  |                  |
|                  |  |                          | (04/01/2022                      | (01/01/2023                      |                  |
|                  |  |                          | through<br>12/31/2022)           | through<br>03/31/2023)           |                  |
|                  |  |                          | 1.00                             | 2. 00                            |                  |
| 8. 00            | Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20  | .6 or your contractor)   | 203. 46                          | 211. 19                          |                  |
| 9. 00            | Rate for Program covered visits (see instructions)   |                          | 203. 46                          | 211. 19                          | 9.00             |
| 10. 00           | CALCULATION OF SETTLEMENT  Program covered visits excluding mental health services (from                                     | contractor records)      | 2, 757                           | 891                              | 10.00            |
| 11. 00           | Program cost excluding costs for mental health services (line  |                          | 560, 939                         | 188, 170                         |                  |
| 12. 00           | Program covered visits for mental health services (from contra   | •                        | 9                                | 1                                | 12.00            |
| 13. 00           | Program covered cost from mental health services (line 9 x li  | ne 12)                   | 1, 831                           | 211                              | 13.00            |
| 14. 00           | Limit adjustment for mental health services (see instructions  |                          | 1, 831                           | 211                              |                  |
| 15. 00           | Graduate Medical Education Pass Through Cost (see instruction:   |                          |                                  | 754 454                          | 15.00            |
| 16. 00<br>16. 01 | Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 Total program charges (see instructions)(from contractor's re- |                          | 0                                | 751, 151<br>617, 038             |                  |
| 16. 02           | Total program preventive charges (see instructions) (from provi  | *                        |                                  | 64, 258                          |                  |
| 16. 03           | Total program preventive costs ((line 16.02/line 16.01) times  | •                        |                                  | 78, 224                          |                  |
| 16. 04           | Total Program non-preventive costs ((line 16 minus lines 16.0)   |                          |                                  | 493, 060                         |                  |
|                  | (Titles V and XIX see instructions.)   |                          |                                  |                                  |                  |
| 16. 05           | Total program cost (see instructions)  |                          | 0                                | 571, 284                         | 16. 05<br>17. 00 |
| 17. 00<br>18. 00 | Primary payer amounts Less: Beneficiary deductible for RHC only (see instructions)   | (from contractor         |                                  | 0<br>56, 602                     |                  |
| 10.00            | records)   | (11 dill doller doller   |                                  | 00, 002                          | 10.00            |
| 19. 00           | Beneficiary coinsurance for RHC/FQHC services (see instruction   | ns) (from contractor     |                                  | 99, 093                          | 19.00            |
| 20.00            | records)   |                          |                                  | E71 204                          | 20.00            |
| 20. 00<br>21. 00 | Net Medicare cost excluding vaccines (see instructions) Program cost of vaccines and their administration (from Wkst.        | M-4 line 16)             |                                  | 571, 284<br>46, 279              |                  |
| 22. 00           | ,  | W-4, 1111e 10)           |                                  | 617, 563                         |                  |
| 23. 00           | , , ,  |                          |                                  | 36, 552                          | 1                |
| 23. 01           | Adjusted reimbursable bad debts (see instructions)   |                          |                                  | 23, 759                          |                  |
| 24. 00           | · · · · · · · · · · · · · · · · · · ·  |                          |                                  | 31, 607                          |                  |
| 25. 00           | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   |                          |                                  | 0                                |                  |
|                  | Pioneer ACO demonstration payment adjustment (see instructions)  |                          |                                  | 0                                |                  |
| 25. 99<br>26. 00 | Demonstration payment adjustment amount before sequestration   |                          |                                  | 641, 322                         |                  |
| 26. 01           | 00 Net reimbursable amount (see instructions)  |                          |                                  | 11, 223                          |                  |
| 26. 02           | O1   Sequestration adjustment (see instructions)   |                          |                                  | 0                                |                  |
| 27. 00           |  |                          |                                  | 557, 498                         |                  |
| 28. 00           | ,  | 00 07 100                |                                  | 0                                | 28. 00           |
| 29. 00           |  | •                        |                                  | 72, 601                          |                  |
| 30. 00           | Protested amounts (nonallowable cost report items) in accordanchapter I, §115.2  | nce with CMS Pub. 15-11, |                                  | 0                                | 30.00            |

|                  | Financial Systems HARRISBURG MEDICAL ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC                                 | CENTER, INC. Provider CCN: 14-0210 | In Lie          | u of Form CMS-2<br>Worksheet M-3 |                  |
|------------------|--|------------------------------------|-----------------|----------------------------------|------------------|
| SERVI (          |  | Provider CCN. 14-0210              | From 04/01/2022 | worksneet w-3                    |                  |
|                  |  | Component CCN: 14-8590             | To 03/31/2023   | Date/Time Prep<br>9/11/2023 9:10 |                  |
|                  |  | Title XVIII                        | RHC II          | Cost                             | o am             |
|                  |  |                                    |                 | 1.00                             |                  |
|                  | DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES   |                                    |                 | 1. 00                            |                  |
| 1. 00            | Total Allowable Cost of hospital-based RHC/FQHC Services (from   | m Wkst. M-2, line 20)              |                 | 2, 509, 709                      | 1.00             |
| 2.00             | Cost of injections/infusions and their administration (from W  |                                    |                 | 57, 768                          | 2. 00            |
| 3.00             | Total allowable cost excluding injections/infusions (line 1 m  | inus line 2)                       |                 | 2, 451, 941                      | 3.00             |
| 4. 00<br>5. 00   | Total Visits (from Wkst. M-2, column 5, line 8) Physicians visits under agreement (from Wkst. M-2, column 5,                       | Line (1)                           |                 | 10, 149<br>0                     | 4. 00<br>5. 00   |
| 6. 00            | Total adjusted visits (line 4 plus line 5)   | 11116 9)                           |                 | 10, 149                          | 6.00             |
| 7. 00            | Adjusted cost per visit (line 3 divided by line 6)   |                                    |                 | 241. 59                          |                  |
|                  |  |                                    | Cal cul ati on  | of Limit (1)                     |                  |
|                  |  |                                    | Rate Period 1   | Rate Period 2                    |                  |
|                  |  |                                    | (04/01/2022     | (01/01/2023                      |                  |
|                  |  |                                    | through         | through                          |                  |
|                  |  |                                    | 12/31/2022)     | 03/31/2023)                      |                  |
| 8. 00            | Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)  |                                    | 213. 90         | 222. 03                          | 8. 00            |
| 9. 00            | Rate for Program covered visits (see instructions)   |                                    | 213. 90         | 222. 03                          |                  |
|                  | CALCULATION OF SETTLEMENT  |                                    |                 |                                  |                  |
| 10.00            | Program covered visits excluding mental health services (from  | •                                  | 1, 895          |                                  | 10.00            |
| 11. 00<br>12. 00 | Program cost excluding costs for mental health services (line<br>Program covered visits for mental health services (from contra    | •                                  | 405, 341<br>43  | 97, 471<br>13                    | 1                |
| 13. 00           | Program covered cost from mental health services (line 9 x lines)  | *                                  | 9, 198          | 2, 886                           |                  |
| 14. 00           | Limit adjustment for mental health services (see instructions  |                                    | 9, 198          | 2, 886                           | 14. 00           |
| 15. 00           | Graduate Medical Education Pass Through Cost (see instructions   |                                    |                 |                                  | 15. 00           |
| 16. 00<br>16. 01 | Total Program cost (sum of lines 11, 14, and 15, columns 1, 2  |                                    | 0               | 514, 896                         |                  |
| 16. 01           | Total program charges (see instructions)(from contractor's real Total program preventive charges (see instructions)(from province) | *                                  |                 | 428, 251<br>28, 015              |                  |
| 16. 03           | Total program preventive costs ((line 16.02/line 16.01) times  | •                                  |                 | 33, 683                          | 1                |
| 16. 04           | Total Program non-preventive costs ((line 16 minus lines 16.0)   |                                    |                 | 351, 319                         | 16. 04           |
|                  | (Titles V and XIX see instructions.)   |                                    |                 | 225 222                          | 4, 05            |
| 16. 05<br>17. 00 | Total program cost (see instructions) Primary payer amounts  |                                    | 0               | 385, 002<br>161                  | 1                |
| 18. 00           | Less: Beneficiary deductible for RHC only (see instructions)   | (from contractor                   |                 | 42, 064                          | 1                |
|                  | records)   |                                    |                 |                                  |                  |
| 19. 00           | Beneficiary coinsurance for RHC/FQHC services (see instruction   | ns) (from contractor               |                 | 71, 634                          | 19. 00           |
| 20. 00           | records) Net Medicare cost excluding vaccines (see instructions)   |                                    |                 | 384, 841                         | 20.00            |
| 21. 00           | Program cost of vaccines and their administration (from Wkst.  | M-4, line 16)                      |                 | 37, 329                          |                  |
| 22. 00           |  |                                    |                 | 422, 170                         |                  |
| 23. 00           | Allowable bad debts (see instructions)   |                                    |                 | 21, 326                          |                  |
| 23. 01<br>24. 00 | Adjusted reimbursable bad debts (see instructions)   | ructions)                          |                 | 13, 862<br>19, 225               |                  |
| 25. 00           | · · · · · · · · · · · · · · · · · · ·  |                                    |                 | 17, 223                          | 1                |
|                  | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)                     |                                    |                 | 0                                |                  |
| 25. 99           | Pioneer ACO demonstration payment adjustment (see instructions) Demonstration payment adjustment amount before sequestration       |                                    |                 | 0                                |                  |
| 26. 00           | Demonstration payment adjustment amount before sequestration Net reimbursable amount (see instructions)                            |                                    |                 | 436, 032                         |                  |
| 26. 01<br>26. 02 | Sequestration adjustment (see instructions)  |                                    |                 | 7, 630                           | 26. 01<br>26. 02 |
| 27. 00           |  |                                    |                 | 376, 522                         |                  |
| 28. 00           | 1 . 3  |                                    |                 | 0                                |                  |
| 29. 00           |  |                                    |                 | 51, 880                          |                  |
| 30. 00           | Protested amounts (nonallowable cost report items) in accordanchapter I, §115.2  | nce with CMS Pub. 15-II,           |                 | 0                                | 30.00            |

| COMPUT         | ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST  | Provider CC<br>Component C |                         | Period:<br>From 04/01/2022<br>To 03/31/2023 | Worksheet M-4 Date/Time Prep 9/11/2023 9:16 | pared:         |
|----------------|--|----------------------------|-------------------------|---|---|----------------|
|                |  | Title                      | XVIII                   | RHC I                                       | Cost  | o aiii         |
|                |  | PNEUMOCOCCAL<br>VACCI NES  | I NFLUENZA<br>VACCI NES | COVI D-19<br>VACCI NES                      | MONOCLONAL<br>ANTI BODY<br>PRODUCTS         |                |
|                |  | 1.00                       | 2.00                    | 2. 01                                       | 2. 02                                       |                |
| 1. 00<br>2. 00 | Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health                  | 1, 012, 380<br>0. 000524   | 1, 012, 38<br>0. 0031   |   | 1, 012, 380<br>0. 000000                    | 1. 00<br>2. 00 |
| 3. 00          | care staff time Injection/infusion health care staff cost (line 1 x line 2)  | 530                        | 3, 15                   | 51 0  | 0   | 3. 00          |
| 4. 00          | Injections/infusions and related medical supplies costs (from your records)  | 14, 151                    | 21, 03                  | 0   | 0   | 4. 00          |
| 5. 00          | Direct cost of injections/infusions (line 3 plus line 4)   | 14, 681                    | 24, 18                  |   | 0   | 5.00           |
| 5. 00          | Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)   | 1, 096, 869                | 1, 096, 86              |   | ,   | 6. 00          |
| 7. 00          | Total overhead (from Wkst. M-2, line 19)   | 1, 931, 281                | 1, 931, 28              |   | 1, 931, 281                                 | 7.0            |
| 3. 00          | Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)  | 0. 013384                  | 0. 02204                |   | 0. 000000                                   |                |
| 9. 00          | Overhead cost - injection/infusion (line 7 x line 8)   | 25, 848                    |                         |   | 0   |                |
| 10. 00         | Total injection/infusion costs and their administration costs (sum of lines 5 and 9)   | 40, 529                    | 66, 76                  |   | 0   |                |
| 11. 00         | Total number of injections/infusions (from your records)   | 92                         | 54                      |   |   |                |
| 12.00          | Cost per injection/infusion (line 10/line 11)  | 440. 53                    |                         |   |   | 12. 0          |
| 3. 00          | Number of injection/infusion administered to Program beneficiaries   | 24                         | 29                      | 92 0  | 0   |                |
| 13. 01         | Number of COVID-19 vaccine injections/infusions administered to MA enrollees   |                            |                         | 0   | 0   |                |
| 14. 00         | Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable) | 10, 573                    | 35, 70                  | 06 0  | 0   | 14. 00         |
|                |  |                            |                         |   | COST OF                                     |                |
|                |  |                            |                         |   | INJECTIONS /                                |                |
|                |  |                            |                         |   | INFUSIONS AND                               |                |
|                |  |                            |                         |   | ADMI NI STRATI ON                           |                |
|                |  | . , ,                      |                         | 1. 00                                       | 2. 00                                       |                |
| 15. 00         | Total cost of injections/infusions and their administration 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.           | M-3, line 2)               |                         |   | 107, 294                                    |                |
| 16. 00         | Total Program cost of injections/infusions and their admini  | stration costs             | (sum of                 |   | 46, 279                                     | 16.0           |

| COMPUT | ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST  | Provider Component ( |            | Period:<br>From 04/01/2022<br>To 03/31/2023 | Worksheet M-4 Date/Time Prep 9/11/2023 9:16 |        |
|--------|--|----------------------|------------|---|---|--------|
|        |  | Ti tl o              | XVIII      | RHC II                                      | 971172023 9.10<br>Cost                      | o alli |
|        |  | PNEUMOCOCCAL         | INFLUENZA  | COVI D-19                                   | MONOCLONAL                                  |        |
|        |  | VACCI NES            | VACCI NES  | VACCINES                                    | ANTI BODY PRODUCTS                          |        |
|        |  | 1. 00                | 2. 00      | 2. 01                                       | 2. 02                                       |        |
| 1. 00  | Health care staff cost (from Wkst. M-1, col. 7, line 10)   | 691, 368             | 691, 36    | 691, 368                                    | 691, 368                                    | 1. 00  |
| 2. 00  | Ratio of injection/infusion staff time to total health care staff time   | 0. 000243            | 0. 00233   | 0. 000000                                   | 0. 000000                                   | 2.00   |
| 3. 00  | Injection/infusion health care staff cost (line 1 x line 2)  | 168                  | 1, 61      | 0   | 0   | 3.00   |
| 4. 00  | Injections/infusions and related medical supplies costs (from your records)  | 4, 247               | 13, 78     | 0   | 0   | 4.00   |
| 5. 00  | Direct cost of injections/infusions (line 3 plus line 4)   | 4, 415               | 15, 40     | 00  | o   | 5.00   |
| 6. 00  | Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)   | 860, 849             | 860, 84    | 860, 849                                    | 860, 849                                    | 6. 00  |
| 7. 00  | Total overhead (from Wkst. M-2, line 19)   | 1, 648, 860          | 1, 648, 86 | 1, 648, 860                                 | 1, 648, 860                                 | 7.00   |
| 8. 00  | Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)  | 0. 005129            | 0. 01788   | 0. 000000                                   | 0. 000000                                   | 8. 00  |
| 9. 00  | Overhead cost - injection/infusion (line 7 x line 8)   | 8, 457               | 29, 49     | 96 0  | 0   | 9.00   |
| 10. 00 | Total injection/infusion costs and their administration costs (sum of lines 5 and 9)   | 12, 872              | 44, 89     | 96 0  | 0   | 10.00  |
| 11. 00 | Total number of injections/infusions (from your records)   | 32                   | 30         |   | 0   | 11.00  |
| 12.00  | Cost per injection/infusion (line 10/line 11)  | 402. 25              | 146. 2     | 0.00  | 0.00  | 12.00  |
| 13. 00 | Number of injection/infusion administered to Program beneficiaries   | 15                   | 21         | 0   | 0   | 13. 00 |
| 13. 01 | Number of COVID-19 vaccine injections/infusions administered to MA enrollees   |                      |            | 0   | 0   | 13. 01 |
| 14. 00 | Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable) | 6, 034               | 31, 29     | 95 0  | 0   | 14. 00 |
|        |  |                      |            |   | COST OF                                     |        |
|        |  |                      |            |   | INJECTIONS /                                |        |
|        |  |                      |            |   | INFUSIONS AND                               |        |
|        |  |                      |            |   | ADMI NI STRATI ON                           |        |
|        |  |                      |            | 1. 00                                       | 2. 00                                       |        |
|        | Total cost of injections/infusions and their administration 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.           | M-3, line 2)         | •          |   | 57, 768                                     |        |
| 16.00  | Total Program cost of injections/infusions and their admini  | stration costs       | (sum of    |   | 37, 329                                     | 16.00  |

| Health Financial Systems   | HARRI SBURG MEDI CAL | CENTER, INC.                                    | In Lie                                       | u of Form CMS-2552-10                               |
|--|----------------------|---|--|---|
| ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHOSERVICES RENDERED TO PROGRAM BENEFICIARIES |                      | Provider CCN: 14-0210<br>Component CCN: 14-3473 | Peri od:<br>From 04/01/2022<br>To 03/31/2023 | Worksheet M-5 Date/Time Prepared: 9/11/2023 9:16 am |

|  | Component Con. 14-3473   | 10 03/31/2023 | 9/11/2023 9: 16 |    |
|--|--------------------------|---------------|-----------------|----|
|  |                          | RHC I         | Cost            |    |
|  |                          | Par           | rt B            |    |
|  |                          | mm/dd/yyyy    | Amount          |    |
|  |                          | 1. 00         | 2.00            |    |
| O Total interim payments paid to hospital-based RHC/FQHC                     |                          |               | 557, 498        | 1  |
| O Interim payments payable on individual bills, either submitted             | d or to be submitted to  |               | 0               | 2  |
| the contractor for services rendered in the cost reporting per               |                          |               |                 | 1  |
| "NONE" or enter a zero   | rod. IT florie, witte    |               |                 |    |
| O List separately each retroactive lump sum adjustment amount ba             | ased on subsequent       |               |                 | 3  |
| revision of the interim rate for the cost reporting period. Al               |                          |               |                 | `  |
| payment. If none, write "NONE" or enter a zero. (1)                          | 30 Show date of each     |               |                 |    |
| Program to Provider  |                          |               |                 | 1  |
| 1  |                          |               | 0               | 3  |
| 2  |                          |               |                 | 3  |
| 3  |                          |               |                 | 3  |
| 4  |                          |               |                 | 3  |
| 5  |                          |               |                 |    |
| Provider to Program  |                          |               | U               | ,  |
| 0  |                          |               | 0               | :  |
| 0<br>1   |                          |               |                 |    |
|  |                          |               |                 |    |
| 2  |                          |               | 0               | 3  |
| 3  |                          |               | 0               |    |
| 4  |                          |               | 0               |    |
| 9 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)             |                          |               | 0               | 3  |
| O Total interim payments (sum of lines 1, 2, and 3.99) (transfer             | r to Worksheet M-3, line |               | 557, 498        | 4  |
| 27) TO BE COMPLETED BY CONTRACTOR  |                          |               |                 | ļ  |
|  |                          | £             |                 |    |
| Ulist separately each tentative settlement payment after desk r              | review. Also show date o | T             |                 | ;  |
| each payment. If none, write "NONE" or enter a zero. (1)                     |                          |               |                 |    |
| Program to Provider  |                          |               |                 | ١, |
| 1  |                          |               | 0               | 5  |
| 2  |                          |               | 0               |    |
| 3  |                          |               | 0               | !  |
| Provider to Program  |                          |               |                 | ١. |
| 0  |                          |               | 0               |    |
| 1  |                          |               | 0               |    |
| 2  |                          |               | 0               |    |
| 9 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)             |                          |               | 0               |    |
| Determined net settlement amount (balance due) based on the cost report. (1) |                          |               | 70 /5:          | 6  |
| 01 SETTLEMENT TO PROVIDER  |                          |               | 72, 601         | 1  |
| 2 SETTLEMENT TO PROGRAM  |                          |               | 0               | 6  |
| O   Total Medicare program liability (see instructions)                      |                          |               | 630, 099        | 7  |
|  |                          | Contractor    | NPR Date        |    |
|  |                          | Number        | (Mo/Day/Yr)     |    |
|  | 0                        | 1. 00         | 2. 00           |    |
| 0 Name of Contractor   |                          |               |                 | 8  |

| Health Financial Systems   | HARRI SBURG MEDI CAL | CENTER, INC.                                    | In Lie                                       | u of Form CMS-2552-10 |
|--|----------------------|---|--|-----------------------|
| ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RH<br>SERVICES RENDERED TO PROGRAM BENEFICIARIE |                      | Provider CCN: 14-0210<br>Component CCN: 14-8590 | Peri od:<br>From 04/01/2022<br>To 03/31/2023 |                       |

|   | Component Con. 14-8370  | 10 03/31/2023  | 9/11/2023 9: 16     |     |
|---|-------------------------|----------------|---------------------|-----|
|   |                         | RHC II         | Cost                |     |
|   |                         | Par            | t B                 |     |
|   |                         | mm/dd/yyyy     | Amount              |     |
|   |                         | 1, 00          | 2.00                |     |
| O Total interim payments paid to hospital-based RHC/FQHC  |                         |                | 376, 522            | 1   |
| O Interim payments payable on individual bills, either submitted  | or to be submitted to   |                | 0/0/022             | 2   |
| the contractor for services rendered in the cost reporting per  |                         |                | Ĭ                   | -   |
| "NONE" or enter a zero  | rou. It hone, witte     |                |                     |     |
| O List separately each retroactive lump sum adjustment amount ba  | sed on subsequent       |                |                     | 3   |
| revision of the interim rate for the cost reporting period. Als   |                         |                |                     |     |
| payment. If none, write "NONE" or enter a zero. (1)   |                         |                |                     |     |
| Program to Provider   |                         |                |                     |     |
| 1   |                         |                | 0                   | 3   |
| 2   |                         |                | 0                   | 3   |
| 3   |                         |                | 0                   | 3   |
| 4   |                         |                | 0                   | 3   |
| 5   |                         |                | Ö                   | 3   |
| Provider to Program   |                         |                | 0                   | ,   |
| 0   |                         |                | 0                   | 1   |
| 1   |                         |                | 0                   | 3   |
| 2   |                         |                |                     | 3   |
| 3   |                         |                |                     | 3   |
| 4   |                         |                |                     |     |
| 9   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)  |                         |                | 0                   |     |
| O Total interim payments (sum of lines 1, 2, and 3.99) (transfer  |                         |                | - 1                 | 2   |
| 27)   | to worksheet M-3, Time  |                | 376, 522            | '   |
| TO BE COMPLETED BY CONTRACTOR   |                         |                |                     |     |
| Ust separately each tentative settlement payment after desk re  | eview Also show date o  | f              |                     |     |
| each payment. If none, write "NONE" or enter a zero. (1)  | eview. Also show date o | '              |                     |     |
| Program to Provider   |                         |                |                     |     |
| 1   |                         |                | 0                   |     |
| 2   |                         |                | Ö                   | Ę   |
| 3   |                         |                | l ol                | Ę   |
| Provider to Program   |                         |                | 0                   |     |
| 0   |                         |                | 0                   |     |
| 1   |                         |                |                     | 5   |
| 2   |                         |                | 0                   |     |
| 9   Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)  |                         |                |                     | 5   |
|   |                         |                |                     |     |
| 00 Determined net settlement amount (balance due) based on the cost report. (1) 01 SETTLEMENT TO PROVIDER |                         |                | 51, 880             |     |
| OZ SETTLEMENT TO PROGRAM  |                         |                | 0                   |     |
| 0   Total Medicare program liability (see instructions)   |                         |                | 428, 402            | -   |
| o protai medicare program mability (see mistructions)   |                         | Contractor     |                     | -   |
|   |                         | Contractor     | NPR Date            |     |
|   | 0                       | Number<br>1.00 | (Mo/Day/Yr)<br>2.00 |     |
| 0 Name of Contractor  | U                       | 1.00           | 2.00                | 8   |
| O INAME OF COURSCIOE  |                         | 1              | ı .                 | . ≻ |