payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

OMB NO. 0938-0050

EXPLIES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-0007 Period: From 01/01/2019 To 12/31/2019 Date/Time Prepared: 8/19/2020 2:00 pm

| | | | | 10 12/31/2017 | 8/19/2020 2: | |
|------------------------|---|-------------------|----------------------|---|----------------|----------|
| PART I - COST | REPORT STATUS | | | | 07 177 2020 2. | оо рііі |
| Provi der | 1. [X] Electronically prepar | ed cost report | | Date: 8/19/202 | 20 Time: | 2: 00 pi |
| use only | 2. [] Manually prepared cos | st report | | | | |
| | 3. [0] If this is an amended 4. [F] Medicare Utilization. | | | resubmitted this co | ost report | |
| Contractor use only | 5. [1]Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended | 7. Contractor No. | this Provider CCN 12 | D.NPR Date: .Contractor's Vendo P.[0]If line 5, co number of tim | lumn 1 is 4: | |

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COMMUNITY HOWARD REGIONAL HEALTH (15-0007) for the cost reporting period beginning 01/01/2019 and ending 12/31/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) HOLLY MILLARD

NETWORK SR VP FINANCE

Officer or Administrator of Provider(s)

Title

(Dated when report is electronically signed.)

Date

| | | | Title | XVIII | | | |
|--------|-------------------------------|---------|----------|---------|-------|-----------|---------|
| | Cost Center Description | Title V | Part A | Part B | HI T | Title XIX | |
| | | 1.00 | 2.00 | 3. 00 | 4. 00 | 5. 00 | |
| | PART III - SETTLEMENT SUMMARY | | | | | | |
| 1.00 | Hospi tal | 0 | 250, 571 | 53, 763 | 0 | 0 | 1.00 |
| 2.00 | Subprovider - IPF | 0 | 0 | 0 | | 0 | 2.00 |
| 3.00 | Subprovider - IRF | 0 | 0 | 0 | | 0 | 3. 00 |
| 5.00 | Swing Bed - SNF | 0 | 0 | 0 | | 0 | 5. 00 |
| 6.00 | Swing Bed - NF | 0 | | | | 0 | 6.00 |
| 200.00 | Total | 0 | 250, 571 | 53, 763 | 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 valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0007 Peri od: Worksheet S-2 From 01/01/2019 Part I Date/Time Prepared: 12/31/2019 8/19/2020 2:00 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 3500 SOUTH LAFOUNTAIN 1.00 PO Box: 1.00 State: IN 2.00 City: KOKOMO Zip Code: 46902 County: HOWARD 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, 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 COMMUNITY HOWARD 150007 29020 07/01/1966 Ν 0 3.00 REGIONAL HEALTH Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF 7.00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 Hospital -Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 Renal Dialysis 18.00 18.00 19.00 Other 19.00 From: 2.00 1.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2019 12/31/2019 20.00 21.00 Type of Control (see instructions) 21.00 2 1. 00 2. 00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Υ N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this 22.01 Υ Υ 22.01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1.

Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)

Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) 22.02 22.02 N Ν 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 22.03 Ν 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. Which method is used to determine Medicaid days on lines 24 and/or 25 3 Ν 23.00 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no. In-State In-State Out-of Out-of Medi cai d 0ther Medi cai d Medi cai d State State HMO days Medi cai d days paid days el i gi bl e Medi cai d Medi cai d paid days unpai d el i gi bl e days unpai d 1.00 2. 00 3. 00 4. 00 5. 00 6.00 24.00 If this provider is an IPPS hospital, enter the 4 24.00 1. 160 221 4. 113 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.

23.00

1

60.01

instructions)

60.01 If line 60 is yes, complete columns 2 and 3 for each program. (see

| Health Financial Systems COMMUNITY | HOWARD F | REGIONAL HEALTH | Н | In Lie | u of Form CMS-2 | 2552-10 |
|---|----------|-----------------|------------------------|--------------------------------|----------------------------------|---------|
| HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA | | Provi der CC | CN: 15-0007 Pe | eri od: | Worksheet S-2 | |
| | | | To | com 01/01/2019 0 12/31/2019 | Part I Date/Time Pre | |
| | Y/N | IME | Direct GME | IME | 8/19/2020 2:00 Direct GME | O pm |
| | 17.14 | TWE | DIT COL OME | 1 1112 | DITION ONE | |
| (1.00 Did your boot tal receive FTF clate under ACA | 1. 00 | 2. 00 | 3. 00 | 4.00 | 5.00 | (1.00 |
| 61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in | N | | | 0.00 | 0.00 | 61. 00 |
| column 1. (see instructions) | | | | | | |
| 61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports | | | | | | 61. 01 |
| ending and submitted before March 23, 2010. (see | | | | | | |
| instructions) | | | | | | (1.00 |
| 61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, | | | | | | 61. 02 |
| and primary care FTEs added under section 5503 of | | | | | | |
| ACA). (see instructions) 61.03 Enter the base line FTE count for primary care | | | | | | 61. 03 |
| and/or general surgery residents, which is used for | | | | | | 01.00 |
| determining compliance with the 75% test. (see | | | | | | |
| instructions) 61.04 Enter the number of unweighted primary care/or | | | | | | 61. 04 |
| surgery allopathic and/or osteopathic FTEs in the | | | | | | |
| current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary | | | | | | 61. 05 |
| and/or general surgery FTEs and the current year's | | | | | | 01.00 |
| primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) | | | | | | |
| 61.06 Enter the amount of ACA \$5503 award that is being | | | | | | 61. 06 |
| used for cap relief and/or FTEs that are nonprimary | | | | | | |
| care or general surgery. (see instructions) | Pro | L ogram Name | Program Code | Unweighted IME | Unwei ghted | |
| | | | | FTE Count | Direct GME FTE | |
| | | 1. 00 | 2.00 | 3.00 | Count 4.00 | |
| 61.10 Of the FTEs in line 61.05, specify each new program | | 1.00 | 2.00 | 0.00 | | 61. 10 |
| specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in | | | | | | |
| column 1, the program name. Enter in column 2, the | | | | | | |
| program code. Enter in column 3, the IME FTE | | | | | | |
| unweighted count. Enter in column 4, the direct GME FTE unweighted count. | | | | | | |
| 61.20 Of the FTEs in line 61.05, specify each expanded | | | | 0. 00 | 0. 00 | 61. 20 |
| program specialty, if any, and the number of FTE residents for each expanded program. (see | | | | | | |
| instructions) Enter in column 1, the program name. | | | | | | |
| Enter in column 2, the program code. Enter in column | | | | | | |
| 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. | | | | | | |
| | | | ' | | | |
| ACA Provisions Affecting the Health Resources and Se | rvi ces | Administration | (HRSA) | | 1.00 | |
| 62.00 Enter the number of FTE residents that your hospital | trai ned | | | od for which | 0.00 | 62. 00 |
| your hospital received HRSA PCRE funding (see instruction 62.01 Enter the number of FTE residents that rotated from a | | no Health Cent | ter (THC) into | vour hosnital | 0.00 | 62. 01 |
| during in this cost reporting period of HRSA THC proj | | | | your nospitui | 0.00 | 02.01 |
| Teaching Hospitals that Claim Residents in Nonprovid 63.00 Has your facility trained residents in nonprovider so | | | et reporting n | ori od? Entor | N | 63. 00 |
| "Y" for yes or "N" for no in column 1. If yes, comple | | | | | IN | 03.00 |
| | | | Unwei ghted | | Ratio (col. 1/ (col. 1 + col. | |
| | | | FTEs Nonprovi der | FTEs in Hospital | 2)) | |
| | | | Si te | · | | |
| Section 5504 of the ACA Base Year FTE Residents in N | onprovi | der Settings | 1.00 This base year | 2.00 | 3.00 | |
| period that begins on or after July 1, 2009 and befo | | | , | | | |
| 64.00 Enter in column 1, if line 63 is yes, or your facili | | | 0.00 | 0. 00 | 0. 000000 | 64. 00 |
| in the base year period, the number of unweighted non resident FTEs attributable to rotations occurring in | | | | | | |
| settings. Enter in column 2 the number of unweighted | d non-pr | rimary care | | | | |
| resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see | | | | | | |
| 1-1 (30. diiii. 1 di 1. dad ay (30. diiii. 1) 30. diiii. 2)). (300 | | , | 1 | 1 | 1 | |

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0007 Peri od: Worksheet S-2 From 01/01/2019 Part I Date/Time Prepared: 12/31/2019 8/19/2020 2:00 pm Ratio (col. 3/ Program Name Program Code Unwei ghted Unwei ghted Ratio (col. (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0.000000 65.00 0. 00 0. 00 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ahted Unwei ghted Ratio (col. 3/ Program Code FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most Ν O N 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF 75.00 Ν subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most Ν Ν 0 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

| Health Financial Systems COMMUNITY HOWARD REGI HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0007 | Peri od: | u of Form CM Worksheet S | |
|--|---|----------------------------------|--------------------------------------|----------------|
| TOST THE AND HOST THE HEALTH GAIL GOING EEX TRENTTH GAIT ON DATA | 11 OVI del 1 Con. 13 Coo7 | From 01/01/2019 To 12/31/2019 | Part I Date/Time P 8/19/2020 2 | repared: |
| | | | 1. 00 | \dashv |
| Long Term Care Hospital PPS | | | | |
| 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes ar 81.00 Is this a LTCH co-located within another hospital for part or a "Y" for yes and "N" for no. | | g period? Enter | N N | 80. 0 81. 0 |
| TEFRA Providers 35.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TE 36.00 Did this facility establish a new Other subprovider (excluded u | | | N | 85. 0 86. 0 |
| §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 87.00 Is this hospital an extended neoplastic disease care hospital of the second of the | lassified under section | 1 | N | 87. C |
| 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. | | V | XI X | |
| | | 1.00 | 2. 00 | |
| Title V and XIX Services | | | .,, | |
| 90.00 Does this facility have title V and/or XIX inpatient hospital s yes or "N" for no in the applicable column. | | N | Y | 90.0 |
| P1.00 Is this hospital reimbursed for title V and/or XIX through the full or in part? Enter "Y" for yes or "N" for no in the application. | ıble column. | N | N | 91.0 |
| P2.00 Are title XIX NF patients occupying title XVIII SNF beds (dual instructions) Enter "Y" for yes or "N" for no in the applicable | | | N | 92.0 |
| 23.00 Does this facility operate an ICF/IID facility for purposes of "Y" for yes or "N" for no in the applicable column. | title V and XIX? Enter | N | N | 93. 0 |
| Does title V or XIX reduce capital cost? Enter "Y" for yes, and applicable column. | I"N" for no in the | N | N | 94. 0 |
| 05.00 If line 94 is "Y", enter the reduction percentage in the applic 06.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or | | 0. 00 N | 0. 00 N | 95. 0 96. 0 |
| applicable column. | | | | |
| 27.00 If line 96 is "Y", enter the reduction percentage in the applicate the stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for | ns and residents post | 0. 00 Y | 0. 00 N | 97. 0 98. 0 |
| column 1 for title V, and in column 2 for title XIX. 188.01 Does title V or XIX follow Medicare (title XVIII) for the repor C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title title XIX. | | | Υ | 98. 0 |
| Does title V or XIX follow Medicare (title XVIII) for the calcubed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "for title V, and in column 2 for title XIX. | | Y | Y | 98. 0 |
| 28.03 Does title V or XIX follow Medicare (title XVIII) for a critical reimbursed 101% of inpatient services cost? Enter "Y" for yes of for title V, and in column 2 for title XIX. | | | N | 98. 0 |
| 18.04 Does title V or XIX follow Medicare (title XVIII) for a CAH rei outpatient services cost? Enter "Y" for yes or "N" for no in co in column 2 for title XIX. | | N N | N | 98. 0 |
| 18.05 Does title V or XIX follow Medicare (title XVIII) and add back Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in colu column 2 for title XIX. | | | Y | 98. 0 |
| 8.06 Does title V or XIX follow Medicare (title XVIII) when cost rei Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 column 2 for title XIX. | | Y | Y | 98. 0 |
| Rural Providers 05.00 Does this hospital qualify as a CAH? | | N | | 105. 0 |
| 106.00 f this facility qualifies as a CAH, has it elected the all-inc for outpatient services? (see instructions) | lusive method of paymer | | | 106. 0 |
| 07.00 Column 1: If line 105 is Y, is this facility eligible for cost training programs? Enter "Y" for yes or "N" for no in column 1. Column 2: If column 1 is Y and line 70 or line 75 is Y, do you | (see instructions) ıtrain I&Rs in an | N | | 107.0 |
| approved medical education program in the CAH's excluded IPF a Enter "Y" for yes or "N" for no in column 2. (see instructions ON ONLY this a rural pospital qualifying for an exception to the CAH. | 5) | N | | 108 (|

| | Physi cal | Occupational | Speech | Respi ratory | |
|---|-----------|--------------|--------|--------------|---------|
| | 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. | N | N | N | N | 109. 00 |
| | | | | | |
| | | | | 1.00 | |

108.00

Ν

108.00 is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.

110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.

| Health Integration Project (FCHIP) demonstration for this cost reporting p "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, e integration prong of the FCHIP demo in which this CAH is participating in Enter all that apply: "A" for Ambulance services; "B" for additional beds; | enter the column 2. | | | |
|---|-----------------------------|--------|-----------|------------|
| for tele-health services. | | | | |
| | 1. 00 | 2. 00 | 3. 00 | |
| 2.00 Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable. | N | | | 112. |
| Miscellaneous Cost Reporting Information 5.00 s this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on | N | | | 0115. |
| the definition in CMS Pub.15-1, chapter 22, §2208.1. 6.00 s this facility classified as a referral center? Enter "Y" for yes or | N | | | 116. |
| "N" for no. 7.00 s this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no. | Y | | | 117. |
| 8.00 is the maipractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence. | 1 | | | 118. |
| | Premiums | Losses | Insurance | |
| | 1.00 | 2. 00 | 3. 00 | - |
| 8.01 List amounts of malpractice premiums and paid losses: | 578, 035 | 0 | | 0118 |
| | | 1. 00 | 2. 00 | - |
| 8.02 Are malpractice premiums and paid losses reported in a cost center other t Administrative and General? If yes, submit supporting schedule listing co and amounts contained therein. | | N | 2.00 | 118 |
| 9.00 DO NOT USE THIS LINE 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless prov §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instruction in column 2, "Y" for yes or "N" for no. | for yes or ne Outpatient | N | N | 119 120 |
| 1.00 Did this facility incur and report costs for high cost implantable devices patients? Enter "Y" for yes or "N" for no. | s charged to | Υ | | 121 |
| 2.00 Does the cost report contain healthcare related taxes as defined in §1903(Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included. | | N | | 122 |
| Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" yes, enter certification date(s) (mm/dd/yyyy) below. 6.00 If this is a Medicare certified kidney transplant center, enter the certifing in column 1 and termination date, if applicable, in column 2. | | N | | 125 |
| 7.00 f this is a Medicare certified heart transplant center, enter the certifi in column 1 and termination date, if applicable, in column 2. 8.00 f this is a Medicare certified liver transplant center, enter the certifi | | | | 127 |
| in column 1 and termination date, if applicable, in column 2. 9.00 If this is a Medicare certified lung transplant center, enter the certific column 1 and termination date, if applicable, in column 2. | | | | 129 |
| D.00 If this is a Medicare certified pancreas transplant center, enter the cert date in column 1 and termination date, if applicable, in column 2. | | | | 130 |
| 1.00 If this is a Medicare certified intestinal transplant center, enter the cedate in column 1 and termination date, if applicable, in column 2. 2.00 If this is a Medicare certified islet transplant center, enter the certifiant center. | | | | 131 |
| | | | | 133 |
| in column 1 and termination date, if applicable, in column 2. 3.00 Removed and reserved 4.00 f this is an organ procurement organization (OPO), enter the OPO number is | n column 1 | 1 | | 1,1,2,4 |
| | | Y | | 134 |

Health Financial Systems COMMUNITY HOWARD REGIONAL HEALTH In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0007 Peri od: Worksheet S-2 From 01/01/2019 Part I Date/Time Prepared: To 12/31/2019 8/19/2020 2:00 pm 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number
Name: COMMUNITY HEALTH NETWORK | Contractor's Name: WISCONSIN PHYSICIA 141 00 Name: Contractor's Name: WISCONSIN PHYSICIAN Contractor's Number: 08101 141 00 SERVI CES 142.00 Street: 1500 NORTH RITTER PO Box: 142.00 143.00 City: INDIANAPOLIS 46219-3095 State: ΙN Zip Code: 143.00 1.00 144.00 Are provider based physicians' costs included in Worksheet A? 144. 00 Υ 2.00 1.00 145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for 145.00 inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? 146, 00 Ν Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 147. 00 N 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. N 148.00 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no Ν 149.00 Part A Part B Title V Title XIX 1 00 2 00 3.00 4 00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal Ν Ν Ν N 155 00 156.00 Subprovi der - IPF 156. 00 Ν Ν Ν Ν 157.00 Subprovi der - IRF 157 00 Ν Ν Ν N 158. 00 SUBPROVI DER 158.00 159.00 SNF N Ν Ν N 159. 00 160.00 HOME HEALTH AGENCY 160.00 Ν Ν Ν Ν 161.00 CMHC Ν Ν Ν 161.00 1.00 Mul ti campus 165.00|Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Enter "Y" for yes or "N" for no. FTE/Campus Name County Zip Code **CBSA** State | 3.00 0 1.00 2 00 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) 1.00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.
168.00 if this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the 167.00 Υ 168.00 reasonable cost incurred for the HIT assets (see instructions) 168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions) 168.01 169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the 0.00169.00 transition factor. (see instructions) Begi nni ng Endi ng 1.00 2.00 170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting 170. 00 period respectively (mm/dd/yyyy) 1. 00 2.00 171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in 0 171. 00 Ν section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)

| | General Instruction: Enter Y for all YES responses. Enter N | for all NO re | esponses. Enter | all dates in | the | |
|-------|--|--|------------------|--------------|-------------|--------|
| | mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS | | | | | - |
| | Provider Organization and Operation | | | | | |
| . 00 | Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in co | | | N | | 1.00 |
| | | • | Y/N | Date | V/I | |
| | | | 1.00 | 2. 00 | 3. 00 | |
| . 00 | Has the provider terminated participation in the Medicare Pryes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary. | n 3, "V" for | N | | | 2.00 |
| 00 | Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions) | ffices, drug er or its f the board | N | | | 3.00 |
| | | | Y/N | Туре | Date | |
| | | | 1.00 | 2. 00 | 3. 00 | |
| | Financial Data and Reports | | | | | 4 |
| . 00 | Column 1: Were the financial statements prepared by a Certi Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date avai column 3. (see instructions) If no, see instructions. | or Compiled, ilable in | Y | А | 03/26/2020 | 4.00 |
| 00 | Are the cost report total expenses and total revenues differ those on the filed financial statements? If yes, submit reco | | N | | | 5.00 |
| | | | | Y/N | Legal Oper. | |
| | | | | 1. 00 | 2. 00 | |
| 00 | Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2: the Legal operator of the program? | | 6. 00 | | | |
| 00 | Are costs claimed for Allied Health Programs? If "Y" see ins | | 7. 00 | | | |
| 00 | Were nursing school and/or allied health programs approved a cost reporting period? If yes, see instructions. | | 8. 0 | | | |
| 00 | Are costs claimed for Interns and Residents in an approved g | N | | 9. 00 | | |
| 0. 00 | program in the current cost report? If yes, see instructions Was an approved Intern and Resident GME program initiated or cost reporting period? If yes, see instructions. | N | | 10.00 | | |
| . 00 | Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions. | & R in an App | oroved | N | | 11. 00 |
| | Treatming Tregram on workeness Tr. Tr. Yes, ess Their ustrano. | | | | Y/N | |
| | | | | | 1.00 | |
| | Bad Debts | | | | | |
| . 00 | Is the provider seeking reimbursement for bad debts? If yes, If line 12 is yes, did the provider's bad debt collection poperiod? If yes, submit copy. | | | t reporting | Y N | 12.00 |
| . 00 | If line 12 is yes, were patient deductibles and/or co-paymer Bed Complement | nts waived? If | f yes, see instr | ructi ons. | N | 14.00 |
| 5 00 | Did total beds available change from the prior cost reportir | ng neriod2 lf | ves see instru | ıctions | Y | 15. 00 |
| . 00 | pro total boas available change from the prior cost reporting | | rt A | | rt B | 10.00 |
| | | Y/N | Date | Y/N | Date | |
| | | 1.00 | 2.00 | 3. 00 | 4. 00 | |
| | PS&R Data | | | | | |
| .00 | Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) | N | | N | | 16. 0 |
| 00 | Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date | Υ | 06/26/2020 | Υ | 06/26/2020 | 17. 0 |
| | in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R | N | | N | | 18. 0 |
| 00 | Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. | | | | | |

| Heal th | Financial Systems COMMUNITY HOWARD | REGIONAL HEALT | Ή | In Lie | u of Form CMS | S-2552-10 | |
|---------|--|-----------------|----------------|--|---------------|-----------|--|
| | AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provi der C | CN: 15-0007 | Peri od: From 01/01/2019 To 12/31/2019 | | repared: | |
| | | | iption | Y/N | Y/N | | |
| | 1011 11 12 12 12 12 12 12 12 12 12 12 12 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 | | |
| 04.00 | Iw ii | 1.00 | 2. 00 | 3.00 | 4. 00 | 01.00 | |
| 21.00 | Was the cost report prepared only using the provider's records? If yes, see instructions. | N | | N | | 21. 00 | |
| | | | | | 1. 00 | | |
| | COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE | PT CHILDRENS H | lOSPI TALS) | | 1.00 | | |
| | Capital Related Cost | | Í | | | | |
| 22. 00 | Have assets been relifed for Medicare purposes? If yes, see | | | | N | 22. 00 | |
| 23. 00 | Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions. | due to apprais | 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 | ed into during | this cost re | porting period? | N | 24. 00 | |
| 25. 00 | Have there been new capitalized leases entered into during instructions. | the cost repor | rting period? | If yes, see | N | 25. 00 | |
| 26. 00 | Were assets subject to Sec. 2314 of DEFRA acquired during th | ne cost reporti | ng period? I | f yes, see | N | 26. 00 | |
| 27. 00 | instructions. Has the provider's capitalization policy changed during the | e cost reportir | ng period? If | yes, submit | N | 27. 00 | |
| | copy. Interest Expense | | | | | | |
| 28. 00 | Were new Loans, mortgage agreements or letters of credit er period? If yes, see instructions. | N | 28. 00 | | | | |
| 29. 00 | Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see instr | N | 29. 00 | | | | |
| 30. 00 | Has existing debt been replaced prior to its scheduled matu | N | 30. 00 | | | | |
| 31. 00 | instructions. Has debt been recalled before scheduled maturity without is | , see | N | 31. 00 | | | |
| | instructions. Purchased Services | | | | | | |
| 32. 00 | 2.00 Have changes or new agreements occurred in patient care services furnished through contractual | | | | | | |
| 33. 00 | arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app | | ng to competi | tive bidding? If | N | 33. 00 | |
| | no, see instructions. Provider-Based Physicians | | | | | | |
| 34.00 | Are services furnished at the provider facility under an ar If yes, see instructions. | rangement with | n provi der-ba | sed physi ci ans? | Υ | 34. 00 | |
| 35. 00 | If line 34 is yes, were there new agreements or amended exi | | nts with the | provi der-based | N | 35. 00 | |
| | physicians during the cost reporting period? If yes, see in | ISTRUCTIONS. | | Y/N | Date | | |
| | | | | 1. 00 | 2. 00 | | |
| | Home Office Costs | | | | | | |
| 36.00 | | | h 66' = | Y | | 36.00 | |
| 37. 00 | If line 36 is yes, has a home office cost statement been pr If yes, see instructions. | repared by the | home office? | Y | | 37. 00 | |
| 38. 00 | | fice different | from that of | N | | 38. 00 | |
| 39. 00 | 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 instructions. | home office? | If yes, see | | | 40. 00 | |
| | THIST UCTIONS. | | | | | | |
| | Cost Donort Droporor Contact Information | 1. | 00 | 2. | 00 | | |
| 41. 00 | Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position SHIRLEY BISHOP | | | | | | |
| 11.00 | held by the cost report preparer in columns 1, 2, and 3, respectively. | | | 51 31131 | | 41. 00 | |
| 42. 00 | Enter the employer/company name of the cost report | COMMUNITY HEAL | TH NETWORK | | | 42. 00 | |
| 43. 00 | l l | 317-355-4135 | | SBI SHOP@ECOMMUI | NITY. COM | 43. 00 | |
| | report preparer in columns 1 and 2, respectively. | I | | 1 | | II | |

| Heal th | Financial Systems COMMUNITY HOWARD | REGIONAL HEALTH | In Lie | eu of Form CMS-2 | 2552-10 |
|---------|--|------------------------|-----------------------------|--------------------------|----------------|
| HOSPI 7 | AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0007 | Peri od: From 01/01/2019 | Worksheet S-2 Part II | |
| | | | To 12/31/2019 | | pared: 0 pm |
| | | | | | |
| | | 3. 00 | | | |
| | Cost Report Preparer Contact Information | | | | |
| 41.00 | Enter the first name, last name and the title/position | DIRECTOR REIMBURSEMENT | | | 41.00 |
| | held by the cost report preparer in columns 1, 2, and 3, | | | | |
| | respecti vel y. | | | | |
| 42.00 | Enter the employer/company name of the cost report | | | | 42.00 |
| | preparer. | | | | |
| 43.00 | Enter the telephone number and email address of the cost | | | | 43.00 |
| | report preparer in columns 1 and 2, respectively. | | | | |

Health Financial Systems COMMUNITY FOR HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Peri od: | Worksheet S-3 | From 01/01/2019 | Part I | To 12/31/2019 | Date/Time Prepared: Provider CCN: 15-0007

| | | | | | 3 12/31/2019 | 8/19/2020 2:00 | |
|------------------|---|-------------|-------------|--------------|--------------|----------------|------------------|
| | | | <u> </u> | | | I/P Days / O/P | |
| | | | | | | Visits / Trips | |
| | Component | Worksheet A | No. of Beds | Bed Days | CAH Hours | Title V | |
| | · | Line Number | | Avai I abl e | | | |
| | | 1.00 | 2.00 | 3.00 | 4. 00 | 5. 00 | |
| 1.00 | Hospital Adults & Peds. (columns 5, 6, 7 and | 30. 00 | 104 | 37, 960 | 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 I RF Subprovi der | | | | | 0 | 4. 00 |
| 5. 00 6. 00 | Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF | | | | | | 5. 00 6. 00 |
| 7. 00 | Total Adults and Peds. (exclude observation | | 104 | 37, 960 | 0.00 | | 7. 00 |
| 7.00 | beds) (see instructions) | | 104 | 37, 900 | 0.00 | U | 7.00 |
| 8. 00 | INTENSIVE CARE UNIT | 31. 00 | 8 | 2, 920 | 0.00 | 0 | 8. 00 |
| 9. 00 | CORONARY CARE UNIT | 01.00 | J | 2, 720 | 0.00 | · · | 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 | 43. 00 | | | | O | 13. 00 |
| 14.00 | Total (see instructions) | | 112 | 40, 880 | 0.00 | 0 | 14.00 |
| 15.00 | CAH visits | | | · | | 0 | 15. 00 |
| 16.00 | SUBPROVIDER - IPF | | | | | | 16. 00 |
| 17.00 | SUBPROVI DER - I RF | | | | | | 17. 00 |
| 18.00 | SUBPROVI DER | | | | | | 18. 00 |
| 19. 00 | SKILLED NURSING FACILITY | | | | | | 19. 00 |
| 20.00 | NURSING FACILITY | | | | | | 20. 00 |
| 21. 00 | OTHER LONG TERM CARE | | | | | | 21. 00 |
| 22. 00 | HOME HEALTH AGENCY | | | | | | 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 | 00.00 | | | | | 26. 00 |
| 26. 25 | FEDERALLY QUALIFIED HEALTH CENTER | 89. 00 | 110 | | | 0 | |
| 27. 00 28. 00 | Total (sum of lines 14-26) | | 112 | | | 0 | 27. 00 28. 00 |
| 28.00 | Observation Bed Days Ambulance Trips | | | | | U | 28.00 |
| 30. 00 | Employee discount days (see instruction) | | | | | | 30.00 |
| 31. 00 | Employee discount days (see instruction) | | | | | | 31.00 |
| 32. 00 | Labor & delivery days (see instructions) | | 0 | 0 | | | 32. 00 |
| 32. 00 | Total ancillary labor & delivery room | | O | J | | | 32. 00 |
| JZ. U1 | outpatient days (see instructions) | | | | | | 32.01 |
| 33. 00 | LTCH non-covered days | | | | | | 33. 00 |
| | LTCH site neutral days and discharges | | | | | | 33. 01 |
| | , | ' | ' | ' | | ' | • |

Health Financial Systems COMMUNITY HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0007

| | | | | | | 8/19/2020 2:0 | O pm |
|--------|--|-------------|--------------|-----------------------|------------------------------|-------------------------|--------|
| | | I/P Days | / O/P Visits | / Trips | Full Time | Equi val ents | |
| | Component | Title XVIII | Title XIX | Total All Patients | Total Interns & Residents | Employees On Payroll | |
| | | 6.00 | 7. 00 | 8. 00 | 9. 00 | 10.00 | |
| 1.00 | Hospital Adults & Peds. (columns 5, 6, 7 and | 6, 057 | 1, 109 | 16, 770 | | | 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, 369 | 3, 805 | | | | 2. 00 |
| 3.00 | HMO IPF Subprovider | 0 | 0 | | | | 3. 00 |
| 4.00 | HMO IRF Subprovider | 0 | 0 | | | | 4. 00 |
| 5.00 | Hospital Adults & Peds. Swing Bed SNF | 0 | 0 | 0 | | | 5. 00 |
| 6.00 | Hospital Adults & Peds. Swing Bed NF | | 0 | 0 | | | 6. 00 |
| 7.00 | Total Adults and Peds. (exclude observation | 6, 057 | 1, 109 | 16, 770 | | | 7. 00 |
| | beds) (see instructions) | | | | | | |
| 8.00 | INTENSIVE CARE UNIT | 624 | 0 | 1, 469 | | | 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 | | 591 | 834 | | | 13. 00 |
| 14. 00 | Total (see instructions) | 6, 681 | 1, 700 | 19, 073 | 0.00 | 665. 81 | |
| 15. 00 | CAH visits | 0 | 0 | 0 | | | 15. 00 |
| 16. 00 | SUBPROVI DER - I PF | | | | | | 16. 00 |
| 17. 00 | SUBPROVI DER - I RF | | | | | | 17. 00 |
| 18. 00 | SUBPROVI DER | | | | | | 18. 00 |
| 19. 00 | SKILLED NURSING FACILITY | | | | | | 19. 00 |
| 20. 00 | NURSING FACILITY | | | | | | 20. 00 |
| 21. 00 | OTHER LONG TERM CARE | | | | | | 21. 00 |
| 22. 00 | | | | | | | 22. 00 |
| 23. 00 | AMBULATORY SURGICAL CENTER (D. P.) | | | | | | 23. 00 |
| 24. 00 | HOSPI CE | | | | | | 24. 00 |
| 24. 10 | HOSPICE (non-distinct part) | | | 21 | | | 24. 10 |
| 25. 00 | CMHC - CMHC | | | | | | 25. 00 |
| 26. 00 | RURAL HEALTH CLINIC | | | | | | 26. 00 |
| 26. 25 | FEDERALLY QUALIFIED HEALTH CENTER | 0 | 0 | 0 | | | |
| 27. 00 | , | | | | 0.00 | 665. 81 | |
| 28. 00 | Observation Bed Days | | 540 | 2, 512 | | | 28. 00 |
| 29. 00 | P. C. | 5 | | | | | 29. 00 |
| 30. 00 | | | | 105 | | | 30. 00 |
| | Employee discount days - IRF | | | 0 | | | 31. 00 |
| 32. 00 | Labor & delivery days (see instructions) | 0 | 4 | 117 | | | 32. 00 |
| 32. 01 | Total ancillary labor & delivery room | | | 0 | | | 32. 01 |
| | outpatient days (see instructions) | | | | | | |
| 33. 00 | | 0 | | | | | 33. 00 |
| 33. 01 | LTCH site neutral days and discharges | 0 | | | | | 33. 01 |
| | | | | | | | |

Health Financial Systems COMMUNITY F
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0007

Peri od: Worksheet S-3
From 01/01/2019 Part I
To 12/31/2019 Date/Time Prepared: 8/19/2020 2: 00 pm

| | | | | | | 8/19/2020 2:0 | Opm |
|--|---|--------------------------|---------|-------------|---------------|-----------------------|--|
| | | Full Time Equivalents | | Di sch | arges | | |
| | Component | Nonpai d Workers | Title V | Title XVIII | Title XIX | Total All Patients | |
| | | 11. 00 | 12.00 | 13. 00 | 14. 00 | 15. 00 | |
| 1. 00 | Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) | | (| | 247 | 4, 953 | 1.00 |
| 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 | HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) | | | 577 | 938 0 0 | | 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 |
| 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 | INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY | | | | | | 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 |
| 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 24. 00 24. 10 25. 00 26. 00 | Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC | 0.00 | C | 1, 672 | 247 | 4, 953 | 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 24. 10 25. 00 26. 00 |
| 26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01 | Employee discount days - IRF | 0. 00 0. 00 | | 0 | | | 26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01 33. 00 33. 01 |

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0007

| Peri od: | Worksheet S-3 | From 01/01/2019 | Part II | To 12/31/2019 | Date/Time Prepared:

| | | | | | T | o 12/31/2019 | Date/Time Pre 8/19/2020 2:0 | |
|------------------|--|------------------------|--------------------|----------------------------------|-------------------------|--------------------------|----------------------------------|------------------|
| | | Wkst. A Line Number | Amount Reported | Reclassificati on of Salaries | Adj usted Sal ari es | Paid Hours Related to | Average Hourly Wage (col. 4 ÷ | |
| | | Namber | Ropor tou | (from Wkst. | (col.2 ± col. | Salaries in | col . 5) | |
| | | 1. 00 | 2. 00 | A-6) 3.00 | 3) 4. 00 | col . 4 5. 00 | 6. 00 | |
| | PART II - WAGE DATA SALARIES | | | | | | | - |
| 1.00 | Total salaries (see | 200. 00 | 44, 647, 988 | -204, 847 | 44, 443, 141 | 1, 384, 883. 00 | 32. 09 | 1.00 |
| 2. 00 | instructions) Non-physician anesthetist Part | | C | 0 | 0 | 0.00 | 0. 00 | 2. 00 |
| 3. 00 | A Non-physician anesthetist Part | | C | 0 | 0 | 0. 00 | 0. 00 | 3. 00 |
| 4. 00 | B Physician-Part A - | | 168, 990 | 0 | 168, 990 | 1, 140. 00 | 148. 24 | 4. 00 |
| 4. 01 5. 00 | Administrative Physicians - Part A - Teaching Physician and Non | | C 344, 134 | 0 | 0 344, 134 | 0. 00 4, 813. 00 | | |
| 6. 00 | Physician-Part B Non-physician-Part B for hospital-based RHC and FQHC | | C | 0 | 0 | 0.00 | 0.00 | 6. 00 |
| 7. 00 | services Interns & residents (in an approved program) | 21. 00 | C | 0 | 0 | 0.00 | 0. 00 | 7. 00 |
| 7. 01 | Contracted interns and residents (in an approved | | C | 0 | 0 | 0.00 | 0.00 | 7. 01 |
| 8. 00 | programs) Home office and/or related organization personnel | | C | 0 | 0 | 0.00 | 0. 00 | 8. 00 |
| 9. 00 10. 00 | SNF Excluded area salaries (see | 44. 00 | 5, 520, 310 | 0 308, 063 | 0 5, 828, 373 | 0. 00 211, 432. 00 | l . | |
| | instructions) OTHER WAGES & RELATED COSTS | | | | | | | |
| 11. 00 | Contract Labor: Direct Patient Care | | 1, 685, 151 | 0 | 1, 685, 151 | | | |
| 12. 00 | Contract labor: Top level management and other management and administrative services | | C | 0 | 0 | 0. 00 | 0.00 | 12.00 |
| 13. 00 | Contract Labor: Physician-Part A - Administrative | | 509, 149 | 0 | 509, 149 | 6, 828. 00 | 74. 57 | 13. 00 |
| 14. 00 | Home office and/or related organization salaries and wage-related costs | | C | О | О | 0.00 | 0.00 | 14. 00 |
| 14. 01 | Home office salaries | | 8, 537, 031 | 0 | 8, 537, 031 | 223, 346. 00 | 38. 22 | 14. 01 |
| 14. 02 15. 00 | Related organization salaries Home office: Physician Part A | | C | 0 | 0 | 0. 00 0. 00 | | 1 |
| 16. 00 | - Administrative Home office and Contract | | C | 0 | 0 | 0. 00 | | |
| | Physicians Part A - Teaching Home office Physicians Part A | | | | | | | 16. 01 |
| 16. 01 | - Teachi ng | | | 0 | 0 | 0.00 | | |
| 16. 02 | Home office contract Physicians Part A - Teaching WAGE-RELATED COSTS | | C | 0 | 0 | 0.00 | 0.00 | 16. 02 |
| 17. 00 | Wage-related costs (core) (see instructions) | | 9, 309, 844 | 0 | 9, 309, 844 | | | 17. 00 |
| 18. 00 | Wage-related costs (other) (see instructions) | | | | | | | 18. 00 |
| 19. 00 20. 00 | Excluded areas Non-physician anesthetist Part | | 1, 609, 560 0 | 0 | 1, 609, 560 0 | | | 19. 00 20. 00 |
| 21. 00 | A Non-physician anesthetist Part | | C | 0 | 0 | | | 21. 00 |
| 22. 00 | Physician Part A - Administrative | | 11, 632 | 0 | 11, 632 | | | 22. 00 |
| 22. 01 23. 00 | Physician Part A - Teaching Physician Part B | | 49, 110 | 0 | 0 49, 110 | | | 22. 01 23. 00 |
| 24. 00 25. 00 | Wage-related costs (RHC/FQHC) Interns & residents (in an | | C | 0 | 0 | | | 24. 00 25. 00 |
| 25. 50 | approved program) Home office wage-related (core) | | 2, 225, 016 | О | 2, 225, 016 | | | 25. 50 |
| 25. 51 | Related organization wage-related (core) | | C | 0 | 0 | | | 25. 51 |
| 25. 52 | Home office: Physician Part A - Administrative - wage-related (core) | | C | 0 | 0 | | | 25. 52 |

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0007

| | | | | | Т | o 12/31/2019 | Date/Time Pre 8/19/2020 2:0 | |
|--------|--|--------------|-------------|-------------------|---------------|--------------|--------------------------------|--------|
| | | Wkst. A Line | Amount | Recl assi fi cati | Adj usted | Pai d Hours | Average Hourly | |
| | | Number | Reported | on of Salaries | Sal ari es | Related to | Wage (col. 4 ÷ | |
| | | | | (from Wkst. | (col.2 ± col. | Salaries in | col. 5) | |
| | | | | A-6) | 3) | col. 4 | | |
| | | 1. 00 | 2. 00 | 3.00 | 4. 00 | 5. 00 | 6. 00 | |
| 25. 53 | Home office: Physicians Part A | | 0 | 0 | 0 | | | 25. 53 |
| | - Teaching - wage-related | | | | | | | |
| | (core) | | | | | | | |
| | OVERHEAD COSTS - DIRECT SALARIE | | 1/0 5/0 | | 1.05.0 | | | |
| 26. 00 | Employee Benefits Department | 4. 00 | 160, 560 | | 160, 560 | | | 26. 00 |
| 27. 00 | Administrative & General | 5. 00 | 4, 511, 713 | | | · | | 27. 00 |
| 28. 00 | Administrative & General under | | 3, 015, 937 | 0 | 3, 015, 937 | 32, 787. 00 | 91. 99 | 28. 00 |
| 00.00 | contract (see inst.) | , 00 | | | | 0.00 | 0.00 | 00.00 |
| 29. 00 | Maintenance & Repairs | 6. 00 | 4 557 004 | 10 00/ | 4 540 440 | 0.00 | | 29. 00 |
| 30.00 | Operation of Plant | 7. 00 | 1, 556, 284 | | | · | | |
| 31.00 | Laundry & Linen Service | 8. 00 | 90, 190 | | 90, 190 | · | | |
| 32.00 | Housekeepi ng | 9. 00 | 1, 024, 639 | -6, 084 | 1, 018, 555 | · | | |
| 33. 00 | Housekeeping under contract (see instructions) | | 0 | 0 | | 0.00 | 0.00 | 33. 00 |
| 34.00 | Di etary | 10. 00 | 944, 853 | -595, 359 | 349, 494 | 26, 471. 00 | 13. 20 | 34.00 |
| 35. 00 | Di etary under contract (see instructions) | | 125, 695 | 0 | 125, 695 | 2, 080. 00 | 60. 43 | 35. 00 |
| 36.00 | Cafeteri a | 11. 00 | 0 | 595, 257 | 595, 257 | 31, 376. 00 | 18. 97 | 36. 00 |
| 37.00 | Maintenance of Personnel | 12. 00 | 0 | 0 | 0 | 0.00 | 0.00 | 37. 00 |
| 38.00 | Nursing Administration | 13. 00 | 873, 155 | -1, 261 | 871, 894 | 24, 441. 00 | 35. 67 | 38. 00 |
| 39.00 | Central Services and Supply | 14. 00 | 0 | 0 | 0 | 0.00 | 0.00 | 39. 00 |
| 40.00 | Pharmacy | 15. 00 | 0 | 0 | 0 | 0.00 | 0.00 | 40. 00 |
| 41.00 | Medical Records & Medical | 16. 00 | 0 | 0 | 0 | 0.00 | 0.00 | 41. 00 |
| | Records Library | | | | | | | |
| 42.00 | Social Service | 17. 00 | 525, 734 | 0 | 525, 734 | 13, 640. 00 | 38. 54 | 42. 00 |
| 43.00 | Other General Service | 18. 00 | 0 | 0 | 0 | 0.00 | 0.00 | 43.00 |

Total overhead cost (see

instructions)

7.00

35. 10

7.00

HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0007 Worksheet S-3 Peri od: From 01/01/2019 To 12/31/2019 Part III Date/Time Prepared: 8/19/2020 2:00 pm 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 . (from Salaries in col . 5) 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 47, 445, 486 -204, 847 47, 240, 639 1, 414, 937. 00 33. 39 1.00 instructions) 2.00 5, 520, 310 308, 063 5, 828, 373 211, 432.00 27.57 2.00 Excluded area salaries (see instructions) 3.00 Subtotal salaries (line 1 41, 925, 176 -512, 910 41, 412, 266 1, 203, 505. 00 34.41 3.00 minus line 2) 4.00 Subtotal other wages & related 10, 731, 331 10, 731, 331 253, 860.00 42. 27 4.00 costs (see inst.) Subtotal wage-related costs 27.88 5.00 11, 546, 492 Ω 11, 546, 492 0.00 5.00 (see inst.) Total (sum of lines 3 thru 5) 6.00 6.00 64, 202, 999 -512, 910 63, 690, 089 1, 457, 365. 00 43 70

-206, 624

12, 622, 136

359, 600. 00

12, 828, 760

| Peri od: | Worksheet S-3 | From 01/01/2019 | Part IV | To 12/31/2019 | Date/Time Prepared:

| | 10 12/31/2019 | 8/19/2020 2:00 | |
|--------|---|----------------|--------|
| | | Amount | |
| | | Reported | |
| | | 1. 00 | |
| | PART IV - WAGE RELATED COSTS | | |
| | Part A - Core List | | |
| | RETI REMENT COST | | |
| 1.00 | 401K Employer Contributions | 1, 491, 150 | 1. 00 |
| 2.00 | Tax Sheltered Annuity (TSA) Employer Contribution | 0 | 2. 00 |
| 3.00 | Nonqualified Defined Benefit Plan Cost (see instructions) | 0 | 3. 00 |
| 4.00 | Qualified Defined Benefit Plan Cost (see instructions) | 0 | 4. 00 |
| | PLAN ADMINISTRATIVE COSTS (Paid to External Organization) | | |
| 5.00 | 401K/TSA Plan Administration fees | 0 | 5. 00 |
| 6.00 | Legal /Accounting/Management Fees-Pension Plan | 0 | 6. 00 |
| 7.00 | Employee Managed Care Program Administration Fees | 0 | 7. 00 |
| | HEALTH AND INSURANCE COST | | |
| 8.00 | Health Insurance (Purchased or Self Funded) | 0 | 8. 00 |
| 8. 01 | Health Insurance (Self Funded without a Third Party Administrator) | 0 | 8. 01 |
| 8. 02 | Health Insurance (Self Funded with a Third Party Administrator) | 4, 588, 287 | 8. 02 |
| 8. 03 | Health Insurance (Purchased) | 0 | 8. 03 |
| 9.00 | Prescription Drug Plan | 1, 173, 943 | 9. 00 |
| 10.00 | Dental, Hearing and Vision Plan | 45, 636 | 10.00 |
| 11. 00 | Life Insurance (If employee is owner or beneficiary) | 25, 784 | 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) | 330, 134 | 13. 00 |
| 14. 00 | Long-Term Care Insurance (If employee is owner or beneficiary) | 0 | 14. 00 |
| 15. 00 | | 99, 745 | 15. 00 |
| 16. 00 | Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. | 0 | 16, 00 |
| | Non cumulative portion) | | |
| | TAXES | | |
| 17.00 | FICA-Employers Portion Only | 3, 160, 163 | 17. 00 |
| 18.00 | Medicare Taxes - Employers Portion Only | 0 | 18. 00 |
| 19.00 | Unemployment Insurance | 0 | 19. 00 |
| 20.00 | State or Federal Unemployment Taxes | 0 | 20.00 |
| | OTHER | | |
| 21. 00 | Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see | 0 | 21. 00 |
| | instructions)) | | |
| 22. 00 | Day Care Cost and Allowances | 0 | 22. 00 |
| 23.00 | Tuition Reimbursement | 65, 304 | 23. 00 |
| 24.00 | Total Wage Related cost (Sum of lines 1 -23) | 10, 980, 146 | 24. 00 |
| | Part B - Other than Core Related Cost | | |
| 25. 00 | OTHER WAGE RELATED COSTS (SPECIFY) | | 25. 00 |
| | | · | |

| Health Financial Systems | COMMUNITY HOWARD REGIONAL HEALTH | In Lie | u of Form CMS-2552-10 |
|--|----------------------------------|-----------------|--|
| HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provi der CCN: 15-0007 | From 01/01/2019 | Worksheet S-3 Part V Date/Time Prepared: |

| | | 0 12/31/2019 | 8/19/2020 2: 00 | |
|--------|---|----------------|-----------------|----------|
| | Cost Center Description | Contract Labor | | <u>Б</u> |
| | | 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 | 1, 685, 151 | 10, 980, 146 | 1.00 |
| 2.00 | Hospi tal | 1, 685, 151 | 9, 370, 586 | 2.00 |
| 3.00 | Subprovi der - I PF | | | 3.00 |
| 4.00 | Subprovi der - I RF | | | 4.00 |
| 5.00 | Subprovi der - (Other) | 0 | 0 | 5.00 |
| 6.00 | Swing Beds - SNF | 0 | 0 | 6.00 |
| 7.00 | Swing Beds - NF | 0 | 0 | 7.00 |
| 8.00 | Hospi tal -Based SNF | | | 8.00 |
| 9.00 | Hospi tal -Based NF | | | 9. 00 |
| 10.00 | Hospi tal -Based OLTC | | | 10.00 |
| 11. 00 | Hospi tal -Based HHA | | | 11. 00 |
| 12.00 | Separately Certified ASC | | | 12.00 |
| 13.00 | Hospi tal -Based Hospi ce | | | 13.00 |
| 14.00 | Hospital-Based Health Clinic RHC | | | 14.00 |
| 15.00 | Hospital-Based Health Clinic FQHC | | | 15.00 |
| 16.00 | Hospi tal -Based-CMHC | | | 16.00 |
| 17. 00 | Renal Di al ysi s | 0 | 0 | 17.00 |
| 18. 00 | Other | 0 | 1, 609, 560 | 18.00 |

| Heal th | Financial Systems COMMUNITY HOWARD REGIO | ONAL HEALTH | | In Li∈ | eu of Form CMS-2 | 2552-10 |
|------------------|--|---------------|------------------|----------------------------------|----------------------|------------------|
| HOSPI T | AL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CC | N: 15-0007 | Peri od: | Worksheet S-1 | 0 |
| | | | | From 01/01/2019 To 12/31/2019 | Date/Time Pre | pared. |
| | | | | | 8/19/2020 2:0 | |
| | | | | | 1. 00 | |
| | Uncompensated and indigent care cost computation | | | | | |
| 1.00 | Cost to charge ratio (Worksheet C, Part I line 202 column 3 div | ided by lir | ie 202 column | 8) | 0. 194400 | 1. 00 |
| 2. 00 | Medicaid (see instructions for each line) Net revenue from Medicaid | | | | 29, 519, 794 | 2.00 |
| 3.00 | Did you receive DSH or supplemental payments from Medicaid? | | | | Υ Υ | 3.00 |
| 4.00 | If line 3 is yes, does line 2 include all DSH and/or supplement | al payments | from Medica | i d? | Y | 4. 00 |
| 5.00 | If line 4 is no, then enter DSH and/or supplemental payments fr | om Medicaic | l | | 0 | 5. 00 |
| 6. 00 | Medi cai d charges | | | | 93, 754, 320 | 6.00 |
| 7.00 | Medicaid cost (line 1 times line 6) | lina 7 min | o oum of lin | oo 2 and E. if | 18, 225, 840 | |
| 8. 00 | Difference between net revenue and costs for Medicaid program (< zero then enter zero) | iine / minc | is suill of fif | es 2 and 5; 11 | 0 | 8. 00 |
| | Children's Health Insurance Program (CHIP) (see instructions for | r each line |) | | | |
| 9.00 | Net revenue from stand-alone CHIP | | | | 0 | 9. 00 |
| 10.00 | Stand-alone CHIP charges | | | | 0 | 10.00 |
| 11. 00 12. 00 | Stand-alone CHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone CHIP (| lino 11 min | uc lino Oci | f . zoro thon | 0 | 11. 00 12. 00 |
| 12.00 | enter zero) | iiile ii iiii | ius IIIIe 9, I | i < Zero trien | 0 | 12.00 |
| | Other state or local government indigent care program (see inst | ructions fo | r each line) | | | |
| 13.00 | Net revenue from state or local indigent care program (Not incl | | |) | 0 | 13. 00 |
| 14. 00 | Charges for patients covered under state or local indigent care | program (N | lot included | in lines 6 or | 0 | 14. 00 |
| 15 00 | 10) | ` | | | | 15 00 |
| 15. 00 16. 00 | State or local indigent care program cost (line 1 times line 14 Difference between net revenue and costs for state or local ind | | program (lir | a 15 minus lina | 0 | 15. 00 16. 00 |
| 10.00 | 13; if < zero then enter zero) | rgent care | program (iii | e is illinus iine | | 10.00 |
| | Grants, donations and total unreimbursed cost for Medicaid, CHII | P and state | /local indig | ent care progra | ms (see | |
| 17 00 | Instructions for each line) Private grants, donations, or endowment income restricted to fu | ndina obosi | +14 0000 | | 0 | 17. 00 |
| 17. 00 18. 00 | Government grants, appropriations or transfers for support of h | J | , | | 0 | 18.00 |
| 19. 00 | Total unreimbursed cost for Medicaid , CHIP and state and local | | | (sum of lines | Ö | 19.00 |
| | 8, 12 and 16) | | | ` | | |
| | | | Uni nsured | Insured | Total (col. 1 | |
| | | - | patients 1.00 | pati ents 2.00 | + col . 2) 3.00 | |
| | Uncompensated Care (see instructions for each line) | | 1.00 | 2.00 | 3.00 | |
| 20. 00 | Charity care charges and uninsured discounts for the entire fac | ility | 6, 881, 39 | 7 811, 853 | 7, 693, 250 | 20. 00 |
| 21. 00 | (see instructions) Cost of patients approved for charity care and uninsured discou | nts (see | 1, 337, 74 | 4 811, 853 | 2, 149, 597 | 21. 00 |
| 21.00 | instructions) | 1113 (366 | 1, 337, 75 | 4 011,033 | 2, 147, 377 | 21.00 |
| 22. 00 | Payments received from patients for amounts previously written | off as | | 0 0 | 0 | 22. 00 |
| 23. 00 | charity care Cost of charity care (line 21 minus line 22) | | 1, 337, 74 | 4 811, 853 | 2, 149, 597 | 23 00 |
| 23.00 | cost of charity care (fille 21 millius fille 22) | | 1, 337, 72 | 4 011,000 | 2, 147, 377 | 23.00 |
| | | | | | 1. 00 | |
| 24. 00 | Does the amount on line 20 column 2, include charges for patien | | nd a Length | of stay limit | N | 24. 00 |
| 25. 00 | imposed on patients covered by Medicaid or other indigent care If line 24 is yes, enter the charges for patient days beyond th | | care program | 's length of | 0 | 25. 00 |
| 0/ 05 | stay limit | | | | | 0, 55 |
| 26. 00 | Total bad debt expense for the entire hospital complex (see ins | , | ruoti ons) | | 714, 047 | 1 |
| 27. 00 27. 01 | Medicare reimbursable bad debts for the entire hospital complex Medicare allowable bad debts for the entire hospital complex (s | • | | | 278, 092 427, 834 | 1 |
| 28. 00 | Non-Medicare bad debt expense (see instructions) | ee matruct | 1 0115) | | 286, 213 | 1 |
| 29. 00 | Cost of non-Medicare and non-reimbursable Medicare bad debt exp | ense (see i | nstructi ons) | | 205, 382 | 1 |
| | Cost of uncompensated care (line 23 column 3 plus line 29) | | , | | 2, 354, 979 | 1 |
| 31. 00 | Total unreimbursed and uncompensated care cost (line 19 plus li | ne 30) | | | 2, 354, 979 | 31.00 |
| | | | | | | |

| | Financial Systems CON SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF | MMUNITY HOWARD R | Provider C | | eriod: | u of Form CMS-: Worksheet A | 2552-10 |
|------------------|--|-----------------------------|---|---------------|-------------------|--------------------------------|--------------------|
| RECLAS | STITICATION AND ADJUSTMENTS OF TRIAL BALANCE OF | F EXPENSES | Provider Co | F | rom 01/01/2019 | | |
| | | | | Ţ | o 12/31/2019 | Date/Time Pre 8/19/2020 2:0 | pared: |
| | Cost Center Description | Sal ari es | Other | Total (col. 1 | Recl assi fi cati | Reclassi fi ed | D DIII |
| | ' | | | + col . 2) | ons (See A-6) | Trial Balance | |
| | | | | | | (col. 3 +- | |
| | | 1.00 | 2.00 | 2 00 | 4.00 | col . 4) 5.00 | |
| | GENERAL SERVICE COST CENTERS | 1.00 | 2. 00 | 3.00 | 4. 00 | 5.00 | _ |
| 1.00 | 00100 CAP REL COSTS-BLDG & FIXT | | 0 | 0 | 4, 180, 342 | 4, 180, 342 | 1.00 |
| 2.00 | 00200 CAP REL COSTS-MVBLE EQUIP | | 0 | 0 | | 2, 667, 647 | 1 |
| 3.00 | 00300 OTHER CAP REL COSTS | | 0 | 0 | 0 | 0 | |
| 4. 00 5. 00 | 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL | 160, 560 4, 511, 713 | 201, 612 48, 871, 676 | | | 314, 134 | 1 |
| 7. 00 | 00700 OPERATION OF PLANT | 1, 556, 284 | 6, 916, 153 | | | 49, 364, 066 7, 118, 141 | |
| 8.00 | 00800 LAUNDRY & LINEN SERVICE | 90, 190 | 304, 426 | | | 387, 122 | 1 |
| 9.00 | 00900 HOUSEKEEPI NG | 1, 024, 639 | 964, 897 | 1, 989, 536 | -27, 098 | 1, 962, 438 | 9. 00 |
| 10.00 | 01000 DI ETARY | 944, 853 | 998, 386 | | | 629, 106 | 1 |
| 11. 00 13. 00 | 01100 CAFETERIA 01300 NURSI NG ADMINI STRATI ON | 0 873, 155 | 3, 233 295, 684 | | | 1, 227, 353 1, 068, 951 | 1 |
| 16. 00 | 01600 MEDICAL RECORDS & LIBRARY | 0/3, 133 | 295, 004 | 1, 100, 639 | -99, 000 0 | 1,000,931 | 1 |
| 17. 00 | 01700 SOCIAL SERVICE | 525, 734 | 102, 074 | 627, 808 | o | 627, 808 | 1 |
| 19. 00 | 01900 NONPHYSICIAN ANESTHETISTS | 0 | 0 | 0 | 0 | 0 | 1 |
| 23. 00 | 02300 PASTORAL CARE | 288, 901 | 81, 601 | 370, 502 | -161, 019 | 209, 483 | 23. 00 |
| 20.00 | I NPATI ENT ROUTI NE SERVI CE COST CENTERS | 10 114 205 | 4, 628, 529 | 14 744 024 | -2, 000, 127 | 12 744 707 | 30.00 |
| 30. 00 31. 00 | 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT | 10, 116, 395 1, 277, 454 | 718, 259 | | | 12, 744, 797 1, 840, 665 | |
| 43. 00 | 1 1 | 0 | 0 | | | | |
| | ANCILLARY SERVICE COST CENTERS | | | | | | 1 |
| 50.00 | 05000 OPERATING ROOM | 2, 719, 903 | 11, 128, 288 | 13, 848, 191 | | 5, 830, 180 | 1 |
| 52.00 | 05200 DELIVERY ROOM & LABOR ROOM | 0 | 0 | 0 | 935, 113 | 935, 113 0 | 1 |
| 53. 00 54. 00 | 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C | 1, 653, 276 | 1, 549, 208 | 3, 202, 484 | -641, 195 | 2, 561, 289 | 1 |
| 54. 01 | 03480 ONCOLOGY | 1, 408, 294 | 2, 270, 843 | | | 4, 138, 946 | |
| 57. 00 | 05700 CT SCAN | 492, 514 | 503, 336 | 995, 850 | | 826, 485 | |
| 58. 00 | 05800 MRI | 391, 224 | 993, 070 | | | 988, 516 | 1 |
| 59.00 | 05900 CARDI AC CATHETERI ZATI ON | 702, 298 | 3, 430, 081 | | | 1, 037, 593 | 1 |
| 60. 00 63. 00 | 06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS. | 0 | 4, 725, 314 | 4, 725, 314 | -8, 233 | 4, 717, 081 0 | 1 |
| 65. 00 | 06500 RESPIRATORY THERAPY | 1, 200, 254 | 495, 578 | 1, 695, 832 | -98, 359 | 1, 597, 473 | |
| 66. 00 | 06600 PHYSI CAL THERAPY | 736, 406 | 240, 994 | 977, 400 | -406, 688 | 570, 712 | 66. 00 |
| 67. 00 | 06700 OCCUPATI ONAL THERAPY | 0 | 0 | | | 310, 198 | 1 |
| 68. 00 69. 00 | 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY | 951, 489 | 460 464, 137 | • | | 84, 125 1, 389, 769 | 1 |
| 70. 00 | 07000 ELECTROENCEPHALOGRAPHY | 27, 131 | 31, 361 | | | 38, 145 | 1 |
| 71. 00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 0 | 683, 398 | 683, 398 | 4, 739, 571 | 5, 422, 969 | 71. 00 |
| 72. 00 | 07200 I MPL. DEV. CHARGED TO PATIENTS | 0 | 0 | 0 | -, , | 6, 815, 633 | |
| 73. 00 74. 00 | 07300 DRUGS CHARGED TO PATIENTS | 2, 139, 661 | 14, 289, 746 | | | 16, 472, 994 298, 311 | |
| | 07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART) | | 300, 076 0 | 300, 076 | -1, 765 0 | 290, 311 | 1 |
| | 03950 WOUND CARE CENTER | 383, 689 | 306, 008 | 689, 697 | -78, 397 | 611, 300 | |
| 76. 00 | 03160 CARDI OPULMONARY | 158, 294 | 59, 305 | 217, 599 | -1, 703 | 215, 896 | 76. 00 |
| 01 00 | OUTPATIENT SERVICE COST CENTERS | 2 550 404 | 1, 616, 399 | 4 1// 003 | 270 504 | 2 000 210 | 01 00 |
| 91. 00 92. 00 | 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART | 2, 550, 404 | 1, 010, 399 | 4, 166, 803 | -278, 584 | 3, 888, 219 | 91. 00 92. 00 |
| 92. 01 | 09201 OBSERVATION BEDS (DISTINCT PART) | o | 0 | О | 0 | 0 | 1 |
| | 04950 OTHER OUTPATIENT SERVICES | O | 0 | 0 | 0 | 0 | |
| 93. 01 | 04951 GENESI S | 1, 167, 705 | 417, 907 | 1, 585, 612 | 798, 617 | 2, 384, 229 | |
| 93. 02 93. 03 | 04952 WOMEN' S CENTER 04953 RESI DENTI AL HOMES | 0 | 0 | 0 | 0 | 0 | |
| 93. 04 | 04954 DR. STEELE | 0 | 0 | 0 | 0 | 0 | 1 |
| 93. 05 | 04955 DI ABETI C EDUCATI ON | o | 0 | Ō | 0 | 0 | 1 |
| 93. 06 | 04956 HOWARD COUNTY CSS | 488, 010 | 352, 589 | | | 900, 999 | |
| 93. 07 | 04957 CLINTON COUNTY | 315, 207 | 186, 429 | | | 586, 859 | |
| 93. 18 | 04968 PSYCH MEDICATION 04993 NEW BEGINNINGS | 527, 637 33, 305 | 172, 477 71, 510 | | | 0 106, 166 | |
| 73. 43 | OTHER REIMBURSABLE COST CENTERS | 33, 303 | 71, 310 | 104, 813 | 1, 351 | 100, 100 | 73.43 |
| 95.00 | 09500 AMBULANCE SERVICES | 1, 191, 999 | 821, 617 | 2, 013, 616 | -181, 990 | 1, 831, 626 | 95. 00 |
| | SPECIAL PURPOSE COST CENTERS | | | 1 | I al | | |
| | 11300 INTEREST EXPENSE 11400 UTILIZATION REVIEW - SNF | | 0 | 0 | 0 | | 113. 00 114. 00 |
| 118. 00 | 1 1 | 40, 608, 578 | 109, 196, 661 | 149, 805, 239 | -586, 997 | | |
| | NONREI MBURSABLE COST CENTERS | | , | | | | |
| | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | 0 | 0 | 0 | | 190.00 |
| | 19001 COMMUNITY HOWARD FOUNDATION 19200 PHYSICIANS' PRIVATE OFFICES | 69, 832 2, 164, 299 | 20, 200 1, 175, 021 | | | 89, 787 3, 404, 062 | 190. 01 |
| | 19300 NONPALD WORKERS | 2, 104, 279 | 1, 175, 021 | 3, 337, 320 | 04, 742 | | 193. 00 |
| 194.00 | 07950 HEALTHY CHILDREN | o | 0 | O | o | 0 | 194. 00 |
| | 07958 SOUTH BERKLEY BLDG | 0 | 800 | | | | 194. 08 |
| 194.09 | 07959 MOBILE CLINIC | 31, 964 | 13, 849 | 45, 813 | -2, 016 | 43, 191 | 194. 09 |

| Health Financial Systems COM | MMUNITY HOWARD I | REGIONAL HEALTI | Н | In Lie | eu of Form CMS-2 | 2552-10 |
|---|------------------|-----------------|---------------|--------------------------------|------------------|----------------|
| RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O | F EXPENSES | Provi der CO | | eri od: | Worksheet A | |
| | | | | rom 01/01/2019 o 12/31/2019 | | pared: 0 pm |
| Cost Center Description | Sal ari es | Other | , | Recl assi fi cati | | |
| | | | + col. 2) | ons (See A-6) | Trial Balance | |
| | | | | | (col. 3 +- | |
| | | | | | col. 4) | |
| | 1.00 | 2. 00 | 3.00 | 4. 00 | 5. 00 | |
| 194. 10 07960 PLASTIC SURGERY | 0 | 21, 437 | 21, 437 | 0 | 21, 437 | 194. 10 |
| 194.11 07961 KOKOMO SCHOOL BASED | 1, 773, 315 | 344, 353 | 2, 117, 668 | 524, 516 | 2, 642, 184 | 194. 11 |
| 194.15 07965 INDIANA SURGERY CENTER | 0 | 37 | 37 | 0 | 37 | 194. 15 |
| 194. 16 07966 PASTORAL CARE ALLIED HEALTH | 0 | 0 | C | 0 | 0 | 194. 16 |
| 200.00 TOTAL (SUM OF LINES 118 through 199) | 44, 647, 988 | 110, 772, 358 | 155, 420, 346 | 0 | 155, 420, 346 | 200. 00 |

| Cost Center Description | | | | REGIONAL HEALTH | | | of Form CMS- | 2552-10 |
|--|---------|--|---------------|-----------------|---------|-----------------------------|--------------------|---------------------------------------|
| Cost Center Description | RECLAS | SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (| OF EXPENSES | Provider CCN: | 15-0007 | Peri od: From 01/01/2019 | Worksheet A | |
| Continue September Septe | | | | | | To 12/31/2019 | | |
| Description Control | | Cost Center Description | | | | <u> </u> | 0, 1, 7, 2020 2.10 | , , , , , , , , , , , , , , , , , , , |
| TOTAL STRUCT COST CENTRES | | | | | | | | |
| 2.00 DOZDOGO FREE COST SHAPPLE EQUIP 0 2.667.647 3.00 4.00 DOZDOGO FREE COST PERFECTIONS 3.00 4.00 DOZDOGO FREE COST PERFECTIONS 2.760.310 2.160.3156 4.00 DOZDOGO FREE COST PERFECTIONS 2.760.310 4.00 DOZDOGO | | GENERAL SERVICE COST CENTERS | 0.00 | 7.00 | | | | |
| 3.00 03000 [INTER CAP REL COSTS | | | 1 | 1 | | | | 1. 00 |
| 4.00 00-000 [RIPLOVER ERPERT TS DEPARTMENT 1,231,509 1,545,335 5.00 00-0000 00-000 00-000 00-000 00-000 00-000 00-000 00-0000 00-000 00-000 00-000 00-000 00-000 00-000 00-0000 00-000 00-00000 00-0000 00-0000 00-0000 00-0000 00-0000 00-0000 00-00000 00-00000 00-00000 00-00000 00-00000 00-00000 00-00000 00-00000 00-00000 00-000000 00-000000 00-000000 00-00000000 | | | | 1 | | | | |
| 5.00 DOSCO AMENIN STRINT UP & GENERAL | | | _ | 1 | | | | |
| 1.00 CORRESPONDED OF PANIES OF PANIES −684,000 6.434,141 41 7.00 7. | | | | 1 | | | | |
| 9.00 00000 HOUSEKEEPI NG | | | | 1 | | | | 7. 00 |
| 10.00 10000 DEFARY | | | | l | | | | 8. 00 |
| 11.00 01100 CAFETERIA | | | 1 | | | | | 1 |
| 13.00 0.1300 MURSI NA ZADAM IN STRATI ON 1.334, 420 2,403, 371 13.00 17.00 | | | | | | | | 1 |
| 10.00 01:000 MEDICAL RECORDS & LIBRARY 845,917 16.00 17.00 | | | | | | | | |
| 17.00 01700 SOCIAL SERVICE 0 6.7,808 17.00 | | | | 1 | | | | 16. 00 |
| 23.00 20300 ANSTORAL CARE 948 208, 537 20.00 20300 ADULTS & PEDIATRIC COST CENTERS 38.346 12,783, 143 30.00 30.00 ADULTS & PEDIATRIC COST CENTERS 38.346 12,783, 143 30.00 30.00 ADULTS & PEDIATRIC COST CENTERS 38.346 12,783, 143 30.00 30.00 30.00 ADULTS & PEDIATRIC COST CENTERS 31.50 30.00 | 17. 00 | | | 1 | | | | 17. 00 |
| IMPATTENT ROUTH & SERVICE COST CENTERS 38, 346 12, 783, 143 30, 00 300 (DUITS & PEDI ATRICS 38, 346 12, 783, 143 31, 00 310 (DUITS & PEDI ATRICS 38, 346 12, 783, 143 31, 00 310 (DUITS & PEDI ATRICS 38, 346 12, 783, 143 31, 00 31, 00 310 (DUITS & PEDI ATRICS 38, 346 12, 783, 143 31, 00 | | | | 1 | | | | 19. 00 |
| 30.00 30.00 30.00 30.00 30.00 30.00 31.0 | 23. 00 | | -946 | 208, 537 | | | | 23. 00 |
| 31.00 03:00 INTENSIVE CARE INNIT 0 1,840,665 31.00 315,363 43.00 30.00 INTENSIVE CARE INNIT 0 315,363 43.00 30.00 50.00 | 30 00 | | 39 346 | 12 792 1/12 | | | | 30 00 |
| 43.00 0.4300 MIRSTRY 0 315,861 43.00 | | 1 | 1 | 1 | | | | 31.00 |
| 50.00 05000 OPERATIN OR ROUM 0 5,830,180 55,000 55,0 | | | | 1 | | | | 43.00 |
| 52.00 05.0 | | | | | | | | |
| 53.00 0.300 ARESTHESICLORY 0 0 53.00 54.01 0.3480 ONCOLORY 148,474 4,287,420 54.01 55.00 0.570 0.570 0.570 0.570 0.580 0 | | | • | | | | | 1 |
| 54.00 05400 NADIOLOGY-DIAGNOSTIC -4, 169 2, 557, 720 54, 00 570, | | | • | 935, 113 | | | | |
| 54.01 03480 (NOCLOGY 0T SCAN | | | 1 | 2, 557, 120 | | | | |
| 58.00 05800 MR | | | | 1 | | | | 54. 01 |
| 59.00 | 57.00 | | -7, 924 | 818, 561 | | | | 57.00 |
| 60.00 6000 LABORATORY 0 4.717.081 60.00 | | | 1 | | | | | 58. 00 |
| 63.00 66300 BLODD STORIN N. PROCESSING & TRANS. 0 0 65.00 | | | | | | | | |
| 65.00 66500 RESPIRATORY THERAPY 0 1,597,473 66.500 66.00 06600 PHYSICAL THERAPY 16,280 554,432 66.60 66.00 06600 DECENTROCARDIOLOGY 0 0 310,198 67.00 69.00 06900 ELECTROCARDIOLOGY 9,867 1,399,636 69.00 71.00 07000 ELECTROCARDIOLOGY 9,867 1,399,636 69.00 71.00 07100 MEDI CALL SUPPLIES CHARGED TO PATIENT 626,082 6,049,051 71.00 72.00 07200 MEDI CALL SUPPLIES CHARGED TO PATIENTS 0 6,815,633 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 398,281 16,871,275 73.00 73.00 07300 DRUGS CHARGED TO PATIENTS 398,281 16,871,275 73.00 73.00 07300 DRUGS CHARGED TO PATIENTS 398,281 16,871,275 73.00 73.00 07300 DRUGS CHARGED TO PATIENTS 398,281 16,871,275 73.00 73.00 07300 DRUGS CHARGED TO PATIENTS 398,281 16,871,275 73.00 73.00 07300 DRUGS CHARGED TO PATIENTS 398,281 16,871,275 73.00 73.00 07300 DRUGS CHARGED TO PATIENTS 398,281 16,871,275 73.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 298,371 74,00 75.01 03950 WOUND CARE CENTER 0 611,300 75,01 75.01 03950 WOUND CARE CENTER 0 611,300 75,01 75.01 03950 WOUND CARE CENTER 0 21,5896 76,00 75.01 03950 URBERDENCY 0 0 0 0 75.01 03950 URBERDENCY 0 0 0 75.01 03950 | | | 1 | 4, /1/, 081 | | | | 1 |
| 66.00 66600 PHYSICAL THERAPY -16,280 554,432 66,00 67.00 66700 CCUPATI OLDAR THERAPY 0 0 310,198 67,00 68.00 66800 SPEECH PATHOLOGY 0 84,125 68,00 69.00 66900 ELECTROCRAID OLOGY 9,867 1,399,636 69,90 70.00 07000 ELECTROCRAID OLOGY 9,867 1,399,636 69,90 70.00 07000 ELECTROCRAID OLOGY 9,867 1,399,636 69,90 70.00 07000 ELECTROCRAID OLOGY 9,867 1,399,636 70,00 72.00 07000 ELECTROCRAID OLOGY 70,00 72,00 72.00 07000 ELECTROCRAID OLOGY 70,00 72,00 72.00 07000 ELECTROCRAID THAT SET SET SET SET SET SET SET SET SET SE | | | 0 | 1, 597, 473 | | | | 65. 00 |
| 68.00 06800 SPECH PATHOLOGY 0 84.125 68.00 69.00 69.00 69.00 69.00 61.00 | 66.00 | | -16, 280 | | | | | 66. 00 |
| 69.00 06900 CLECTROCARDIOLOGY | | | | l | | | | 67. 00 |
| 70. 00 07000 CILCTROENCEPHALOGRAPHY 0 33,145 70. 00 71. 00 7100 MEDI CAL SUPPLIES CHARGED TO PATIENT 626,082 6,049,051 71. 00 7100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 6,815,633 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 398,281 16,871,275 73. 00 73. 00 7300 DRUGS CHARGED TO PATIENTS 398,281 16,871,275 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 75. | | | | | | | | 1 |
| 17. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 626, 082 6, 049, 051 71. 00 72. 00 72.00 MPL DEV CHARGED TO PATIENTS 0 6, 815, 633 72. 20 72. 00 72.00 MPL DEV CHARGED TO PATIENTS 398, 281 16, 871, 275 73. 00 74. 00 75. 00 | | | 1 | 1 | | | | |
| 72. 00 O7200 IMPL DEV. CHARGED TO PATI ENTS 0 6, 815, 633 72. 00 7300 DRUGS CHARGED TO PATI ENTS 398, 281 16, 871, 275 73. 00 7300 DRUGS CHARGED TO PATI ENTS 398, 281 16, 871, 275 73. 00 7300 DRUGS CHARGED TO PATI ENTS 398, 281 16, 871, 275 73. 00 7300 07500 ASC (NON-DIST INCT PART) 0 0 0 0 0 0 0 0 0 | | | - | 1 | | | | |
| 74.00 | | | 1 | 1 | | | | 72. 00 |
| 75. 00 | | | 398, 281 | | | | | 73.00 |
| 75. 01 03950 WOUND CARE CENTER 0 611, 300 75. 01 76. 00 03160 CARDI OPULMONARY 0 215, 896 76. 00 0010 EMERGENCY 79. 00 0010 EMERGENCY 91. 00 0900 085ERVATI ON BEDS (NON-DISTINCT PART 92. 00 0920 085ERVATI ON BEDS (NON-DISTINCT PART 92. 00 04950 OTHER OUTPATI ENT SERVICES 0 0 0 0 0 0 0 0 0 | | | 0 | 298, 311 | | | | |
| 76. 00 | | | 0 | 611 200 | | | | |
| OUTPATLENT SERVICE COST CENTERS 91.00 | | 1 | | | | | | |
| 92. 00 99200 09200 09500 09200 09500 | , 0, 00 | | | 2.07070 | | | | 70.00 |
| 92. 01 09201 08SERVATION BEDS (DISTINCT PART) 0 0 0 0 0 0 0 0 0 | | | 0 | 3, 888, 219 | | | | 91.00 |
| 93. 00 04950 OTHER OUTPATIENT SERVICES 0 0 0 93. 00 93. 01 04951 GENESIS 7-68, 978 1, 615, 251 93. 01 93. 02 04952 WOMEN'S CENTER 0 0 0 93. 02 93. 03 04953 RESI DENTI AL HOMES 0 0 0 93. 03 93. 04 04954 DR. STEELE 0 0 0 0 93. 03 93. 05 04955 DIABETIC EDUCATION 0 0 0 0 93. 06 04956 HOWARD COUNTY CSS -604, 404 296, 595 93. 06 93. 10 04956 POST MEDICATION 0 0 0 0 93. 18 04968 PSYCH MEDICATION 0 0 0 0 93. 18 04968 PSYCH MEDICATION 0 0 0 0 93. 18 04968 PSYCH MEDICATION 0 0 0 0 93. 18 04993 NEW BEGINNINGS -205, 008 321, 851 0 95. 00 0500 AMBURANCE SERVICES 0 1, 831, 626 0 95. 00 SPECIAL PURPOSE COST CENTERS 0 0 0 114. 00 11400 UTILIZATION REVIEW - SNF 0 0 0 118. 00 NONNEE MBURSABLE COST CENTERS 0 0 0 119. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190. 01 19001 COMMUNITY HOWARD FOUNDATION 0 89, 787 190. 01 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 3, 404, 062 192. 00 194. 00 07950 HEALTHY CHILDREN 0 0 0 194. 00 07950 MEALTHY CHILDREN 0 0 0 194. 00 07950 MOBILE CLINIC C 0 43, 797 194. 00 194. 10 07960 PLASTIC SURGERY 0 21, 437 194. 10 | | | | | | | | |
| 93. 01 04951 GENESIS | | | 0 | | | | | |
| 93. 02 04952 WOMEN'S CENTER 0 0 0 0 93. 02 93. 02 94953 RESI IDENTI AL HOMES 0 0 0 93. 03 04953 RESI IDENTI AL HOMES 0 0 0 0 93. 03 04953 RESI IDENTI AL HOMES 0 0 0 0 93. 03 04953 DI ABETI C EDUCATI ON 0 0 93. 05 93. 06 04956 DI ABETI C EDUCATI ON 0 0 0 93. 05 93. 06 04955 DI ABETI C EDUCATI ON 0 0 0 0 93. 05 93. 06 04957 CLI INTON COUNTY 5 -265, 008 321, 851 93. 06 94957 CLI INTON COUNTY -2655, 008 321, 851 93. 06 93. 18 04968 PSYCH MEDI CATI ON 0 0 0 0 93. 18 04968 PSYCH MEDI CATI ON 0 0 0 0 93. 18 04968 PSYCH MEDI CATI ON 0 0 0 0 93. 18 04968 PSYCH MEDI CATI ON 0 0 0 0 93. 18 04968 PSYCH MEDI CATI ON 0 0 0 0 93. 18 04968 PSYCH MEDI CATI ON 0 0 0 0 11. 831, 626 PSYCH REI MBURSABLE COST CENTERS 95. 00 1, 831, 626 PSYCH PURPOSE COST CENTERS 95. 00 11. 831, 626 PSYCH PURPOSE COST CENTERS 95. 00 11. 831, 626 PSYCH PURPOSE COST CENTERS 95. 00 11. 831, 626 PSYCH PURPOSE COST CENTERS 95. 00 11. 831, 626 PSYCH PURPOSE COST CENTERS 95. 00 0 0 11. 831, 626 PSYCH PURPOSE COST CENTERS 95. 00 0 0 11. 831, 626 PSYCH PURPOSE COST CENTERS 95. 00 0 0 11. 831, 626 PSYCH PURPOSE COST CENTERS 95. 00 0 0 0 11. 831, 626 PSYCH PURPOSE COST CENTERS 95. 00 0 0 0 11. 831, 626 PSYCH PURPOSE COST CENTERS 95. 00 0 0 0 11. 831, 626 PSYCH PURPOSE COST CENTERS 95. 00 0 0 0 11. 831, 626 PSYCH PURPOSE COST CENTERS 95. 00 0 0 0 11. 831, 626 PSYCH PURPOSE COST CENTERS 95. 00 0 0 0 11. 831, 626 PSYCH PURPOSE COST CENTERS 95. 00 0 0 0 11. 831, 626 PSYCH PURPOSE COST CENTERS 95. 00 0 0 0 11. 831, 626 PSYCH PURPOSE COST CENTERS 95. 00 0 0 0 11. 831, 626 PSYCH PURPOSE COST CENTERS 95. 00 0 0 0 0 11. 831, 626 PSYCH PURPOSE COST CENTERS 95. 00 0 0 0 0 11. 831, 626 PSYCH PURPOSE COST CENTERS 95. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | | -768.978 | 1, 615, 251 | | | | 93. 01 |
| 93. 04 04954 DR. STEELE 0 0 0 93. 04 93. 05 94955 DI ABETI C EDUCATION 0 0 0 0 0 0 0 0 0 | 93. 02 | | 0 | o | | | | 93. 02 |
| 93. 05 | | | 0 | 0 | | | | 93. 03 |
| 93. 06 04956 HOWARD COUNTY CSS | | | 0 | 0 | | | | |
| 93. 07 | | | - | 206 505 | | | | |
| 93. 18 04968 PSYCH MEDICATION 0 0 93. 18 93. 43 04998 PSYCH MEDICATION 0 0 93. 18 93. 43 04998 PSYCH MEDICATION 0 0 9500 AMBURANCE SERVICES 95. 00 1,831,626 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 0 0 114. 00 11400 UTILIZATION REVIEW - SNF 0 0 114. 00 11400 UTILIZATION REVIEW - SNF 0 0 114. 00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) -25,816,009 123,402,233 118. 00 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 89,787 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 89,787 190. 00 193. 00 19300 NONPAID WORKERS 0 3,404,062 193. 00 19300 NONPAID WORKERS 0 0 0 193. 00 19300 NONPAID WORKERS 0 0 0 194. 00 194. 00 194. 00 07950 HEALTHY CHILDREN 0 0 194. 00 194. 00 07958 SOUTH BERKLEY BLDG 0 43,797 194. 10 07960 PLASTIC SURGERY 0 21,437 194. 10 07960 PLASTIC SURGERY | | | | 1 | | | | |
| OTHER REIMBURSABLE COST CENTERS O 1,831,626 95.00 | | | 0 | | | | | 93. 18 |
| 95. 00 | 93. 43 | | -30, 109 | 76, 057 | | | | 93. 43 |
| SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 05 00 | | | 4 004 (0/ | | | | 05.00 |
| 113. 00 114. 00 114. 00 114. 00 114. 00 114. 00 114. 00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) SUBTOTALS (SUM OF LINES 1 through 117) NONRE! MBURSABLE COST CENTERS 190. 00 190. 01 1900. 01 19 | 95.00 | | 0 | 1, 831, 626 | | | | 95.00 |
| 114. 00 | 113.00 | | 0 | 0 | | | | 113. 00 |
| NONREI MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190.00 190.01 | | | 0 | o | | | | 114. 00 |
| 190. 00 | 118.00 | 3 / | -25, 816, 009 | 123, 402, 233 | | | | 118. 00 |
| 190. 01 19001 COMMUNITY HOWARD FOUNDATION 0 89, 787 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 3, 404, 062 193. 00 194. 00 07950 HEALTHY CHI LDREN 0 0 194. 00 194. 00 07958 SOUTH BERKLEY BLDG 0 800 194. 00 194. 00 07959 MOBI LE CLI NI C 0 43, 797 194. 10 07960 PLASTI C SURGERY 0 21, 437 194. 10 | 100 00 | | 1 | O | | | | 190 00 |
| 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 3, 404, 062 192. 00 193. 00 19300 NONPAI D WORKERS 0 0 193. 00 194. 00 07950 HEALTHY CHI LDREN 0 0 194. 00 194. 08 07958 SOUTH BERKLEY BLDG 0 800 194. 08 194. 09 07959 MOBI LE CLINIC 0 43, 797 194. 09 194. 10 07960 PLASTIC SURGERY 0 21, 437 194. 10 | | | | 89. 787 | | | | 190.00 |
| 193. 00 19300 NONPAI D WORKERS 0 0 193. 00 194. 00 07950 HEALTHY CHI LDREN 0 0 194. 00 194. 08 07958 SOUTH BERKLEY BLDG 0 800 194. 08 194. 09 07959 MOBI LE CLINIC 0 43, 797 194. 09 194. 10 07960 PLASTIC SURGERY 0 21, 437 194. 10 | | | | | | | | 192. 00 |
| 194. 08 07958 SOUTH BERKLEY BLDG 0 800 194. 08 194. 09 07959 MOBI LE CLINIC 0 43, 797 194. 09 194. 10 07960 PLASTIC SURGERY 0 21, 437 194. 10 | 193.00 | 19300 NONPALD WORKERS | 0 | 1 | | | | 193. 00 |
| 194. 09 07959 MOBILE CLINIC 0 43, 797 194. 10 07960 PLASTIC SURGERY 0 21, 437 194. 10 | | | 0 | 0 | | | | 194. 00 |
| 194. 10 07960 PLASTIC SURGERY 0 21, 437 194. 10 | | | 0 | | | | | |
| | | | 1 | | | | | 194. 09 |
| | | | 1 | 1 | | | | 194. 11 |

| Health Financial Systems | COMMUNITY HOWARD REC | GIONAL HEALTH | In Lie | u of Form CMS-2552-10 |
|---|----------------------|-----------------------|-----------------------------|-----------------------|
| RECLASSIFICATION AND ADJUSTMENTS OF TRIAL | BALANCE OF EXPENSES | Provider CCN: 15-0007 | Peri od: From 01/01/2019 | Worksheet A |
| | | | To 12/31/2019 | Date/Time Prepared: |

| | | | 0/19/2020 2.00 | J PIII |
|---|---------------|----------------|----------------|---------|
| Cost Center Description | Adjustments | Net Expenses | | |
| | (See A-8) | For Allocation | | |
| | 6. 00 | 7.00 | | |
| 194. 15 07965 I NDI ANA SURGERY CENTER | 0 | 37 | | 194. 15 |
| 194.16 07966 PASTORAL CARE ALLIED HEALTH | 0 | 0 | | 194. 16 |
| 200.00 TOTAL (SUM OF LINES 118 through 199) | -25, 816, 009 | 129, 604, 337 | | 200. 00 |

Health Financial Systems RECLASSIFICATIONS

Provider CCN: 15-0007

| Period: | Worksheet A-6 | From 01/01/2019 | To 12/31/2019 | Date/Time Prepared: 8/19/2020 2:00 pm

| | | | | | 8/19/2020 2 | : 00 pm |
|------------------|-------------------------------------|----------------|---------|-------------|-------------|----------------|
| | | Increases | | | | |
| | Cost Center | Li ne # | Sal ary | 0ther | | |
| | 2. 00 | 3. 00 | 4. 00 | 5. 00 | | |
| | A - Chargeable Medical Suppli | | | 057.047 | | |
| 1.00 | ADMI NI STRATI VE & GENERAL | 5. 00 | 0 | 257, 067 | | 1.00 |
| 2.00 | MEDICAL SUPPLIES CHARGED TO PATIENT | 71. 00 | 0 | 4, 781, 902 | | 2. 00 |
| 2 00 | PATTENT | 0.00 | | 0 | | 2 00 |
| 3. 00 4. 00 | | 0.00 | 0 | 0 | | 3. 00 4. 00 |
| 5. 00 | | 0.00 | 0 | 0 | | 5. 00 |
| 6. 00 | | 0.00 | 0 | 0 | | 6. 00 |
| 7. 00 | | 0.00 | 0 | 0 | | 7. 00 |
| 8. 00 | | 0.00 | 0 | 0 | | 8. 00 |
| 9. 00 | | 0.00 | 0 | 0 | | 9. 00 |
| | | | 0 | 0 | | 1 |
| 10. 00 11. 00 | | 0.00 | | - | | 10.00 |
| 12. 00 | | 0. 00 0. 00 | 0 | 0 | | 11.00 |
| | | 0.00 | 0 | 0 | | 12.00 |
| 13.00 | | | | 0 | | 13.00 |
| 14.00 | | 0.00 | 0 | - | | 14. 00 |
| 15.00 | | 0.00 | 0 | 0 | | 15. 00 |
| 16.00 | | 0.00 | 0 | 0 | | 16.00 |
| 17. 00 | | 0.00 | 0 | 0 | | 17. 00 |
| 18. 00 | | 0.00 | 0 | 0 | | 18. 00 |
| 19. 00 | | 0.00 | 0 | 0 | | 19. 00 |
| 20. 00 | | 0.00 | 0 | 0 | | 20. 00 |
| 21. 00 | | 0.00 | 0 | 0 | | 21. 00 |
| 22. 00 | | 0.00 | 0 | 0 | | 22. 00 |
| 23.00 | | 0.00 | 0 | 0 | | 23. 00 |
| 24.00 | | 0. 00 | 0_ | 0 | | 24. 00 |
| | TOTALS | | 0 | 5, 038, 969 | | |
| | B - Implantable Device Reclas | s | | | | |
| 1.00 | IMPL. DEV. CHARGED TO | 72. 00 | | 6, 815, 633 | | 1. 00 |
| | PATI ENTS | | | | | |
| 2.00 | | | | | | 2. 00 |
| 3.00 | | | | | | 3. 00 |
| | | | | 6, 815, 633 | | |
| | C - Drugs Charges to Pat | <u> </u> | | | | |
| 1.00 | MEDICAL SUPPLIES CHARGED TO | 71.00 | | 355 | | 1.00 |
| | PATI ENT | | | | | |
| 2.00 | DRUGS CHARGED TO PATIENTS | 73.00 | | 228, 601 | | 2. 00 |
| 3. 00 | | | | , | | 3. 00 |
| 4.00 | | | | | | 4. 00 |
| 5. 00 | | | | | | 5. 00 |
| 6. 00 | | | | | | 6. 00 |
| 7. 00 | | | | | | 7. 00 |
| 8. 00 | | | | | | 8. 00 |
| 9. 00 | | | | | | 9. 00 |
| 10. 00 | | | | | | 1 |
| | | | | | | 10.00 |
| 11.00 | | | | | | 11.00 |
| 12.00 | | | | | | 12.00 |
| 13.00 | | | | | | 13.00 |
| 14.00 | | | | | | 14. 00 |
| 15. 00 | | | | | | 15. 00 |
| 16. 00 | | | | | | 16. 00 |
| 17. 00 | | | | | | 17. 00 |
| 18. 00 | | | | | | 18. 00 |
| 19. 00 | \vdash $ -$ | + | | | | 19. 00 |
| | | | 0 | 228, 956 | | _ |
| | D - Depreciation Expense | | | | | |
| 1.00 | CAP REL COSTS-MVBLE EQUIP | 2. 00 | 0 | 6, 750, 517 | | 1. 00 |
| 2.00 | | 0.00 | 0 | 0 | | 2. 00 |
| 3.00 | | 0.00 | 0 | 0 | | 3. 00 |
| 4.00 | | 0.00 | 0 | 0 | | 4. 00 |
| 5.00 | | 0.00 | 0 | 0 | | 5. 00 |
| 6. 00 | | 0.00 | Ö | 0 | | 6. 00 |
| 7. 00 | | 0.00 | o | 0 | | 7. 00 |
| 8. 00 | | 0.00 | o | 0 | | 8. 00 |
| 9. 00 | | 0.00 | o | 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 |
| 16.00 | | 0.00 | 0 | 0 | | 16. 00 |
| 17.00 | | 0.00 | 0 | 0 | | 17. 00 |
| 18. 00 | | 0.00 | О | 0 | | 18. 00 |
| | <u>'</u> | | | <u>'</u> | | · · |

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0007

Peri od: From 01/01/2019 To 12/31/2019 Date/Ti me Prepared: 8/19/2020 2:00 pm

| | | | | | 8/19/2020 2:0 | <u> 70 pm</u> |
|--------|-------------------------------|------------------------------------|--------------------|------------------|---------------|---------------|
| | | Increases | | | | |
| | Cost Center | Li ne # | Sal ary | 0ther | | |
| | 2. 00 | 3. 00 | 4.00 | 5. 00 | | |
| 19.00 | | 0.00 | 0 | 0 | | 19. 00 |
| 20.00 | | 0.00 | 0 | 0 | | 20. 00 |
| 21.00 | | 0.00 | O | 0 | | 21. 00 |
| 22.00 | | 0.00 | 0 | 0 | | 22. 00 |
| 23. 00 | | 0.00 | 0 | 0 | | 23. 00 |
| 24. 00 | | 0.00 | 0 | 0 | | 24. 00 |
| 25. 00 | | 0.00 | o | Ö | | 25. 00 |
| 26. 00 | | 0.00 | 0 | 0 | | 26. 00 |
| 27. 00 | | 0.00 | 0 | 0 | | 27. 00 |
| 27.00 | TOTALS — — — — | <u> </u> | — — ў | 6, 750, 517 | | 27.00 |
| | F - Infusion Equipment Rental | | <u> </u> | 0, 730, 317 | | - |
| 1. 00 | ONCOLOGY | 54. 01 | | 730, 573 | | 1.00 |
| 1.00 | <u> </u> | | — — — | 730, 573 | | 1.00 |
| | C CTD DENEELT DECLASS | | U | 730, 373 | | - |
| 1 00 | G - STD BENEFIT RECLASS | F 00 | | 14 174 | | 1 00 |
| 1.00 | ADMI NI STRATI VE & GENERAL | 5.00 | 0 | 14, 174 | | 1.00 |
| 2.00 | OPERATION OF PLANT | 7. 00 | 0 | 13, 836 | | 2. 00 |
| 3. 00 | HOUSEKEEPI NG | 9. 00 | 0 | 6, 084 | | 3. 00 |
| 4.00 | DI ETARY | 10. 00 | 0 | 102 | | 4. 00 |
| 5.00 | NURSING ADMINISTRATION | 13. 00 | 0 | 1, 261 | | 5. 00 |
| 6.00 | ADULTS & PEDIATRICS | 30.00 | 0 | 61, 385 | | 6. 00 |
| 7.00 | INTENSIVE CARE UNIT | 31.00 | 0 | 7, 860 | | 7. 00 |
| 8.00 | OPERATING ROOM | 50.00 | 0 | 2, 778 | | 8. 00 |
| 9.00 | RADI OLOGY-DI AGNOSTI C | 54.00 | 0 | 6, 735 | | 9. 00 |
| 10.00 | ONCOLOGY | 54. 01 | 0 | 2, 878 | | 10.00 |
| 11.00 | MRI | 58.00 | 0 | 1, 075 | | 11.00 |
| 12.00 | CARDIAC CATHETERIZATION | 59.00 | o | 7, 894 | | 12.00 |
| 13. 00 | RESPIRATORY THERAPY | 65.00 | 0 | 13, 731 | | 13.00 |
| 14. 00 | PHYSI CAL THERAPY | 66. 00 | o | 767 | | 14. 00 |
| 15. 00 | ELECTROCARDI OLOGY | 69.00 | 0 | 10, 726 | | 15. 00 |
| 16. 00 | DRUGS CHARGED TO PATIENTS | 73. 00 | 0 | 1, 467 | | 16. 00 |
| 17. 00 | WOUND CARE CENTER | 75. 01 | 0 | 813 | | 17. 00 |
| | | 91. 00 | -1 | | | 1 |
| 18.00 | EMERGENCY | | 0 | 21, 902 | | 18. 00 |
| 19.00 | GENESI S | 93. 01 | U | 6, 136 | | 19. 00 |
| 20.00 | HOWARD COUNTY CSS | 93.06 | 0 | 6, 426 | | 20. 00 |
| 21. 00 | PSYCH MEDICATION | 93. 18 | 0 | 603 | | 21. 00 |
| 22. 00 | AMBULANCE SERVICES | 95. 00 | 0 | 1, 143 | | 22. 00 |
| 23. 00 | PHYSICIANS' PRIVATE OFFICES | 192. 00 | 0 | 13, 963 | | 23. 00 |
| 24. 00 | KOKOMO SCHOOL BASED | 1 <u>94.</u> 11 | • | <u>1, 1</u> 08 | | 24. 00 |
| | TOTALS | | 0 | 204, 847 | | |
| | H - Labor and Delivery | | | | | 4 |
| 1.00 | NURSERY | 43.00 | 217, 885 | 97, 478 | | 1. 00 |
| 2.00 | DELIVERY ROOM & LABOR ROOM | 52. 00 | 646, 072 | 289, 041 | | 2. 00 |
| | TOTALS | | 863, 957 | 386, 519 | | |
| | I - Cafeteria Salary | | | | | |
| 1.00 | CAFETERI A | 11. 00 | 595, 257 | 628, 983 | | 1. 00 |
| | TOTALS | | 595, 257 | 628, 983 | | İ |
| | J - Therapy Reclass | | | | | 1 |
| 1.00 | OCCUPATI ONAL THERAPY | 67.00 | 234, 770 | 75, 428 | | 1.00 |
| 2.00 | SPEECH PATHOLOGY | 68. 00 | 63, 321 | 20, 344 | | 2. 00 |
| | TOTALS | | 298, 091 | 95, 772 | | |
| | K - Depreciation Expense | | | | | i |
| 1.00 | CAP REL COSTS-BLDG & FIXT | 1.00 | 0 | 4, 082, 870 | | 1.00 |
| 1.00 | TOTALS | — — -:. °° | — — " | 4, 082, 870 | | 1.00 |
| | L - Capital Insurance Costs | | <u> </u> | 1,002,010 | | |
| 1.00 | CAP REL COSTS-BLDG & FIXT | 1.00 | 0 | 97, 472 | | 1. 00 |
| 1.00 | TOTALS | | — — — ў | 97, 472 | | 1.00 |
| | M - Psych Admin Reclass | | <u> </u> | 71,412 | | - |
| 1 00 | | 93. 01 | 252 205 | 475 274 | | 1 00 |
| 1.00 | GENESI S | | 253, 385 | 475, 374 | | 1.00 |
| 2.00 | HOWARD COUNTY CSS | 93.06 | 8, 856 | 16, 615 | | 2. 00 |
| 3.00 | CLINTON COUNTY | 93. 07 | 30, 786 | 57, 757 | | 3. 00 |
| 4.00 | NEW BEGI NNI NGS | <u>93.</u> 43 | 1, 907 | 3, 578 | | 4. 00 |
| | TOTALS | | 294, 934 | 553, 324 | | - |
| | N - Pastoral Ed Allied Health | | | | | 4 |
| 1.00 | ADMI NI STRATI VE & GENERAL | | 12 <u>3, 7</u> 67 | 3 <u>7, 2</u> 52 | | 1. 00 |
| | TOTALS | | 123, 767 | 37, 252 | | _ |
| | 0 - Psych Medicine Clinic Rec | lass | | | | |
| 1.00 | GENESIS | 93. 01 | 52, 660 | 17, 198 | | 1. 00 |
| 2.00 | HOWARD COUNTY CSS | 93. 06 | 26, 330 | 8, 599 | | 2. 00 |
| 3.00 | PHYSICIANS' PRIVATE OFFICES | 192.00 | 52, 660 | 17, 198 | | 3. 00 |
| 4.00 | KOKOMO SCHOOL BASED | 194. 11 | 395, 384 | 129, 132 | | 4. 00 |
| | TOTALS | + | 527, 034 | 172, 127 | | |
| 500.00 | Grand Total: Increases | | 2, 703, 040 | 25, 823, 814 | | 500.00 |
| | . ' | ' | • | • | | • |

Peri od: From 01/01/2019 To 12/31/2019

Date/Time Prepared: 8/19/2020 2:00 pm

| | | | | | | 8/19/2020 2:0 | JO pm |
|--------|-------------------------------|------------------------|------------------|-------------|----------------|---------------|--------|
| | | Decreases | | | | | |
| | Cost Center | Li ne # | Sal ary | Other | Wkst. A-7 Ref. | | |
| | 6. 00 | 7.00 | 8.00 | 9. 00 | 10. 00 | | |
| | A - Chargeable Medical Suppli | es | | | | | |
| 1.00 | OPERATION OF PLANT | 7.00 | 0 | 4, 906 | 0 | | 1.00 |
| 2.00 | LAUNDRY & LINEN SERVICE | 8.00 | O | 7, 494 | | | 2. 00 |
| 3. 00 | ADULTS & PEDIATRICS | 30.00 | Ö | 466, 973 | | | 3. 00 |
| | | | | · | 1 | | |
| 4.00 | INTENSIVE CARE UNIT | 31.00 | 0 | 98, 130 | 0 | | 4. 00 |
| 5.00 | OPERATING ROOM | 50.00 | 0 | 1, 947, 304 | 0 | | 5. 00 |
| 6.00 | RADI OLOGY-DI AGNOSTI C | 54.00 | 0 | 307, 358 | 0 | | 6. 00 |
| 7.00 | ONCOLOGY | 54. 01 | ol | 66, 131 | o | | 7. 00 |
| 8. 00 | CT SCAN | 57.00 | o | 98, 750 | | | 8. 00 |
| 9. 00 | MRI | 58.00 | 0 | 87, 881 | 0 | | 9. 00 |
| | • | | | | | | 1 |
| 10. 00 | CARDIAC CATHETERIZATION | 59.00 | 0 | 1, 513, 127 | 0 | | 10.00 |
| 11. 00 | LABORATORY | 60.00 | 0 | 3, 869 | 0 | | 11. 00 |
| 12.00 | RESPIRATORY THERAPY | 65.00 | 0 | 86, 916 | 0 | | 12. 00 |
| 13.00 | PHYSI CAL THERAPY | 66.00 | o | 8, 429 | | | 13.00 |
| 14. 00 | ELECTROCARDI OLOGY | 69.00 | Ö | 12, 317 | o | | 14. 00 |
| | | | | | | | |
| 15. 00 | DRUGS CHARGED TO PATIENTS | 73.00 | 0 | 59, 184 | | | 15. 00 |
| 16. 00 | RENAL DI ALYSI S | 74.00 | 0 | 1, 072 | | | 16. 00 |
| 17. 00 | WOUND CARE CENTER | 75. 01 | 0 | 14, 572 | 0 | | 17. 00 |
| 18. 00 | CARDI OPULMONARY | 76.00 | 0 | 1, 703 | 0 | | 18. 00 |
| 19.00 | EMERGENCY | 91.00 | 0 | 186, 809 | ol | | 19. 00 |
| 20. 00 | CLINTON COUNTY | 93. 07 | 0 | 3, 320 | o | | 20.00 |
| | | 93. 18 | 0 | | | | 1 |
| 21. 00 | PSYCH MEDICATION | | ĭ | 772 | 0 | | 21. 00 |
| 22. 00 | NEW BEGINNINGS | 93. 43 | 0 | 3, 243 | | | 22. 00 |
| 23.00 | AMBULANCE SERVICES | 95.00 | 0 | 53, 694 | 0 | | 23. 00 |
| 24.00 | PHYSICIANS' PRIVATE OFFICES | 192.00 | o | 5, 015 | o | | 24. 00 |
| 2 00 | TOTALS | — — 1721 05 | — — o | 5, 038, 969 | | | 2 00 |
| | | | <u> </u> | 3, 030, 707 | | | - |
| | B - Implantable Device Reclas | | | | | | 4 |
| 1. 00 | OPERATING ROOM | 50.00 | | 5, 575, 785 | | | 1.00 |
| 2.00 | CARDIAC CATHETERIZATION | 59. 00 | | 1, 192, 918 | | | 2. 00 |
| 3.00 | WOUND CARE CENTER | 75. 01 | | 46, 930 | | | 3. 00 |
| | | | ₀ | 6, 815, 633 | | | |
| | C - Drugs Charges to Pat | l l | - 1 | .,, | l l | | 1 |
| 1. 00 | EMPLOYEE BENEFITS DEPARTMENT | 4.00 | | 35, 517 | | | 1. 00 |
| | • | | | | | | |
| 2.00 | ADMINISTRATIVE & GENERAL | 5. 00 | | 882 | | | 2. 00 |
| 3.00 | ADULTS & PEDIATRICS | 30.00 | | 22, 975 | | | 3. 00 |
| 4.00 | INTENSIVE CARE UNIT | 31.00 | | 4, 782 | | | 4. 00 |
| 5.00 | OPERATING ROOM | 50.00 | | 10, 338 | | | 5. 00 |
| 6.00 | RADI OLOGY-DI AGNOSTI C | 54.00 | | 5, 129 | | | 6. 00 |
| 7. 00 | ONCOLOGY | 54. 01 | | 2, 478 | | | 7. 00 |
| | • | | | | | | 1 |
| 8. 00 | CT SCAN | 57.00 | | 63, 540 | | | 8. 00 |
| 9.00 | MRI | 58. 00 | | 29, 660 | | | 9. 00 |
| 10.00 | CARDIAC CATHETERIZATION | 59.00 | | 25, 541 | | | 10. 00 |
| 11.00 | RESPIRATORY THERAPY | 65.00 | | 274 | | | 11. 00 |
| 12.00 | ELECTROCARDI OLOGY | 69.00 | | 1, 287 | | | 12. 00 |
| 13. 00 | RENAL DI ALYSI S | 74.00 | | 693 | | | 13. 00 |
| | | | | | | | |
| 14. 00 | WOUND CARE CENTER | 75. 01 | | 14, 654 | | | 14. 00 |
| 15. 00 | EMERGENCY | 91.00 | | 8, 152 | | | 15. 00 |
| 16.00 | PSYCH MEDICATION | 93. 18 | | 181 | | | 16. 00 |
| 17.00 | AMBULANCE SERVICES | 95.00 | | 756 | | | 17. 00 |
| | PHYSICIANS' PRIVATE OFFICES | 192. 00 | | 101 | | | 18. 00 |
| 19. 00 | MOBILE CLINIC | 194. 09 | • | 2, 016 | | | 19. 00 |
| 19.00 | MODITE CLINIC | | + | | | | 19.00 |
| | | | 0 | 228, 956 | | | - |
| | D - Depreciation Expense | | | | | | 4 |
| 1. 00 | EMPLOYEE BENEFITS DEPARTMENT | 4.00 | 0 | 12, 521 | 9 | | 1. 00 |
| 2.00 | ADMINISTRATIVE & GENERAL | 5.00 | 0 | 3, 490, 797 | 0 | | 2. 00 |
| 3.00 | OPERATION OF PLANT | 7.00 | o | 618, 817 | ol | | 3.00 |
| 4. 00 | HOUSEKEEPI NG | 9.00 | o | 27, 098 | | | 4. 00 |
| | | l l | | | 1 | | 1 |
| 5. 00 | DI ETARY | 10.00 | 0 | 89, 893 | 1 | | 5. 00 |
| 6. 00 | CAFETERI A | 11.00 | 0 | 120 | | | 6. 00 |
| 7.00 | NURSING ADMINISTRATION | 13.00 | 0 | 99, 888 | 0 | | 7. 00 |
| 8.00 | ADULTS & PEDIATRICS | 30.00 | o | 259, 703 | 0 | | 8. 00 |
| 9. 00 | INTENSIVE CARE UNIT | 31.00 | o | 52, 136 | | | 9. 00 |
| 10. 00 | OPERATING ROOM | 50.00 | 0 | 484, 584 | | | 10.00 |
| | | | | | | | 1 |
| 11.00 | RADI OLOGY-DI AGNOSTI C | 54.00 | 0 | 328, 708 | | | 11. 00 |
| 12. 00 | ONCOLOGY | 54. 01 | 0 | 202, 155 | | | 12. 00 |
| 13.00 | CT SCAN | 57.00 | 0 | 7, 075 | 0 | | 13. 00 |
| 14.00 | MRI | 58.00 | 0 | 278, 237 | o | | 14.00 |
| 15. 00 | CARDIAC CATHETERIZATION | 59.00 | o | 363, 200 | | | 15. 00 |
| 16. 00 | LABORATORY | 60.00 | 0 | 4, 364 | | | 16. 00 |
| | • | | ol S | | | | |
| 17. 00 | RESPI RATORY THERAPY | 65. 00 | 이 | 11, 169 | | | 17. 00 |
| 18. 00 | PHYSI CAL THERAPY | 66.00 | 0 | 4, 396 | | | 18. 00 |
| 19.00 | ELECTROCARDI OLOGY | 69.00 | 0 | 12, 253 | 0 | | 19. 00 |
| | ELECTROENCEPHALOGRAPHY | 70.00 | О | 20, 347 | | | 20.00 |
| 00 | | , , , , , , , | 9 | _0,017 | , 9 | | |
| | | | | | | | |

| | Financial Systems | COM | MUNITY HOWARD F | | | In Lieu of For | |
|------------------|--|-------------------|-------------------------------|-------------------------------|-------------------------|------------------------------------|-----------------------------|
| RECLAS | SI FI CATI ONS | | | Provi der (| | Period: Workshe From 01/01/2019 | eet A-6 |
| | | | | | - | | me Prepared: 020 2:00 pm |
| | | Decreases | | | | | |
| | Cost Center 6.00 | Li ne # 7.00 | Sal ary 8.00 | 0ther 9.00 | Wkst. A-7 Ref. 10.00 | _ | |
| 21. 00 | MEDICAL SUPPLIES CHARGED TO | 71.00 | 0 | 42, 686 | | | 21.00 |
| 22.00 | PATI ENT | 72.00 | | 125 020 | | | 22.00 |
| 22. 00 23. 00 | DRUGS CHARGED TO PATIENTS WOUND CARE CENTER | 73. 00 75. 01 | 0 | 125, 830 2, 241 | 0 | I | 22. 00 23. 00 |
| 24. 00 | EMERGENCY | 91.00 | ő | 83, 623 | 0 | I | 24. 00 |
| 25. 00 | NEW BEGINNINGS | 93. 43 | O | 891 | 0 | | 25. 00 |
| 26. 00 27. 00 | AMBULANCE SERVICES COMMUNITY HOWARD FOUNDATION | 95. 00 190. 01 | 0 | 127, 540 245 | | | 26. 00 27. 00 |
| 27.00 | TOTALS | | | | <u> </u> | | 27.00 |
| | F - Infusion Equipment Rental | | | ., ., | | | |
| 1. 00 | OPERATION OF PLANT | | | 730, 573 | | | 1. 00 |
| | G - STD BENEFIT RECLASS | | 0 | 730, 573 | | | |
| 1.00 | ADMI NI STRATI VE & GENERAL | 5. 00 | 14, 174 | 0 | 0 | | 1.00 |
| 2.00 | OPERATION OF PLANT | 7. 00 | 13, 836 | 0 | | | 2. 00 |
| 3. 00 4. 00 | HOUSEKEEPI NG DI ETARY | 9. 00 10. 00 | 6, 084 102 | 0 | 0 | | 3. 00 4. 00 |
| 5. 00 | NURSING ADMINISTRATION | 13. 00 | 1, 261 | 0 | 0 | 1 | 5. 00 |
| 6.00 | ADULTS & PEDIATRICS | 30.00 | 61, 385 | 0 | 0 | l . | 6. 00 |
| 7.00 | INTENSIVE CARE UNIT | 31.00 | 7, 860 | 0 | _ | 1 | 7. 00 |
| 8. 00 9. 00 | OPERATING ROOM RADIOLOGY-DIAGNOSTIC | 50. 00 54. 00 | 2, 778 6, 735 | 0 | 0 | 1 | 8. 00 9. 00 |
| 10.00 | ONCOLOGY | 54. 01 | 2, 878 | 0 | Ö | | 10.00 |
| 11. 00 | MRI | 58. 00 | 1, 075 | 0 | 0 | 1 | 11. 00 |
| 12.00 | CARDI AC CATHETERI ZATI ON | 59.00 | 7, 894 | 0 | 0 | 1 | 12.00 |
| 13. 00 14. 00 | RESPIRATORY THERAPY PHYSICAL THERAPY | 65. 00 66. 00 | 13, 731 767 | 0 | 0 | l . | 13. 00 14. 00 |
| 15. 00 | ELECTROCARDI OLOGY | 69.00 | 10, 726 | 0 | 0 | l . | 15. 00 |
| 16. 00 | DRUGS CHARGED TO PATIENTS | 73.00 | 1, 467 | 0 | _ | | 16. 00 |
| 17. 00 18. 00 | WOUND CARE CENTER EMERGENCY | 75. 01 91. 00 | 813 21, 902 | 0 | 0 | l e | 17. 00 18. 00 |
| 19. 00 | GENESI S | 93. 01 | 6, 136 | 0 | 0 | | 19. 00 |
| 20.00 | HOWARD COUNTY CSS | 93. 06 | 6, 426 | 0 | 0 |) | 20. 00 |
| 21. 00 | PSYCH MEDICATION | 93. 18 | 603 | 0 | 0 | | 21.00 |
| 22. 00 23. 00 | AMBULANCE SERVICES PHYSICIANS' PRIVATE OFFICES | 95. 00 192. 00 | 1, 143 13, 963 | 0 | 0 | l . | 22. 00 23. 00 |
| 24. 00 | KOKOMO SCHOOL BASED | 194. 11 | 1, 108 | 0 | | l . | 24. 00 |
| | TOTALS | | 204, 847 | | | | |
| 1. 00 | H - Labor and Delivery ADULTS & PEDIATRICS | 30.00 | 863, 957 | 386, 519 | 0 | 1 | 1.00 |
| 2.00 | ADULIS & PEDIATRICS | 0.00 | 003, 937 | 360, 519 | 0 | | 2.00 |
| | TOTALS | | 863, 957 | 386, 519 | | | |
| 4 00 | I - Cafeteria Salary | 40.00 | 505 057 | 400.000 | | J | 4.00 |
| 1. 00 | TOTALS | 10.00 | 59 <u>5, 2</u> 57 595, 257 | 62 <u>8, 9</u> 83 628, 983 | | <u>)</u> | 1. 00 |
| | J - Therapy Reclass | | 070, 201 | 020, 700 | | <u> </u> | |
| 1.00 | PHYSI CAL THERAPY | 66.00 | 298, 091 | 95, 772 | | | 1. 00 |
| 2. 00 | TOTALS — — — — | | 0 298, 091 | 00 95, 772 | 0 | <u>)</u> | 2. 00 |
| | K - Depreciation Expense | | 290, 091 | 75, 772 | | | |
| 1.00 | CAP REL COSTS-MVBLE EQUIP | 2.00 | 0 | 4, 082, 870 | | | 1. 00 |
| | TOTALS | | 0 | 4, 082, 870 | | | |
| 1. 00 | L - Capital Insurance Costs ADMINISTRATIVE & GENERAL | 5. 00 | 0 | 97, 472 | 12 | | 1. 00 |
| 1.00 | TOTALS | | | — — <u>77, 172</u> 97, 472 | | <u>.</u> | 1.00 |
| | M - Psych Admin Reclass | | | | _ | | |
| 1. 00 2. 00 | ADMINISTRATIVE & GENERAL | 5. 00 0. 00 | 294, 934 | 553, 324 | 0 | | 1. 00 2. 00 |
| 3.00 | | 0.00 | o | 0 | | | 3. 00 |
| 4.00 | | 0.00 | 0 | 0 | 0 |) | 4. 00 |
| | TOTALS | | 294, 934 | 553, 324 | | | |
| 1. 00 | N - Pastoral Ed Allied Health PASTORAL CARE | 23. 00 | 123, 767 | 37, 252 | 0 | | 1. 00 |
| 1. 00 | TOTALS | | 123, 767 | 37, 252 | | | |
| | 0 - Psych Medicine Clinic Rec | | | | | | |
| 1. 00 2. 00 | PSYCH MEDICATION | 93. 18 0. 00 | 527, 034 | 172, 127 0 | 0 | 1 | 1. 00 2. 00 |
| 3.00 | | 0.00 | ol | 0 | 0 | | 3. 00 |
| 4. 00 | | 0.00 | | 0 | 0 | | 4. 00 |
| E00 00 | TOTALS Crand Total: Docroses | | 527, 034 | 172, 127 | | 1 | E00.00 |
| 500.00 | Grand Total: Decreases | I | 2, 907, 887 | 25, 618, 967 | I | I | 500.00 |

Subtotal (sum of lines 1-7)

Reconciling Items

10.00 Total (line 8 minus line 9)

8.00

9.00

8.00

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-0007 Peri od: Worksheet A-7 From 01/01/2019 Part I 12/31/2019 Date/Time Prepared: 8/19/2020 2:00 pm 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 4, 583, 000 0 1.00 0 4, 193, 828 2.00 Land Improvements 0 2.00 3.00 101, 895, 179 6, 985, 018 6, 985, 018 4, 101, 323 3 00 Buildings and Fixtures 0 4.00 Building Improvements 112, 695 26, 724 26, 724 0 4.00 5.00 Fixed Equipment 0 5.00 0 6.00 Movable Equipment 27, 565, 029 4, 000, 521 4, 000, 521 3, 240 6.00 0 7.00 HIT designated Assets 0 7.00 8.00 Subtotal (sum of lines 1-7) 138, 349, 731 11, 012, 263 11, 012, 263 4, 104, 563 8.00 9.00 Reconciling Items 0 9.00 138, 349, 731 4, 104, 563 Total (line 8 minus line 9) 11, 012, 263 O 10.00 11, 012, 263 10.00 Endi ng Bal ance Fully Depreci ated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 4, 583, 000 0 1.00 2.00 Land Improvements 4, 193, 828 0 2.00 3.00 Buildings and Fixtures 104, 778, 874 0 3.00 0) 4.00 Building Improvements 139, 419 4.00 5.00 Fi xed Equipment 0 5.00 Movable Equipment 6.00 31, 562, 310 0 6.00 7.00 HIT designated Assets 0 7.00

145, 257, 431

145, 257, 431

0

0

| Health Financial Systems C | OMMUNITY HOWARD | REGIONAL HEALT | ⁻ H | In Li€ | eu of Form CMS-2 | 2552-10 |
|---|------------------|-----------------|-------------------|-----------------|--------------------------------|---------|
| RECONCILIATION OF CAPITAL COSTS CENTERS | | Provi der C | CN: 15-0007 | Peri od: | Worksheet A-7 | |
| | | | | From 01/01/2019 | | |
| | | | | To 12/31/2019 | Date/Time Pre 8/19/2020 2:0 | pared: |
| | | SI | UMMARY OF CAP | ΙΤΛΙ | 0/19/2020 2.0 | I |
| | | 31 | DIVINIANT OF CALL | ITAL | | |
| Cost Center Description | Depreciation | Lease | Interest | Insurance (see | Taxes (see | |
| | | | | instructions) | instructions) | |
| | 9. 00 | 10.00 | 11.00 | 12.00 | 13. 00 | |
| PART II - RECONCILIATION OF AMOUNTS FROM WO | RKSHEET A, COLUM | N 2, LINES 1 a | and 2 | | | |
| 1.00 CAP REL COSTS-BLDG & FLXT | 0 | C | | 0 | 0 | 1. 00 |
| 2.00 CAP REL COSTS-MVBLE EQUIP | 0 | C | | 0 0 | 0 | 2. 00 |
| 3.00 Total (sum of lines 1-2) | 0 | C | | 0 0 | 0 | 3. 00 |
| | SUMMARY 0 | F CAPITAL | | | | |
| | | | | | | |
| Cost Center Description | | Total (1) (sum | 1 | | | |
| | Capi tal -Relate | | | | | |
| | d Costs (see | through 14) | | | | |
| | instructions) | | | | | |
| | 14. 00 | 15. 00 | | | | |
| PART II - RECONCILIATION OF AMOUNTS FROM WO | RKSHEET A, COLUM | IN 2, LINES 1 a | and 2 | | | |
| 1.00 CAP REL COSTS-BLDG & FLXT | 0 | C | | | | 1. 00 |
| 2.00 CAP REL COSTS-MVBLE EQUIP | 0 | C | | | | 2. 00 |
| 3.00 Total (sum of lines 1-2) | 0 | [C |) | | | 3. 00 |
| | | | | | | |

| Heal th | n Financial Systems COM | MUNITY HOWARD | REGIONAL HEALT | Н | In Lie | u of Form CMS-2 | 2552-10 |
|---------|---|---------------|---|----------------|-------------------|----------------------------------|----------|
| RECON | CILIATION OF CAPITAL COSTS CENTERS | | Provi der Co | | Peri od: | Worksheet A-7 | |
| | | | | | From 01/01/2019 | | |
| | | | | | Го 12/31/2019 | Date/Time Prep 8/19/2020 2:00 | oared: |
| | | COMF | PUTATION OF RAT | ΓΙΟS | ALLOCATION OF | | У |
| | | | | | | | |
| | Cost Center Description | Gross Assets | Capi tal i zed | Gross Assets | Ratio (see | Insurance | |
| | | | Leases | for Ratio | instructions) | | |
| | | | | (col. 1 - col. | | | |
| | | | | 2) | | | |
| | | 1. 00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | |
| | PART III - RECONCILIATION OF CAPITAL COSTS CE | | _ | T | | | |
| 1.00 | CAP REL COSTS-BLDG & FIXT | 113, 695, 121 | 0 | 113, 695, 121 | | 0 | 1. 00 |
| 2.00 | CAP REL COSTS-MVBLE EQUIP | 31, 562, 310 | 0 | 31, 562, 310 | | 0 | 2. 00 |
| 3.00 | Total (sum of lines 1-2) | 145, 257, 431 | 0 | 145, 257, 431 | | 0 | 3. 00 |
| | | ALLOCAT | TION OF OTHER (| CAPI TAL | SUMMARY O | F CAPITAL | |
| | Cost Center Description | Taxes | Other | Total (sum of | Depreciation | Lease | |
| | | | Capi tal -Relate | cols. 5 | | | |
| | | | d Costs | through 7) | | | |
| | | 6. 00 | 7. 00 | 8. 00 | 9. 00 | 10.00 | |
| | PART III - RECONCILIATION OF CAPITAL COSTS CE | ENTERS | | | | | |
| 1.00 | CAP REL COSTS-BLDG & FLXT | 0 | 0 | (| 4, 082, 870 | 0 | 1.00 |
| 2.00 | CAP REL COSTS-MVBLE EQUIP | 0 | 0 | (| 2, 667, 647 | 0 | 2.00 |
| 3.00 | Total (sum of lines 1-2) | 0 | 0 | (| 6, 750, 517 | 0 | 3.00 |
| | | | SL | JMMARY OF CAPI | TAL | | |
| | Cost Center Description | Interest | Insurance (see | Taxes (see | Other | Total (2) (sum | |
| | | | , | , | Capi tal -Rel ate | | |
| | | | , | | d Costs (see | through 14) | |
| | | | | | instructions) | 5 , | |

0 0 0 12. 00

97, 472 0 97, 472 13.00

0 0 0 14. 00

0 0 0 15.00

4, 180, 342 1. 00 2, 667, 647 2. 00 6, 847, 989 3. 00

11.00

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS
CAP REL COSTS-BLDG & FIXT

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

Health Financial Systems
ADJUSTMENTS TO EXPENSES COMMUNITY HOWARD REGIONAL HEALTH
Provider CCN: 15-0007

| | | | | | To 12/31/2019 | | |
|------------------|--|-------------------------|----------------|-----------------------------|-----------------|----------------|------------------|
| | | | | Expense Classification on | | 8/19/2020 2:00 | J pili |
| | | | | To/From Which the Amount is | to be Adjusted | | |
| | | | | | | | |
| | | | | | | | |
| | Cost Center Description | Basi s/Code (2) 1.00 | Amount 2.00 | Cost Center 3.00 | Li ne # 4.00 | Wkst. A-7 Ref. | |
| 1. 00 | Investment income - CAP REL | 1.00 | | CAP REL COSTS-BLDG & FIXT | 1.00 | 5. 00 0 | 1. 00 |
| 2. 00 | COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL | | 0 | CAP REL COSTS-MVBLE EQUIP | 2.00 | 0 | 2. 00 |
| | COSTS-MVBLE EQUIP (chapter 2) | | 0 | CAF REE COSTS-WVDEE EQUIP | | | |
| 3. 00 | Investment income - other (chapter 2) | | 0 | | 0.00 | 0 | 3. 00 |
| 4.00 | Trade, quantity, and time | | 0 | | 0.00 | 0 | 4. 00 |
| 5.00 | discounts (chapter 8) Refunds and rebates of | В | -4, 464 | ADMINISTRATIVE & GENERAL | 5.00 | 0 | 5. 00 |
| 6. 00 | expenses (chapter 8) Rental of provider space by | | 0 | | 0.00 | 0 | 6. 00 |
| | suppliers (chapter 8) | | 0 | | | | |
| 7. 00 | Tel ephone services (pay stations excluded) (chapter | | 0 | | 0.00 | 0 | 7. 00 |
| 0.00 | 21) | | | | 0.00 | | 0.00 |
| 8. 00 | Television and radio service (chapter 21) | | 0 | | 0.00 | 0 | 8. 00 |
| 9. 00 10. 00 | Parking Lot (chapter 21) Provider-based physician | A-8-2 | 0 -210, 558 | | 0.00 | 0 | 9. 00 10. 00 |
| 10.00 | adj ustment | A-0-2 | -210, 556 | | | | |
| 11. 00 | Sale of scrap, waste, etc. (chapter 23) | | 0 | | 0.00 | 0 | 11. 00 |
| 12. 00 | Related organization | A-8-1 | -5, 898, 015 | | | 0 | 12. 00 |
| 13. 00 | transactions (chapter 10) Laundry and Linen service | | 0 | | 0.00 | 0 | 13. 00 |
| 14. 00 15. 00 | Cafeteria-employees and guests Rental of quarters to employee | | -372, 908 | CAFETERI A | 11. 00 0. 00 | 0 | 14. 00 15. 00 |
| 13.00 | and others | | 0 | | | | |
| 16. 00 | Sale of medical and surgical supplies to other than | | 0 | | 0.00 | 0 | 16. 00 |
| 17. 00 | patients Sale of drugs to other than | | 0 | | 0.00 | 0 | 17. 00 |
| 18. 00 | patients Sale of medical records and | | 0 | | 0.00 | 0 | 18. 00 |
| 19. 00 | abstracts Nursing and allied health | | 0 | | 0.00 | 0 | 19. 00 |
| . , . 00 | education (tuition, fees, books, etc.) | | Ç | | 0.00 | | . , , , , |
| 20.00 | Vending machines | | 0 | | 0.00 | 0 | |
| 21. 00 | Income from imposition of interest, finance or penalty | | 0 | | 0.00 | 0 | 21. 00 |
| 22.00 | charges (chapter 21) | | 0 | | 0.00 | | 22.00 |
| 22. 00 | Interest expense on Medicare overpayments and borrowings to | | 0 | | 0.00 | 0 | 22. 00 |
| 23. 00 | repay Medicare overpayments Adjustment for respiratory | A-8-3 | 0 | RESPIRATORY THERAPY | 65. 00 | | 23. 00 |
| 20.00 | therapy costs in excess of | | C | | 00.00 | | 20.00 |
| 24. 00 | limitation (chapter 14) Adjustment for physical | A-8-3 | 0 | PHYSICAL THERAPY | 66.00 | | 24. 00 |
| | therapy costs in excess of limitation (chapter 14) | | | | | | |
| 25. 00 | Utilization review - | | 0 | UTILIZATION REVIEW - SNF | 114.00 | | 25. 00 |
| | physicians' compensation (chapter 21) | | | | | | |
| 26. 00 | Depreciation - CAP REL COSTS-BLDG & FLXT | | 0 | CAP REL COSTS-BLDG & FIXT | 1.00 | o | 26. 00 |
| 27. 00 | Depreciation - CAP REL | | 0 | CAP REL COSTS-MVBLE EQUIP | 2. 00 | 0 | 27. 00 |
| 28. 00 | COSTS-MVBLE EQUIP Non-physician Anesthetist | | 0 | NONPHYSICIAN ANESTHETISTS | 19. 00 | | 28. 00 |
| 29. 00 30. 00 | Physicians' assistant Adjustment for occupational | A-8-3 | 0 | OCCUPATI ONAL THERAPY | 0. 00 67. 00 | 0 | 29. 00 30. 00 |
| 55. 50 | therapy costs in excess of | | 0 | TIENN I | 37.30 | | 55. 50 |
| 30. 99 | limitation (chapter 14) Hospice (non-distinct) (see | | 0 | ADULTS & PEDIATRICS | 30.00 | | 30. 99 |
| | instructions) | A-8-3 | | | | | 31. 00 |
| 31. 00 | Adjustment for speech pathology costs in excess of | A-0-3 | U | SPEECH PATHOLOGY | 68. 00 | | 31.00 |
| 32. 00 | limitation (chapter 14) CAH HIT Adjustment for | | 0 | | 0.00 | 0 | 32. 00 |
| | Depreciation and Interest | | | | | | |
| | | | | | | | |

Provider CCN: 15-0007 Peri od: Worksheet A-8 | Period: | | WOFKSHeet A-o | | From 01/01/2019 | | To 12/31/2019 | Date/Time Prepared:

| | | | | 1 | o 12/31/2019 | Date/Time Pre 8/19/2020 2:0 | |
|--------|--------------------------------|----------------|---------------|------------------------------|-----------------|--------------------------------|--------|
| | | | | Expense Classification on | Worksheet A | 07 1 97 2020 2.0 | O pili |
| | | | | To/From Which the Amount is | | | |
| | | | | TOTT OIL WITCH THE AMOUNT TS | to be haj astea | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | Cost Center Description | Basis/Code (2) | Amount | Cost Center | Li ne # | Wkst. A-7 Ref. | |
| | • | 1.00 | 2. 00 | 3.00 | 4. 00 | 5. 00 | |
| 33. 00 | OTHER ADJUSTMENTS (SPECIFY) | | 0 | | 0.00 | 0 | 33. 00 |
| | (3) | | | | | | |
| 33. 01 | Mi sc Revenue | В | -946 | PASTORAL CARE | 23. 00 | 0 | 33. 01 |
| 33. 02 | Mi sc Revenue | В | -9, 311 | ELECTROCARDI OLOGY | 69. 00 | 0 | 33. 02 |
| 33. 03 | LEASE REVENUE | В | -684, 000 | OPERATION OF PLANT | 7. 00 | 0 | 33. 03 |
| 34.00 | HAF Tax Offset | A | -8, 041, 791 | ADMINISTRATIVE & GENERAL | 5. 00 | 0 | 34.00 |
| 34. 01 | Non-Allow Interest Expense | A | -29, 965 | ADMINISTRATIVE & GENERAL | 5. 00 | 0 | 34. 01 |
| 34. 02 | Chari table | A | -92, 333 | ADMINISTRATIVE & GENERAL | 5. 00 | 0 | 34. 02 |
| | Contri buti ons-Offset | | | | | | |
| 34.03 | Chari tabl e | A | -500 | NURSING ADMINISTRATION | 13. 00 | 0 | 34. 03 |
| | Contri buti ons-Offset | | | | | | |
| 34.04 | Advertising Expense Offset | A | -46, 737 | ADMINISTRATIVE & GENERAL | 5. 00 | 0 | 34. 04 |
| 34. 05 | Governing Board-Offset | A | -3, 169 | ADMINISTRATIVE & GENERAL | 5. 00 | 0 | 34. 05 |
| 34.06 | BH Professional Billing | A | -768, 978 | GENESI S | 93. 01 | 0 | 34. 06 |
| | Expense | | | | | | |
| 34. 07 | BH Professional Billing | A | -540, 497 | HOWARD COUNTY CSS | 93. 06 | 0 | 34. 07 |
| | Expense | | | | | | |
| 34. 08 | BH Professional Billing | A | -265, 008 | CLINTON COUNTY | 93. 07 | 0 | 34. 08 |
| | Expense | | | | | | |
| 34. 09 | BH Professional Billing | A | -30, 109 | NEW BEGINNINGS | 93. 43 | 0 | 34. 09 |
| | Expense | | 0 744 540 | A SAME A SEMENAL | | | |
| 35. 00 | Bad Debt | A | | ADMI NI STRATI VE & GENERAL | 5. 00 | 0 | 00.00 |
| 35. 01 | Misc Revenue Rental Lease | В | · · | HOWARD COUNTY CSS | 93. 06 | 0 | 35. 01 |
| 35. 02 | Vendi ng Revenue | В | · · | DI ETARY | 10.00 | 0 | 35. 02 |
| 50.00 | TOTAL (sum of lines 1 thru 49) | | -25, 816, 009 | ' | | | 50. 00 |
| | (Transfer to Worksheet A, | | | | | | |
| | column 6, line 200.) | | | | | | |

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

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

B. Amount Received - if cost cannot be determined.

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME

Provider CCN: 15-0007

Worksheet A-8-1

Peri od: From 01/01/2019 OFFICE COSTS 12/31/2019 Date/Time Prepared:

| | | | | <u> 8/19/2020 2: 0</u> | O pm |
|-------------------------------|---|--|--|-------------------------|---|
| Li ne No. | Cost Center | Expense I tems | Amount of | Amount | |
| | | | Allowable Cost | Included in | |
| | | | 1 | Wks. A, column | |
| | | | | 5 | |
| 1. 00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | |
| A. COSTS INCURRED AND ADJUSTM | MENTS REQUIRED AS A RESULT OF | TRANSACTIONS WITH RELATED OR | GANIZATIONS OR | CLAIMED | |
| HOME OFFICE COSTS: | | | | | |
| 5. 00 | ADMINISTRATIVE & GENERAL | SPECIALTY PURCH SVSCS-A&G | 567, 170 | 328, 641 | 1.00 |
| 5. 00 | ADMINISTRATIVE & GENERAL | SPECIALTY PURCH PATIENT SVCS | 95, 379 | 0 | 2.00 |
| 54.00 | RADI OLOGY-DI AGNOSTI C | SPECIALTY PURCH PATIENT SVCS | 0 | 26, 465 | 3.00 |
| 57. 00 | CT SCAN | SPECIALTY PURCH PATIENT SVCS | 0 | 7, 924 | 3. 01 |
| 58.00 | MRI | SPECIALTY PURCH PATIENT SVCS | 0 | 7, 706 | 3. 02 |
| 66. 00 | PHYSI CAL THERAPY | SPECIALTY PURCH PATIENT SVCS | 0 | 16, 280 | 3.03 |
| 69. 00 | ELECTROCARDI OLOGY | SPECIALTY PURCH PATIENT SVCS | 0 | 7, 847 | 3.04 |
| 4.00 | EMPLOYEE BENEFITS DEPARTMENT | HOME OFFICE | 1, 231, 599 | 0 | 4.00 |
| 5. 00 | ADMINISTRATIVE & GENERAL | HOME OFFICE | 13, 480, 376 | 24, 463, 407 | 4. 01 |
| 13.00 | NURSING ADMINISTRATION | HOME OFFICE | 1, 334, 920 | 0 | 4. 02 |
| 16.00 | MEDICAL RECORDS & LIBRARY | HOME OFFICE | 845, 917 | 0 | 4. 03 |
| 30.00 | ADULTS & PEDIATRICS | HOME OFFICE | 182, 736 | o | 4.04 |
| I | l l | HOME OFFICE | | 0 | 4. 05 |
| 54. 01 | ONCOLOGY | HOME OFFICE | | 0 | 4. 06 |
| 69.00 | | • | | 0 | 4. 07 |
| | | HOME OFFICE | | 0 | 4. 08 |
| 71. 00 | MEDICAL SUPPLIES CHARGED TO | HOME OFFICE | | 0 | 4. 09 |
| | | | | 24, 858, 270 | 5. 00 |
| | | | 12, 122, 200 | , | |
| | | | | | |
| line 12. | | | | | |
| | 1.00 A. COSTS INCURRED AND ADJUSTM HOME OFFICE COSTS: 5.00 5.00 54.00 57.00 66.00 69.00 4.00 5.00 13.00 16.00 30.00 54.00 54.01 69.00 73.00 73.00 70TALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, | 1. 00 2. 00 A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF HOME OFFICE COSTS: 5. 00 ADMINISTRATIVE & GENERAL 5. 00 ADMINISTRATIVE & GENERAL 54. 00 RADIOLOGY-DIAGNOSTIC 57. 00 CT SCAN 58. 00 MRI 66. 00 PHYSICAL THERAPY 69. 00 ELECTROCARDIOLOGY 4. 00 EMPLOYEE BENEFITS DEPARTMENT 5. 00 ADMINISTRATIVE & GENERAL 13. 00 NURSING ADMINISTRATION 16. 00 MEDICAL RECORDS & LIBRARY 30. 00 ADULTS & PEDIATRICS 54. 00 RADIOLOGY-DIAGNOSTIC 54. 01 ONCOLOGY 69. 00 ELECTROCARDIOLOGY 73. 00 DRUGS CHARGED TO PATIENTS 71. 00 MEDICAL SUPPLIES CHARGED TO TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, | 1.00 2.00 3.00 A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED OR HOME OFFICE COSTS: 5.00 ADMINISTRATIVE & GENERAL 6.00 PHYSICAL THERAPY 5.00 ADMINISTRATIVE & GENERAL 6.00 PHYSICAL THERAPY 5.00 ADMINISTRATIVE & GENERAL 6.00 ADMINISTRATIVE & GENERAL 6.00 ADMINISTRATIVE & GENERAL 6.00 ADMINISTRATIVE & GENERAL 6.00 ADMINISTRATION 6.00 ADMINISTRATIVE 8.00 ADMINISTRATIVE | 1. 00 | Line No. Cost Center Expense I tems Amount of All lowable Cost Included in Nks. A, column 5 Included in Nks. A, column 5 Nks. A, column 5 |

* 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

| nas no | has not been posted to worksheet A, cordinas i and/or 2, the amount arrowable should be indicated in cordinar 4 or this part. | | | | | | | |
|--------|---|--------|---------------|------------------------------|----------------|--|--|--|
| | | | | Related Organization(s) and/ | or Home Office | | | |
| | | | | | | | | |
| | | | | | | | | |
| | Symbol (1) | Name | Percentage of | Name | Percentage of | | | |
| | Symbol (1) | Ivalie | | Name | | | | |
| | | | Ownershi p | | Ownershi p | | | |
| | 1. 00 | 2.00 | 3.00 | 4. 00 | 5. 00 | | | |
| | B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE: | | | | | | | |

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

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

| 6.00 | В | CHNW | 100.00 | 0. 00 | 6. 00 |
|--------|-------------------------|------|--------|-------|--------|
| 7.00 | | | 0.00 | 0. 00 | 7. 00 |
| 8.00 | | | 0.00 | 0. 00 | 8. 00 |
| 9.00 | | | 0.00 | 0. 00 | 9. 00 |
| 10.00 | | | 0.00 | 0. 00 | 10.00 |
| 100.00 | G. Other (financial or | | | | 100.00 |
| | non-financial) specify: | | | | |

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

| | | | | | 8/19/2020 2:0 | |
|-------|----------------|----------------|--|-------------|---------------|-------|
| | Net | Wkst. A-7 Ref. | | | | |
| | Adjustments | | | | | |
| | (col. 4 minus | | | | | |
| | col. 5)* | | | | | |
| | 6. 00 | 7. 00 | | | | |
| Į. | | | ENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZ | ATIONS OR C | CLAI MED | |
| | HOME OFFICE CO | | | | | |
| 1.00 | 238, 529 | | | | | 1. 00 |
| 2. 00 | 95, 379 | | | | | 2. 00 |
| 3.00 | -26, 465 | | | | | 3. 00 |
| 3. 01 | -7, 924 | | | | | 3. 01 |
| 3. 02 | -7, 706 | | | | | 3. 02 |
| 3. 03 | -16, 280 | | | | | 3. 03 |
| 3. 04 | -7, 847 | | | | | 3. 04 |
| 4.00 | 1, 231, 599 | 1 | | | | 4. 00 |
| 4. 01 | -10, 983, 031 | | | | | 4. 01 |
| 4. 02 | 1, 334, 920 | | | | | 4. 02 |
| 4. 03 | 845, 917 | | | | | 4. 03 |
| 4.04 | 182, 736 | | | | | 4. 04 |
| 4. 05 | 22, 296 | | | | | 4. 05 |
| 4.06 | 148, 474 | | | | | 4. 06 |
| 4. 07 | 27, 025 | 1 | | | | 4. 07 |
| 4. 08 | 398, 281 | 0 | | | | 4. 08 |
| 4. 09 | 626, 082 | | | | | 4. 09 |
| 5.00 | -5, 898, 015 | | | | | 5. 00 |

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

| Related Organization(s) | | |
|-------------------------------|---|--|
| and/or Home Office | | |
| | | |
| | | |
| Type of Business | | |
| | | |
| 6. 00 | | |
| B. INTERRELATIONSHIP TO RELAT | FED 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.

| Termbar Sement under titte AVIII. | | | |
|-----------------------------------|--|--------|----------|
| 6.00 | | 6.00 | <u> </u> |
| 7. 00 8. 00 | | 7.00 | |
| 8. 00 | | 8.00 | |
| 9.00 | | 9.00 |) |
| 10. 00 | | 10.00 |) |
| 10. 00 100. 00 | | 100.00 |) |

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provi der CCN: 15-0007

Peri od: Worksheet A-8-2 From 01/01/2019 To 12/31/2019 Date/Time Prepared:

8/19/2020 2:00 pm Wkst. A Line # Cost Center/Physician Total Professi onal Provi der RCE Amount Physi ci an/Prov Identi fi er ider Component Remuneration Component Component Hours 1. 00 2.00 3.00 4.00 5. 00 6. 00 7. 00 5. OO AGGREGATE-ADMINISTRATIVE & 185, 000 211, 500 1, 248 1.00 8,068 193, 068 1.00 GENERAL 2.00 30. 00 AGGREGATE-ADULTS & 144, 390 144, 390 2.00 0 PEDI ATRI CS 3.00 0.00 0 3.00 0 ol 0.00 0 0 4.00 0 0 4.00 5.00 0.00 0 0 0 0 0 5.00 6.00 0.00 0 0 0 0 6.00 7.00 0.00 0 0 0 0 7 00 0.00 8.00 0 0 0 8.00 9.00 0.00 9.00 0 10.00 0.00 0 10.00 185,000 1, 248 200.00 200.00 337.458 152, 458 Wkst. A Line # Cost Center/Physician Unadjusted RCE 5 Percent of Cost of Provi der Physician Cost I denti fi er Unadjusted RCE Memberships & Component of Malpractice Limit Conti nui ng Share of col. Insurance Educati on 12. 00 1. 00 2.00 8.00 9.00 13. 00 14.00 1.00 5. 00 AGGREGATE-ADMINISTRATIVE & 126, 900 6, 345 0 1.00 GENERAL 2.00 30. 00 AGGREGATE-ADULTS & 0 0 2.00 PEDI ATRI CS 3.00 0.00 0 3.00 0.00 0 0 4.00 0 0 0 0 0 0 4.00 0.00 5.00 0 0 0 5.00 0.00 0 0 6.00 6.00 7.00 0.00 0 0 0 7.00 0.00 0 0 8.00 8.00 9.00 0.00 9.00 10.00 0.00 0 0 10.00 126, 900 o 200.00 200.00 6.345 Cost Center/Physician Wkst. A Line # Provi der Adjusted RCE RCE Adjustment I denti fi er Component Limit Di sal I owance Share of col. 14 1. 00 2.00 15. 00 16. 00 17. 00 18. 00 1.00 5. 00 AGGREGATE-ADMINISTRATIVE & 126, 900 58, 100 66, 168 1.00 GENERAL 2.00 30. 00 AGGREGATE-ADULTS & 144, 390 2.00 PEDI ATRI CS 3.00 0.00 0 3.00 0.00 0 0 4.00 0 0 4.00 5.00 0.00 0 0 0 5.00 0.00 0 0 0 6.00 0 6.00 01 0 7.00 0.00 7.00 0 0 0.00 0 8.00 0 0 0 8.00 9.00 0.00 0 9.00 10.00 0.00 0 0 10.00 126, 900 58, 100 210, 558 200.00 200.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS COMMUNITY HOWARD REGIONAL HEALTH In Lieu of Form CMS-2552-10 Worksheet B Part I Date/Time Prepared: 8/19/2020 2:00 pm Provider CCN: 15-0007 Peri od: From 01/01/2019 To 12/31/2019 CAPITAL RELATED COSTS Cost Center Description Net Expenses | BLDG & FIXT | MVBLE EQUIP EMPLOYEE Subtotal

| | Cost Center Description | Net Expenses for Cost Allocation | BLDG & FIXT | MVBLE EQUIP | EMPLOYEE BENEFITS DEPARTMENT | Subtotal | |
|------------------|--|--|--------------|-------------|------------------------------------|------------------------|--------------------|
| | | (from Wkst A col. 7) | | | | | |
| | | 0 | 1.00 | 2. 00 | 4. 00 | 4A | |
| 4 00 | GENERAL SERVICE COST CENTERS | 4 400 040 | 4 400 040 | | | | 4 00 |
| 1. 00 2. 00 | 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP | 4, 180, 342 2, 667, 647 | | 2, 667, 647 | | | 1. 00 2. 00 |
| 4.00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | 1, 545, 733 | | | 1, 607, 949 | | 4.00 |
| 5. 00 | 00500 ADMINISTRATIVE & GENERAL | 21, 683, 756 | l | | 157, 095 | 23, 527, 302 | 5. 00 |
| 7.00 | 00700 OPERATION OF PLANT | 6, 434, 141 | 424, 633 | | 56, 008 | 7, 185, 757 | 7. 00 |
| 8.00 | 00800 LAUNDRY & LINEN SERVICE | 387, 122 | l | | 3, 275 | 426, 366 | |
| 9.00 | 00900 HOUSEKEEPI NG | 1, 962, 438 | | | 36, 985 | 2, 038, 279 | |
| 10. 00 11. 00 | 01000 DI ETARY 01100 CAFETERI A | 622, 853 854, 445 | l | | 12, 690 21, 614 | 719, 260 975, 289 | |
| 13. 00 | 01300 NURSING ADMINISTRATION | 2, 403, 371 | 7, 363 | | 31, 659 | 2, 447, 092 | 13.00 |
| 16. 00 | 01600 MEDICAL RECORDS & LIBRARY | 845, 917 | | | 01,007 | 895, 276 | |
| 17. 00 | 01700 SOCIAL SERVICE | 627, 808 | l | | 19, 090 | 646, 898 | 1 |
| 19. 00 | 01900 NONPHYSICIAN ANESTHETISTS | 0 | 0 | | 0 | 0 | 19. 00 |
| 23. 00 | | 208, 537 | 8, 751 | 5, 584 | 5, 996 | 228, 868 | 23. 00 |
| 30. 00 | I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS | 12, 783, 143 | 570, 748 | 364, 217 | 333, 738 | 14, 051, 846 | 30.00 |
| 31. 00 | 03100 NTENSI VE CARE UNI T | 1, 840, 665 | l | | 46, 100 | 1, 973, 452 | 1 |
| 43. 00 | 04300 NURSERY | 315, 363 | | | 7, 912 | 354, 416 | |
| | ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50.00 | 05000 OPERATING ROOM | 5, 830, 180 | | | 98, 662 | 6, 257, 376 | 1 |
| 52. 00 53. 00 | 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY | 935, 113 | | | 23, 460 0 | 1, 050, 902 0 | 52. 00 53. 00 |
| 54. 00 | 05400 RADI OLOGY-DI AGNOSTI C | 2, 557, 120 | ľ | - | 59, 788 | 2, 935, 471 | 54.00 |
| 54. 01 | 03480 ONCOLOGY | 4, 287, 420 | | | 51, 032 | 4, 679, 130 | |
| 57.00 | 05700 CT SCAN | 818, 561 | 6, 077 | 3, 878 | 17, 884 | 846, 400 | 57. 00 |
| 58. 00 | 05800 MRI | 980, 810 | l . | | 14, 167 | 994, 977 | 1 |
| 59.00 | 05900 CARDI AC CATHETERI ZATI ON | 1, 037, 593 | | | 25, 215 | 1, 132, 490 | |
| 60. 00 63. 00 | 06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS. | 4, 717, 081 | 49, 677 0 | | 0 0 | 4, 798, 459 0 | 60. 00 63. 00 |
| 65. 00 | 06500 RESPIRATORY THERAPY | 1, 597, 473 | | | 43, 084 | 1, 713, 458 | 1 |
| 66. 00 | 06600 PHYSI CAL THERAPY | 554, 432 | l | | 15, 888 | 581, 602 | 1 |
| 67. 00 | 06700 OCCUPATI ONAL THERAPY | 310, 198 | | | 8, 525 | 336, 425 | |
| 68. 00 | 06800 SPEECH PATHOLOGY | 84, 125 | | | 2, 299 | 93, 890 | |
| 69. 00 70. 00 | 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY | 1, 399, 636 38, 145 | l | | 34, 160 985 | 1, 435, 521 44, 423 | 1 |
| 70.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 6, 049, 051 | 65, 214 | | 903 | 6, 155, 880 | |
| 72. 00 | 07200 I MPL. DEV. CHARGED TO PATIENTS | 6, 815, 633 | | | Ö | 6, 815, 633 | 1 |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 16, 871, 275 | 34, 627 | 22, 097 | 77, 640 | 17, 005, 639 | 73. 00 |
| 74. 00 | 07400 RENAL DI ALYSI S | 298, 311 | 0 | _ | 0 | 298, 311 | 1 |
| 75. 00 75. 01 | 07500 ASC (NON-DISTINCT PART) 03950 WOUND CARE CENTER | 611, 300 | 1 | - | 0 13, 903 | 0 659, 480 | 75. 00 75. 01 |
| 76. 00 | 03160 CARDI OPULMONARY | 215, 896 | l | | 5, 748 | 221, 644 | 1 |
| , 0. 00 | OUTPATIENT SERVICE COST CENTERS | 210,070 | | <u> </u> | 37 7 13 | 22.7011 | 70.00 |
| 91. 00 | I I | 3, 888, 219 | 231, 554 | 147, 764 | 91, 812 | 4, 359, 349 | 1 |
| 92. 00 | | | | | | 0 | 1 |
| 92. 01 93. 00 | 09201 OBSERVATION BEDS (DISTINCT PART) 04950 OTHER OUTPATIENT SERVICES | 0 | | 0 | ol ol | 0 | 1 |
| 93. 00 | 04951 GENESIS | 1, 615, 251 | 0 | | 53, 291 | 1, 668, 542 | 93. 01 |
| 93. 02 | 04952 WOMEN' S CENTER | 0 | Ö | Ö | 0 | 0 | 93. 02 |
| 93. 03 | 04953 RESIDENTIAL HOMES | 0 | 0 | 0 | o | 0 | 93. 03 |
| 93. 04 | | 0 | 0 | 0 | 0 | 0 | 93. 04 |
| 93. 05 93. 06 | 04955 DI ABETI C EDUCATION | 0 | 0 | 0 | 10.744 | 215 250 | 93. 05 93. 06 |
| 93.06 | 04956 HOWARD COUNTY CSS 04957 CLI NTON COUNTY | 296, 595 321, 851 | 0 | 0 | 18, 764 12, 563 | 315, 359 334, 414 | |
| 93. 18 | 04968 PSYCH MEDICATION | 021,001 | Ö | o o | 0 | 0 | 1 |
| 93. 43 | | 76, 057 | 0 | 0 | 1, 279 | 77, 336 | 93. 43 |
| 05.00 | OTHER REIMBURSABLE COST CENTERS | 1 001 (0) | 47.504 | | | 1 000 5/0 | |
| 95. 00 | O9500 AMBULANCE SERVI CES SPECI AL PURPOSE COST CENTERS | 1, 831, 626 | 17, 521 | 11, 181 | 43, 241 | 1, 903, 569 | 95. 00 |
| 113. 0 | 11300 INTEREST EXPENSE | | | | | | 113. 00 |
| | 11400 UTILIZATION REVIEW - SNF | | | | | | 114. 00 |
| 118. 0 | . 3 / | 123, 402, 233 | 3, 536, 896 | 2, 257, 038 | 1, 445, 552 | 122, 185, 781 | 118. 00 |
| 100.0 | NONREI MBURSABLE COST CENTERS | 1 ~ | | | اء | | 100.00 |
| | D 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1 19001 COMMUNITY HOWARD FOUNDATION | 0 89, 787 | - | | 0 2, 536 | | 190. 00 190. 01 |
| | 1900 PHYSICIANS' PRIVATE OFFICES | 3, 404, 062 | ŀ | | 79, 993 | 3, 983, 840 | |
| 193.0 | 19300 NONPALD WORKERS | 0 | 0 | 0 | 0 | 0 | 193. 00 |
| 194. 0 | 07950 HEALTHY CHILDREN | 0 | 0 | o | o | 0 | 194. 00 |
| | | | | | | | |

| Health Financial Systems | COMMUNITY HOWARD REGIONAL HEALTH | In Lie | u of Form CMS-2552-10 |
|---|----------------------------------|--|--|
| COST ALLOCATION - GENERAL SERVICE COSTS | Provi der CCN: 15-0007 | Peri od: From 01/01/2019 To 12/31/2019 | Worksheet B Part I Date/Time Prepared: |

| | | | | 12/31/2019 | 8/19/2020 2:0 | |
|--|---|--------------|-------------|------------------------------------|---------------|---------|
| | | CAPI TAL REL | LATED COSTS | | | |
| Cost Center Description | Net Expenses for Cost Allocation (from Wkst A col. 7) | BLDG & FIXT | MVBLE EQUIP | EMPLOYEE BENEFITS DEPARTMENT | Subtotal | |
| | 0 | 1.00 | 2.00 | 4. 00 | 4A | |
| 194.08 07958 SOUTH BERKLEY BLDG | 800 | 0 | 0 | 0 | 800 | 194. 08 |
| 194.09 07959 MOBILE CLINIC | 43, 797 | 0 | 0 | 1, 161 | 44, 958 | 194. 09 |
| 194. 10 07960 PLASTIC SURGERY | 21, 437 | 0 | 0 | 0 | 21, 437 | 194. 10 |
| 194.11 07961 KOKOMO SCHOOL BASED | 2, 642, 184 | 0 | 0 | 78, 707 | 2, 720, 891 | 194. 11 |
| 194. 15 07965 INDIANA SURGERY CENTER | 37 | 338, 353 | 215, 917 | 0 | 554, 307 | 194. 15 |
| 194.16 07966 PASTORAL CARE ALLIED HEALTH | 0 | 0 | 0 | 0 | 0 | 194. 16 |
| 200.00 Cross Foot Adjustments | | | | | 0 | 200. 00 |
| 201.00 Negative Cost Centers | | 0 | 0 | 0 | 0 | 201. 00 |
| 202.00 TOTAL (sum lines 118 through 201) | 129, 604, 337 | 4, 180, 342 | 2, 667, 647 | 1, 607, 949 | 129, 604, 337 | 202. 00 |

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0007

Peri od: Worksheet B From 01/01/2019 Part I To 12/31/2019 Date/Time Prepared:

8/19/2020 2:00 pm 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 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 23, 527, 302 5 00 5 00 7.00 00700 OPERATION OF PLANT 1, 593, 758 8, 779, 515 7.00 94, 565 00800 LAUNDRY & LINEN SERVICE 574, 625 8.00 53, 694 8.00 9.00 00900 HOUSEKEEPI NG 452,078 58, 004 0 2, 548, 361 9.00 01000 DI ETARY 159, 528 1, 040, 503 10.00 10.00 124, 973 0 36, 742 11.00 01100 CAFETERI A 216, 313 148, 130 43, 551 11.00 0 13 00 01300 NURSING ADMINISTRATION 542, 750 18,005 0 5, 294 0 13.00 198, 567 01600 MEDICAL RECORDS & LIBRARY 0 16.00 16 00 73, 681 21,662 0 0 17.00 01700 SOCIAL SERVICE 143, 478 0 17.00 19.00 01900 NONPHYSICIAN ANESTHETISTS 0 0 19.00 02300 PASTORAL CARE 50, 762 <u>6,</u> 291 23.00 21, 398 23.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 3, 116, 615 1, 395, 705 505, 241 410, 341 914, 866 30.00 03100 INTENSIVE CARE UNIT 31.00 437, 700 129, 406 44, 258 38, 046 80, 139 31.00 04300 NURSERY ANCILLARY SERVICE COST CENTERS 25, 126 78, 607 46, 487 45, 498 43.00 43.00 13, 667 50.00 05000 OPERATING ROOM 1, 387, 848 490, 431 144, 188 50.00 0 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 233, 084 137, 827 40, 521 0 52.00 05300 ANESTHESI OLOGY 0 0 53.00 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 651, 070 475, 546 139, 812 0 54.00 54.01 03480 ONCOLOGY 1,037,803 508, 560 0 149, 518 0 54.01 57.00 05700 CT SCAN 187, 726 0 57.00 14, 860 4.369 0 05800 MRI 0 58 00 220, 680 0 58.00 05900 CARDIAC CATHETERIZATION 59.00 251, 179 104,020 0 30, 582 0 59.00 06000 LABORATORY 60.00 1,064,269 121, 481 35, 716 0 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 0 63.00 06500 RESPIRATORY THERAPY 380, 035 108, 825 0 31, 995 65.00 0 65.00 66.00 06600 PHYSI CAL THERAPY 128, 996 16, 841 4, 951 0 66.00 06700 OCCUPATI ONAL THERAPY 0 67.00 74,617 26, 426 7,769 0 67.00 68 00 06800 SPEECH PATHOLOGY 20 824 11 145 0 3, 277 0 68 00 06900 ELECTROCARDI OLOGY 0 69.00 318, 390 2, 576 757 0 69.00 07000 ELECTROENCEPHALOGRAPHY 9,853 7, 901 0 2, 323 0 70.00 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 1, 365, 337 159, 473 0 46, 886 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 1, 511, 667 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 3, 771, 801 84, 678 0 24, 895 0 73.00 07400 RENAL DIALYSIS 66, 164 74.00 0 0 74.00 75 00 07500 ASC (NON-DISTINCT PART) 0 Ω 75 00 0 03950 WOUND CARE CENTER 75.01 146, 269 51, 168 15,044 0 75.01 03160 CARDI OPULMONARY 0 76.00 76.00 49, 159 OUTPATIENT SERVICE COST CENTERS 91 00 O 91 00 09100 EMERGENCY 966.877 566, 242 166, 477 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.01 09201 OBSERVATION BEDS (DISTINCT PART) 0 0 92.01 04950 OTHER OUTPATIENT SERVICES 93.00 93.00 0 0 04951 GENESI S 0 93.01 370.073 93.01 735, 572 216, 260 0 93.02 04952 WOMEN'S CENTER 0 0 93.02 04953 RESIDENTIAL HOMES 93.03 93.03 0 0 04954 DR. STEELE 0 93.04 93.04 0 0 0 0 0 93.05 93 05 04955 DIABETIC EDUCATION 0 0 0 04956 HOWARD COUNTY CSS 69, 945 0 93.06 93.06 245, 191 72,087 93 07 04957 CLINTON COUNTY 74, 171 0 0 93.07 0 04968 PSYCH MEDICATION 0 93. 18 93.18 0 0 0 93.43 04993 NEW BEGINNINGS 17.153 0 93.43 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 0 95.00 422, 200 42, 846 12, 597 0 95.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW - SNF 114.00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 21, 881, 911 5, 981, 092 574, 625 1, 725, 618 1, 040, 503 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 190. 01 19001 COMMUNITY HOWARD FOUNDATION 0 0 190. 01 20, 477 192.00 19200 PHYSICIANS' PRIVATE OFFICES 1, 971, 015 0 579, 483 0 192, 00 883.592 193. 00 19300 NONPALD WORKERS 0 0 193. 00 194. 00 07950 HEALTHY CHILDREN 0 0 0 194.00 0 0 194. 08 07958 SOUTH BERKLEY BLDG 177 0 0 0 194. 08 0 194. 09 07959 MOBILE CLINIC 0 0 194. 09 9.971 0 C 194. 10 07960 PLASTIC SURGERY 4,755 0 0 0 194. 10 C 194. 11 07961 KOKOMO SCHOOL BASED 0 194. 11 603, 477 0 194. 15 07965 INDIANA SURGERY CENTER 122, 942 827.408 0 0 194. 15 243 260

Health Financial Systems COMMUNITY HOWARD REGIONAL HEALTH In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0007
From 01/01/2019
To 12/31/2019
Date/Time Prepared:
8/19/2020 2:00 pm

| | | | | | | 0/19/2020 2.0 | U PIII |
|---------------|-----------------------------------|-------------------|--------------|---------------|---------------|---------------|---------|
| | Cost Center Description | ADMI NI STRATI VE | OPERATION OF | LAUNDRY & | HOUSEKEEPI NG | DI ETARY | |
| | | & GENERAL | PLANT | LINEN SERVICE | | | |
| | | 5. 00 | 7. 00 | 8. 00 | 9. 00 | 10.00 | |
| 194. 16 07966 | PASTORAL CARE ALLIED HEALTH | 0 | 0 | 0 | 0 | 0 | 194. 16 |
| 200.00 | Cross Foot Adjustments | | | | | | 200.00 |
| 201.00 | Negative Cost Centers | 0 | 0 | 0 | 0 | 0 | 201.00 |
| 202. 00 | TOTAL (sum lines 118 through 201) | 23, 527, 302 | 8, 779, 515 | 574, 625 | 2, 548, 361 | 1, 040, 503 | 202. 00 |

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2019 Part I
To 12/31/2019 Date/Time Prepared:
8/19/2020 2:00 pm Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS COMMUNITY HOWARD REGIONAL HEALTH Provider CCN: 15-0007

| | | | | | ' | | 8/19/2020 2:0 | |
|------------------|--------|--|------------------------|-------------------|-----------------------|----------------|---------------|--------------------|
| | | Cost Center Description | CAFETERI A | NURSI NG | | SOCIAL SERVICE | | |
| | | | | ADMI NI STRATI ON | RECORDS & LI BRARY | | ANESTHETI STS | |
| | | | 11. 00 | 13.00 | 16. 00 | 17. 00 | 19. 00 | |
| | | AL SERVICE COST CENTERS | | | | | | |
| 1.00 | 1 | CAP REL COSTS-BLDG & FIXT | | | | | | 1.00 |
| 2. 00 4. 00 | | CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT | | | | | | 2. 00 4. 00 |
| 5.00 | 1 | ADMINISTRATIVE & GENERAL | | | | | | 5. 00 |
| 7. 00 | | OPERATION OF PLANT | | | | | | 7. 00 |
| 8.00 | 1 | LAUNDRY & LINEN SERVICE | | | | | | 8. 00 |
| 9.00 | | HOUSEKEEPI NG | | | | | | 9. 00 |
| 10.00 | | DIETARY | 4 000 000 | | | | | 10.00 |
| 11. 00 13. 00 | | CAFETERIA NURSING ADMINISTRATION | 1, 383, 283 41, 261 | 3, 054, 402 | | | | 11. 00 13. 00 |
| 16. 00 | | MEDICAL RECORDS & LIBRARY | 41, 201 | 3,034,402 | | | | 16. 00 |
| 17. 00 | | SOCIAL SERVICE | 24, 844 | 58, 938 | | 874, 158 | | 17. 00 |
| 19. 00 | | NONPHYSICIAN ANESTHETISTS | 0 | 0 | | O | 0 | |
| 23. 00 | | PASTORAL CARE | 7, 803 | 0 | 0 | 0 | | 23. 00 |
| 30. 00 | | I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS | 456, 064 | 1, 500, 405 | 108, 820 | 768, 606 | 0 | 30. 00 |
| 31. 00 | | INTENSIVE CARE UNIT | 65, 148 | 1 | | 67, 328 | 0 | |
| 43. 00 | | NURSERY | 10, 296 | l · | | 38, 224 | 0 | |
| | ANCI L | LARY SERVICE COST CENTERS | · | | · | · | | |
| 50. 00 | 1 | OPERATI NG ROOM | 146, 187 | 457, 013 | | 0 | 0 | • |
| 52.00 | | DELIVERY ROOM & LABOR ROOM | 30, 530 | l ' | 6, 801 | 0 | 0 | 52.00 |
| 53. 00 54. 00 | | ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C | 79, 683 | 0 | | 0 | 0 | 53. 00 54. 00 |
| 54. 01 | | ONCOLOGY | 66, 549 | 1 | | 0 | 0 | 54. 01 |
| 57. 00 | 1 | CT SCAN | 23, 274 | 0 1,700 | | Ö | 0 | 57. 00 |
| 58. 00 | 05800 | | 5, 964 | 8, 100 | 27, 131 | 0 | 0 | 58. 00 |
| 59. 00 | | CARDI AC CATHETERI ZATI ON | 33, 187 | 75, 423 | | 0 | 0 | 59. 00 |
| 60.00 | 1 | LABORATORY | 0 | 0 | | 0 | 0 | 60.00 |
| 63. 00 65. 00 | | BLOOD STORING, PROCESSING & TRANS. RESPIRATORY THERAPY | 56, 718 | 0 | 0 19, 780 | 0 | 0 | 63. 00 65. 00 |
| 66. 00 | 1 | PHYSI CAL THERAPY | 20, 974 | 0 | | 0 | 0 | 66.00 |
| 67. 00 | 1 | OCCUPATI ONAL THERAPY | 11, 094 | Ō | 1 | Ö | 0 | 67. 00 |
| 68. 00 | | SPEECH PATHOLOGY | 2, 992 | 0 | 506 | O | 0 | 68. 00 |
| 69. 00 | 1 | ELECTROCARDI OLOGY | 44, 963 | 1 | | 0 | 0 | 69. 00 |
| 70.00 | 1 | ELECTROENCEPHALOGRAPHY | 1, 282 | 0 | | 0 | 0 | 70.00 |
| 71. 00 72. 00 | | MEDICAL SUPPLIES CHARGED TO PATIENT IMPL. DEV. CHARGED TO PATIENTS | 0 | 0 | 40, 360 36, 745 | 0 | 0 | 71. 00 72. 00 |
| 73. 00 | | DRUGS CHARGED TO PATTENTS | 101, 110 | · | 196, 696 | 0 | 0 | 73.00 |
| 74. 00 | | RENAL DIALYSIS | 0 | Ö | 1, 189 | o | 0 | 74. 00 |
| 75. 00 | 07500 | ASC (NON-DISTINCT PART) | 0 | 0 | 0 | O | 0 | 75. 00 |
| 75. 01 | | WOUND CARE CENTER | 18, 131 | 43, 648 | | 0 | 0 | 75. 01 |
| 76. 00 | | CARDIOPULMONARY TIENT SERVICE COST CENTERS | 7, 480 | 16, 480 | 2, 505 | 0 | 0 | 76. 00 |
| 91. 00 | | EMERGENCY | 127, 749 | 400, 757 | 138, 505 | o | 0 | 91. 00 |
| 92. 00 | | OBSERVATION BEDS (NON-DISTINCT PART | 127,717 | 100,707 | 100,000 | | Ü | 92.00 |
| 92. 01 | 09201 | OBSERVATION BEDS (DISTINCT PART) | 0 | 0 | 0 | 0 | 0 | |
| 93. 00 | 1 | OTHER OUTPATIENT SERVICES | 0 | 0 | 0 | 0 | 0 | |
| 93. 01 | | GENESI S | 0 | 0 | 7, 690 | 0 | 0 | 93. 01 |
| 93. 02 93. 03 | | WOMEN' S CENTER RESI DENTI AL HOMES | 0 | 0 | 0 | 0 | 0 | 93. 02 93. 03 |
| 93. 04 | 1 | DR. STEELE | 0 | 0 | 0 | 0 | 0 | 93. 04 |
| 93. 05 | | DI ABETI C EDUCATION | 0 | Ō | Ō | Ö | 0 | 93. 05 |
| 93. 06 | 04956 | HOWARD COUNTY CSS | 0 | 0 | 271 | 0 | 0 | 93. 06 |
| 93. 07 | 1 | CLINTON COUNTY | 0 | 0 | 942 | 0 | 0 | 93. 07 |
| 93. 18 | | PSYCH MEDICATION | 0 | 0 | 0 | 0 | 0 | 93. 18 |
| 93. 43 | | NEW BEGINNINGS REIMBURSABLE COST CENTERS | 0 | 0 | 56 | 0 | 0 | 93. 43 |
| 95. 00 | | AMBULANCE SERVICES | 0 | 0 | 12, 621 | o | 0 | 95. 00 |
| 70.00 | | AL PURPOSE COST CENTERS | | | 12,021 | 91 | | 70.00 |
| | | INTEREST EXPENSE | | | | | | 113. 00 |
| | 1 | UTILIZATION REVIEW - SNF | | | | | _ | 114. 00 |
| 118.00 | | SUBTOTALS (SUM OF LINES 1 through 117) | 1, 383, 283 | 3, 054, 402 | 1, 189, 186 | 874, 158 | 0 | 118. 00 |
| 100 00 | | IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | 0 | 0 | ol | 0 | 190. 00 |
| | | COMMUNITY HOWARD FOUNDATION | 0 | 0 | | | | 190. 00 |
| | | PHYSICIANS' PRIVATE OFFICES | 0 | 0 | Ö | o | | 192. 00 |
| 193.00 | 19300 | NONPALD WORKERS | 0 | 0 | 0 | 0 | 0 | 193. 00 |
| | | HEALTHY CHILDREN | 0 | 0 | 0 | 0 | 0 | 194. 00 |
| | | SOUTH BERKLEY BLDG MOBILE CLINIC | 0 | 0 | 0 | 0 | | 194. 08 194. 09 |
| | | PLASTIC SURGERY | 0 | | 0 | | | 194. 09 |
| | 1 | KOKOMO SCHOOL BASED | 0 | o o | | o | | 194. 10 |
| | | | | | | | | |

Health Financial Systems COMMUNITY HOWARD REGIONAL HEALTH In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0007
From 01/01/2019
To 12/31/2019
Date/Time Prepared:

| | | | | | | 8/19/2020 2:0 | O pm |
|---------------|-----------------------------------|-------------|-------------------|-------------|----------------|----------------|---------|
| | Cost Center Description | CAFETERI A | NURSI NG | MEDI CAL | SOCIAL SERVICE | NONPHYSI CI AN | |
| | | | ADMI NI STRATI ON | RECORDS & | | ANESTHETI STS | |
| | | | | LI BRARY | | | |
| | | 11. 00 | 13.00 | 16.00 | 17. 00 | 19. 00 | |
| 194. 15 07965 | INDIANA SURGERY CENTER | 0 | 0 | C | 0 | 0 | 194. 15 |
| 194. 16 07966 | PASTORAL CARE ALLIED HEALTH | 0 | o | C | 0 | 0 | 194. 16 |
| 200. 00 | Cross Foot Adjustments | | | | | 0 | 200. 00 |
| 201.00 | Negative Cost Centers | 0 | o | C | 0 | 0 | 201. 00 |
| 202.00 | TOTAL (sum lines 118 through 201) | 1, 383, 283 | 3, 054, 402 | 1, 189, 186 | 874, 158 | 0 | 202. 00 |

| Peri od: | Worksheet B | From 01/01/2019 | Part | | To 12/31/2019 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS COMMUNITY HOWARD REGIONAL HEALTH Provider CCN: 15-0007

| | | | | | T | 12/31/2019 | Date/Time Prep 8/19/2020 2:00 | |
|------------------|-------|--|---------------|----------------------------|--------------------------|----------------------------|----------------------------------|--------------------|
| | | Cost Center Description | PASTORAL CARE | Subtotal | Intern & | Total | 0/1//2020 2.00 | Э ріп |
| | | | | | Residents Cost & Post | | | |
| | | | | | Stepdown | | | |
| | | | 23.00 | 24.00 | Adjustments 25.00 | 26. 00 | | |
| | GENER | AL SERVICE COST CENTERS | 23.00 | 24.00 | 23.00 | 20.00 | | |
| 1.00 | | CAP REL COSTS MAYBLE FOULD | | | | | | 1.00 |
| 2. 00 4. 00 | | CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT | | | | | | 2. 00 4. 00 |
| 5. 00 | | ADMINISTRATIVE & GENERAL | | | | | | 5. 00 |
| 7.00 | | OPERATION OF PLANT | | | | | | 7. 00 |
| 8. 00 9. 00 | | LAUNDRY & LINEN SERVICE HOUSEKEEPING | | | | | | 8. 00 9. 00 |
| 10. 00 | 1 | DI ETARY | | | | | | 10. 00 |
| 11.00 | 1 | CAFETERI A | | | | | | 11.00 |
| 13. 00 16. 00 | | NURSING ADMINISTRATION MEDICAL RECORDS & LIBRARY | | | | | | 13. 00 16. 00 |
| 17. 00 | | SOCIAL SERVICE | | | | | | 17. 00 |
| 19. 00 | | NONPHYSICIAN ANESTHETISTS | | | | | | 19. 00 |
| 23. 00 | | PASTORAL CARE ENT ROUTINE SERVICE COST CENTERS | 315, 122 | | | | | 23. 00 |
| 30. 00 | | ADULTS & PEDIATRICS | 315, 122 | 23, 543, 631 | 0 | 23, 543, 631 | | 30. 00 |
| 31. 00 | 1 | INTENSIVE CARE UNIT | O | 3, 075, 414 | | 3, 075, 414 | | 31. 00 |
| 43. 00 | | NURSERY LARY SERVICE COST CENTERS | 0 | 651, 379 | 0 | 651, 379 | | 43. 00 |
| 50. 00 | | OPERATING ROOM | O | 9, 021, 896 | 0 | 9, 021, 896 | | 50. 00 |
| 52. 00 | 05200 | DELIVERY ROOM & LABOR ROOM | o | 1, 608, 676 | | 1, 608, 676 | | 52. 00 |
| 53.00 | | ANESTHESI OLOGY | 0 | 0 | _ | 0 | | 53.00 |
| 54. 00 54. 01 | 1 | RADI OLOGY-DI AGNOSTI C ONCOLOGY | | 4, 332, 323 6, 592, 795 | | 4, 332, 323 6, 592, 795 | | 54. 00 54. 01 |
| 57. 00 | | CT SCAN | Ö | 1, 144, 324 | | 1, 144, 324 | | 57. 00 |
| 58. 00 | 05800 | | 0 | 1, 256, 852 | | 1, 256, 852 | | 58. 00 |
| 59. 00 60. 00 | | CARDI AC CATHETERI ZATI ON LABORATORY | 0 | 1, 724, 343 6, 129, 764 | | 1, 724, 343 6, 129, 764 | | 59. 00 60. 00 |
| 63. 00 | 1 | BLOOD STORING, PROCESSING & TRANS. | | 0, 129, 704 | | 0, 129, 704 | | 63. 00 |
| 65.00 | 06500 | RESPI RATORY THERAPY | O | 2, 310, 811 | 0 | 2, 310, 811 | | 65. 00 |
| 66.00 | 1 | PHYSI CAL THERAPY | 0 | 756, 830 | | 756, 830 | | 66. 00 |
| 67. 00 68. 00 | 1 | OCCUPATIONAL THERAPY SPEECH PATHOLOGY | 0 | 458, 208 132, 634 | | 458, 208 132, 634 | | 67. 00 68. 00 |
| 69. 00 | 06900 | ELECTROCARDI OLOGY | o | 1, 868, 127 | | 1, 868, 127 | | 69. 00 |
| 70.00 | 1 | ELECTROENCEPHALOGRAPHY | 0 | 66, 048 | | 66, 048 | | 70.00 |
| 71. 00 72. 00 | | MEDICAL SUPPLIES CHARGED TO PATIENT IMPL. DEV. CHARGED TO PATIENTS | | 7, 767, 936 8, 364, 045 | | 7, 767, 936 8, 364, 045 | | 71. 00 72. 00 |
| 73. 00 | | DRUGS CHARGED TO PATIENTS | o o | 21, 184, 819 | | 21, 184, 819 | | 73. 00 |
| 74.00 | | RENAL DIALYSIS | 0 | 365, 664 | 0 | 365, 664 | | 74.00 |
| 75. 00 75. 01 | | ASC (NON-DISTINCT PART) WOUND CARE CENTER | 0 | 940, 586 | 0 0 | 940, 586 | | 75. 00 75. 01 |
| 76. 00 | 1 | CARDI OPULMONARY | Ö | 297, 268 | | 297, 268 | | 76. 00 |
| | | TIENT SERVICE COST CENTERS | | , 705 05/ | | . === == . | | |
| 91. 00 92. 00 | | EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART | 0 | 6, 725, 956 | | 6, 725, 956 | | 91. 00 92. 00 |
| 92. 01 | 09201 | OBSERVATION BEDS (DISTINCT PART) | o | 0 | 1 | 0 | | 92. 01 |
| 93. 00 | | OTHER OUTPATIENT SERVICES | 0 | 2 000 127 | 0 | 2 000 127 | | 93. 00 |
| 93. 01 93. 02 | | GENESIS WOMEN'S CENTER | | 2, 998, 137 0 |] 0] | 2, 998, 137 0 | | 93. 01 93. 02 |
| | | RESIDENTIAL HOMES | o | 0 | 0 | O | | 93. 03 |
| 93. 04 | | DR. STEELE | 0 | 0 | 0 | 0 | | 93. 04 |
| | | DIABETIC EDUCATION HOWARD COUNTY CSS | 0 | 702, 853 |] 0] | 702, 853 | | 93. 05 93. 06 |
| 93. 07 | 04957 | CLINTON COUNTY | o | 409, 527 | | 409, 527 | | 93. 07 |
| | | PSYCH MEDICATION | 0 | 0 | _ | 0 | | 93. 18 |
| 93. 43 | | NEW BEGINNINGS REIMBURSABLE COST CENTERS | 0 | 94, 545 | 0 | 94, 545 | | 93. 43 |
| 95. 00 | | AMBULANCE SERVICES | 0 | 2, 393, 833 | 0 | 2, 393, 833 | | 95. 00 |
| 112 00 | | AL PURPOSE COST CENTERS | | | | | | 112 00 |
| | | INTEREST EXPENSE UTILIZATION REVIEW - SNF | | | | | | 113. 00 114. 00 |
| 118.00 | | SUBTOTALS (SUM OF LINES 1 through 117) | 315, 122 | 116, 919, 224 | 0 | 116, 919, 224 | | 118. 00 |
| 100.00 | | I MBURSABLE COST CENTERS | | 0 | | 0 | | 100 00 |
| | | GIFT, FLOWER, COFFEE SHOP & CANTEEN COMMUNITY HOWARD FOUNDATION | 0 | 0 112, 800 | | 112, 800 | | 190. 00 190. 01 |
| 192.00 | 19200 | PHYSICIANS' PRIVATE OFFICES | o | 7, 417, 930 | | 7, 417, 930 | | 192. 00 |
| | | NONPALD WORKERS HEALTHY CHILDREN | 0 | 0 | 0 | 0 | | 193. 00 194. 00 |
| | | SOUTH BERKLEY BLDG | | 977 | 0 | 977 | | 194. 00 194. 08 |
| | | MOBILE CLINIC | | 54, 929 | | 54, 929 | | 194. 09 |
| | | | | | | | | |

| Health Financial Systems CC | MMUNITY HOWARD R | EGIONAL HEALTI | Н | In Lie | u of Form CMS-2552-10 |
|---|------------------|----------------|---------------|-----------------------------|--|
| COST ALLOCATION - GENERAL SERVICE COSTS | | Provi der CO | CN: 15-0007 | Peri od: From 01/01/2019 | Worksheet B Part I |
| | | | | To 12/31/2019 | Date/Time Prepared: 8/19/2020 2:00 pm |
| Cost Center Description | PASTORAL CARE | Subtotal | Intern & | Total | |
| | | | Residents Cos | t | |
| | | | & Post | | |
| | | | Stepdown | | |
| | | | Adjustments | | |
| | 23. 00 | 24.00 | 25. 00 | 26.00 | |
| 194. 10 07960 PLASTIC SURGERY | 0 | 26, 192 | | 0 26, 192 | 194. 10 |
| 194.11 07961 KOKOMO SCHOOL BASED | 0 | 3, 324, 368 | | 0 3, 324, 368 | 194. 11 |
| 194. 15 07965 INDIANA SURGERY CENTER | 0 | 1, 747, 917 | | 0 1, 747, 917 | 194. 15 |
| 194. 16 07966 PASTORAL CARE ALLIED HEALTH | 0 | 0 | | 0 0 | 194. 16 |
| 200.00 Cross Foot Adjustments | o | 0 | | o o | 200. 00 |
| 201.00 Negative Cost Centers | 0 | 0 | | 0 0 | 201. 00 |
| 202.00 TOTAL (sum lines 118 through 201) | 315, 122 | 129, 604, 337 | | 0 129, 604, 337 | 202. 00 |

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0007

| | | | | | lo | 12/31/2019 | Date/lime Pre 8/19/2020 2:0 | |
|------------------|--------|---|----------------------------|--------------------|-------------|--------------------|----------------------------------|--------------------|
| | | | | CAPI TAL REI | LATED COSTS | | | |
| | | Cost Center Description | Directly | BLDG & FIXT | MVBLE EQUIP | Subtotal | EMPLOYEE | |
| | | <u>'</u> | Assigned New | | | | BENEFITS | |
| | | | Capi tal Rel ated Costs | | | | DEPARTMENT | |
| | | | 0 | 1. 00 | 2.00 | 2A | 4. 00 | |
| 1 00 | | AL SERVICE COST CENTERS | | | | | | 1 00 |
| 1. 00 2. 00 | | CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP | | | | | | 1. 00 2. 00 |
| 4.00 | | EMPLOYEE BENEFITS DEPARTMENT | o | 37, 980 | 24, 236 | 62, 216 | 62, 216 | 4. 00 |
| 5.00 | | ADMINISTRATIVE & GENERAL | 70, 288 | 1, 029, 490 | | 1, 756, 739 | 6, 079 | 5. 00 |
| 7.00 | 1 | OPERATION OF PLANT | 266, 193 | 424, 633 | | 961, 801 | 2, 167 | 7. 00 |
| 8. 00 9. 00 | | LAUNDRY & LINEN SERVICE HOUSEKEEPING | 7 272 | 21, 957 23, 720 | | 35, 969 46, 128 | 127 1, 431 | 8. 00 9. 00 |
| 10.00 | | DIETARY | 7, 272 37 | 51, 105 | | 83, 754 | 491 | 10.00 |
| 11. 00 | 1 | CAFETERI A | 0 | 60, 575 | | 99, 230 | 836 | 11. 00 |
| 13.00 | | NURSING ADMINISTRATION | O | 7, 363 | | 12, 062 | 1, 225 | 13. 00 |
| 16.00 | | MEDICAL RECORDS & LIBRARY | 0 | 30, 131 | | 49, 359 | 0 | 16.00 |
| 17. 00 19. 00 | 1 | SOCIAL SERVICE NONPHYSICIAN ANESTHETISTS | 0 | 0 | | 0 | 739 0 | 17. 00 19. 00 |
| 23. 00 | | PASTORAL CARE | l o | 8, 751 | | 14, 335 | 232 | 23. 00 |
| | I NPAT | IENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30.00 | 1 | ADULTS & PEDIATRICS | 77 | 570, 748 | | 935, 042 | 12, 912 | 30.00 |
| 31. 00 43. 00 | | INTENSIVE CARE UNIT NURSERY | 6 | 52, 918 19, 010 | | 86, 693 31, 141 | 1, 784 306 | 31. 00 43. 00 |
| 43.00 | | LARY SERVICE COST CENTERS | <u> </u> | 17,010 | 12, 131 | 31, 141 | 300 | 43.00 |
| 50.00 | 1 | OPERATING ROOM | 118, 527 | 200, 553 | | 447, 061 | 3, 818 | 50. 00 |
| 52.00 | | DELIVERY ROOM & LABOR ROOM | 0 | 56, 362 | | 92, 329 | 908 | 52. 00 |
| 53. 00 54. 00 | | ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C | 196, 421 | 0 194, 466 | _ | 514, 984 | 0 2, 313 | 53. 00 54. 00 |
| 54. 01 | 1 | ONCOLOGY | 1, 415, 573 | 207, 966 | | 1, 756, 251 | 1, 975 | 54. 01 |
| 57. 00 | 05700 | CT SCAN | 108, 336 | 6, 077 | | 118, 291 | 692 | 57. 00 |
| 58. 00 | 05800 | | 457, 814 | 0 | | 457, 814 | 548 | |
| 59. 00 60. 00 | | CARDI AC CATHETERI ZATI ON LABORATORY | 1, 669 | 42, 537 49, 677 | | 71, 351 81, 378 | 976 0 | 59. 00 60. 00 |
| 63.00 | | BLOOD STORING, PROCESSING & TRANS. | 0 | 49, 077 | | 01, 376 | 0 | 63.00 |
| 65.00 | 06500 | RESPI RATORY THERAPY | 47 | 44, 502 | 28, 399 | 72, 948 | 1, 667 | 65. 00 |
| 66. 00 | | PHYSI CAL THERAPY | 0 | 6, 887 | | 11, 282 | 615 | |
| 67. 00 68. 00 | 1 | OCCUPATIONAL THERAPY SPEECH PATHOLOGY | 0 | 10, 806 4, 558 | | 17, 702 7, 466 | 330 89 | 67. 00 68. 00 |
| 69.00 | 1 | ELECTROCARDI OLOGY | 121, 823 | 1, 053 | | 123, 548 | 1, 322 | 69.00 |
| 70.00 | | ELECTROENCEPHALOGRAPHY | 0 | 3, 231 | | 5, 293 | 38 | 70. 00 |
| 71. 00 | | MEDICAL SUPPLIES CHARGED TO PATIENT | 21 | 65, 214 | | 106, 850 | 0 | 71. 00 |
| 72. 00 73. 00 | | IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS | 362, 884 | 0 34, 627 | - | 419, 608 | 0 3, 004 | 72. 00 73. 00 |
| 74. 00 | | RENAL DIALYSIS | 0 | 0 34, 027 | | 417,000 | 0,004 | 74.00 |
| 75. 00 | 07500 | ASC (NON-DISTINCT PART) | O | 0 | - | o | 0 | 75. 00 |
| 75. 01 | | WOUND CARE CENTER | 17, 700 | 20, 924 | | 51, 977 | 538 | 75. 01 |
| 76. 00 | _ | CARDIOPULMONARY TIENT SERVICE COST CENTERS | 0 | 0 | 0 | 0 | 222 | 76. 00 |
| 91. 00 | | EMERGENCY | 0 | 231, 554 | 147, 764 | 379, 318 | 3, 553 | 91. 00 |
| 92.00 | 1 | OBSERVATION BEDS (NON-DISTINCT PART | | | | o | | 92. 00 |
| 92. 01 | 1 | OBSERVATION BEDS (DISTINCT PART) | 0 | 0 | 0 | 0 | 0 | 92. 01 |
| 93. 00 93. 01 | | OTHER OUTPATIENT SERVICES GENESIS | 311 | 0 | 0 | 311 | 0 2, 062 | 93. 00 93. 01 |
| 93. 02 | 1 | WOMEN'S CENTER | 0 | 0 | Ö | o | 0 | |
| 93. 03 | | RESI DENTI AL HOMES | 0 | 0 | 0 | 0 | 0 | |
| 93. 04 93. 05 | | DR. STEELE DIABETIC EDUCATION | 0 | 0 | 0 | 0 | 0 | 93. 04 93. 05 |
| 93. 05 | | HOWARD COUNTY CSS | 7, 567 | 0 | 0 | 7, 567 | 726 | |
| 93. 07 | | CLINTON COUNTY | 70, 104 | 0 | O | 70, 104 | 486 | |
| | 1 | PSYCH MEDICATION | 0 | 0 | 0 | 0 | 0 | 93. 18 |
| 93. 43 | | NEW BEGINNINGS REIMBURSABLE COST CENTERS | 24, 109 | 0 | 0 | 24, 109 | 49 | 93. 43 |
| 95. 00 | | AMBULANCE SERVICES | O | 17, 521 | 11, 181 | 28, 702 | 1, 673 | 95. 00 |
| | | AL PURPOSE COST CENTERS | - | , | .,, | | ., | |
| | | I NTEREST EXPENSE | | | | | | 113.00 |
| 114.00 | | UTILIZATION REVIEW - SNF SUBTOTALS (SUM OF LINES 1 through 117) | 3, 246, 779 | 3, 536, 896 | 2, 257, 038 | 9, 040, 713 | 55, 933 | 114.00 |
| 110.00 | | IMBURSABLE COST CENTERS | 3, 240, 779 | 3, 530, 690 | 2, 201, 030 | 7, 040, 713 | 55, 755 | 110.00 |
| | 19000 | GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | 0 | 0 | 0 | | 190. 00 |
| | | COMMUNITY HOWARD FOUNDATION | 0 | 0 | 0 | 0 | | 190. 01 |
| | | PHYSICIANS' PRIVATE OFFICES NONPAID WORKERS | 292, 008 | 305, 093 0 | _ | 791, 793 0 | • | 192. 00 193. 00 |
| | | HEALTHY CHILDREN | | 0 | - | ol | | 194. 00 |
| | | SOUTH BERKLEY BLDG | 800 | 0 | 0 | 800 | | 194. 08 |
| | | | | | | | | |

| | | | | | 8/19/2020 2:0 | O pm |
|--|---------------|--------------|-------------|--------------|---------------|---------|
| | | CAPI TAL REL | LATED COSTS | | | |
| | | | | | | |
| Cost Center Description | Di rectly | BLDG & FIXT | MVBLE EQUIP | Subtotal | EMPLOYEE | |
| | Assigned New | | | | BENEFI TS | |
| | Capi tal | | | | DEPARTMENT | |
| | Related Costs | | | | | |
| | 0 | 1. 00 | 2.00 | 2A | 4. 00 | |
| 194. 09 07959 MOBILE CLINIC | 0 | 0 | 0 | 0 | 45 | 194. 09 |
| 194. 10 07960 PLASTIC SURGERY | 21, 437 | 0 | 0 | 21, 437 | 0 | 194. 10 |
| 194.11 07961 KOKOMO SCHOOL BASED | 3, 141 | 0 | 0 | 3, 141 | 3, 045 | 194. 11 |
| 194.15 07965 INDIANA SURGERY CENTER | 0 | 338, 353 | 215, 917 | 554, 270 | 0 | 194. 15 |
| 194.16 07966 PASTORAL CARE ALLIED HEALTH | 0 | 0 | 0 | 0 | 0 | 194. 16 |
| 200.00 Cross Foot Adjustments | | | | 0 | | 200. 00 |
| 201.00 Negative Cost Centers | | 0 | 0 | 0 | 0 | 201. 00 |
| 202.00 TOTAL (sum lines 118 through 201) | 3, 564, 165 | 4, 180, 342 | 2, 667, 647 | 10, 412, 154 | 62, 216 | 202. 00 |

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0007

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2019 | Part II | To 12/31/2019 | Date/Time Prepared: | 8/19/2020 2:00 pm

| Count Center Description | | | LOW W OTRATIVE | 005047101105 | 1.414155)/ 6 | HOUGEVEEN NO | 8/19/2020 2:00 | 0 pm |
|--|---------|---|--|--------------|--------------|---------------|----------------|---------|
| Seneral Service Cost Centers | | Cost Center Description | | | LAUNDRY & | HOUSEKEEPI NG | DI ETARY | |
| FINISEAL STROTO COST CINTURES 1 00 0000 QAP RELL COSTS-AMPLE EQUIPMENT 2 00 0000 QAP RELL COSTS-AMPLE EQUIPMENT 2 00 0000 QAP RELL COSTS-AMPLE EQUIPMENT 2 00 00000 QAP RELL COSTS-AMPLE EQUIPMENT 119, 413 1.083, 381 7.70 00000 QAP RELL COSTS-AMPLE EQUIPMENT 119, 413 1.083, 381 7.70 00000 QAP RELL COSTS-AMPLE EQUIPMENT 119, 413 1.083, 381 7.70 00000 QAP RELL COSTS-AMPLE EQUIPMENT 119, 413 1.083, 381 7.70 00000 QAP RELL COSTS-AMPLE EQUIPMENT 119, 413 1.083, 381 7.70 00000 QAP RELL COSTS-AMPLE EQUIPMENT 119, 413 1.083, 381 7.70 00000 QAP RELL COSTS-AMPLE EQUIPMENT 119, 413 1.083, 381 7.70 00000 QAP RELL COSTS AMPLE EQUIPMENT 119, 413 1.083, 381 7.70 00000 QAP RELL COSTS AMPLE EQUIPMENT 119, 413 1.083, 381 7.70 00000 QAP RELL COSTS AMPLE EQUIPMENT 119, 413 1.083, 381 7.70 00000 QAP RELL COSTS AMPLE EQUIPMENT 119, 413 1.083, 381 7.70 000000 QAP RELL COSTS AMPLE EQUIPMENT 119, 413 000000 QAP RELL COSTS AMPLE EQUIPMENT 119, 413 0000000 QAP RELL COSTS AMPLE EQUIPMENT 119, 413 0000000 QAP RELL COSTS AMPLE EQUIPMENT 119, 413 00000000000000000000000000000000000 | | | | | | 9, 00 | 10.00 | |
| 2.00 | | GENERAL SERVICE COST CENTERS | 0.00 | 7.00 | 0.00 | 7, 00 | 10100 | |
| 0,0400 DIPLOYEE BENEFITS DEPARTMENT 1,762,818 5,00 0,0500 OMINISTRATION OF PLANT 119,413 1,083,381 7,085 36,626 49,807 8,00 0,000 OMINISTRATION 11,087 11,083 31,083,381 0 1,077 112,897 10,000 10,000 1,777 112,897 10,000 10,000 1,777 112,897 10,000 10,000 1,777 112,897 10,000 13,000 1,000 | 1.00 | | | | | | | 1. 00 |
| 5.00 0.0500 AMIN INSTRATIVE & CEMERAL 1, 762, 818 1, 0.83, 381 7, 0.00 7.00 0.0000 ORBATION OF PLATT 119, 413 1, 0.83, 381 7, 108 0.00 0.0000 ORBATION OF PLATT 119, 413 1, 0.83, 381 7, 108 0.00 0.0000 ORBATION OF PLATT 119, 413 1, 0.83, 381 7, 108 0.00 0.0000 ORBATION OF PLATT 11, 953 15, 429 0.00 1, 207 112, 897 10, 0.00 0.0000 ORBATION OF PLATT 11, 953 15, 429 0.00 1, 207 112, 897 10, 0.00 0.0000 ORBATION OF PLATT 11, 953 15, 429 0.00 1, 207 112, 897 10, 0.00 0.0000 0.0000 ORBATION OF PLATT 10, 953 0.00000 ORBATION OF PLATT 10, 953 0.00000 ORBATION OF PLATT | | | | | | | | |
| 0.00 | | | | | | | | |
| 8, 00 00800 (LAUNDRY & LINEN SERVICE 7, 065 6, 626 49, 807 88, 599 10.00 0000 (DICTUDE) DELTARY 11, 93 15, 422 00 1.277 112, 897 10.00 10.00 (DICTUDE) DELTARY 11, 93 15, 422 00 1.277 112, 897 10.00 11.00 01.00 (DICTUDE) DELTARY 11, 93 15, 422 00 1.277 112, 897 10.00 11.00 01.00 (DICTUDE) DELTARY 11, 93 15, 422 00 1.277 112, 897 10.00 11.00 01.00 01.00 (DICTUDE) DELTARY 14, 898 10, 999 10.00 16 | | I I | The state of the s | | | | | |
| 9, 00 00900 MUSISKEFEN METATOR | | | | | | | | |
| 10.00 01000 DIELARY 11,993 15,422 0 1,277 112,897 10.00 13.00 13.00 0300 MURSING ADMINISTRATION 40,666 2,222 0 184 0 11.00 13.00 17. | | | | | | 00 500 | | |
| 11.00 0 1100 (ARETERIA 11.00 11.00 11.00 12.00 12.00 12.00 12.00 13.00 | | | 1 | | | | 112 007 | |
| 13.00 01300 MURSIAN AMMINISTRATION 40, 666 2, 222 0 184 0 13.00 | | | 1 | | | | | |
| 10.00 01000 MEDICAL RECORDS & LIBRARY 14, 878 9,002 0 753 0 10,00 170,00 | | | 1 | | | | | |
| 17.00 01700 SOCIAL SERVICE 10,750 0 0 0 0 17.00 12.00 12.00 02300 PASTORAL CARE 3,803 2,641 0 219 0 22.00 19.0 | | | | | | 1 | | |
| 19, 00 01900 NONPHYSICIAN AMESTHETISTS 0 0 0 0 0 0 0 0 0 | | | | | 0 | . 1 | - | |
| INPATI ENT ROUTH NE_SERVICE COST CENTERS 30.00 30.00 | 19.00 | 01900 NONPHYSICIAN ANESTHETISTS | 0 | 0 | 0 | O | 0 | 19. 00 |
| 30 00 | 23. 00 | | 3, 803 | 2, 641 | 0 | 219 | 0 | 23. 00 |
| 31.00 03100 INTERSIVE CARE UNIT 32,795 15,960 2,186 1,322 8,695 31.00 | | | | | | | | |
| 43.00 0.4300 NURSERY 5,890 5,736 2,178 475 4,937 43.00 | | | 1 | | | | | |
| ANCILLARY SERVICE COST CENTERS | | | | | | | | |
| 50.00 OSDOO OPERATING ROOM 103, 985 60, 519 0 5, 012 0 50, 00 52, 00 53, 00 05300 OSSOO DELIVERY ROOM & LABOR ROOM 17, 464 17, 008 0 0 0 0 0 53, 00 53, 00 05300 ARISTHESI OLOGY 77, 758 62, 56, 682 0 4, 860 0 54, 00 54, 00 54, 00 5400 RADIOLOGY 77, 758 62, 756 0 5, 198 0 54, 00 5 | 43.00 | | 5, 890 | 5, /36 | 2, 1/8 | 4/5 | 4, 937 | 43.00 |
| 17, 000 05200 05200 05200 05200 05300 05 | 50.00 | | 102 005 | 60 510 | | 5 012 | 0 | 50.00 |
| S3.0 OS300 ANESTHESI OLOGY 0 0 0 0 53.0 | | I I | 1 | | | | | |
| 54.00 05400 RADI OLOGY-DI AGNOSTIC 48, 782 58, 682 0 4, 860 0 54, 01 57.00 05700 CT SCAN 14, 065 1,834 0 152 0 57.00 058.00 05800 MR 16, 535 0 0 0 0 0 0 0 0 0 | | | 1 | | | 1, 407 | - | |
| S4.0 03480 0MCOLOGY | | | - | | _ | 4, 860 | - | |
| SB. 00 OSBOO MR 16, 535 0 0 0 0 0 0 58, 00 | 54. 01 | 03480 ONCOLOGY | 1 | 62, 756 | 0 | | 0 | |
| 59. 00 05900 CARDILAC CATHETERI ZATION 18, 820 12, 836 0 1, 06.3 0 59. 00 | 57.00 | 05700 CT SCAN | 14, 065 | 1, 834 | 0 | 152 | 0 | 57. 00 |
| 60.00 06000 LAGONOTION PROCESSING & TRANS. 0 0 0 0 0 0 0 0 0 | | I I | | 0 | 0 | 0 | - | |
| 63.00 06300 BLODO STORING, PROCESSING & TRANS. 0 0 0 0 0 0 3.0 65.00 06500 RESPIRATORY THERAPY 28, 474 13, 429 0 1,112 0 65.00 66.00 06600 PHYSI CAL THERAPY 9, 665 2, 078 0 172 0 66.00 67.00 06700 06700 06700 06700 0 0 0 0 0 0 0 67.00 06700 06700 06700 0 0 0 0 0 0 0 67.00 06700 06700 0 0 0 0 0 0 0 68.00 06800 SPECH PATHOLOGY 1, 550 1,375 0 114 0 68.00 69.00 06900 ELECTROCARDI OLOGY 23, 855 318 0 26 0 69.00 69.00 06900 ELECTROCECPHAL OGRAPHY 738 975 0 81 0 70.00 71.00 071000 07100 MEDICAL SUPPLIES CHARGED TO PATI ENT 102, 298 19,679 0 1,630 0 71.00 72.00 07200 IMPL DEV CHARGED TO PATI ENT 113, 262 0 0 0 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATI ENT 113, 262 0 0 0 0 0 0 0 74.00 07400 RENAL DIALYSIS 4,957 0 0 0 0 0 0 0 0 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 75.00 07500 OSCOO ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 76.00 07500 OSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 76.00 07500 OSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 76.00 07500 OSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 76.00 07500 OSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 76.01 07500 OSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 0 76.01 07500 OSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 0 76.01 07500 OSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 0 76.01 07500 OSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 76.01 07500 OSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 76.01 07500 OSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 76.01 07500 OSERVATION BEDS (NON-DISTINCT PART) | | | | | | | | |
| 65.00 06500 RESPI RATORY THERAPY 28, 474 13, 429 0 1, 112 0 65. 00 66.00 06600 PHYSI CAL THERAPY 9, 665 2, 078 0 172 0 66. 00 67.00 06700 06CUIPATI ONAL THERAPY 5, 591 3, 261 0 270 0 67. 00 68.00 06800 SPEECH PATHOLOGY 1, 560 1, 375 0 114 0 68. 00 69.00 06900 ELECTROCARDIOLOGY 1, 560 1, 375 0 114 0 68. 00 70.00 07000 CLECTROCARDIOLOGY 738 975 0 81 0 70. 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 102, 298 19, 679 0 1, 630 0 71. 00 72.00 07200 MPL DEV. CHARGED TO PATIENTS 113, 262 0 0 0 0 0 72. 00 73.00 07300 DRUGS CHARGED TO PATIENTS 113, 262 0 0 0 0 0 0 73. 00 74.00 07400 RENAL DIALYSI S 4, 957 0 0 0 0 0 0 74. 00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 76.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0 76.00 03760 CARDIOPULINONARY 3, 683 0 0 0 5, 787 0 79.00 09100 EMERGENCY 0 0 0 0 0 0 0 79.01 09200 OSSERWATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 0 79.01 09200 OSSERWATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 0 79.02 09200 OSSERWATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 0 79.01 09201 OSSERWATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 0 79.02 09200 OSSERWATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 0 79.03 04951 GRESIS 04951 | | I I | 1 | | | | - | |
| 66.00 06600 PHYSI CAL THERAPY 9, 665 2, 078 0 172 0 66, 00 67. 00 06700 COLORATIONAL THERAPY 5, 551 3, 261 0 270 0, 67, 00 68. 00 06600 SPEECH PATHOLOGY 1, 560 1, 375 0 114 0 68, 00 69. 00 06600 SELECTROCARDIOLOGY 23, 855 318 0 26 0 69, 00 69. 00 06600 SELECTROCARDIOLOGY 23, 855 318 0 26 0 69, 00 69. 00 06600 SELECTROCARDIOLOGY 23, 855 318 0 26 0 69, 00 69. 00 06600 SELECTROCARDIOLOGY 23, 855 318 0 26 0 69, 00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 102, 298 19, 679 0 1, 630 0 71, 00 72. 00 07200 IMPL. DeV. CHARGED TO PATIENTS 113, 262 0 0 0 0 0 0 73. 00 07300 ORUGS CHARGED TO PATIENTS 282, 631 10, 449 0 865 0 73, 00 74. 00 07400 RENAL DIALYSIS 4, 957 0 0 0 0 0 0 75. 01 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0 75. 01 03950 WOUND CARE CENTER 10, 959 6, 314 0 523 0 75, 00 76. 00 03160 CARDIOPULIMONARY 3, 683 0 0 0 0 0 0 0 77. 00 09200 OSSERVATION BEDS (NON-DISTINCT PART 92, 00 79. 00 09200 OSSERVATION BEDS (NON-DISTINCT PART 92, 00 79. 01 09201 OSSERVATION BEDS (NON-DISTINCT PART 92, 00 79. 02 09200 OSSERVATION BEDS (NON-DISTINCT PART 92, 00 79. 01 09451 OSSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 0 0 79. 02 09404 ORSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 0 79. 02 09404 ORSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 0 79. 02 09404 ORSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 0 79. 02 09404 ORSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 0 79. 02 09404 ORSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 0 79. 03 09404 ORSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 0 79. 04 09404 ORSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 0 79. 00 09404 ORSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 0 79. 00 | | | | Ĭ | 1 | 9 | - | |
| 67.00 06700 OCCUPATI ONAL THERAPY 5,591 3,261 0 270 0 67,00 88.00 06800 SPEECH PATHOLOGY 1,560 1,375 0 114 0 68.00 99.00 06900 ELECTROCARDI OLOGY 23,855 318 0 26 0 69.00 70.00 07000 ELECTROCARDI OLOGY 23,855 318 0 26 0 69.00 70.00 07000 ELECTROCARDI OLOGY 23,855 318 0 26 0 69.00 70.00 07000 OTOTO OLOGY 20,00 20 0 1,630 0 71.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 102,298 19,679 0 1,630 0 71.00 72.00 07200 IMPL DEV. CHARGED TO PATI ENTS 113,262 0 0 0 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATI ENTS 282,631 10,449 0 865 0 73.00 74.00 07300 DRUGS CHARGED TO PATI ENTS 282,631 10,449 0 865 0 74.00 75.00 07500 ASC (NON-DI STI NCT PART) 0 0 0 0 0 0 75.01 03950 WOUND CARE CENTER 10,959 6,314 0 523 0 75.01 76.00 03160 CARDI OPULMONARY 3,683 0 0 0 0 0 0 90 DUPTATIENT SERVICE COST CENTERS | | | | | | | - 1 | |
| 68.00 06800 SPEECH PATHOLOGY 1,560 1,375 0 114 0 68.00 69.00 06900 ELECTROCARDIOLOGY 23,855 318 0 26 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 738 975 0 811 0 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 102,298 19,679 0 1,630 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 113,262 0 0 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 282,631 10,449 0 865 0 73.00 74.00 07400 RENAL DIALYSIS 4,957 0 0 0 0 0 0 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0 76.00 03950 MOUND CARE CENTER 10,959 6.314 0 523 0 75.01 76.00 03100 CARDIOPULMONARY 3,683 0 0 0 0 0 0 0 79.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 0 79.01 09201 OBSERVATION BEDS (DISTINCT PART) 0 0 0 0 0 0 0 79.02 09200 OBSERVATION BEDS (DISTINCT PART) 0 0 0 0 0 0 0 79.03 00 04950 OHERO CHARGED (DISTINCT PART) 0 0 0 0 0 0 0 79.04950 OHERO CHARGED (DISTINCT PART) 0 0 0 0 0 0 0 79.01 09201 OBSERVATION BEDS (DISTINCT PART) 0 0 0 0 0 0 0 79.02 09300 OBSERVATION BEDS (DISTINCT PART) 0 0 0 0 0 0 0 79.03 00 04950 OHERO CHARGED (DISTINCT PART) 0 0 0 0 0 0 79.04950 OHERO CHARGED (DISTINCT PART) 0 0 0 0 0 0 79.05 09400 OSC CHARGED (DISTINCT PART) 0 0 0 0 0 0 79.06 094950 OHERO CHARGED (DISTINCT PART) 0 0 0 0 0 0 79.07 094950 OHERO CHARGED (DISTINCT PART) 0 0 0 0 0 79.08 094950 OHERO CHARGED (DISTINCT PART) 0 0 0 0 0 79.09 09500 09 | | I I | 1 | | | | - | |
| 69.00 06900 ELECTROCARDI OLOGY 23,855 318 0 26 0 69,00 70.00 07000 ELECTROENCEPHALOGRAPHY 738 975 0 81 0 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 102,298 19,679 0 1,630 0 71.00 72.00 07200 INPL. DEV. CHARGED TO PATIENTS 113,262 0 0 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 282,631 10,449 0 865 0 73.00 74.00 07400 RENAL DIALYSI S 4,957 0 0 0 0 0 0 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 76.01 03950 WOUND CARE CENTER 10,959 6,314 0 523 0 75.01 76.00 03160 CARDI OPULMONARY 3,683 0 0 0 0 0 0 0 0 76.00 00100 EMERGENCY 72,444 69,874 0 5,787 0 91.00 79.00 09200 08SERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 0 79.01 09201 0928ERVATI ON BEDS (DISTINCT PART) 0 0 0 0 0 0 0 79.02 09200 09350 SCENYATI ON BEDS (DISTINCT PART) 0 0 0 0 0 0 0 79.02 04953 RESIDENTIAL HOMES 0 0 0 0 0 0 0 79.03 04954 DR. STEELE 0 0 0 0 0 0 0 79.04 09451 GENESIS 5 27,728 90,769 0 7,518 0 93.02 79.04 09453 RESIDENTIAL HOMES 0 0 0 0 0 0 0 79.05 04955 DIABETI C EDUCATION 0 0 0 0 0 0 0 79.06 04956 HOWARD COUNTY CSS 5,241 30,256 0 2,506 0 93.05 79.07 04957 CLINTON COUNTY 5,557 0 0 0 0 0 0 79.08 0700 0700 0700 0700 0 0 0 | | | 1 | | | | - | |
| 70. 00 07000 CLECTROENCEPHALOGRAPHY 738 975 0 | | | | | | | - | |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 102, 298 19, 679 0 1, 630 0 71. 00 72. 00 0 0 0 0 0 0 72. 00 0 0 0 0 0 0 0 0 0 | | I I | | | | | | |
| 72. 00 07200 IMPL DEV. CHARGED TO PATIENTS 113, 262 0 0 0 0 72. 00 73. 00 | | I I | | | | | - | |
| 74, 00 | | I I | 1 | 0 | | 0 | 0 | |
| 75. 00 07500 ASC (NON-DI STINCT PART) | 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 282, 631 | 10, 449 | 0 | 865 | 0 | 73. 00 |
| 75. 01 03950 WOUND CARE CENTER 10,959 6,314 0 523 0 75. 01 76. 00 03160 CARDI OPULMONARY 3,683 0 0 0 0 0 0 76. 00 OUTPATIENT SERVI CE COST CENTERS 91. 00 09100 EMERGENCY 72,444 69,874 0 5,787 0 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 92. 00 93. 00 04950 OTHER OUTPATIENT SERVI CES 0 0 0 0 0 0 0 93. 00 93. 01 04951 GENESI S 27,728 90,769 0 7,518 0 93. 01 93. 02 04952 WOMEN'S CENTER 0 0 0 0 0 7,518 0 93. 01 93. 03 04953 RESIDENTI AL HOMES 0 0 0 0 0 0 0 93. 02 93. 04 04954 DR. STEELE 0 0 0 0 0 0 0 0 93. 02 93. 05 04955 DI ABETI C EDUCATION 0 0 0 0 0 0 0 93. 05 93. 07 04956 HOWARD COUNTY CSS 5,241 30,256 0 2,506 0 93. 05 93. 07 04957 CLI NTON COUNTY 5,5577 0 0 0 0 0 0 93. 07 93. 43 04993 NEW BEGI NNI NGS 1,285 0 0 0 0 0 0 0 0 93. 18 94. 40 04958 PSYCH MEDI CATION 0 0 0 0 0 0 0 93. 18 95. 00 09500 AMBULANCE SERVI CES 3 1,634 5,287 0 488 0 93. 112,897 113. 00 11400 UTI LI ZATI ON REVI EW - SNF 113. 00 11400 UTI LI ZATI ON REVI EW - SNF 114. 00 11400 UTI LI ZATI ON REVI EW - SNF 118. 00 NONREI MBURSABLE COST CENTERS | 74.00 | 07400 RENAL DIALYSIS | 4, 957 | 0 | 0 | 0 | 0 | 74. 00 |
| 76. 00 03160 CARDI OPULMONARY 3, 683 0 0 0 0 0 76. 00 | | | - | 0 | 0 | 0 | - | |
| 91. 00 O9100 EMERGENCY 72, 444 69, 874 0 5, 787 0 91. 00 92. 00 O9200 OBSERVATI ON BEDS (NON-DISTINCT PART 92. 00 92. 01 O9201 OBSERVATI ON BEDS (DISTINCT PART) 0 0 0 0 0 0 93. 00 O4950 OTHER OUTPATIENT SERVICES 0 0 0 0 0 0 93. 01 O4951 GENESI S 27, 728 90, 769 0 7, 518 0 93. 01 93. 02 O4952 WOMEN'S CENTER 0 0 0 0 0 0 0 93. 03 O4953 RESI DENTI AL HOMES 0 0 0 0 0 0 0 93. 04 O4954 DR. STEELE 0 0 0 0 0 0 0 93. 05 O4955 DABETI C EDUCATION 0 0 0 0 0 0 93. 06 O4956 HOWARD COUNTY CSS 5, 241 30, 256 0 2, 506 0 93. 05 93. 07 O4957 CLI NTON COUNTY 5, 557 0 0 0 0 0 93. 05 93. 43 O4993 NEW BEGI NNI NGS 1, 285 0 0 0 0 0 93. 43 O4993 NEW BEGI NNI NGS 1, 285 0 0 0 0 94. 00 O9500 AMBULANCE SERVICES 31, 634 5, 287 0 438 0 95. 00 SPECIAL PURPOSE COST CENTERS 113. 00 114.00 UTI LI ZATI ON REVIEW - SNF 114. 00 NONRE MBURSABLE COST CENTERS 118. 00 NORE MBURSA | | | 1 | 6, 314 | | 523 | - | |
| 91. 00 | 76. 00 | | 3, 683 | 0 |) 0 | 0 | 0 | 76. 00 |
| 92. 00 | 01 00 | | 70.444 | (0.074 | | F 707 | | 01 00 |
| 92. 01 | | | 12, 444 | 69,874 | | 5, 787 | 0 | |
| 93. 00 | | | 0 | 0 | | 0 | 0 | |
| 93. 01 04951 GENESIS 27,728 90,769 0 7,518 0 93. 01 93. 02 04952 WOMEN'S CENTER 0 0 0 0 0 0 0 0 93. 02 93. 03 04953 RESIDENTIAL HOMES 0 0 0 0 0 0 0 0 93. 02 93. 04 04954 DR. STEELE 0 0 0 0 0 0 0 0 0 0 0 93. 04 93. 05 04955 DI ABETI C EDUCATION 0 0 0 0 0 0 0 93. 04 93. 05 04956 HOWARD COUNTY CSS 5,241 30,256 0 2,506 0 93. 06 93. 07 04957 CLI NTON COUNTY 5,557 0 0 0 0 0 0 93. 06 93. 18 04968 PSYCH MEDI CATION 0 0 0 0 0 0 0 93. 07 93. 18 04968 PSYCH MEDI CATION 0 0 0 0 0 0 0 0 93. 18 93. 43 04993 NEW BEGINNI NGS 0 0 0 0 0 0 0 0 93. 43 OTHER REI MBURSABLE COST CENTERS 95. 00 0500 AMBULANCE SERVI CES 31,634 5,287 0 438 0 95. 00 SPECI AL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113. 00 114.00 UTI LI ZATI ON REVI EW - SNF 118. 00 SUBTOTALS (SUM OF LI NES 1 through 117) 1,639,538 738,063 49,807 59,988 112,897 118. 00 NONREI MBURSABLE COST CENTERS | | 1 , | | 0 | _ | 0 | | |
| 93. 02 04952 WOMEN'S CENTER | | | | | | 7. 518 | | |
| 93. 03 | | | 0 | 0 | 1 | 0 | | |
| 93. 05 | 93. 03 | | 0 | 0 | 0 | 0 | 0 | 93. 03 |
| 93. 06 | 93.04 | 04954 DR. STEELE | 0 | 0 | 0 | O | 0 | 93. 04 |
| 93. 07 | 93. 05 | 04955 DI ABETI C EDUCATI ON | 0 | 0 | 0 | 0 | 0 | 93. 05 |
| 93. 18 04968 PSYCH MEDICATION 0 0 0 0 0 0 93. 18 93. 43 04993 NEW BEGINNINGS 1, 285 0 0 0 0 93. 43 OTHER REIMBURSABLE COST CENTERS 95. 00 O500 AMBULANCE SERVICES 31, 634 5, 287 0 438 0 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113. 00 114. 00 UTILIZATION REVIEW - SNF 114. 00 NONREI MBURSABLE COST CENTERS | | | | 30, 256 | 0 | 2, 506 | - | |
| 93. 43 04993 NEW BEGINNINGS 1, 285 0 0 0 0 0 93. 43 OTHER REIMBURSABLE COST CENTERS | | | 5, 557 | 0 | 0 | 0 | | |
| OTHER REI MBURSABLE COST CENTERS 95. 00 | | I I | 0 | 0 | 0 | 0 | | |
| 95. 00 09500 AMBULANCE SERVI CES 31, 634 5, 287 0 438 0 95. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 1NTEREST EXPENSE 114. 00 11400 UTI LI ZATI ON REVI EW - SNF 114. 00 SUBTOTALS (SUM OF LI NES 1 through 117) 1, 639, 538 738, 063 49, 807 59, 988 112, 897 118. 00 NONREI MBURSABLE COST CENTERS | 93. 43 | | 1, 285 | 0 |) | U | 0 | 93. 43 |
| SPECIAL PURPOSE COST CENTERS 113. 00 113.00 114. 00 114. 00 114. 00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) SUBTOTALS (SUM OF LINES 1 through 117) SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 113. 00 114. 00 114. 00 114. 00 115. 00 116. 00 117. 00 118. 00 118. 00 | 05 00 | | 21 624 | E 207 | | 120 | 0 | 05.00 |
| 113. 00 | 93.00 | | 31,034 | 5, 267 | | 430 | U | 95.00 |
| 114. 00 11400 UTI LI ZATI ON REVI EW - SNF 114. 00 118. 00 SUBTOTALS (SUM OF LI NES 1 through 117) 1,639,538 738,063 49,807 59,988 112,897 118. 00 NONREI MBURSABLE COST CENTERS | 113 00 | | | | | | | 113 00 |
| 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 1, 639, 538 738, 063 49, 807 59, 988 112, 897 118. 00 NONREI MBURSABLE COST CENTERS | | | | | | | | |
| NONREI MBURSABLE COST CENTERS | | I I | 1, 639, 538 | 738, 063 | 49, 807 | 59, 988 | 112, 897 | |
| 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 0 1190. 00 | | | , | | | , , , , , , , | , | |
| | 190.00 | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | 0 | 0 | 0 | 0 | 190. 00 |
| 190. 01 19001 COMMUNI TY HOWARD FOUNDATION 1, 534 0 0 0 0 0 190. 01 | 190. 01 | 19001 COMMUNITY HOWARD FOUNDATION | 1, 534 | 0 | 0 | 0 | 0 | 190. 01 |
| 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 66, 203 243, 217 0 20, 145 0 192. 00 | | | 66, 203 | 243, 217 | 0 | 20, 145 | | |
| 193. 00 19300 NONPAI D WORKERS 0 0 0 193. 00 | | | 0 | 0 | 0 | 0 | | |
| 194. 00 07950 HEALTHY CHILDREN 0 0 0 194. 00 | | | _ | 0 | 0 | 0 | | |
| 194. 08 07958 SOUTH BERKLEY BLDG 13 0 0 0 194. 08 | | | 1 | 0 | 0 | 0 | | |
| 194. 09 07959 MOBILE CLINIC 747 0 0 0 194. 09 | | | 1 | 0 | 0 | 0 | | |
| 194. 10 07960 PLASTIC SURGERY 356 0 0 0 194. 10 194. 11 07961 KOKOMO SCHOOL BASED 45, 216 0 0 0 194. 11 | 194. IC | 10/900 PLASTIC SUKGEKY | 1 | | | 0 | | |
| 194. 11 07961 ROROMO SCHOOL BASED 45, 216 0 0 194. 11 194. 15 07965 I NDI ANA SURGERY CENTER 9, 211 102, 101 0 8, 456 0 194. 15 | | | 1 | | | 8 456 | | |
| <u> </u> | | 1 | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | 1 | ٥, .٥٥١ | | |

| In Lieu of Form CMS-2552-10 | Period: Worksheet B | From 01/01/2019 | Part II | To 12/31/2019 | Date/Time Prepared: 8/19/2020 2:00 pm Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS COMMUNITY HOWARD REGIONAL HEALTH Provider CCN: 15-0007

| | | | | | | 0/ 19/ 2020 2.0 | U pili |
|---------------|-----------------------------------|-------------------|--------------|---------------|---------------|-----------------|---------|
| | Cost Center Description | ADMI NI STRATI VE | OPERATION OF | LAUNDRY & | HOUSEKEEPI NG | DI ETARY | |
| | | & GENERAL | PLANT | LINEN SERVICE | | | |
| | | 5.00 | 7. 00 | 8. 00 | 9. 00 | 10.00 | |
| 194. 16 07966 | PASTORAL CARE ALLIED HEALTH | 0 | 0 | 0 | 0 | 0 | 194. 16 |
| 200.00 | Cross Foot Adjustments | | | | | | 200.00 |
| 201.00 | Negative Cost Centers | 0 | 0 | 0 | 0 | 0 | 201.00 |
| 202. 00 | TOTAL (sum lines 118 through 201) | 1, 762, 818 | 1, 083, 381 | 49, 807 | 88, 589 | 112, 897 | 202. 00 |

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0007

| | | | Ť | o 12/31/2019 | Date/Time Pre 8/19/2020 2:0 | |
|--|------------------|-------------------------------|------------------|----------------|--------------------------------|--------------------|
| Cost Center Description | CAFETERI A | NURSI NG ADMI NI STRATI ON | | SOCIAL SERVICE | | рііі |
| | 11. 00 | 13. 00 | 16. 00 | 17. 00 | 19. 00 | |
| GENERAL SERVICE COST CENTERS | | | | | | |
| 1.00 00100 CAP REL COSTS-BLDG & FLXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP | | | | | | 1. 00 2. 00 |
| 2.00 00200 CAP REL COSTS-MVBLE EQUIP 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 | 136, 066 | l | | | | 11.00 |
| 13. 00 O1300 NURSI NG ADMINI STRATI ON 16. 00 O1600 MEDI CAL RECORDS & LI BRARY | 4, 058 0 | 60, 417 | 74, 082 | | | 13. 00 16. 00 |
| 17. 00 01700 SOCIAL SERVICE | 2, 444 | 1, 166 | 74, 082 | I I | | 17. 00 |
| 19. 00 01900 NONPHYSICIAN ANESTHETISTS | 0 | 0 | Ö | I | 0 | |
| 23. 00 02300 PASTORAL CARE | 768 | 0 | C | 0 | i . | 23. 00 |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30. 00 03000 ADULTS & PEDI ATRI CS | 44, 864 | | 6, 770 | | | 30.00 |
| 31. 00 03100 NTENSI VE CARE UNIT 43. 00 04300 NURSERY | 6, 408 1, 013 | | 851 143 | | | 31. 00 43. 00 |
| ANCI LLARY SERVI CE COST CENTERS | 1,013 | 121 | 143 | 000 | | 43.00 |
| 50. 00 05000 OPERATI NG ROOM | 14, 379 | 9, 039 | 8, 639 | 0 | | 50.00 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 3, 003 | | 423 | I I | | 52. 00 |
| 53. 00 05300 ANESTHESI OLOGY | 0 | - | 0 | - 1 | | 53.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 03480 ONCOLOGY | 7, 838 | l | 3, 157 | I I | | 54.00 |
| 54. 01 03480 0NCOLOGY 57. 00 05700 CT SCAN | 6, 546 2, 289 | | 4, 135 4, 212 | I I | | 54. 01 57. 00 |
| 58. 00 05800 MRI | 587 | 160 | 1, 688 | I I | | 58. 00 |
| 59. 00 05900 CARDI AC CATHETERI ZATI ON | 3, 264 | 1, 492 | 6, 064 | I I | | 59.00 |
| 60. 00 06000 LABORATORY | 0 | 0 | 6, 834 | . 0 | | 60.00 |
| 63.00 06300 BLOOD STORING, PROCESSING & TRANS. | 0 | 0 | C | - 1 | | 63. 00 |
| 65. 00 06500 RESPIRATORY THERAPY | 5, 579 | 1 | 1, 231 | I I | | 65. 00 |
| 66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY | 2, 063 | l I | 216 | I . | | 66.00 |
| 67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY | 1, 091 294 | 0 | 117 31 | I I | | 67. 00 68. 00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 4, 423 | 728 | 1, 810 | I . | | 69. 00 |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY | 126 | o | 17 | I I | | 70.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 0 | 0 | 2, 511 | 1 | | 71. 00 |
| 72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS | 0 | 0 | 2, 286 | | | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS 74.00 07400 RENAL DIALYSIS | 9, 945 0 | 0 | 12, 332 74 | I I | | 73. 00 74. 00 |
| 75. 00 07500 ASC (NON-DISTINCT PART) | 0 | | 0 | I . | | 75. 00 |
| 75. 01 03950 WOUND CARE CENTER | 1, 783 | 863 | 426 | o | | 75. 01 |
| 76. 00 03160 CARDI OPULMONARY | 736 | 326 | 156 | 0 | | 76. 00 |
| OUTPATIENT SERVICE COST CENTERS 91.00 O9100 EMERGENCY | 12 5/5 | 7 027 | 0 (17 | l ol | | 01 00 |
| 91.00 09100 EMERGENCY 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART | 12, 565 | 7, 927 | 8, 617 | ١ | | 91. 00 92. 00 |
| 92. 01 09201 OBSERVATION BEDS (DISTINCT PART) | 0 | ol | C | ol | | 92. 01 |
| 93. 00 04950 OTHER OUTPATIENT SERVICES | 0 | o | C | o | | 93.00 |
| 93. 01 04951 GENESI S | 0 | 0 | 478 | 0 | | 93. 01 |
| 93. 02 04952 WOMEN' S CENTER | 0 | 0 | O | 0 | | 93. 02 |
| 93. 03 04953 RESI DENTI AL HOMES 93. 04 04954 DR. STEELE | 0 | 0 | | | | 93. 03 93. 04 |
| 93. 04 04954 DK. 31EEEE 93. 05 04955 DI ABETI C EDUCATI ON | 0 | | 0 | | | 93. 05 |
| 93. 06 04956 HOWARD COUNTY CSS | 0 | o | 17 | o | | 93. 06 |
| 93. 07 04957 CLINTON COUNTY | 0 | o | 59 | o | | 93. 07 |
| 93. 18 04968 PSYCH MEDI CATI ON | 0 | 0 | C | 0 | | 93. 18 |
| 93. 43 O4993 NEW BEGINNINGS | 0 | 0 | 3 | 0 | | 93. 43 |
| OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES | 0 | ol | 785 | ol | | 95. 00 |
| SPECIAL PURPOSE COST CENTERS | 0 | <u> </u> | 703 | 1 0 | | 73.00 |
| 113. 00 11300 I NTEREST EXPENSE | | | | | | 113. 00 |
| 114. 00 11400 UTI LI ZATI ON REVI EW - SNF | | | | | i _ | 114. 00 |
| 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) | 136, 066 | 60, 417 | 74, 082 | 15, 099 | 0 | 118. 00 |
| NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | O | C | ا ا | | 190. 00 |
| 190. 01 19001 COMMUNITY HOWARD FOUNDATION | 0 | 1 | O | | | 190. 01 |
| 192.00 19200 PHYSI CLANS' PRI VATE OFFI CES | 0 | o | C | o | | 192. 00 |
| 193. 00 19300 NONPALD WORKERS | 0 | 0 | C | 0 | | 193. 00 |
| 194. 00 07950 HEALTHY CHILDREN | 0 | 0 | 0 | 0 | | 194. 00 |
| 194. 08 07958 SOUTH BERKLEY BLDG 194. 09 07959 MOBI LE CLINI C | 0 | | | 0 | | 194. 08 194. 09 |
| 194. 10 07960 PLASTIC SURGERY | 0 | | o d | | | 194. 09 |
| 194. 11 07961 KOKOMO SCHOOL BASED | 0 | Ö | d | o o | | 194. 11 |
| | | ' | | | | |

Heal th Financial Systems COMMUNITY HOWARD REGIONAL HEALTH In Lieu of Form CMS-2552-10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0007
From 01/01/2019
To 12/31/2019
Date/Time Prepared:

| | | | | | | 8/19/2020 2:0 | O pm |
|---------------|-----------------------------------|------------|-------------------|-----------|----------------|----------------|---------|
| | Cost Center Description | CAFETERI A | NURSI NG | MEDI CAL | SOCIAL SERVICE | NONPHYSI CI AN | |
| | | | ADMI NI STRATI ON | RECORDS & | | ANESTHETI STS | |
| | | | | LI BRARY | | | |
| | | 11.00 | 13. 00 | 16.00 | 17. 00 | 19. 00 | |
| 194. 15 0796! | INDIANA SURGERY CENTER | 0 | 0 | C | 0 | | 194. 15 |
| 194. 16 07966 | PASTORAL CARE ALLIED HEALTH | 0 | 0 | C | o | | 194. 16 |
| 200. 00 | Cross Foot Adjustments | | | | | 0 | 200. 00 |
| 201. 00 | Negative Cost Centers | 0 | o | (| o | 0 | 201. 00 |
| 202. 00 | TOTAL (sum lines 118 through 201) | 136, 066 | 60, 417 | 74, 082 | 15, 099 | 0 | 202. 00 |

In Lieu of Form CMS-2552-10
Worksheet B
01/2019 Part II
01/2019 Date/Time Prepared:
01/2019 R/19/2020 2:00 pm Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS COMMUNITY HOWARD REGIONAL HEALTH Provider CCN: 15-0007 Peri od: From 01/01/2019 To 12/31/2019 Cost Center Description

| PASSEGUE SERVICE COST CHILDREN 23.00 24.00 26. | | Cost Center Description | PASTORAL CARE | Subtotal | Intern & | Total | | |
|--|--------|--------------------------------|---------------|-------------|--------------|-------------|--------|---------|
| CAMPAIN SERVICE COST CENTERS 23.00 24.00 59.00 26.00 | | | | | | | | |
| CALIFORM SPRINGE COST CENTERS 23.90 24.00 25.90 26.00 | | | | | | | | |
| DESIGNAL SQUART COST COST COST COST COST COST COST COS | | | | | • | | | |
| 1.00 001000 CAP PEL COSTS-BLOC & FIRTY 2.00 000000 CAPER LOSTS-BLOC & 10 00000 3.00 00000 CAPER LOSTS-BLOC & 10 000000 3.00 00000 CAPER LOSTS-BLOC & 10 0000000 3.00 00000 CAPER LOSTS-BLOC & 10 000000000 3.00 00000 CAPER LOSTS-BLOC & 10 000000000000000000000000000000000 | | | 23.00 | 24. 00 | | 26. 00 | | |
| 2.00 00000 CAP REL COSIS-YMBLE EDUIT P 0.00 00000 ADM INSTRATIVE & GARRAL 13.00 00000 ADM INSTRATIVE & CONTROL & CONT | | GENERAL SERVICE COST CENTERS | | | | | | _ |
| 4.00 OBSTORM STRATUS & GENERAL S. DEPARTMENT S. DEPART | | | | | | | | |
| 5.00 DOSEQ ARMIN STRATIVE A CHINEM. 7.00 BOTO GERATION OF PLANT THE STRUCT BOTO DOSEQ ARMIN STRATION STRUCT BOTO DOSEQ ARMIN STRATION THE STRUCT BOTO OF DOSEQ ARMIN STRATION THE STRUCT BOTO OF DOSEQ ARMIN STRATION THE STRUCT BOTO OF DOSEQ ARMIN STRATION THE STRUCT STRUCT BOTO OF DOSEQ ARMIN STRATION THE STRUCT STRUC | | | | | | | | |
| 0.0700 0.07 | | | | | | | | |
| 8.00 00000 LUMBRY S LINEN SERVICE 9.00 0.00 | | | | | | | | |
| 9.00 000000 MUSERCEP NO | | | | | | | | |
| 10.00 0.000 DETARY | | I I | | | | | | |
| 11.00 01100 CAFETERIA | | | | | | | | |
| 16.00 16.00 MEDICAL RECORDS & LIBRARY | | | | | | | | |
| 17.00 1700 SOCIAL SERVICE | 13.00 | 01300 NURSING ADMINISTRATION | | | | | 13. 0 |)() |
| 19.00 1900 MORPHYSICIAN AMESTIELISIS 21,908 | | | | | | | | |
| 23.00 | | | | | | | | |
| IMPART ENT ROUTH NE SERVICE OOST CENTERS 1,605,610 | | | 04 000 | | | | | |
| 30.00 | 23. 00 | | 21, 998 | | | | 23. 0 | Ю |
| 31.00 03100 INTERSITY CARE UNIT 163, 992 0 163, 992 31.00 A30 MUSERY 53, 206 0 53, 206 43.00 A80 | 30 00 | | | 1 605 610 | | 1 605 610 | 30.0 | 10 |
| 43. 00 | | | | | | | | |
| MICH LARY SERVICE COST CENTERS | | | | | | | | |
| 52.00 05200 BELIVERY ROMA & LABOR ROM | | ANCILLARY SERVICE COST CENTERS | | · | | | | |
| 53.00 05300 AMESTHESIOLOGY 0 0 0 640, 616 54.00 540.00 | 50.00 | | | 652, 452 | 0 | 652, 452 | 50.0 |)() |
| 54. 00 05400 RADIOLOGY-DI AGNOSTIC 640, 616 0 640, 616 54. 00 | | I I | | 134, 700 | | | | |
| 54 OI 03480 ONCOLOGY | | | | | 1 | | | |
| 141,535 | | | | | 1 | | | |
| 58. 00 05800 MR | | | | | | | • | |
| 59 00 05900 CARDIA CATHETER ZATION 115, 866 0 115, 866 69, 00 00 00 03 00 06300 BODOD STORINO, PROCESSING & TRANS. 0 0 0 0 03 00 06300 BODOD STORINO, PROCESSING & TRANS. 0 0 0 0 03 00 06500 BESPORATORY HERAPY 26, 091 0 26, 091 06 00 0600 BESPORATORY HERAPY 28, 362 0 28, 362 0 28, 362 07, 00 0700 020 | | | | | 1 | | • | |
| 00.00 0.00000 0.00000 0.0000 0.000 0.00 | | | | | 1 | | • | |
| 0 | | | | | 1 | | | |
| 65.00 06500 RESPIRATORY THERAPY 124, 440 0 124, 440 65.00 66.00 06600 PRIST LAIL THERAPY 26.091 0 26.091 66.00 66.00 06500 PRIST LAIL THERAPY 28.362 0 28.362 67.00 67.00 06700 05000 DELECTROCARDIOLOGY 10.929 0 10.929 68.00 6800 05000 SPEECH PATHOLOGY 156.030 0 156.030 69.00 69.00 06900 ELECTROCARDIOLOGY 7.268 0 7.268 70.00 70.00 70.00 ELECTROCARDIOLOGY 7.268 0 7.268 7.000 7.268 71.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 232,968 0 222,968 71.00 71.00 71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS 115.548 0 115.548 72.00 73.00 73.00 RUSS CHARGED TO PATIENTS 73.8834 0 73.8834 73.00 74.00 70.00 70.00 70.00 70.00 70.00 RUSS CHARGED TO PATIENTS 73.8834 0 73.8834 73.00 75.00 | | | | | 1 | | | |
| 67.00 0670 | | | | 124, 440 | o | 124, 440 | | |
| 68. 00 06800 SPEECH PATHOLOGY 10, 929 0 10, 929 68. 00 | | | | 26, 091 | 0 | 26, 091 | | |
| 69.00 06900 ELECTROCARDIOLOGY 156.030 0 156.030 69.00 | | | | | | | | |
| 70.00 070000 07000 07000 07000 07000 07000 07000 07000 07000 07000 07000 07000 07000 07000 07000 07000 070000 070000 070000 070000 070000 070000 070000 0700000 07000000 0700000000 | | | | | | | | |
| 171.00 | | | | | | | | |
| 172.00 07200 IMPL DEV. CHARGED TO PATIENTS 115, 548 0 115, 548 72.00 730.00 | | | | | | | | |
| 73.0 07300 DRUGS CHARGED TO PATIENTS 738, 834 0 738, 834 73. 00 | | | | | | | | |
| 74.00 07400 RFANL DI ALYSI S 5.031 0 5.031 74.00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 0 0 0 0 0 | | | | | | | | |
| 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 75. 00 | | | | | | | | |
| 75. 01 03950 WOUND CARE CENTER 73, 383 0 73, 383 75. 01 76. 00 03100 CARD DOPLMONARY 5, 123 0 5, 123 76. 00 00 00 00 00 00 00 00 | | | | | | | | |
| DUTPATI_ENT_SERVICE_COST_CENTERS | 75. 01 | | | 73, 383 | 0 | 73, 383 | 75. 0 |)1 |
| 991. 00 09100 BERRGENCY 560, 085 0 560, 085 0 92. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 92. 01 93. 00 04950 OTHER OUTPATIENT SERVICES 0 0 0 0 0 93. 00 93. 01 04951 GENESIS 128, 866 0 128, 866 93. 01 04951 GENESIS 28. 866 0 0 0 0 0 0 0 0 0 | 76. 00 | | | 5, 123 | 0 | 5, 123 | 76. 0 |)() |
| 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 92. 00 92. 01 09201 OBSERVATI ON BEDS (I) STINCT PART) 0 0 0 0 93. 00 93. 00 04950 OTHER OUTPATI ENT SERVI CES 0 0 0 0 93. 00 93. 01 04951 GENESI S 128,866 0 128,866 93. 01 93. 02 04952 WOMEN'S CENTER 0 0 0 0 93. 02 93. 04 04953 RESI DENTI AL HOMES 0 0 0 0 93. 03 93. 04 04953 RESI DENTI AL HOMES 0 0 0 0 93. 03 93. 04 04954 DR. STEELE 0 0 0 0 0 93. 04 93. 05 04955 DI ABETI C EDUCATI ON 0 0 0 0 93. 05 93. 07 04956 HOMARD COUNTY CSS 46,313 0 46,313 93. 06 93. 07 04956 HOMARD COUNTY CSS 46,313 0 46,313 93. 06 93. 07 04957 CLI NTON COUNTY 76,206 0 76,206 93. 07 93. 18 04968 PSYCH MEDI CATI ON 0 0 0 0 93. 18 95. 00 OBSECIAL PURPOSE COST CENTERS | | | | | | | | |
| 92.01 09201 08SERVATI ON BEDS (DISTINCT PART) 0 0 0 92.01 93.00 04950 OTHER OUTPATIENT SERVICES 0 0 0 93.00 93.01 04951 GENESI S 128,866 0 128,866 93.01 93.02 04952 WOMEN'S CENTER 0 0 0 0 93.02 93.03 04953 RESI DENTI AL HOMES 0 0 0 0 93.02 93.04 04954 DR. STEELE 0 0 0 0 93.03 93.05 04955 DI ABETI C EDUCATION 0 0 0 93.05 93.06 04955 DI ABETI C EDUCATION 0 0 0 93.05 93.07 04957 CLI NTON COUNTY 76,206 0 76,206 93.07 93.18 04968 PSYCH MEDI CATION 0 0 0 93.18 93.43 04968 PSYCH MEDI CATION 0 0 0 93.18 93.43 04968 PSYCH MEDI CATION 0 0 0 93.18 93.43 04968 PSYCH MEDI CATION 0 0 0 93.18 95.00 0500 AMBULANCE SERVICES 0 68,519 0 68,519 95.00 9500 AMBULANCE SERVICES 0 68,519 0 68,519 95.00 114.00 11300 INTEREST EXPENSE 113.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 119.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190.00 190 | | | | 560, 085 | | 560, 085 | | |
| 93. 00 04950 OTHER OUTPATIENT SERVICES | | | | 0 | | | | |
| 93. 01 04951 GENESIS 128, 866 0 128, 866 93. 01 93. 02 04952 WOMEN'S CENTER 0 0 0 0 93. 03 04954 DR. STEELE 0 0 0 0 93. 03 04954 DR. STEELE 0 0 0 0 93. 04 93. 05 04955 DI ABETI C EDUCATI ON 0 0 0 93. 05 04955 DI ABETI C EDUCATION 0 0 0 93. 05 04957 CLI NTON COUNTY CSS 46, 313 0 46, 313 93. 07 04957 CLI NTON COUNTY 76, 206 0 76, 206 93. 07 93. 18 04968 PSYCH MEDI CATI ON 0 0 0 93. 18 93. 43 04993 NEW BEGI NIN INGS 25, 446 0 25, 446 93. 43 0THER REI MBURSABLE COST CENTERS 0 68, 519 95. 00 113. 00 11400 UTI LI ZATI ON REVIEW - SNF 114. 00 118. 00 NONREI MBURSABLE COST CENTERS 5 5 5 5 1190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190. 01 19001 COMMUNI TY HOWARD FOUNDATI ON 1, 632 0 1, 632 190. 01 191. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 1, 124, 453 0 1, 124, 453 192. 00 194. 08 07958 SOUTH BERKLEY BLDG 813 0 813 194. 00 194. 08 07958 SOUTH BERKLEY BLDG 813 0 813 194. 00 194. 08 07958 SOUTH BERKLEY BLDG 190. 01 190. 01 190. 01 190. 01 190. 01 190. 00 190. 01 194. 08 07958 SOUTH BERKLEY BLDG 190. 01 195. 00 190. 00 190. 00 190. 00 190. 00 190. 01 190. 01 190. 01 190. 00 190. 00 190. 01 19 | | | | | | | | |
| 93. 02 04952 WOMEN'S CENTER 0 0 0 0 93. 02 93. 03 04953 RESI DENTI AL HOMES 0 0 0 0 0 93. 03 93. 04 04954 DR. STEELE 0 0 0 0 0 93. 03 93. 05 04955 DI ABETI C EDUCATI ON 0 0 0 0 93. 05 93. 06 04956 HOWARD COUNTY CSS 46, 313 0 46, 313 93. 06 93. 07 04957 CLI NTON COUNTY 7 76, 206 0 76, 206 93. 07 93. 18 04968 PSYCH MEDI CATI ON 0 0 0 0 93. 18 93. 43 04993 NEW BEGI NNI NGS 0 25, 446 0 25, 446 93. 43 0THER REI MBURSABLE COST CENTERS 95. 00 SPECI AL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 114. 00 114. 00 11400 UTI LI ZATI ON REVI EW - SNF 114. 00 118. 00 SUBTOTALS (SUM OF LI NES 1 through 117) 0 8, 515, 233 0 8, 515, 233 118. 00 190. 01 19000 G I FT, FLOWER, COFFEE SHOP & CANTEEN 190. 01 190. 01 19000 O 01 19000 G I FT, FLOWER, COFFEE SHOP & CANTEEN 1, 632 0 1, 632 190. 01 191. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 1, 124, 453 0 1, 124, 453 192. 00 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 194. 00 194. 00 19795 BOUTH BERKLEY BLDG 813 0 9, 813 194. 00 | | 1 1 | | - | 1 | - | • | |
| 93. 04 | | | | O | 1 | 0 | | |
| 93. 05 | 93. 03 | 04953 RESIDENTIAL HOMES | | 0 | 0 | 0 | 93. 0 |)3 |
| 93. 06 | | | | 0 | 0 | 0 | • | |
| 93. 07 | | | | 0 | 0 | - | | |
| 93. 18 | | I I | | | 1 | | | |
| 93. 43 04993 NEW BEGINNINGS 25, 446 0 25, 446 93. 43 07HER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 68, 519 0 68, 519 95. 00 13000 INTEREST EXPENSE 113. 00 114000 UTILIZATION REVIEW - SNF 114. 00 11400 UTILIZATION REVIEW - SNF 114. 00 NONREI MBURSABLE COST CENTERS 118. 00 NONREI MBURSABLE COST CENTERS 18. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190. 00 190. 01 19001 COMMUNITY HOWARD FOUNDATION 1, 632 0 1, 632 190. 01 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 1, 124, 453 0 1, 124, 453 192. 00 193. 00 19300 NONPAI D WORKERS 0 0 0 0 193. 00 194. 00 07950 HEALTHY CHILDREN 0 0 0 0 194. 00 194. 08 07958 SOUTH BERKLEY BLDG 813 194. 08 | | I I | | | | . 1 | | |
| OTHER REIMBURSABLE COST CENTERS 95.00 99500 AMBULANCE SERVI CES 95.00 99500 AMBULANCE SERVI CES 95.00 99500 MBULANCE SERVI CES 95.00 99500 MBULANCE SERVI CES 995.00 995 | | | | - | 1 | - 1 | | |
| 95. 00 09500 AMBULANCE SERVICES 68, 519 0 68, 519 95. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 114. 00 11400 UTILIZATION REVIEW - SNF 114. 00 SUBTOTALS (SUM OF LINES 1 through 117) 0 8, 515, 233 0 8, 515, 233 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190. 00 190. | 73. 43 | | | 23, 440 | η Ο | 23, 440 | 75. 4 | |
| 113. 00 114.00 114.00 114.00 114.00 114.00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 0 8, 515, 233 0 8, 515, 233 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190. 00 190. 01 190.01 | 95.00 | | | 68, 519 | 0 | 68, 519 | 95. 0 | 00 |
| 114.00 118.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 8,515,233 0 8,515,233 0 118.00 NONREI MBURSABLE COST CENTERS 190.00 19001 COMMUNITY HOWARD FOUNDATION 1,632 0 1,632 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 1,124,453 0 1,124,453 192.00 193.00 193.00 193.00 194.00 0 0 0 0 194.00 194.00 194.08 0 0 0 0 194.00 194.08 0 0 0 0 194.08 1 | | | | | | , | | |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 8,515,233 0 8,515,233 118.00 | | 1 1 | | | | | | |
| NONRE MBURSABLE COST CENTERS 190. 00 1900 1900 1900 0 1900 0 1900 0 1900 0 1900 0 1900 0 1900 0 1900 0 1900 0 1900 0 1900 0 1900 | | | | 0 515 222 | | 0 515 333 | | |
| 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190. 00 190. 00 190. 01 19001 COMMUNITY HOWARD FOUNDATION 1, 632 0 1, 632 190. 01 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 1, 124, 453 0 1, 124, 453 192. 00 193. 00 19300 NONPAI D WORKERS 0 0 0 0 193. 00 194. 00 07950 HEALTHY CHI LDREN 0 0 0 0 194. 00 194. 08 07958 SOUTH BERKLEY BLDG 813 0 813 194. 08 | 118.00 | | l o | 8, 515, 233 | 3 <u> </u> U | 8, 515, 233 | 118.0 | Ю |
| 190. 01 19001 COMMUNITY HOWARD FOUNDATION 1, 632 0 1, 632 190. 01 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 1, 124, 453 0 1, 124, 453 192. 00 193. 00 19300 NONPAI D WORKERS 0 0 0 0 193. 00 194. 00 07950 HEALTHY CHI LDREN 0 0 0 0 194. 00 194. 08 07958 SOUTH BERKLEY BLDG 813 0 813 194. 08 | 190 0 | | | 0 | | n | 190 0 |)() |
| 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 1, 124, 453 0 1, 124, 453 192.00 193.00 193.00 193.00 193.00 193.00 193.00 194 | | | | | 1 | | | |
| 193. 00 19300 NONPAI D WORKERS 0 0 0 0 193. 00 194. 00 194. 00 194. 00 194. 00 194. 00 194. 08 194. | | | | | | | | |
| 194. 00 07950 HEALTHY CHI LDREN 0 0 0 194. 00 194. 00 194. 08 07958 SOUTH BERKLEY BLDG 813 0 813 194. 08 | | | | 0 | | i | | |
| | | | | 0 | 0 | 0 | | |
| 194. 09 07959 MOBI LE CLI NI C 792 0 792 194. 09 | | | | | | | | |
| | 194.0 | 9 07959 MOBI LE CLI NI C | | 792 | 2 0 | 792 | 194. 0 |)9 — |

| Health Financial Systems C | OMMUNITY HOWARD R | EGIONAL HEALTI | Н | In Lie | eu of Form CMS-2552-10 |
|--|-------------------|----------------|---------------|----------------------------------|------------------------|
| ALLOCATION OF CAPITAL RELATED COSTS | | Provi der CC | | Peri od: | Worksheet B |
| | | | | From 01/01/2019 To 12/31/2019 | Date/Time Prepared: |
| | | | | | 8/19/2020 2:00 pm |
| Cost Center Description | PASTORAL CARE | Subtotal | Intern & | Total | |
| | | | Residents Cos | t | |
| | | | & Post | | |
| | | | Stepdown | | |
| | | | Adjustments | | |
| | 23. 00 | 24. 00 | 25. 00 | 26.00 | |
| 194. 10 07960 PLASTIC SURGERY | | 21, 793 | | 0 21, 793 | 194. 10 |
| 194.11 07961 KOKOMO SCHOOL BASED | | 51, 402 | | 0 51, 402 | 194. 11 |
| 194. 15 07965 INDIANA SURGERY CENTER | | 674, 038 | | 0 674, 038 | 194. 15 |
| 194.16 07966 PASTORAL CARE ALLIED HEALTH | | O | | 0 0 | 194. 16 |
| 200.00 Cross Foot Adjustments | 21, 998 | 21, 998 | | 0 21, 998 | 200. 00 |
| 201.00 Negative Cost Centers | 0 | O | | 0 | 201.00 |
| 202.00 TOTAL (sum lines 118 through 201) | 21, 998 | 10, 412, 154 | | 0 10, 412, 154 | 202. 00 |

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 COMMUNITY HOWARD REGIONAL HEALTH Provider CCN: 15-0007

| | | | | T | o 12/31/2019 | Date/Time Pre 8/19/2020 2:0 | |
|------------------|---|------------------|------------------------------|----------------------|----------------|-----------------------------|--------------------|
| | | CAPITAL RE | LATED COSTS | | | 07 1 77 2020 2.0 | D DIII |
| | | DI DO A FLYT | I 10/01 5 50/11 5 | | | | |
| | Cost Center Description | BLDG & FIXT | MVBLE EQUIP (SQUARE FEET) | EMPLOYEE BENEFITS | Reconciliation | ADMINISTRATIVE & GENERAL | |
| | | (SQUARE FEET) | (SQUARE FEET) | DEPARTMENT | | (ACCUM. COST) | |
| | | | | (GROSS | | (1000) | |
| | | | | SALARI ES) | | | |
| | OFNEDAL CERVILOE COCT OFNITERS | 1.00 | 2.00 | 4.00 | 5A | 5. 00 | |
| 1. 00 | GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FIXT | 412, 755 | | | | I | 1.00 |
| 2.00 | 00200 CAP REL COSTS-MVBLE EQUIP | 412,755 | 412, 755 | | | | 2.00 |
| 4. 00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | 3, 750 | | | | | 4. 00 |
| 5.00 | 00500 ADMINISTRATIVE & GENERAL | 101, 649 | 101, 649 | 4, 326, 372 | -23, 527, 302 | | 1 |
| 7.00 | 00700 OPERATION OF PLANT | 41, 927 | | | | | 1 |
| 8. 00 9. 00 | OO800 LAUNDRY & LI NEN SERVI CE OO900 HOUSEKEEPI NG | 2, 168 | 1 | | | 426, 366 2, 038, 279 | 1 |
| 10.00 | 01000 DI ETARY | 2, 342 5, 046 | 1 | | | 719, 260 | 1 |
| 11. 00 | 01100 CAFETERI A | 5, 981 | 1 | | | | 1 |
| 13.00 | 01300 NURSING ADMINISTRATION | 727 | | | 0 | 2, 447, 092 | 13. 00 |
| 16. 00 | 01600 MEDI CAL RECORDS & LI BRARY | 2, 975 | | | | , | 1 |
| 17. 00 19. 00 | 01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS | 0 | 0 | | | | 1 |
| 23. 00 | 02300 PASTORAL CARE | 864 | 864 | · · | _ | | 1 |
| 20.00 | INPATIENT ROUTINE SERVICE COST CENTERS | 001 | 001 | 100, 101 | | 220, 000 | 20.00 |
| 30.00 | 03000 ADULTS & PEDI ATRI CS | 56, 354 | 56, 354 | 9, 191, 053 | 0 | 14, 051, 846 | 30.00 |
| 31. 00 | 03100 I NTENSI VE CARE UNI T | 5, 225 | | | | | |
| 43. 00 | 04300 NURSERY | 1, 877 | 1, 877 | 217, 885 | 0 | 354, 416 | 43. 00 |
| 50. 00 | ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM | 19, 802 | 19, 802 | 2, 717, 125 | 0 | 6, 257, 376 | 50.00 |
| 52. 00 | 05200 DELIVERY ROOM & LABOR ROOM | 5, 565 | | | | | |
| 53.00 | 05300 ANESTHESI OLOGY | 0 | 0 | l | | | 1 |
| 54. 00 | 05400 RADI OLOGY-DI AGNOSTI C | 19, 201 | 19, 201 | 1, 646, 541 | | _,, | 1 |
| 54. 01 | 03480 ONCOLOGY | 20, 534 | | | | 4, 679, 130 | 1 |
| 57. 00 58. 00 | 05700 CT SCAN 05800 MRI | 600 | | | | 846, 400 994, 977 | 1 |
| 59. 00 | 05900 CARDI AC CATHETERI ZATI ON | 4, 200 | 1 | 1, | | | 1 |
| 60.00 | 06000 LABORATORY | 4, 905 | | · · | | | 1 |
| 63. 00 | 06300 BLOOD STORING, PROCESSING & TRANS. | 0 | _ | | _ | | |
| 65. 00 | 06500 RESPI RATORY THERAPY | 4, 394 | | | | ., | 1 |
| 66. 00 67. 00 | 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY | 680 1, 067 | l . | | | 581, 602 336, 425 | 1 |
| 68. 00 | 06800 SPEECH PATHOLOGY | 450 | 1 | | | | 1 |
| 69. 00 | 06900 ELECTROCARDI OLOGY | 104 | | | | | 1 |
| 70.00 | 07000 ELECTROENCEPHALOGRAPHY | 319 | 319 | 27, 131 | 0 | 44, 423 | 70. 00 |
| 71. 00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 6, 439 | 6, 439 | | | -, , | |
| 72. 00 | 07200 I MPL. DEV. CHARGED TO PATIENTS | 0 | 0 | 2 120 104 | _ | | 1 |
| 73. 00 74. 00 | 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS | 3, 419 | 3, 419 | 2, 138, 194 | 0 | 17, 005, 639 298, 311 | 1 |
| 75.00 | 07500 ASC (NON-DISTINCT PART) | | 0 | | 0 | 290, 311 | 1 |
| | 03950 WOUND CARE CENTER | 2, 066 | 2, 066 | 382, 876 | Ö | | |
| 76. 00 | 03160 CARDI OPULMONARY | 0 | 0 | 158, 294 | . 0 | 221, 644 | 76. 00 |
| 04 00 | OUTPATIENT SERVICE COST CENTERS | 00.040 | 1 00 0/0 | 0 500 500 | | 1 250 040 | 04.00 |
| | O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT PART | 22, 863 | 22, 863 | 2, 528, 502 | 0 | 4, 359, 349 | 91. 00 92. 00 |
| 92. 00 | 09201 OBSERVATION BEDS (NON-DISTINCT PART | 0 | 0 | l c | 0 | 0 | |
| | 04950 OTHER OUTPATIENT SERVICES | 0 | Ö | C | Ö | Ö | 1 |
| 93. 01 | 04951 GENESI S | 0 | 0 | 1, 467, 614 | 0 | 1, 668, 542 | 1 |
| | 04952 WOMEN'S CENTER | 0 | 0 | C | 0 | 0 | |
| 93. 03 | 04953 RESI DENTI AL HOMES | 0 | 0 | | 0 | 0 | |
| 93. 04 | O4954 DR. STEELE O4955 DI ABETI C EDUCATI ON | | 0 | | 0 | 0 | |
| | 04956 HOWARD COUNTY CSS | 0 | 0 | 516, 770 | 0 | 315, 359 | |
| | 04957 CLI NTON COUNTY | | Ö | 345, 993 | | 334, 414 | 1 |
| | 04968 PSYCH MEDICATION | 0 | 0 | C | 0 | 0 | 93. 18 |
| 93. 43 | 04993 NEW BEGINNINGS | 0 | 0 | 35, 212 | 0 | 77, 336 | 93. 43 |
| 05 00 | OTHER REIMBURSABLE COST CENTERS | 1 720 | 1 720 | 1 100 054 | 0 | 1 002 540 | 05 00 |
| 75. UU | O9500 AMBULANCE SERVI CES SPECI AL PURPOSE COST CENTERS | 1, 730 | 1, 730 | 1, 190, 856 | 0 | 1, 903, 569 | 75.00 |
| 113.00 | 11300 I NTEREST EXPENSE | | | | | | 113. 00 |
| 114.00 | 11400 UTILIZATION REVIEW - SNF |] | | | | | 114. 00 |
| 118.00 | | 349, 223 | 349, 223 | 39, 810, 198 | -23, 527, 302 | 98, 658, 479 | 118. 00 |
| 100.00 | NONREI MBURSABLE COST CENTERS | _ | _ | _ | 1 ^ | _ | 100 00 |
| | 1900 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1900 COMMUNITY HOWARD FOUNDATION | | 0 | 69, 832 | | | 190. 00 190. 01 |
| | 19200 PHYSI CLANS' PRI VATE OFFI CES | 30, 124 | 30, 124 | | | 3, 983, 840 | |
| | 19300 NONPALD WORKERS | 0 | 0 | | | 0 | 193. 00 |
| 194.00 | 07950 HEALTHY CHILDREN | 0 | 0 | [c | 0 | 0 | 194. 00 |
| | | | | | | | |

| | | | | 1 | 0 12/31/2019 | 8/19/2020 2:00 | |
|---------------|---|---------------|---------------|----------------------|----------------|-------------------|---------|
| | | CAPITAL REL | ATED COSTS | | | | |
| | | | | | | | |
| | Cost Center Description | BLDG & FIXT | MVBLE EQUIP | | Reconciliation | ADMI NI STRATI VE | |
| | | (SQUARE FEET) | (SQUARE FEET) | | | & GENERAL | |
| | | | | DEPARTMENT | | (ACCUM. COST) | |
| | | | | (GROSS SALARI ES) | | | |
| | | 1.00 | 2.00 | 4, 00 | 5A | 5. 00 | |
| 194, 08 07958 | SOUTH BERKLEY BLDG | 0 | 0 | 0 | 0 | | 194. 08 |
| | MOBILE CLINIC | 0 | 0 | 31, 964 | 0 | 44, 958 | |
| 194. 10 07960 | PLASTIC SURGERY | 0 | 0 | 0 | 0 | 21, 437 | 194. 10 |
| 194. 11 07961 | KOKOMO SCHOOL BASED | 0 | 0 | 2, 167, 591 | 0 | 2, 720, 891 | 194. 11 |
| 194. 15 07965 | INDIANA SURGERY CENTER | 33, 408 | 33, 408 | 0 | 0 | 554, 307 | 194. 15 |
| 194. 16 07966 | PASTORAL CARE ALLIED HEALTH | 0 | 0 | 0 | 0 | 0 | 194. 16 |
| 200. 00 | Cross Foot Adjustments | | | | | | 200. 00 |
| 201. 00 | Negative Cost Centers | | | | | | 201. 00 |
| 202. 00 | Cost to be allocated (per Wkst. B, Part I) | 4, 180, 342 | 2, 667, 647 | 1, 607, 949 | | 23, 527, 302 | 202. 00 |
| 203. 00 | Unit cost multiplier (Wkst. B, Part I) | 10. 127902 | 6. 463028 | 0. 036311 | | 0. 221794 | 203. 00 |
| 204. 00 | Cost to be allocated (per Wkst. B, | | | 62, 216 | | 1, 762, 818 | 204. 00 |
| | Part II) | | | | | | |
| 205. 00 | Unit cost multiplier (Wkst. B, Part | | | 0. 001405 | | 0. 016618 | 205. 00 |
| 201 20 | | | | | | | 00/ 00 |
| 206. 00 | NAHE adjustment amount to be allocated | | | | | | 206. 00 |
| 207. 00 | (per Wkst. B-2) | | | | | | 207. 00 |
| 207.00 | NAHE unit cost multiplier (Wkst. D, Parts III and IV) | | | | | | 207.00 |
| I | i ai to i i ai ai v | 1 | l | l | I | | l |

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0007 Peri od: Worksheet B-1 From 01/01/2019 12/31/2019 Date/Time Prepared: 8/19/2020 2:00 pm Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A LINEN SERVICE (TOTAL PATI (SALARI ES) PLANT (SQUARE FEET) (SQUARE FEET) (TOTAL PATI ENT DAYS) ENT DAYS) 7.00 10.00 9.00 11.00 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 00700 OPERATION OF PLANT 7.00 354, 488 7 00 00800 LAUNDRY & LINEN SERVICE 19,073 8.00 2, 168 8.00 00900 HOUSEKEEPI NG 9.00 2, 342 349, 978 9.00 10.00 01000 DI ETARY 5,046 5,046 19,073 10.00 11.00 01100 CAFETERI A 5, 981 5, 981 29, 272, 879 11.00 01300 NURSING ADMINISTRATION 13.00 727 727 0 873, 155 13.00 16.00 01600 MEDICAL RECORDS & LIBRARY 2,975 2, 975 0 0 16.00 17.00 01700 SOCIAL SERVICE C 525, 734 17.00 01900 NONPHYSICIAN ANESTHETISTS 0 19.00 0 C 0 0 19.00 02300 PASTORAL CARE 23.00 864 864 165, 134 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 56, 354 16, 770 56, 354 16, 770 9, 651, 273 30.00 03100 INTENSIVE CARE UNIT 1, 469 31 00 5 225 5 225 1 469 1, 378, 653 31 00 43.00 04300 NURSERY 1,877 834 1, 877 834 217, 885 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 19, 802 19, 802 3, 093, 580 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 5.565 Ω 5, 565 646, 072 52 00 0 53.00 05300 ANESTHESI OLOGY 0 C 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 19, 201 19, 201 1, 686, 227 54.00 54 01 03480 ONCOLOGY 20 534 Ω 20 534 1, 408, 294 54 01 05700 CT SCAN 57.00 600 C 600 492, 514 57.00 58.00 05800 MRI 126, 209 58.00 59.00 05900 CARDIAC CATHETERIZATION 4, 200 0 4, 200 702, 298 59.00 06000 LABORATORY 60 00 4.905 60 00 4.905 0 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0 63.00 06500 RESPIRATORY THERAPY 4, 394 4, 394 1, 200, 254 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 680 680 443, 852 66, 00 06700 OCCUPATIONAL THERAPY 234, 770 67.00 67 00 1.067 1.067 68.00 06800 SPEECH PATHOLOGY 450 450 63, 321 68.00 06900 ELECTROCARDI OLOGY 951, 489 69.00 104 104 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 319 27, 131 70.00 319 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 6.439 6, 439 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0 73 00 07300 DRUGS CHARGED TO PATIENTS 3 419 3, 419 2, 139, 661 73.00 07400 RENAL DIALYSIS 74.00 0 74.00 C 0 07500 ASC (NON-DISTINCT PART) 75.00 Ω Λ Λ 75.00 75.01 03950 WOUND CARE CENTER 2,066 0 2,066 0 383, 689 75.01 76.00 03160 CARDI OPULMONARY 158, 294 76.00 OUTPATIENT SERVICE COST CENTERS n 0 2, 703, 390 91.00 91.00 09100 EMERGENCY 22, 863 22, 863 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 09201 OBSERVATION BEDS (DISTINCT PART) 0 92.01 92.01 0 0 0 04950 OTHER OUTPATIENT SERVICES 93.00 Λ C 0 0 93.00 04951 GENESI S 0 0 0 93.01 93.01 29,700 29, 700 04952 WOMEN'S CENTER 93.02 O 93.02 0 0 04953 RESIDENTIAL HOMES 93.03 0 0 0 93.03 93.04 04954 DR. STEELE 0 0 0 93.04 93.05 04955 DIABETIC EDUCATION C 0 93.05 0 04956 HOWARD COUNTY CSS 9, 900 93.06 93.06 9.900 04957 CLINTON COUNTY 93.07 0 0 \cap Λ 93.07 93.18 04968 PSYCH MEDICATION 0 C 0 0 0 93.18 04993 NEW BEGINNINGS 93.43 0 0 93.43 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 0 0 95.00 1, 730 1, 730 0 95.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 114.00 11400 UTI LI ZATI ON REVIEW - SNF 114 00 SUBTOTALS (SUM OF LINES 1 through 117) 29, 272, 879 118. 00 118.00 241, 497 19,073 236, 987 19,073 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 0 190. 01 190. 01 19001 COMMUNITY HOWARD FOUNDATION 0 0 0 Ω 192.00 19200 PHYSICIANS' PRIVATE OFFICES 79, 583 0 79, 583 0 0 192.00 193. 00 19300 NONPALD WORKERS 0 0 193.00 0 194. 00 07950 HEALTHY CHILDREN 0 0 0 0 194.00 194. 08 07958 SOUTH BERKLEY BLDG 0 0 0 194. 08 0 194.09 07959 MOBILE CLINIC 0 0 0 0 194. 09 194. 10 07960 PLASTIC SURGERY 0 0 194. 10

| Health Financial Systems | COMMUNITY HOWARD REGIONAL HEALTH | In Lieu of Form CMS-2552-10 |
|-------------------------------------|----------------------------------|---------------------------------------|
| COST ALLOCATION - STATISTICAL BASIS | Provi der CCN: 15-0007 | Peri od: Worksheet B-1 |
| | | From 01/01/2019 Date/Time Propaged: |

| | | | | | o 12/31/2019 | Date/Time Pre 8/19/2020 2:0 | |
|--------------|--|---------------|---------------|---------------|--------------|--------------------------------|---------|
| | Cost Center Description | OPERATION OF | LAUNDRY & | HOUSEKEEPI NG | DI ETARY | CAFETERI A | |
| | | PLANT | LINEN SERVICE | (SQUARE FEET) | (TOTAL PATI | (SALARI ES) | |
| | | (SQUARE FEET) | (TOTAL PATI | | ENT DAYS) | | |
| | | | ENT DAYS) | | | | |
| | | 7. 00 | 8. 00 | 9. 00 | 10.00 | 11. 00 | |
| 194. 11 0796 | 1 KOKOMO SCHOOL BASED | 0 | 0 | C | 0 | 0 | 194. 11 |
| 194. 15 0796 | 5 INDIANA SURGERY CENTER | 33, 408 | 0 | 33, 408 | 0 | 0 | 194. 15 |
| 194. 16 0796 | 6 PASTORAL CARE ALLIED HEALTH | 0 | 0 | C | 0 | 0 | 194. 16 |
| 200.00 | Cross Foot Adjustments | | | | | | 200. 00 |
| 201.00 | Negative Cost Centers | | | | | | 201. 00 |
| 202.00 | Cost to be allocated (per Wkst. B, | 8, 779, 515 | 574, 625 | 2, 548, 361 | 1, 040, 503 | 1, 383, 283 | 202. 00 |
| | Part I) | | | | | | |
| 203. 00 | Unit cost multiplier (Wkst. B, Part I) | 24. 766748 | 30. 127667 | 7. 281489 | 54. 553715 | 0. 047255 | 203. 00 |
| 204.00 | Cost to be allocated (per Wkst. B, | 1, 083, 381 | 49, 807 | 88, 589 | 112, 897 | 136, 066 | 204. 00 |
| | Part II) | | | | | | |
| 205.00 | Unit cost multiplier (Wkst. B, Part | 3. 056185 | 2. 611388 | 0. 253127 | 5. 919205 | 0. 004648 | 205. 00 |
| | 11) | | | | | | |
| 206. 00 | NAHE adjustment amount to be allocated | | | | | | 206. 00 |
| | (per Wkst. B-2) | | | | | | |
| 207. 00 | NAHE unit cost multiplier (Wkst. D, | | | | | | 207. 00 |
| | Parts III and IV) | | | | | | |
| | | | | | | | |

Health Financial Systems COMMUNITY HOWARD REGIONAL HEALTH In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0007 | Period: From 01/01/2019 | To 12/31/2019 | Date/Time Prepared: 8/19/2020 2:00 pm

| | | | | | T | 0 12/31/2019 | Date/Time Pre 8/19/2020 2:0 | |
|--------------------|-------|---|-------------------------|------------------------------|----------------|-----------------------------|--------------------------------|--------------------|
| | | Cost Center Description | NURSI NG | MEDI CAL | SOCIAL SERVICE | | PASTORAL CARE | Э |
| | | | ADMI NI STRATI ON | RECORDS & LI BRARY | (TOTAL PATI | ANESTHETI STS (ASSI GNED | (ASSI GNED TIME) | |
| | | | (NURSING SA | (GROSS CHAR | ENT DAYS) | TI ME) | · | |
| | | | 13. 00 | GES) 16. 00 | 17. 00 | 19. 00 | 23. 00 | |
| | | AL SERVICE COST CENTERS | | | T | , | | |
| 1. 00 2. 00 | 1 | CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP | | | | | | 1. 00 2. 00 |
| 4.00 | | EMPLOYEE BENEFITS DEPARTMENT | | | | | | 4. 00 |
| 5.00 | | ADMINISTRATIVE & GENERAL | | | | | | 5. 00 |
| 7. 00 8. 00 | | OPERATION OF PLANT LAUNDRY & LINEN SERVICE | | | | | | 7. 00 8. 00 |
| 9. 00 | | HOUSEKEEPI NG | | | | | | 9. 00 |
| 10.00 | 1 | DI ETARY | | | | | | 10. 00 |
| 11. 00 13. 00 | | CAFETERIA NURSING ADMINISTRATION | 17, 027, 238 | | | | | 11. 00 13. 00 |
| 16. 00 | 1 | MEDICAL RECORDS & LIBRARY | 0 | 601, 436, 290 | | | | 16. 00 |
| 17. 00 | 01700 | SOCIAL SERVICE | 328, 557 | 0 | | | | 17. 00 |
| 19. 00 23. 00 | | NONPHYSICIAN ANESTHETISTS PASTORAL CARE | 0 | 0 | | 0 | 100 | 19. 00 23. 00 |
| 23.00 | | I ENT ROUTINE SERVICE COST CENTERS | l o | 0 | 0 | | 100 | 23.00 |
| 30. 00 | 03000 | ADULTS & PEDIATRICS | 8, 364, 225 | 55, 042, 847 | | 0 | 100 | 30. 00 |
| 31. 00 43. 00 | 1 | INTENSIVE CARE UNIT NURSERY | 1, 261, 290 204, 945 | 6, 921, 070 1, 160, 094 | · | 0 | 0 | 31. 00 43. 00 |
| 43.00 | | LARY SERVICE COST CENTERS | 204, 945 | 1, 100, 094 | 034 | | | 43.00 |
| 50.00 | 1 | OPERATING ROOM | 2, 547, 692 | 70, 234, 329 | | 0 | 0 | 50. 00 |
| 52. 00 53. 00 | | DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY | 607, 702 | 3, 439, 903 | 0 | 0 | 0 | 52. 00 53. 00 |
| 54. 00 | | RADI OLOGY-DI AGNOSTI C | | 25, 665, 726 | | 0 | 0 | 54. 00 |
| 54. 01 | 03480 | ONCOLOGY | 472, 622 | 33, 614, 158 | | 0 | 0 | 54. 01 |
| 57. 00 | 1 | CT SCAN | 0 | 34, 241, 273 | | 0 | 0 | 57. 00 |
| 58. 00 59. 00 | 05800 | CARDIAC CATHETERIZATION | 45, 152 420, 458 | 13, 723, 367 49, 297, 871 | | 0 | 0 | 58. 00 59. 00 |
| 60.00 | | LABORATORY | 0 | 55, 558, 308 | | 0 | 0 | 60.00 |
| 63.00 | 1 | BLOOD STORING, PROCESSING & TRANS. | 0 | 0 | | 0 | 0 | 63.00 |
| 65. 00 66. 00 | | RESPIRATORY THERAPY PHYSICAL THERAPY | 0 | 10, 005, 172 1, 753, 058 | | 0 | 0 | 65. 00 66. 00 |
| 67. 00 | 1 | OCCUPATIONAL THERAPY | o o | 949, 403 | | 0 | 0 | 67. 00 |
| 68. 00 | 1 | SPEECH PATHOLOGY | 0 | 256, 007 | | 0 | 0 | 68. 00 |
| 69. 00 70. 00 | | ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY | 205, 312 | 14, 714, 531 134, 655 | | 0 | 0 | 69. 00 70. 00 |
| 71.00 | | MEDICAL SUPPLIES CHARGED TO PATIENT | 0 | 20, 414, 836 | | 0 | 0 | 71.00 |
| 72. 00 | 07200 | IMPL. DEV. CHARGED TO PATIENTS | 0 | 18, 586, 312 | 0 | 0 | 0 | 72. 00 |
| 73. 00 74. 00 | | DRUGS CHARGED TO PATIENTS RENAL DIALYSIS | 0 | 99, 418, 524 | | 0 | 0 | 73. 00 74. 00 |
| 75. 00 | | ASC (NON-DISTINCT PART) | 0 | 601, 186 0 | 0 | 0 | 0 | 74. 00 75. 00 |
| 75. 01 | | WOUND CARE CENTER | 243, 325 | 3, 462, 874 | | 0 | 0 | 75. 01 |
| 76. 00 | | CARDIOPULMONARY TIENT SERVICE COST CENTERS | 91, 873 | 1, 266, 966 | 0 | 0 | 0 | 76. 00 |
| 91. 00 | | EMERGENCY | 2, 234, 085 | 70, 057, 935 | 0 | 0 | 0 | 91. 00 |
| 92. 00 | 09200 | OBSERVATION BEDS (NON-DISTINCT PART | | | | | | 92.00 |
| 92. 01 93. 00 | | OBSERVATION BEDS (DISTINCT PART) OTHER OUTPATIENT SERVICES | 0 | 0 | 0 | 0 | 0 | 92. 01 93. 00 |
| 93. 01 | 1 | GENESI S | o o | 3, 889, 767 | o o | 0 | 0 | 93. 01 |
| 93. 02 | | WOMEN'S CENTER | 0 | 0 | 0 | 0 | 0 | 93. 02 |
| 93. 03 93. 04 | 1 | RESIDENTIAL HOMES DR. STEELE | 0 | 0 | 0 | 0 | 0 | 93. 03 93. 04 |
| 93. 05 | | DI ABETI C EDUCATION | 0 | 0 | ő | 0 | 0 | 93. 05 |
| 93. 06 | | HOWARD COUNTY CSS | 0 | 137, 264 | | 0 | 0 | 93. 06 |
| 93. 07 93. 18 | | CLINTON COUNTY PSYCH MEDICATION | 0 | 476, 604 | 0 | 0 | 0 | 93. 07 93. 18 |
| | 04993 | NEW BEGINNINGS | 0 | 28, 084 | | 0 | 0 | 93. 43 |
| 95. 00 | | REIMBURSABLE COST CENTERS AMBULANCE SERVICES | l ol | 6, 384, 166 | 0 | 0 | 0 | 95. 00 |
| 93.00 | | AL PURPOSE COST CENTERS | l O | 0, 364, 100 | 0 | <u> </u> | | 93.00 |
| | 11300 | I NTEREST EXPENSE | | | | | | 113. 00 |
| 114. 00 118. 00 | | UTILIZATION REVIEW - SNF SUBTOTALS (SUM OF LINES 1 through 117) | 17, 027, 238 | 601, 436, 290 | 19, 073 | 0 | 100 | 114. 00 118. 00 |
| | NONRE | IMBURSABLE COST CENTERS | 17,027,200 | 001, 100, 270 | 17,070 | <u> </u> | 100 | 110.00 |
| | | GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | 0 | 0 | 0 | | 190.00 |
| | | COMMUNITY HOWARD FOUNDATION PHYSICIANS' PRIVATE OFFICES | | 0 | 0 | 0 | | 190. 01 192. 00 |
| 193.00 | 19300 | NONPALD WORKERS | O | 0 | Ö | o | 0 | 193. 00 |
| | | HEALTHY CHILDREN | 0 | 0 | 0 | 0 | | 194. 00 |
| | | SOUTH BERKLEY BLDG MOBILE CLINIC | | 0 | | 0 | | 194. 08 194. 09 |
| | , | , | 1 | | | | | |

| | | | | '' | 0 12/31/2019 | 8/19/2020 2:00 | |
|---------------|--|-------------------|-------------|----------------|----------------|----------------|---------|
| | Cost Center Description | NURSI NG | MEDI CAL | SOCIAL SERVICE | NONPHYSI CI AN | PASTORAL CARE | |
| | | ADMI NI STRATI ON | RECORDS & | | ANESTHETI STS | (ASSI GNED | |
| | | | LI BRARY | (TOTAL PATI | (ASSI GNED | TIME) | |
| | | (NURSING SA | (GROSS CHAR | ENT DAYS) | TIME) | | |
| | | LARI ES) | GES) | | | | |
| | | 13. 00 | 16. 00 | 17. 00 | 19. 00 | 23. 00 | |
| 194. 10 07960 | PLASTIC SURGERY | 0 | 0 | 0 | 0 | 0 | 194. 10 |
| 194. 11 07961 | KOKOMO SCHOOL BASED | 0 | 0 | 0 | 0 | 0 | 194. 11 |
| 194. 15 07965 | INDIANA SURGERY CENTER | 0 | 0 | 0 | 0 | 0 | 194. 15 |
| 194. 16 07966 | PASTORAL CARE ALLIED HEALTH | 0 | 0 | 0 | 0 | 0 | 194. 16 |
| 200. 00 | Cross Foot Adjustments | | | | | | 200. 00 |
| 201. 00 | Negative Cost Centers | | | | | | 201. 00 |
| 202. 00 | Cost to be allocated (per Wkst. B, | 3, 054, 402 | 1, 189, 186 | 874, 158 | 0 | 315, 122 | 202. 00 |
| | Part I) | | | | | | |
| 203. 00 | Unit cost multiplier (Wkst. B, Part I) | 0. 179383 | 0. 001977 | 45. 832224 | 0. 000000 | 3, 151. 220000 | 203. 00 |
| 204.00 | Cost to be allocated (per Wkst. B, | 60, 417 | 74, 082 | 15, 099 | 0 | 21, 998 | 204. 00 |
| | Part II) | | | | | | |
| 205. 00 | Unit cost multiplier (Wkst. B, Part | 0. 003548 | 0. 000123 | 0. 791643 | 0. 000000 | 219. 980000 | 205. 00 |
| | [11] | | | | | | |
| 206. 00 | NAHE adjustment amount to be allocated | | | | | 0 | 206. 00 |
| | (per Wkst. B-2) | | | | | | |
| 207. 00 | NAHE unit cost multiplier (Wkst. D, | | | | | 0.000000 | 207. 00 |
| | Parts III and IV) | | | | | | |

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0007 Peri od: Worksheet C From 01/01/2019 Part I Date/Time Prepared: 12/31/2019 8/19/2020 2:00 pm Title XVIII Hospi tal PPS Costs Cost Center Description Total Cost Therapy Limit 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 03000 ADULTS & PEDIATRICS 23, 543, 631 30 00 23, 543, 631 23, 543, 631 3, 075, 414 3, 075, 414 3, 075, 414 03100 INTENSIVE CARE UNIT 0 31.00 31.00 04300 NURSERY 43.00 651, 379 651, 379 0 651, 379 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 9,021,896 9, 021, 896 9, 021, 896 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 1,608,676 1, 608, 676 0 1, 608, 676 52.00 0 53.00 05300 ANESTHESI OLOGY 53.00 4, 332, 323 54.00 05400 RADI OLOGY-DI AGNOSTI C 4.332.323 4, 332, 323 54 00 0 54.01 03480 ONCOLOGY 6, 592, 795 6, 592, 795 6, 592, 795 54.01 57.00 05700 CT SCAN 1, 144, 324 1, 144, 324 0 0 0 1, 144, 324 57.00 58.00 05800 MRI 1, 256, 852 1, 256, 852 1, 256, 852 58.00 05900 CARDIAC CATHETERIZATION 1, 724, 343 1, 724, 343 59.00 1,724,343 59 00 60.00 06000 LABORATORY 6, 129, 764 6, 129, 764 6, 129, 764 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0 0 63.00 06500 RESPIRATORY THERAPY 2, 310, 811 2, 310, 811 2, 310, 811 65 00 65 00 66.00 06600 PHYSI CAL THERAPY 756, 830 756, 830 756, 830 66.00 06700 OCCUPATIONAL THERAPY 458, 208 458, 208 458, 208 67.00 67.00 0 0 0 06800 SPEECH PATHOLOGY 68.00 132, 634 132, 634 132, 634 68.00 06900 ELECTROCARDI OLOGY 69 00 1, 868, 127 1, 868, 127 1, 868, 127 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 66,048 66,048 66,048 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 7, 767, 936 7, 767, 936 0 0 0 7, 767, 936 71.00 72 00 07200 IMPL. DEV. CHARGED TO PATIENTS 8.364.045 8. 364. 045 8 364 045 72 00 07300 DRUGS CHARGED TO PATIENTS 73.00 21, 184, 819 21, 184, 819 21, 184, 819 73.00 74.00 07400 RENAL DIALYSIS 365, 664 365, 664 365, 664 74.00 07500 ASC (NON-DISTINCT PART) 0 75.00 75.00 C 0 o 940, 586 03950 WOUND CARE CENTER 75 01 940, 586 940, 586 75 01 03160 CARDI OPULMONARY 76.00 297, 268 297, 268 297, 268 76.00 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 6, 725, 956 6, 725, 956 0 6, 725, 956 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 3, 067, 202 3, 067, 202 92 00 3, 067, 202 92 00 92.01 09201 OBSERVATION BEDS (DISTINCT PART) 0 92.01 0 C 0 04950 OTHER OUTPATIENT SERVICES 0 93.00 93.00 2, 998, 137 93.01 04951 GENESIS 2, 998, 137 0 2, 998, 137 93.01 93.02 93.02 04952 WOMEN'S CENTER 0 C 0 93.03 04953 RESIDENTIAL HOMES 0 0 0 93.03 93 04 04954 DR. STEELE 0 0 0 Ω 93 04 04955 DIABETIC EDUCATION 93.05 0 0 93.05 0 04956 HOWARD COUNTY CSS 702, 853 93.06 702 853 702.853 93.06 93.07 04957 CLINTON COUNTY 409, 527 409, 527 0 409, 527 93.07 93. 18 04968 PSYCH MEDICATION o 93.18 04993 NEW BEGINNINGS 94, 5<u>45</u> 93.43 94, 545 93.43 94.545 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 2, 393, 833 2, 393, 833 0 2, 393, 833 95.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | I NTEREST EXPENSE 113 00 114.00 11400 UTILIZATION REVIEW - SNF 114.00 200.00 Subtotal (see instructions) 119, 986, 426 0 119, 986, 426 0 119, 986, 426 200. 00 3, 067, 202 201. 00 3, 067, 202 3, 067, 202 201.00 Less Observation Beds 202.00 Total (see instructions) 116, 919, 224 116, 919, 224 116, 919, 224 202. 00

Provider CCN: 15-0007

Peri od:

COMPUTATION OF RATIO OF COSTS TO CHARGES

Part I

From 01/01/2019 Date/Time Prepared: 12/31/2019 8/19/2020 2:00 pm Title XVIII Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 51, 045, 173 51, 045, 173 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 6, 921, 070 6, 921, 070 31.00 04300 NURSERY 1, 160, 094 43.00 43.00 1, 160, 094 ANCILLARY SERVICE COST CENTERS 70. 234. 329 50.00 50.00 36, 139, 741 34, 094, 588 0 128454 0.000000 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM 3, 439, 903 3, 439, 903 0.467652 0.000000 52.00 53 00 05300 ANESTHESI OLOGY 0.000000 0.000000 53.00 05400 RADI OLOGY-DI AGNOSTI C 3, 599, 322 22, 066, 404 0.168798 0.000000 54.00 25, 665, 726 54.00 03480 ONCOLOGY 33, 022, 973 0.000000 54.01 591, 185 33, 614, 158 0.196131 54.01 57.00 05700 CT SCAN 7, 463, 506 26, 777, 767 34, 241, 273 0.033419 0.000000 57.00 58.00 05800 MRI 849, 745 12, 873, 622 13, 723, 367 0.091585 0.000000 58.00 30, 317, 800 05900 CARDI AC CATHETERI ZATI ON 18, 980, 071 49, 297, 871 0.000000 59.00 0.034978 59.00 60.00 06000 LABORATORY 19, 249, 858 36, 308, 450 55, 558, 308 0.110330 0.000000 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 0.000000 63.00 63.00 65.00 06500 RESPIRATORY THERAPY 7, 224, 726 2, 780, 446 10, 005, 172 0.230962 0.000000 65.00 06600 PHYSI CAL THERAPY 201.825 0.431720 66,00 1, 551, 233 1, 753, 058 0.000000 66,00 67.00 06700 OCCUPATIONAL THERAPY 847, 783 101, 620 949, 403 0. 482628 0.000000 67.00 06800 SPEECH PATHOLOGY 0.518087 68.00 126, 353 129, 654 256, 007 0.000000 68.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 3, 668, 187 11, 046, 344 14, 714, 531 0.126958 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 31,050 103, 605 134, 655 0.490498 0.000000 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 10, 624, 738 9, 790, 098 20, 414, 836 0.380504 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 11, 026, 388 7, 559, 924 18, 586, 312 0.450011 0.000000 72.00 73 00 07300 DRUGS CHARGED TO PATIENTS 15, 651, 279 83, 767, 245 99, 418, 524 0 213087 0 000000 73 00 74.00 07400 RENAL DIALYSIS 601, 186 601, 186 0.608238 0.000000 74.00 07500 ASC (NON-DISTINCT PART) 0.000000 0.000000 75.00 75.00 03950 WOUND CARE CENTER 75. 01 188,030 3, 274, 844 3, 462, 874 0.271620 0.000000 75.01 03160 CARDI OPULMONARY 76.00 3, 234 1, 263, 732 1, 266, 966 0. 234630 0.000000 76.00 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 14, 303, 877 55, 754, 058 70, 057, 935 0.096006 0.000000 91.00 92 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1, 206, 162 2, 791, 512 3, 997, 674 0 767247 0.000000 92 00 09201 OBSERVATION BEDS (DISTINCT PART) 92.01 0.000000 0.000000 92.01 04950 OTHER OUTPATIENT SERVICES 0 0.000000 0.000000 93.00 93.00 0 93.01 04951 GENESIS 3, 889, 767 3, 889, 767 0.770775 0.000000 93.01 04952 WOMEN'S CENTER 93 02 0.000000 0.000000 93 02 r C 0 0.000000 0.000000 93.03 04953 RESIDENTIAL HOMES 0 93.03 04954 DR. STEELE 0.000000 0.000000 93.04 93.04 93.05 04955 DIABETIC EDUCATION 0 0 C 0.000000 0.000000 93.05 04956 HOWARD COUNTY CSS 93 06 137, 264 137, 264 5. 120447 0.000000 93 06 93.07 04957 CLINTON COUNTY 476, 604 0.859261 0.000000 93.07 476, 604 93.18 04968 PSYCH MEDICATION 0 0.000000 0.000000 93.18 04993 NEW BEGINNINGS 0.000000 28, 084 28.084 3.366508 93.43 93.43 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 6, 384, 166 6, 384, 166 0. 374964 0.000000 95.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW - SNF 114.00 200.00 216, 493, 894 Subtotal (see instructions) 384, 942, 396 601, 436, 290 200.00 201.00 Less Observation Beds 201.00 202.00 Total (see instructions) 216, 493, 894 384, 942, 396 601, 436, 290 202, 00

| | | | 10 12/31/2019 | Date/IIme Prepared: 8/19/2020 2:00 pm |
|---|---------------|-------------|---------------|--|
| | | Title XVIII | Hospi tal | PPS |
| Cost Center Description | PPS Inpatient | | 110001 tui | |
| 555t 5511t61 55551 pt. 511 | Ratio | | | |
| | 11.00 | | | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | |
| 30. 00 03000 ADULTS & PEDI ATRI CS | | | | 30.00 |
| 31.00 03100 INTENSIVE CARE UNIT | | | | 31.00 |
| 43. 00 04300 NURSERY | | | | 43. 00 |
| ANCILLARY SERVICE COST CENTERS | <u> </u> | | | |
| 50. 00 05000 OPERATING ROOM | 0. 128454 | | | 50.00 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 0. 467652 | | | 52. 00 |
| 53. 00 05300 ANESTHESI OLOGY | 0. 000000 | | | 53. 00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 0. 168798 | | | 54. 00 |
| 54. 01 03480 ONCOLOGY | 0. 196131 | | | 54. 01 |
| 57. 00 05700 CT SCAN | 0. 033419 | | | 57. 00 |
| 58. 00 05800 MRI | 0. 091585 | | | 58. 00 |
| 59. 00 05900 CARDI AC CATHETERI ZATI ON | 0. 034978 | | | 59. 00 |
| 60. 00 06000 LABORATORY | 0. 110330 | | | 60.00 |
| 63.00 06300 BLOOD STORING, PROCESSING & TRANS. | 0. 000000 | | | 63. 00 |
| 65. 00 06500 RESPIRATORY THERAPY | 0. 230962 | | | 65. 00 |
| 66. 00 06600 PHYSI CAL THERAPY | 0. 431720 | | | 66. 00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | 0. 482628 | | | 67. 00 |
| 68. 00 06800 SPEECH PATHOLOGY | 0. 518087 | | | 68. 00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0. 126958 | | | 69. 00 |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY | 0. 490498 | | | 70.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 0. 380504 | | | 71. 00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS | 0. 450011 | | | 72. 00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 0. 213087 | | | 73. 00 |
| 74. 00 07400 RENAL DIALYSIS | 0. 608238 | | | 74. 00 |
| 75.00 07500 ASC (NON-DISTINCT PART) | 0. 000000 | | | 75. 00 |
| 75. 01 03950 WOUND CARE CENTER | 0. 271620 | | | 75. 01 |
| 76. 00 03160 CARDI OPULMONARY | 0. 234630 | | | 76. 00 |
| OUTPATIENT SERVICE COST CENTERS | | | | |
| 91. 00 09100 EMERGENCY | 0. 096006 | | | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART | 0. 767247 | | | 92. 00 |
| 92.01 09201 OBSERVATION BEDS (DISTINCT PART) | 0. 000000 | | | 92. 01 |
| 93. 00 04950 OTHER OUTPATIENT SERVICES | 0. 000000 | | | 93.00 |
| 93. 01 04951 GENESI S | 0. 770775 | | | 93. 01 |
| 93. 02 04952 WOMEN' S CENTER | 0. 000000 | | | 93. 02 |
| 93. 03 04953 RESIDENTIAL HOMES | 0. 000000 | | | 93. 03 |
| 93. 04 04954 DR. STEELE | 0. 000000 | | | 93. 04 |
| 93. 05 04955 DI ABETI C EDUCATI ON | 0. 000000 | | | 93. 05 |
| 93.06 O4956 HOWARD COUNTY CSS | 5. 120447 | | | 93. 06 |
| 93. 07 04957 CLI NTON COUNTY | 0. 859261 | | | 93. 07 |
| 93.18 O4968 PSYCH MEDICATION | 0. 000000 | | | 93. 18 |
| 93. 43 04993 NEW BEGINNINGS | 3. 366508 | | | 93. 43 |
| OTHER REIMBURSABLE COST CENTERS | | | | |
| 95. 00 09500 AMBULANCE SERVICES | 0. 374964 | | | 95. 00 |
| SPECIAL PURPOSE COST CENTERS | | | | |
| 113.00 11300 I NTEREST EXPENSE | | | | 113. 00 |
| 114.00 11400 UTILIZATION REVIEW - SNF | | | | 114. 00 |
| 200.00 Subtotal (see instructions) | | | | 200. 00 |
| 201.00 Less Observation Beds | | | | 201. 00 |
| 202.00 Total (see instructions) | | | | 202. 00 |

Provider CCN: 15-0007

Peri od:

From 01/01/2019 Part I Date/Time Prepared: 12/31/2019 8/19/2020 2:00 pm Title XIX Hospi tal Cost Costs Cost Center Description Total Cost Therapy Limit 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 03000 ADULTS & PEDIATRICS 23, 543, 631 30 00 23, 543, 631 23, 543, 631 3, 075, 414 3, 075, 414 3, 075, 414 03100 INTENSIVE CARE UNIT 0 31.00 31.00 04300 NURSERY 43.00 651, 379 651, 379 0 651, 379 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 9,021,896 9, 021, 896 9, 021, 896 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 1,608,676 1, 608, 676 0 1, 608, 676 52.00 0 53.00 05300 ANESTHESI OLOGY 53.00 4, 332, 323 54.00 05400 RADI OLOGY-DI AGNOSTI C 4.332.323 4, 332, 323 54 00 0 54.01 03480 ONCOLOGY 6, 592, 795 6, 592, 795 6, 592, 795 54.01 57.00 05700 CT SCAN 1, 144, 324 1, 144, 324 0 0 0 1, 144, 324 57.00 58.00 05800 MRI 1, 256, 852 1, 256, 852 1, 256, 852 58.00 05900 CARDIAC CATHETERIZATION 1, 724, 343 1, 724, 343 59.00 1,724,343 59 00 60.00 06000 LABORATORY 6, 129, 764 6, 129, 764 6, 129, 764 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0 0 63.00 06500 RESPIRATORY THERAPY 2, 310, 811 2, 310, 811 2, 310, 811 65 00 65 00 66.00 06600 PHYSI CAL THERAPY 756, 830 756, 830 756, 830 66.00 06700 OCCUPATIONAL THERAPY 458, 208 458, 208 458, 208 67.00 67.00 0 0 0 06800 SPEECH PATHOLOGY 68.00 132, 634 132, 634 132, 634 68.00 06900 ELECTROCARDI OLOGY 69 00 1, 868, 127 1, 868, 127 1, 868, 127 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 66,048 66,048 66,048 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 7, 767, 936 7, 767, 936 0 0 0 7, 767, 936 71.00 72 00 07200 IMPL. DEV. CHARGED TO PATIENTS 8.364.045 8. 364. 045 8 364 045 72 00 07300 DRUGS CHARGED TO PATIENTS 73.00 21, 184, 819 21, 184, 819 21, 184, 819 73.00 74.00 07400 RENAL DIALYSIS 365, 664 365, 664 365, 664 74.00 07500 ASC (NON-DISTINCT PART) 0 75.00 75.00 C 0 o 03950 WOUND CARE CENTER 75 01 940 586 940, 586 940, 586 75 01 03160 CARDI OPULMONARY 76.00 297, 268 297, 268 297, 268 76.00 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 6, 725, 956 6, 725, 956 0 6, 725, 956 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 3, 067, 202 3, 067, 202 92 00 3, 067, 202 92 00 92.01 09201 OBSERVATION BEDS (DISTINCT PART) 0 92.01 0 C 0 04950 OTHER OUTPATIENT SERVICES 0 93.00 93.00 2, 998, 137 93.01 04951 GENESIS 2, 998, 137 0 2, 998, 137 93.01 93.02 93.02 04952 WOMEN'S CENTER 0 C 0 93.03 04953 RESIDENTIAL HOMES 0 0 0 93.03 93 04 04954 DR. STEELE 0 0 0 Ω 93 04 04955 DIABETIC EDUCATION 93.05 0 0 93.05 0 04956 HOWARD COUNTY CSS 93.06 702 853 702.853 702.853 93.06 93.07 04957 CLINTON COUNTY 409, 527 409, 527 0 409, 527 93.07 93. 18 04968 PSYCH MEDICATION o 93.18 04993 NEW BEGINNINGS 94, 5<u>45</u> 93.43 94, 545 93.43 94.545 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 2, 393, 833 2, 393, 833 0 2, 393, 833 95.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113 00 114.00 11400 UTILIZATION REVIEW - SNF 114.00 200.00 Subtotal (see instructions) 119, 986, 426 0 119, 986, 426 0 119, 986, 426 200. 00 3, 067, 202 201. 00 3, 067, 202 3, 067, 202 201.00 Less Observation Beds 202.00 Total (see instructions) 116, 919, 224 116, 919, 224 116, 919, 224 202. 00

Provider CCN: 15-0007

Peri od:

COMPUTATION OF RATIO OF COSTS TO CHARGES

From 01/01/2019 Part I Date/Time Prepared: 12/31/2019 8/19/2020 2:00 pm Title XIX Hospi tal Cost Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 51, 045, 173 51, 045, 173 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 6, 921, 070 6, 921, 070 31.00 04300 NURSERY 1, 160, 094 43.00 43.00 1, 160, 094 ANCILLARY SERVICE COST CENTERS 70. 234. 329 50.00 50.00 36, 139, 741 34, 094, 588 0 128454 0.000000 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM 3, 439, 903 3, 439, 903 0.467652 0.000000 52.00 53 00 05300 ANESTHESI OLOGY 0.000000 0.000000 53.00 05400 RADI OLOGY-DI AGNOSTI C 3, 599, 322 22, 066, 404 0.168798 0.000000 54.00 25, 665, 726 54.00 03480 ONCOLOGY 0.000000 54.01 591, 185 33, 022, 973 33, 614, 158 0.196131 54.01 57.00 05700 CT SCAN 7, 463, 506 26, 777, 767 34, 241, 273 0.033419 0.000000 57.00 58.00 05800 MRI 849, 745 12, 873, 622 13, 723, 367 0.091585 0.000000 58.00 30, 317, 800 05900 CARDI AC CATHETERI ZATI ON 18, 980, 071 49, 297, 871 0.000000 59.00 0.034978 59.00 60.00 06000 LABORATORY 19, 249, 858 36, 308, 450 55, 558, 308 0.110330 0.000000 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 0.000000 63.00 63.00 65.00 06500 RESPIRATORY THERAPY 7, 224, 726 2, 780, 446 10, 005, 172 0.230962 0.000000 65.00 06600 PHYSI CAL THERAPY 201.825 0.431720 66,00 1, 551, 233 1, 753, 058 0.000000 66,00 67.00 06700 OCCUPATIONAL THERAPY 847, 783 101, 620 949, 403 0. 482628 0.000000 67.00 06800 SPEECH PATHOLOGY 0.518087 68.00 126, 353 129, 654 256, 007 0.000000 68.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 3, 668, 187 11, 046, 344 14, 714, 531 0.126958 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 31,050 103, 605 134, 655 0.490498 0.000000 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 10, 624, 738 9, 790, 098 20, 414, 836 0.380504 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 11, 026, 388 7, 559, 924 18, 586, 312 0.450011 0.000000 72.00 73 00 07300 DRUGS CHARGED TO PATIENTS 15, 651, 279 83, 767, 245 99, 418, 524 0 213087 0 000000 73 00 74.00 07400 RENAL DIALYSIS 601, 186 601, 186 0.608238 0.000000 74.00 07500 ASC (NON-DISTINCT PART) 0.000000 0.000000 75.00 75.00 75. 01 03950 WOUND CARE CENTER 188,030 3, 274, 844 3, 462, 874 0.271620 0.000000 75.01 03160 CARDI OPULMONARY 76.00 3, 234 1, 263, 732 1, 266, 966 0. 234630 0.000000 76.00 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 14, 303, 877 55, 754, 058 70, 057, 935 0.096006 0.000000 91.00 92 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1, 206, 162 2, 791, 512 3, 997, 674 0 767247 0.000000 92 00 09201 OBSERVATION BEDS (DISTINCT PART) 92.01 0.000000 0.000000 92.01 04950 OTHER OUTPATIENT SERVICES 0 0.000000 0.000000 93.00 93.00 0 93.01 04951 GENESIS 3, 889, 767 3, 889, 767 0.770775 0.000000 93.01 04952 WOMEN'S CENTER 93 02 0.000000 0.000000 93 02 r C 0 0.000000 0.000000 93.03 04953 RESIDENTIAL HOMES 0 93.03 04954 DR. STEELE 0.000000 0.000000 93.04 93.04 93.05 04955 DIABETIC EDUCATION 0 0 C 0.000000 0.000000 93.05 04956 HOWARD COUNTY CSS 93 06 137, 264 137, 264 5. 120447 0.000000 93 06 93.07 04957 CLINTON COUNTY 476, 604 0.859261 0.000000 93.07 476, 604 93.18 04968 PSYCH MEDICATION 0 0.000000 0.000000 93.18 04993 NEW BEGINNINGS 0.000000 28, 084 28.084 3.366508 93.43 93.43 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 6, 384, 166 6, 384, 166 0. 374964 0.000000 95.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW - SNF 114.00 200.00 216, 493, 894 Subtotal (see instructions) 384, 942, 396 601, 436, 290 200.00 201.00 Less Observation Beds 201.00 202.00 Total (see instructions) 216, 493, 894 384, 942, 396 601, 436, 290 202, 00

8/19/2020 2:00 pm Title XIX Hospi tal Cost PPS Inpatient Cost Center Description Ratio 11 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 43. 00 | 04300 NURSERY 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 000000 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 52.00 05300 ANESTHESI OLOGY 0.000000 53.00 53.00 54. 00 | 05400 | RADI OLOGY-DI AGNOSTI C 0.000000 54.00 54.01 03480 ONCOLOGY 0.000000 54.01 57. 00 05700 CT SCAN 0.000000 57 00 58.00 05800 MRI 0.000000 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.000000 59.00 06000 LABORATORY 0.000000 60.00 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 63.00 63.00 06500 RESPIRATORY THERAPY 65.00 0.000000 65.00 06600 PHYSI CAL THERAPY 0.000000 66.00 66.00 06700 OCCUPATI ONAL THERAPY 0.000000 67.00 67.00 06800 SPEECH PATHOLOGY 0.000000 68.00 68 00 69.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 0.000000 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.000000 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 74.00 07400 RENAL DIALYSIS 0.000000 74.00 07500 ASC (NON-DISTINCT PART) 75.00 0.000000 75.00 75. 01 03950 WOUND CARE CENTER 0.000000 75.01 03160 CARDI OPULMONARY 0.000000 76.00 76.00 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 92.00 09201 OBSERVATION BEDS (DISTINCT PART) 0.000000 92. 01 92.01 93. 00 |04950 OTHER OUTPATIENT SERVICES 0.000000 93 00 04951 GENESIS 0.000000 93.01 93.01 93.02 04952 WOMEN'S CENTER 0.000000 93.02 93. 03 04953 RESIDENTIAL HOMES 0.000000 93.03 93. 04 04954 DR. STEELE 0.000000 93.04 04955 DIABETIC EDUCATION 93.05 0.000000 93.05 04956 HOWARD COUNTY CSS 93.06 0.000000 93.06 93.07 04957 CLINTON COUNTY 0.000000 93.07 04968 PSYCH MEDICATION 93.18 0.000000 93.18 04993 NEW BEGINNINGS 0.000000 93.43 93.43 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 0. 000000 95.00 95.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW - SNF 114. 00 200.00 Subtotal (see instructions) 200. 00 201.00 Less Observation Beds 201. 00

202. 00

202.00

Total (see instructions)

| Health Financial Systems CO | MMUNITY HOWARD | REGIONAL HEALT | TH | In Lie | eu of Form CMS- | 2552-10 |
|--|----------------|----------------|----------------|----------------------------------|-----------------|---------|
| APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL | COSTS | Provi der C | | Peri od: | Worksheet D | |
| | | | | From 01/01/2019 To 12/31/2019 | | narodi |
| | | | | 10 12/31/2019 | 8/19/2020 2:0 | |
| | | Ti tl e | e 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 | 1, 605, 610 | 0 | 1, 605, 61 | 0 19, 282 | 83. 27 | 30.00 |
| 31.00 INTENSIVE CARE UNIT | 163, 992 | | 163, 99 | 2 1, 469 | 111. 64 | 31.00 |
| 43. 00 NURSERY | 53, 206 | | 53, 20 | 6 834 | 63. 80 | 43.00 |
| 200.00 Total (lines 30 through 199) | 1, 822, 808 | | 1, 822, 80 | 8 21, 585 | | 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 | 6, 057 | | • | | | 30.00 |
| 31.00 INTENSIVE CARE UNIT | 624 | 69, 663 | ; | | | 31. 00 |
| 43. 00 NURSERY | 0 | 0 | 1 | | | 43.00 |
| 200.00 Total (lines 30 through 199) | 6, 681 | 574, 029 | 9 | | | 200. 00 |

| Health Financial Systems CC | MMUNITY HOWARD | REGIONAL HEALT | Н | In Lie | u of Form CMS-2 | 2552-10 |
|---|----------------|----------------|---------------|---|--|----------------|
| APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA | AL COSTS | Provider Co | | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part II Date/Time Pre 8/19/2020 2:0 | pared: O pm |
| | | Title | · XVIII | Hospi tal | PPS | |
| Cost Center Description | Capi tal | Total Charges | Ratio of Cos | t Inpatient | Capital Costs | |
| · | Related Cost | (from Wkst. C, | to Charges | Program | column 3 x | |
| | (from Wkst. B, | Part I, col. | (col. 1 ÷ col | . Charges | column 4) | |
| | Part II, col. | 8) | 2) | | | |
| | 26) | | | | | |
| | 1. 00 | 2. 00 | 3.00 | 4. 00 | 5. 00 | |
| ANCILLARY SERVICE COST CENTERS | _ | | | | | |
| 50.00 05000 OPERATING ROOM | 652, 452 | | | | 118, 461 | |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 134, 700 | 3, 439, 903 | | | 0 | 52.00 |
| 53. 00 05300 ANESTHESI OLOGY | 0 | 0 | 0.00000 | | 0 | 53. 00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 640, 616 | | | | 38, 283 | 54.00 |
| 54. 01 03480 ONCOLOGY | 1, 916, 296 | 33, 614, 158 | 0.05700 | 9 244, 499 | 13, 939 | 54. 01 |
| 57.00 05700 CT SCAN | 141, 535 | 34, 241, 273 | | | 13, 141 | |
| 58. 00 05800 MRI | 477, 332 | 13, 723, 367 | 0. 03478 | 2 333, 361 | 11, 595 | 58. 00 |
| 59. 00 05900 CARDI AC CATHETERI ZATI ON | 115, 866 | 49, 297, 871 | 0. 00235 | 0 7, 965, 559 | 18, 719 | 59. 00 |
| 60. 00 06000 LABORATORY | 184, 186 | 55, 558, 308 | 0. 00331 | 5 8, 171, 476 | 27, 088 | 60.00 |
| 63.00 06300 BLOOD STORING, PROCESSING & TRANS. | 0 | 0 | 0.00000 | 0 0 | 0 | 63.00 |
| 65. 00 06500 RESPIRATORY THERAPY | 124, 440 | 10, 005, 172 | 0. 01243 | 8 3, 160, 323 | 39, 308 | 65. 00 |
| 66. 00 06600 PHYSI CAL THERAPY | 26, 091 | 1, 753, 058 | 0. 01488 | 3 696, 870 | 10, 372 | 66.00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | 28, 362 | 949, 403 | 0. 02987 | 4 399, 424 | 11, 932 | 67.00 |
| 68. 00 06800 SPEECH PATHOLOGY | 10, 929 | 256, 007 | 0. 04269 | 0 61, 547 | 2, 627 | 68. 00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 156, 030 | 14, 714, 531 | 0. 01060 | 4 1, 689, 747 | 17, 918 | 69. 00 |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY | 7, 268 | 134, 655 | 0. 05397 | 5 15, 346 | 828 | 70. 00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 232, 968 | 20, 414, 836 | 0. 01141 | 2 4, 146, 349 | 47, 318 | 71. 00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS | 115, 548 | 18, 586, 312 | 0. 00621 | 7 3, 988, 101 | 24, 794 | 72. 00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 738, 834 | 99, 418, 524 | 0.00743 | 2 6, 141, 767 | 45, 646 | 73.00 |
| 74. 00 07400 RENAL DIALYSIS | 5, 031 | 601, 186 | 0. 00836 | 8 357, 492 | 2, 991 | 74. 00 |
| 75.00 07500 ASC (NON-DISTINCT PART) | 0 | 0 | 0.00000 | 0 0 | 0 | 75. 00 |
| 75. 01 03950 WOUND CARE CENTER | 73, 383 | 3, 462, 874 | 0. 02119 | 1 124, 437 | 2, 637 | 75. 01 |
| 76. 00 03160 CARDI OPULMONARY | 5, 123 | | | | 5 | 76. 00 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 91. 00 09100 EMERGENCY | 560, 085 | 70, 057, 935 | 0. 00799 | 5 5, 682, 267 | 45, 430 | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART | 209, 174 | 3, 997, 674 | 0. 05232 | 4 0 | 0 | 92.00 |
| 92.01 09201 OBSERVATION BEDS (DISTINCT PART) | 0 | 0 | 0.00000 | 0 | 0 | 92. 01 |
| 93.00 04950 OTHER OUTPATIENT SERVICES | 0 | 0 | 0.00000 | 0 | 0 | 93. 00 |
| 93. 01 04951 GENESI S | 128, 866 | 3, 889, 767 | 0. 03312 | 9 0 | 0 | 93. 01 |
| 93. 02 04952 WOMEN' S CENTER | 0 | 0 | 0.00000 | 0 | 0 | 93. 02 |
| 93.03 04953 RESIDENTIAL HOMES | 0 | 0 | 0.00000 | 0 | 0 | 93. 03 |
| 93. 04 04954 DR. STEELE | 0 | 0 | 0.00000 | 0 0 | 0 | 93. 04 |
| 93. 05 O4955 DIABETIC EDUCATION | 0 | 0 | 0.00000 | 0 0 | 0 | 93. 05 |
| 93. 06 04956 HOWARD COUNTY CSS | 46, 313 | 137, 264 | 0. 33740 | 1 0 | 0 | 93. 06 |
| 93. 07 04957 CLINTON COUNTY | 76, 206 | | 0. 15989 | | 0 | 93. 07 |
| 93.18 04968 PSYCH MEDICATION | 0 | 0 | 0.00000 | 0 0 | 0 | 93. 18 |
| 93. 43 04993 NEW BEGI NNI NGS | 25, 446 | 28, 084 | | | 0 | 93. 43 |
| OTHER REIMBURSABLE COST CENTERS | | | | • | | 1 |
| 95. 00 09500 AMBULANCE SERVICES | | | | | | 95. 00 |
| 200.00 Total (lines 50 through 199) | 6, 833, 080 | 535, 925, 787 | | 60, 644, 549 | 493, 032 | 200. 00 |

| Health Financial Systems CO | MMUNITY HOWARD | REGIONAL HEALT | TH | In Lie | eu of Form CMS-: | 2552-10 |
|---|---|----------------|------------------------------|---|--|---------|
| APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA | ASS THROUGH COS | | | Period: From 01/01/2019 To 12/31/2019 | | |
| | | Ti tl e | XVIII | Hospi tal | PPS | |
| Cost Center Description | Post-Stepdown Adjustments | Ü | Post-Stepdowr Adjustments | | All Other Medical Education Cost | |
| | 1A | 1.00 | 2A | 2. 00 | 3. 00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30. 00 03000 ADULTS & PEDIATRICS | 0 | 0 | | 315, 122 | l | |
| 31.00 03100 INTENSIVE CARE UNIT | 0 | 0 | | 0 | 0 | 31. 00 |
| 43. 00 04300 NURSERY | 0 | 0 | | 0 | 0 | 43.00 |
| 200.00 Total (lines 30 through 199) | 0 | 0 |) | 315, 122 | | 200. 00 |
| Cost Center Description | Swi ng-Bed | Total Costs | | Per Diem (col. | Inpati ent | |
| | 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 | 1 | | | | | |
| 30. 00 03000 ADULTS & PEDI ATRI CS | 0 | 315, 122 | • | | | 30.00 |
| 31. 00 03100 INTENSIVE CARE UNIT | | 0 | 1, 46 | | l e | |
| 43. 00 04300 NURSERY | | 0 | 83 | | l e | |
| 200.00 Total (lines 30 through 199) | | 315, 122 | 21, 58 | 5 | 6, 681 | 200. 00 |
| Cost Center Description | Inpatient Program Pass-Through Cost (col. 7 x col. 8) | | | | | |
| | 9. 00 | | | | | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | · | | | | |
| 30. 00 03000 ADULTS & PEDI ATRI CS | 98, 971 | • | | | | 30.00 |
| 31.00 03100 INTENSIVE CARE UNIT | 0 | | | | | 31. 00 |
| 43. 00 04300 NURSERY | 0 | | | | | 43. 00 |
| 200.00 Total (lines 30 through 199) | 98, 971 | | | | | 200. 00 |

In Lieu of Form CMS-2552-10

Period: Worksheet D
From 01/01/2019 Part IV
To 12/31/2019 Date/Time Prepared: 8/19/2020 2:00 pm
 Heal th Financial APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY
 COMMUNITY HOWARD REGIONAL HEALTH ANCILLARY

 COMMUNITY HOWARD REGIONAL HEALTH

 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY
 SERVICE OTHER PASS
 Provider CCN
 Provider CCN: 15-0007 THROUGH COSTS

| Non-Physician Non-Physicia | | | | ' | | 8/19/2020 2:00 | 0 pm |
|--|---|---------------|----------------|----------------|---------------|----------------|---------------------|
| AmcILLARY SERVICE COST CENTERS | | | Title | : XVIII | Hospi tal | PPS | |
| AmcILLARY SERVICE COST CENTERS | Cost Center Description | Non Physician | Nursing School | Nursing School | Allied Health | Allied Health | |
| ANCILLARY SERVICE COST CENTERS | · · | | | | | | |
| ANCILLARY SERVICE COST CENTERS | | Cost | | | | | |
| ANCILLARY SERVICE COST CENTERS | | | | 2, 00 | | 3. 00 | |
| 50.00 05000 05000 05000 0 0 0 | ANCILLARY SERVICE COST CENTERS | <u>'</u> | | | | | |
| 53.00 05300 ANESTHESI OLOGY 0 0 0 0 0 53.00 | 50. 00 05000 OPERATING ROOM | 0 | C | C | 0 | 0 | 50.00 |
| 53.00 05300 ANESTHESI OLOGY 0 0 0 0 53.00 | 52.00 05200 DELIVERY ROOM & LABOR ROOM | 0 | 0 | | 0 | 0 | 52. 00 |
| 54. 00 05400 RADIOLOGY-DI AGNOSTIC 0 0 0 0 0 54. 00 57. 00 05700 CT SCAN 0 0 0 0 0 0 0 0 58. 00 05800 MRI 0 0 0 0 0 0 0 0 0 59. 00 05900 CARDIA C CATHETERI ZATI ON 0 0 0 0 0 0 0 0 59. 00 05900 CARDIA C CATHETERI ZATI ON 0 0 0 0 0 0 0 60. 00 06000 LABORATIORY 0 0 0 0 0 0 0 61. 00 06300 BLODD STORIN R, PROCESSI NG & TRANS. 0 0 0 0 0 0 65. 00 06500 RESPI RATORY THERAPY 0 0 0 0 0 0 0 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 67. 00 06700 CCUPATI ONAL THERAPY 0 0 0 0 0 0 0 68. 00 06800 SPECH PATHOLOGY 0 0 0 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 69. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 75. 00 07500 OSCONO DISTINCT PART) 0 0 0 0 0 0 0 75. 00 07500 OSCONO DISTINCT PART) 0 0 0 0 0 0 0 75. 00 07500 OSCONO DISTINCT PART) 0 0 0 0 0 0 0 75. 00 07500 OSCONO DISTINCT PART) 0 0 0 0 0 0 75. 00 07500 OSSERVATI ON BEDS (INSTINCT PART) 0 0 0 0 0 0 0 75. 00 07500 OSSERVATI ON BEDS (INSTINCT PART) 0 0 0 0 0 0 0 75. 00 07500 OSSERVATI ON BEDS (INSTINCT PART) 0 0 0 0 0 0 0 75. 00 07500 OSSERVATI ON BEDS (INSTINCT PART) 0 0 0 0 0 0 0 75. 00 07500 OSSERVATI ON BEDS (INSTINCT PART) 0 0 0 0 0 0 0 75. 00 07500 OSSERVATI ON BEDS (INSTINCT PART) 0 0 0 0 0 0 0 75. 00 07500 OSSERVATI ON BEDS (INSTINCT PART) 0 0 0 0 0 0 0 75. 00 07500 OSSERVATI ON BEDS (INSTINCT PART) 0 0 0 0 0 0 0 75. 00 | | 0 | 0 | | 0 | 0 | 53. 00 |
| 54. 01 03480 NOCLOGY | 54, 00 05400 RADI OLOGY-DI AGNOSTI C | 0 | | | 0 | 0 | 54.00 |
| 57.00 05700 CT SCAN 0 0 0 0 0 0 0 0 0 | | 0 | 0 | | 0 | | |
| 58.00 05800 MR 0 0 0 0 0 0 0 0 58.00 59.00 05800 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 0 0 0 60.00 06000 LABORATORY 0 0 0 0 0 0 0 63.00 06500 RESPI RATORY THERAPY 0 0 0 0 0 0 0 65.00 06500 RESPI RATORY THERAPY 0 0 0 0 0 0 0 66.00 06600 RESPI RATORY THERAPY 0 0 0 0 0 0 0 66.00 06600 RESPI RATORY THERAPY 0 0 0 0 0 0 0 66.00 06600 RESPI RATORY THERAPY 0 0 0 0 0 0 0 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 0 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 69.00 06900 LECTROCARDI OLOGY 0 0 0 0 0 0 0 70.00 07000 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 71.00 07000 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 71.00 07100 MBL DEV CHARGED TO PATIENT 0 0 0 0 0 0 0 72.00 07200 MPL. DEV CHARGED TO PATIENT 0 0 0 0 0 0 0 73.00 07300 RUISC CHARGED TO PATIENTS 0 0 0 0 0 0 0 75.00 07500 ASC (MON-DISTINCT PART) 0 0 0 0 0 0 0 76.01 03950 WOUND CARE CENTER 0 0 0 0 0 0 0 76.02 07500 ASC (MON-DISTINCT PART) 0 0 0 0 0 0 0 79.00 07000 EMERGENCY 0 0 0 0 0 0 0 0 79.00 07000 EMERGENCY 0 0 0 0 0 0 0 79.01 04951 GANESIS 0 0 0 0 0 0 0 0 79.02 04952 WOMEN'S CENTER 0 0 0 0 0 0 0 79.03 04953 GANDI OLOGATI ON DESTINCT PART 0 0 0 0 0 0 79.04 04955 DABSENYATI ON BEDS (NON-DISTINCT PART 0 0 0 0 0 0 0 79.01 04951 GANDING CARRES 0 0 0 0 0 0 0 79.02 04952 WOMEN'S CENTER 0 0 0 0 0 0 0 79.03 04954 DR. STEELE 0 0 0 0 0 0 0 0 79.04 04955 WOMEN'S CENTER 0 0 0 0 0 0 0 79.05 07000 07000 07000 07000 07000 79.00 07000 0700 | | 0 | |] | | | |
| 59,00 05900 CARDIAC CATHETERIZATION 0 0 0 0 0 0 0 0 0 | | 0 | | | | - | |
| 60. 00 06000 LABORATORY 0 0 0 0 0 0 0 0 0 | | 0 | | | | | |
| 63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0 0 63. 00 65. 00 06500 RESPIRATORY THERAPY 0 0 0 0 0 0 65. 00 65. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 66. 00 67. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 0 68. 00 06600 SPECEN PATHOLOGY 0 0 0 0 0 0 0 69. 00 06900 DELECTROCARDIOLOGY 0 0 0 0 0 0 0 69. 00 06900 ELECTROCARDIOLOGY 0 0 0 0 0 0 0 71. 00 07000 ELECTROCEPHALOGRAPHY 0 0 0 0 0 0 0 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 73. 00 07300 BRUDS CHARGED TO PATIENTS 0 0 0 0 0 0 0 74. 00 07400 RENAL DIALYSIS 0 0 0 0 0 0 0 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0 76. 00 03160 CARDI OPULMONARY 0 0 0 0 0 0 0 76. 01 03950 WOUND CARE CENTER 0 0 0 0 0 0 0 76. 00 09100 EMERGENCY 0 0 0 0 0 0 0 79. 00 09200 DESERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 79. 00 09200 095ERVATION BEDS (DISTINCT PART) 0 0 0 0 0 0 79. 00 09300 095ERVATION SEDS (DISTINCT PART) 0 0 0 0 0 0 79. 00 09300 095ERVATION SEDS (DISTINCT PART) 0 0 0 0 0 0 79. 00 09450 GARGED TO SERVICES 0 0 0 0 0 79. 00 09450 OFTER ORDER | | | | | | - | |
| 65.00 06500 RESPIRATORY THERAPY 0 0 0 0 0 0 0 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 0 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 0 0 0 66.00 68.00 06800 SPECH PATHOLOGY 0 0 0 0 0 0 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | 0 | | | | | |
| 66.00 06600 PHYSICAL THERAPY 0 0 0 0 0 66.00 67.00 06700 0CUPATI ONAL THERAPY 0 0 0 0 0 0 67.00 67.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 69.00 07000 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 71.00 07100 ELECTROCARDI OLOGY 0 0 0 0 0 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 0 0 0 72.00 07200 IMPL DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 74.00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 75.01 07500 ASC (NON-DI STI NCT PART) 0 0 0 0 0 0 76.01 07500 ASC (NON-DI STI NCT PART) 0 0 0 0 0 76.00 07500 ASE (NON-DI STI NCT PART) 0 0 0 0 0 76.00 07100 EMERGENCY 0 0 0 0 0 76.00 07100 EMERGENCY 0 0 0 0 0 76.00 07500 OSSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 76.00 07500 OSSERVATI ON BEDS (DI STI NCT PART) 0 0 0 0 76.00 07500 OSSERVATI ON BEDS (DI STI NCT PART) 0 0 0 0 76.00 07500 OSSERVATI ON BEDS (DI STI NCT PART) 0 0 0 0 77.00 07500 OSSERVATI ON BEDS (DI STI NCT PART) 0 0 0 0 77.00 07500 OSSERVATI ON BEDS (DI STI NCT PART) 0 0 0 0 77.00 07500 OSSERVATI ON BEDS (DI STI NCT PART) 0 0 0 0 77.00 07500 OSSERVATI ON BEDS (DI STI NCT PART) 0 0 0 0 77.00 07500 OSSERVATI ON BEDS (DI STI NCT PART) 0 0 0 0 77.00 07500 OSSERVATI ON BEDS (DI STI NCT PART) 0 0 0 0 77.00 07500 OSSERVATI ON BEDS (DI STI NCT PART) 0 0 0 0 77.00 07500 OSSERVATI ON BEDS (DI STI NCT PART) 0 0 0 0 77.00 07500 OSSERVATI ON BEDS (DI STI NCT PART) 0 0 0 0 77.00 07500 OSSERVATI ON BEDS (DI STI NCT PART) 0 0 0 0 77.00 07500 OSSERVATI ON BEDS (DI STI NCT PART) 0 0 0 0 77.00 07500 OSSERVA | · | 0 | | | | - | |
| 67. 00 06700 OCCUPATI ONAL THERAPY | | 0 | | | | | |
| 68. 00 06800 SPEECH PATHOLOGY | | 0 | | 1 | | | |
| 69. 00 06900 ELECTROCARDIOLOGY 0 0 0 0 0 0 0 0 0 | | 0 | | | 0 | - | |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 0 70. 00 | | 0 | 0 | | 0 | | |
| 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0 0 72. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 73. 00 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 0 74. 00 75. 00 07500 ASC (NON-DI STI NCT PART) 0 0 0 0 0 0 75. 00 75. 01 03950 WOUND CARE CENTER 0 0 0 0 0 0 0 75. 00 76. 00 03160 CARDI OPULMONARY 0 0 0 0 0 0 75. 00 00100 EMERGENCY 0 0 0 0 0 0 0 75. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 0 0 0 0 91. 00 92. 01 09201 OBSERVATI ON BEDS (DI STI NCT PART) 0 0 0 0 0 0 0 92. 01 93. 00 04950 OTHER OUTPATI ENT SERVI CES 0 0 0 0 0 0 0 93. 01 93. 01 04951 GENESIS 0 0 0 0 0 0 0 0 93. 01 93. 02 04952 WOMEN'S CENTER 0 0 0 0 0 0 0 0 0 93. 01 93. 03 04953 RESI DENTI AL HOMES 0 0 0 0 0 0 0 0 93. 02 93. 04955 DI ABETI C EDUCATI ON 0 0 0 0 0 0 0 0 93. 03 93. 05 04955 DI ABETI C EDUCATION 0 0 0 0 0 0 0 0 93. 05 93. 06 04956 HOWARD COUNTY CSS 0 0 0 0 0 0 0 0 93. 05 93. 07 04957 CIT NON 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | 0 | 0 | 1 | 0 | - | |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 73.00 74.00 07400 RENAL DIALYSIS 0 0 0 0 0 0 75.00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 75.01 03950 WOUND CARE CENTER 0 0 0 0 0 0 76.01 03950 WOUND CARE CENTER 0 0 0 0 0 0 76.01 03950 WOUND CARE CENTER 0 0 0 0 0 0 76.00 00160 CARDI OPULMONARY 0 0 0 0 0 0 76.00 00170 EMERGENCY 0 0 0 0 0 0 91.00 92.00 08SERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 92.01 09201 08SERVATI ON BEDS (DISTINCT PART) 0 0 0 0 0 0 93.00 04950 OTHER OUTPATIENT SERVICES 0 0 0 0 0 0 93.01 04951 GENESIS 0 0 0 0 0 0 93.02 04952 WOMEN'S CENTER 0 0 0 0 0 0 93.03 04953 RSIS DENTIAL HOMES 0 0 0 0 0 93.04 04954 DR. STEELE 0 0 0 0 0 0 93.05 04955 DI ABETI C EDUCATION 0 0 0 0 0 93.06 04956 DI ABETI C EDUCATION 0 0 0 0 0 93.07 04957 CLINTON COUNTY 0 0 0 0 0 93.08 04958 RSI DENTIAL HOMES 0 0 0 0 0 93.09 04958 PSYCH MEDI CATION 0 0 0 0 93.01 04958 PSYCH MEDI CATION 0 0 0 0 93.03 04993 NEW BEGI INNI NGS 0 0 0 0 0 93.04 04958 PSYCH MEDI CATION 0 0 0 0 93.05 04957 CLINTON COUNTY 0 0 0 0 93.06 04950 PSYCH MEDI CATION 0 0 0 0 93.07 04957 CLINTON COUNTY 0 0 0 0 93.08 04908 PSYCH MEDI CATION 0 0 0 0 93.08 04908 PSYCH MEDI CATION 0 0 0 0 93.09 04900 PSYCH MEDI CATION 0 0 0 0 93.01 04900 PSYCH MEDI CATION 0 0 0 0 93.02 04900 PSYCH MEDI CATION 0 0 0 0 93.03 04900 PSYCH MEDI CATION 0 0 0 93.04 04900 PSYCH MEDI CATION 0 0 0 93.05 04900 PSY | | 0 | 0 |) C | 0 | | |
| 73. 00 | | 0 | 0 | l c | 0 | - | |
| 74. 00 | | 0 | 0 |) C | 0 | | |
| 75. 00 | | 0 | 0 | C | 0 | 0 | |
| 75. 01 | | 0 | 0 | C | 0 | 0 | 74.00 |
| 76. 00 | | 0 | 0 | C | 0 | 0 | 75. 00 |
| OUTPATI ENT SERVICE COST CENTERS O O O O O O O O O | 75. 01 03950 WOUND CARE CENTER | 0 | 0 | C | 0 | 0 | 75. 01 |
| 91. 00 09100 EMERGENCY 0 0 0 0 0 0 91. 00 92. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0 0 0 0 0 0 0 92. 01 09201 OBSERVATI ON BEDS (DISTINCT PART) 0 0 0 0 0 0 92. 01 093. 00 09450 OTHER OUTPATI ENT SERVICES 0 0 0 0 0 0 0 93. 00 093. 01 094951 OSERVATI ON BEDS (DISTINCT PART) 0 0 0 0 0 0 0 0 0 | 76.00 03160 CARDI OPULMONARY | 0 | 0 |) c | 0 | 0 | 76. 00 |
| 92. 00 09200 09500 | OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 92. 01 09201 09201 0BSERVATI ON BEDS (DISTINCT PART) 0 0 0 0 0 0 92. 01 93. 00 04950 OTHER OUTPATI ENT SERVI CES 0 0 0 0 0 0 93. 00 93. 01 04951 GENESI S 0 0 0 0 0 0 0 93. 02 04952 WOMEN'S CENTER 0 0 0 0 0 0 0 93. 03 04953 RESI DENTI AL HOMES 0 0 0 0 0 0 93. 04 04954 DR. STEELE 0 0 0 0 0 0 93. 05 04955 DI ABETI C EDUCATI ON 0 0 0 0 0 93. 06 04956 HOWARD COUNTY CSS 0 0 0 0 0 93. 07 04957 CLI NTON COUNTY 0 0 0 0 0 93. 08 04998 PSYCH MEDI CATI ON 0 0 0 0 93. 18 04998 PSYCH MEDI CATI ON 0 0 0 0 93. 18 04999 NEW BEGI NNI NGS 0 0 0 0 95. 00 09500 AMBULANCE SERVI CES 95. 00 | | 0 | C | C | 0 | 0 | 91. 00 |
| 93. 00 | 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART | 0 | | | | 41, 054 | 92.00 |
| 93. 01 | 92.01 09201 OBSERVATION BEDS (DISTINCT PART) | 0 | 0 | ıl c | 0 | 0 | 92. 01 |
| 93. 02 04952 WOMEN'S CENTER 0 0 0 0 0 0 0 93. 02 93. 03 04953 RESIDENTIAL HOMES 0 0 0 0 0 0 0 93. 03 93. 04 04954 DR. STEELE 0 0 0 0 0 0 0 0 93. 04 93. 05 04955 DI ABETI C EDUCATION 0 0 0 0 0 0 0 93. 05 93. 06 04956 HOWARD COUNTY CSS 0 0 0 0 0 0 0 93. 06 93. 07 04957 CLI NTON COUNTY 0 0 0 0 0 0 93. 07 93. 18 04968 PSYCH MEDI CATION 0 0 0 0 0 0 93. 18 93. 43 04968 PSYCH MEDI CATION 0 0 0 0 0 0 93. 18 93. 44 04993 NEW BEGINNI NGS 0 0 0 0 0 0 93. 18 01HER REI MBURSABLE COST CENTERS | 93. 00 04950 OTHER OUTPATIENT SERVICES | 0 | 0 | | 0 | 0 | 93. 00 |
| 93. 03 | 93. 01 04951 GENESI S | 0 | 0 | | 0 | O | 93. 01 |
| 93. 04 04954 DR. STEELE 0 0 0 0 0 93. 04 93. 05 04955 DI ABETI C EDUCATI ON 0 0 0 0 0 93. 05 93. 06 04956 HOWARD COUNTY CSS 0 0 0 0 0 0 93. 07 04957 CLI NTON COUNTY 0 0 0 0 0 0 93. 08 04968 PSYCH MEDI CATI ON 0 0 0 0 0 93. 18 04993 NEW BEGI NNI NGS 0 0 0 0 0 93. 18 04993 NEW BEGI NNI NGS 0 0 0 0 93. 43 OTHER REI MBURSABLE COST CENTERS 95. 00 | 93. 02 04952 WOMEN' S CENTER | 0 | | | 0 | o | 93. 02 |
| 93. 04 04954 DR. STEELE 0 0 0 0 0 93. 04 93. 05 04955 DI ABETI C EDUCATI ON 0 0 0 0 0 93. 05 93. 06 04956 HOWARD COUNTY CSS 0 0 0 0 0 0 93. 07 04957 CLI NTON COUNTY 0 0 0 0 0 0 93. 08 04968 PSYCH MEDI CATI ON 0 0 0 0 0 93. 18 04993 NEW BEGI NNI NGS 0 0 0 0 0 93. 18 04993 NEW BEGI NNI NGS 0 0 0 0 93. 43 OTHER REI MBURSABLE COST CENTERS 95. 00 | 93. 03 04953 RESIDENTIAL HOMES | 0 | | | 0 | 0 | 93. 03 |
| 93. 05 | | 0 | 0 | | 0 | 0 | |
| 93. 06 | | 0 | |] | | _ | |
| 93. 07 | | 0 | |] | | _ | |
| 93. 18 04968 PSYCH MEDICATION 0 0 0 0 0 93. 18 93. 43 04993 NEW BEGINNINGS 0 0 0 0 0 93. 43 07HER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95. 00 | | 0 | |] | | - | |
| 93. 43 04993 NEW BEGINNINGS 0 0 0 0 0 93. 43 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95. 00 | | 0 | | | | | |
| OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 95. 00 | | | | | | | |
| 95. 00 | | | <u> </u> | ή | , | 1 0 | 13.43 |
| | | | | | | | 05 00 |
| 200.00 10tal (11165 50 till dugli 177) 0 0 0 0 41,054 200.00 | | | | | | 41 OE 4 | |
| | 200.00 Total (Titles 50 till ough 199) | 1 | 1 | 11 | , | 1 41,034 | ₁ 200.00 |

| Peri od: | Worksheet D | From 01/01/2019 | Part IV | To 12/31/2019 | Date/Time Prepared:
 Heal th Financial APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY
 COMMUNITY HOWARD REGIONAL HEALTH ANCILLARY

 COMMUNITY HOWARD REGIONAL HEALTH

 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY
 SERVICE OTHER PASS
 Provider CCN
 Provider CCN: 15-0007 THROUGH COSTS

| | | | Т | o 12/31/2019 | Date/Time Prep 8/19/2020 2:00 | pared: O nm |
|--|----------------|---------------|--------------|----------------|----------------------------------|------------------|
| | | Title | : XVIII | Hospi tal | PPS | o piii |
| Cost Center Description | All Other | Total Cost | Total | Total Charges | Ratio of Cost | |
| | Medi cal | (sum of cols. | Outpati ent | (from Wkst. C, | to Charges | |
| | Education Cost | 1, 2, 3, and | Cost (sum of | Part I, col. | (col. 5 ÷ col. | |
| | | 4) | col s. 2, 3, | 8) | 7) | |
| | | | and 4) | | (see | |
| | | | | | instructions) | |
| | 4. 00 | 5. 00 | 6. 00 | 7. 00 | 8. 00 | |
| ANCILLARY SERVICE COST CENTERS | | | 1 | 70 004 000 | 0.00000 | F0 00 |
| 50. 00 05000 OPERATING ROOM | 0 | 0 | C | ,, | 0. 000000 | 50.00 |
| 52. 00 05200 DELIVERY ROOM & LABOR ROOM | 0 | 0 | 1 | 3, 439, 903 | 0.000000 | 52.00 |
| 53. 00 05300 ANESTHESI OLOGY | 0 | 0 | C | 05 ((5 72(| 0.000000 | 53.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 0 | 0 | C | ,, | 0.000000 | 54.00 |
| 54. 01 03480 ONCOLOGY | 0 | 0 | C | 33, 614, 158 | 0.000000 | 54. 01 |
| 57. 00 05700 CT SCAN | 0 | 0 | C | , , | 0. 000000 | 57. 00 |
| 58. 00 05800 MRI | 0 | 0 | | 13, 723, 367 | 0. 000000 | 58. 00 |
| 59. 00 05900 CARDI AC CATHETERI ZATI ON | 0 | 0 | C | , = , = | 0. 000000 | 59. 00 |
| 60. 00 06000 LABORATORY | 0 | 0 | C | 55, 558, 308 | 0. 000000 | 60.00 |
| 63. 00 06300 BLOOD STORING, PROCESSING & TRANS. | 0 | 0 | C | 10 005 170 | 0. 000000 | 63.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 0 | 0 | C | 10, 005, 172 | 0. 000000 | 65. 00 |
| 66. 00 06600 PHYSI CAL THERAPY | 0 | 0 | C | ., | 0. 000000 | 66.00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | 0 | 0 | C | 949, 403 | 0. 000000 | 67. 00 |
| 68. 00 06800 SPEECH PATHOLOGY | 0 | 0 | C | | 0. 000000 | 68. 00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0 | 0 | C | ,, | 0. 000000 | 69. 00 |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY | 0 | 0 | C | 134, 655 | 0. 000000 | 70.00 |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 0 | 0 | C | ,, | 0. 000000 | 71.00 |
| 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS | 0 | 0 | C | 18, 586, 312 | 0. 000000 | 72.00 |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | C | , , | 0. 000000 | 73.00 |
| 74. 00 07400 RENAL DI ALYSI S | 0 | 0 | | 601, 186 | 0. 000000 | 74.00 |
| 75. 00 07500 ASC (NON-DISTINCT PART) | 0 | 0 | C | 0 4/0 074 | 0. 000000 | 75. 00 |
| 75. 01 03950 WOUND CARE CENTER | 0 | 0 | C | 3, 462, 874 | 0. 000000 | 75. 01 |
| 76. 00 03160 CARDI OPULMONARY | 0 | 0 | C | 1, 266, 966 | 0. 000000 | 76. 00 |
| OUTPATIENT SERVICE COST CENTERS 91. 00 09100 EMERGENCY | 0 | 0 | 1 0 | 70, 057, 935 | 0.00000 | 91.00 |
| | 0 | _ | | | 0. 000000 0. 010269 | |
| | | 41, 054 | | 3, 997, 674 | 0.010269 | 92. 00 92. 01 |
| 92. 01 09201 OBSERVATI ON BEDS (DI STINCT PART) 93. 00 04950 OTHER OUTPATI ENT SERVI CES | 0 | 0 | C | 0 | | 92.01 |
| | 0 | 0 | | 2 000 7/7 | 0.000000 | |
| · · · · · · · · · · · · · · · · · · · | 0 | 0 | | 3, 889, 767 | 0.000000 | 93. 01 93. 02 |
| | 0 | 0 | | 0 | 0.000000 | 93. 02 |
| | 0 | 0 | | U | 0.000000 | |
| 93. 04 04954 DR. STEELE | 0 | 0 | | 0 | 0.000000 | 93. 04 |
| 93. 05 04955 DI ABETI C EDUCATI ON | 0 | 0 | | 127 2/4 | 0.000000 | 93. 05 |
| 93. 06 04956 HOWARD COUNTY CSS | 0 | 0 | | 137, 264 | 0.000000 | 93. 06 |
| 93. 07 04957 CLI NTON COUNTY | 0 | 0 | C | 476, 604 | 0.000000 | 93. 07 |
| 93. 18 04968 PSYCH MEDI CATI ON | 0 | 0 | C | | 0.000000 | 93. 18 |
| 93. 43 04993 NEW BEGINNINGS | 0 | 0 | 1 | 28, 084 | 0. 000000 | 93. 43 |
| OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES | | | | | | 95. 00 |
| 200.00 Total (lines 50 through 199) | 0 | 41, 054 | 41, 054 | 535, 925, 787 | | 200.00 |
| 200.00 10tai (111163 30 tili 0ugii 177) | ١ | 41,004 | 1 41,034 | 333, 723, 767 | ļ | 1200.00 |

| Heal th Financial | Systems | COMMUNI | TY HOWARD REG | ONAL HEALTH | | In Lie | u of Form CMS-2552-10 |
|--------------------|-------------------------|----------------------|---------------|-------------|---------|--------|-----------------------|
| A DDODTI ONMENT OF | L ND ATLENT (OUTDATLENT | ANOLLI ADV. CEDVI OF | OTHER DAGG | D ' I 00N | 45 0007 | D . I | W I I I D |

| S2200 OS200 OS20 | APPOR1 | TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF | RVICE OTHER PASS | Provi der C | Provi der CCN: 15-0007 | | Worksheet D Part IV Date/Time Prepared 8/19/2020 2:00 pm | |
|--|--------|--|------------------|--------------|------------------------|------------------------------|---|---------------------|
| Ratio of Cost to Charges (col 6 * col 1 to 1 to Charges (col 6 * col 1 to 1 | | | | | | | | |
| Charges Charges Charges Charges Charges Charges Charges Cot | | Cost Center Description | | | | | | |
| Cost | | | | | | | | |
| ANCILLARY SERVICE COST CENTERS 9.00 10.00 11.00 12.00 13.00 | | | | charges | | | | |
| ANCILLARY SERVICE COST CENTERS | | | | | , | 5 | , | |
| ANCIL LARY SERVICE COST CENTERS | | | | 10.00 | | 12.00 | | |
| 50. 00 050000 050000 050000 0500000000 | | ANCILLARY SERVICE COST CENTERS | 9.00 | 10.00 | 11.00 | 12.00 | 13.00 | |
| 52.00 0520 | 50 00 | | 0.00000 | 12 751 ///6 | | 0 7 268 728 | 0 | 50.00 |
| 53.00 085300 ANESTHESI OLOGY 0.000000 0 0 0 5.3.0 | | | | | • | ., | - | |
| 54.00 OS400 RADI OLOGY-DI AGNOSTI C 0.000000 1, 533, 769 0 6, 268, 348 0 54.0 6.0 0.000000 24.4 499 0 15, 079, 569 0.54.0 6.0 0.000000 24.4 499 0 15, 079, 569 0.54.0 6.0 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000 | | | | 0 | | | | |
| 54.01 03480 0x0CuCocy | | | 1 | 1 522 7/0 | | | | |
| 57. 00 05700 CT SCAN 0.000000 3.179, 597 0 8.064, 792 0 57.0 58. 00 05800 MRI 0.000000 333, 361 0 4.516, 168 0 58.0 59. 00 05900 CARDIAC CATHETERIZATION 0.000000 7, 965, 559 0 12, 986, 326 0 59.0 60. 00 06000 LABORATORY 0.000000 0 0 0 0 0 63. 00 05000 CASPIRATORY THERAPY 0.000000 0 0 0 0 0 65. 00 05000 O5000 STORI NG, PROCESSING & TRANS. 0.000000 0 0 0 0 0 66. 00 05000 O5000 O5000 O5000 O5000 O5000 O5000 67. 00 06000 PSPIRATORY THERAPY 0.000000 0 39, 424 0 0 38, 098 0 66. 00 05000 O5000 O5000 O5000 O5000 O5000 O5000 O5000 68. 00 05000 O5000 O5000 O5000 O5000 O5000 O5000 O5000 69. 00 05000 O5000 O5000 O5000 O5000 O5000 O5000 69. 00 05000 O5000 O5000 O5000 O5000 O5000 O5000 69. 00 05000 O5000 O5000 O5000 O5000 O5000 O5000 69. 00 05000 O5000 O5000 O5000 O5000 O5000 O5000 69. 00 05000 O5000 O5000 O5000 O5000 O5000 O5000 69. 00 05000 O5000 O5000 O5000 O5000 O5000 O5000 69. 00 05000 O5000 O5000 O5000 O5000 O5000 O5000 69. 00 05000 O5000 O5000 O5000 O5000 O5000 O5000 69. 00 05000 O5000 O5000 O5000 O5000 O5000 O5000 69. 00 05000 O5000 O50000 O5000 O50000 O500000 O500000 O500000 O5000000 O500000 O5000000 O50000000 O5000000 O50000000 O50000000 O50000000 O50000000 O5000000000 O500000000 O500000000 O5000000000 O5000000000 O5000000000 O50000000000 | | | 1 | | | -,, | _ | |
| 58.00 05800 MR 0.000000 333, 361 0 4,516, 168 0 58.6 0.00000 0.00000 0.0000000 0.0000000 0.000000 0.0000000 0.0000000 0.00000000 | | | | | | | _ | |
| 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 7, 965, 559 0 12, 986, 326 0 59.0 | | | | | | | ı | |
| 60. 00 06000 LABORATORY 0. 000000 0. 0 | | | 1 | | | | - | |
| 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 0 0 0 0 0 0 0 | | | 1 | | | | _ | |
| 65.00 06500 RESPI RATORY THERAPY 0.000000 3,160,323 0 900,523 0 65.0 66.00 06600 PHYSI CAL THERAPY 0.000000 696,870 0 38,098 0 66.0 67.00 06700 0CCUPATI ONAL THERAPY 0.000000 399,424 0 8,570 0 67.0 68.00 06800 SPEECH PATHOLOGY 0.000000 61,547 0 547 0 68.0 69.00 06900 ELECTROCARDI OLOGY 0.000000 16,889,747 0 4,035,822 0 69.0 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 15,346 0 28,064 0 70.0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.000000 4,146,349 0 3,025,914 0 71.0 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 0.000000 4,146,349 0 3,025,914 0 71.0 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 357,492 0 0 0 73.0 74.00 07400 RENAL DI ALYSI S 0.000000 357,492 0 0 0 75.0 75.00 07500 ASC (NON-DI STI NCT PART) 0.000000 124,437 0 1,595,258 0 75.0 76.00 03010 CARDI OPULMONARY 0.000000 124,437 0 1,595,258 0 75.0 76.00 03100 CARDI OPULMONARY 0.000000 0 0 0 2,398,406 24,629 92.0 79.00 09200 DRSERVATI ON BEDS (DI STI NCT PART) 0.000000 0 0 2,398,406 24,629 92.0 79.01 09200 OBSERVATI ON BEDS (DI STI NCT PART) 0.000000 0 0 0 347,212 0 93.0 79.01 04950 OWINEN S CENTER 0.000000 0 0 0 347,212 0 93.0 79.02 04952 WOMEN'S CENTER 0.000000 0 0 0 0 0 0 79.03 04954 DRS STEELE 0.000000 0 0 0 0 0 0 79.04 04954 DR. STEELE 0.000000 0 0 0 0 0 79.05 04955 DASETITI LED CENTIC CENTES 0.000000 0 0 0 0 79.06 04955 DASETITI LED CENTIC CENTES 0.000000 0 0 0 0 79.07 04957 CLI NTON COUNTY 0.000000 0 0 0 0 79.08 04958 DASETITI LED CENTER 0.000000 0 0 0 0 79.09 04950 ONDORNO CENTER 0.000000 0 0 0 0 79.00 04950 ONDORNO CENTER 0.000000 0 0 0 79.00 04950 ONDORNO CENTER 0.000000 0 0 0 0 79.0 | | | 1 | 8, 1/1, 4/6 | | | _ | |
| 66. 00 06600 PHYSICAL THERAPY 0.000000 696, 870 0 38, 098 0 66. 06. 06700 OCCUPATI ONAL THERAPY 0.000000 399, 424 0 8, 570 0 67. 07. 07. 07. 07. 07. 07. 07. 07. 07. 0 | | | | 0 | | ٥ | _ | |
| 67. 00 06700 0CCUPATI ONAL THERAPY 0.000000 399, 424 0 8,570 0 67. 00 68. 00 06800 SPECH PATHOLOGY 0.000000 1,689,747 0 4,035,822 0 69. 00 6900 ELECTROCARDI OLOGY 0.000000 1,689,747 0 4,035,822 0 69. 00 6900 ELECTROCARDI OLOGY 0.000000 1,5,346 0 28,064 0 70. 00 | | | 1 | | | | _ | 65. 00 |
| 68. 00 06800 SPEECH PATHOLOGY | | | 1 | | | | | 66. 00 |
| 69.00 06900 ELECTROCARD OLOGY 0.000000 1, 689, 747 0 4, 035, 822 0 69.00 0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.00000000 | | | 1 | • | | | _ | 67. 00 |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 000000 15, 346 0 28, 064 0 70. 071. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0. 000000 4, 146, 349 0 3, 025, 914 0 71. 00 07200 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0. 0000000 3, 988, 101 0 2, 186, 840 0 72. 07. 07. 07. 07. 07. 07. 07. 07. 07. 07 | | | | | | | - | |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0. 000000 4, 146, 349 0 3, 025, 914 0 71. 072. 072. 072. 072. 072. 072. 072. 072 | | | | | | ., | _ | 69. 00 |
| 72. 00 | | | | • | | | | |
| 73. 00 | | | | | | | | |
| 74. 00 | | | | | | | _ | |
| 75. 00 | | | 1 | | • | | _ | |
| 75. 01 03950 WOUND CARE CENTER | | | 1 | | 1 | ٦ | _ | 74. 00 |
| 76. 00 03160 CARDI OPULMONARY 0. 000000 1, 172 0 689, 296 0 76. 0 OUTPATIENT SERVI CE COST CENTERS 91. 00 09100 EMERGENCY 0. 000000 5, 682, 267 0 11, 143, 156 0 91. 0 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0. 010269 0 0 2, 398, 406 24, 629 92. 0 93. 00 04950 OTHER OUTPATIENT SERVI CES 0. 000000 0 0 0 0 0 93. 0 93. 01 04951 GENESI S 0. 000000 0 0 0 347, 212 0 93. 0 93. 02 04952 WOMEN'S CENTER 0. 000000 0 0 0 0 0 0 93. 0 93. 03 04953 RESI DENTI AL HOMES 0. 000000 0 0 0 0 0 0 93. 0 93. 040454 DR. STEELE 0. 0. 000000 0 0 0 0 0 0 93. 0 93. 05 04955 DI ABETI C EDUCATI ON 0. 000000 0 0 0 52, 141 0 93. 0 93. 06 04956 HOWARD COUNTY CSS 0. 000000 0 0 0 0 0 0 93. 0 93. 07 04957 CLI NTON COUNTY 0. 000000 0 0 0 0 0 0 0 93. 0 93. 08 04993 NEW BEGI INNI NGS 0. 0. 000000 0 0 0 0 0 0 0 0 0 0 0 0 0 | | | | - | | | - | 75. 00 |
| 91. 00 | | l l | 1 | | • | | - | 75. 01 |
| 91. 00 09100 EMERGENCY 0.000000 5, 682, 267 0 11, 143, 156 0 91. 0 92. 0 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 0.010269 0 0 2, 398, 406 24, 629 92. 0 92. 0 09201 0BSERVATI ON BEDS (DI STI NCT PART 0.000000 0 0 0 0 0 92. 0 09200 000000 0 0 0 0 0 0 0 | 76. 00 | | 0. 000000 | 1, 172 | | 0 689, 296 | 0 | 76. 00 |
| 92. 00 | | | | | 1 | | | |
| 92. 01 09201 0BSERVATI ON BEDS (DI STINCT PART) 0.000000 0 0 0 0 92. 0 93. 00 04950 OTHER OUTPATI ENT SERVI CES 0.000000 0 0 347, 212 0 93. 0 93. 01 04951 GENESI S 0.000000 0 0 347, 212 0 93. 0 93. 02 04952 WOMEN' S CENTER 0.000000 0 0 0 0 0 93. 03 04953 RESI DENTI AL HOMES 0.000000 0 0 0 0 0 93. 04 04954 DR. STEELE 0.000000 0 0 0 0 93. 0 93. 05 04955 DI ABETI C EDUCATI ON 0.000000 0 0 0 0 93. 06 04956 HOWARD COUNTY CSS 0.000000 0 0 52, 141 0 93. 0 93. 07 04957 CLI NTON COUNTY 0.000000 0 0 0 0 93. 18 04968 PSYCH MEDI CATI ON 0.000000 0 0 0 0 93. 43 04993 NEW BEGI NNI NGS 0.000000 0 0 0 93. 0 95. 00 OTHER REI MBURSABLE COST CENTERS 95. 00 | | | 1 | | 1 | | | |
| 93. 00 | | | | | | | ' | |
| 93. 01 | | | | - | | - | - | |
| 93. 02 | | | 1 | - | | -1 | | |
| 93. 03 | | | 1 | | • | | | 93. 01 |
| 93. 04 04954 DR. STEELE 0. 000000 0 0 0 93. 00 93. 05 04955 DI ABETI C EDUCATI ON 0. 000000 0 0 0 0 93. 00 93. 06 04956 HOWARD COUNTY CSS 0. 000000 0 0 52, 141 0 93. 00 93. 07 04957 CLI NTON COUNTY 0. 000000 0 0 0 0 93. 00 93. 18 04968 PSYCH MEDI CATI ON 0. 000000 0 0 0 0 93. 00 93. 43 04993 NEW BEGI NNI NGS 0. 000000 0 0 0 93. 00 95. 00 OTHER REI MBURSABLE COST CENTERS 95. 00 97. 00 09500 AMBULANCE SERVI CES 95. 00 98. 00 0 0 0 0 0 99. 00 0 0 0 0 99. 00 0 0 0 99. 00 0 0 0 99. 00 0 0 99. 00 0 0 99. 00 0 0 99. 00 0 0 99. 00 0 0 99. 00 0 0 99. 00 0 0 99. 00 0 99. 00 0 0 99. 00 0 0 99. 00 0 0 99. 00 0 99. 00 0 0 99. 00 99. 00 0 99. 00 | | | | | | 0 | _ | |
| 93. 05 04955 | | | | - | | 0 | _ | |
| 93. 06 04956 HOWARD COUNTY CSS 0.000000 0 0 52,141 0 93. 0 93. 07 04957 CLI NTON COUNTY 0.000000 0 0 0 0 93. 18 04968 PSYCH MEDI CATI ON 0.000000 0 0 0 0 93. 43 04993 NEW BEGI NNI NGS 0.000000 0 0 0 0 94. 44 04993 NEW BEGI NNI NGS 0.000000 0 0 0 95. 00 09500 AMBULANCE SERVI CES 95. 00 97. 40 04956 HOWARD COUNTY CSS 0.000000 0 0 0 98. 40 04957 CLI NTON COUNTY 0.000000 0 0 0 99. 40 04957 CLI NTON COUNTY 0.000000 0 0 99. 40 04958 04958 0.000000 0 0 99. 40 04958 04958 0.000000 0 99. 40 04958 04958 0.000000 0 99. 40 04958 0.000000 0 99. 40 04958 0.000000 0 99. 40 04958 0.000000 0 99. 40 04958 0.000000 0 99. 40 04958 0.000000 0 99. 40 04958 0.000000 0 99. 40 04958 0.0000000 0 99. 40 04958 0.0000 | | | 1 | - | | 0 | _ | 93. 04 |
| 93. 07 04957 CLI NTON COUNTY 0. 000000 0 0 0 93. 0 93. 18 04968 PSYCH MEDI CATI ON 0. 000000 0 0 0 0 93. 1 93. 43 04993 NEW BEGI NNI NGS 0. 000000 0 0 0 0 95. 00 09500 AMBULANCE SERVI CES 95. 0 97. 00 00 00 00 00 00 00 98. 00 00 00 00 00 99. 00 00 00 00 00 99. 00 00 00 00 99. 00 00 00 00 99. 00 00 00 00 99. 00 00 00 99. 00 00 00 99. 00 00 00 99. 00 00 00 99. 00 00 00 99. 00 00 00 99. 00 00 00 99. 00 00 99. 00 00 00 99. 00 00 00 99. 00 99. 00 00 99. 00 00 99. 00 00 99. 00 00 99. 00 99. 00 00 99. 00 99. 00 00 99. 00 00 99. 00 99. 00 00 99. 00 | | | | 0 | | 0 | | 93. 05 |
| 93. 18 04968 PSYCH MEDI CATI ON 0.000000 0 0 0 0 93. 1 93. 43 04993 NEW BEGI NNI NGS 0.000000 0 0 0 0 95. 00 09500 AMBULANCE SERVI CES 95. 00 0 0 0 0 96. 00 09500 | | | | 0 | | | _ | 93. 06 |
| 93. 43 04993 NEW BEGINNINGS 0.000000 0 0 0 0 0 93. 4 | | | | 0 | | ٦ | _ | 93. 07 |
| OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95. 0 | | | | | | | - | |
| 95. 00 09500 AMBULANCE SERVICES 95. 0 | 93. 43 | | 0.000000 | 0 | | 0 0 | 0 | 93. 43 |
| | | | | | 1 | | | |
| 200.00 Total (Tines 50 through 199) 60,644,549 0 127,218,504 24,629 200.0 | | | | (0 (44 540 | | 107 010 504 | 24 /00 | 95. 00 |
| | 200.00 | of total (Titles 50 through 199) | 1 1 | 00, 044, 549 | I | U 127, 218, 504 | 24, 629 | ₁ 200.00 |

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0007 Peri od: Worksheet D From 01/01/2019 Part V Date/Time Prepared: 12/31/2019 8/19/2020 2:00 pm Title XVIII Hospi tal **PPS** Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 128454 7, 268, 728 2, 180 933, 697 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.467652 0 52.00 C 05300 ANESTHESI OLOGY 0.000000 0 0 53 00 53 00 0 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.168798 6, 268, 348 1, 058, 085 54.00 54.01 03480 ONCOLOGY 0. 196131 15, 079, 589 0 2, 957, 575 54.01 57.00 05700 CT SCAN 0.033419 8.064.792 0 0 57.00 269 517 05800 MRI 0 58.00 0.091585 4, 516, 168 413, 613 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.034978 12, 986, 326 454, 236 59.00 60.00 06000 LABORATORY 0.110330 6, 848, 876 0 0 755, 636 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0.000000 63 00 63 00 0 65.00 06500 RESPIRATORY THERAPY 0.230962 900, 523 0 207, 987 65.00 06600 PHYSI CAL THERAPY 0. 431720 38, 098 0 0 66.00 16, 448 66.00 0 06700 OCCUPATIONAL THERAPY 0.482628 0 67.00 8, 570 4, 136 67.00 0 06800 SPEECH PATHOLOGY 68 00 0.518087 547 283 68 00 69.00 06900 ELECTROCARDI OLOGY 0. 126958 4, 035, 822 0 0 512, 380 69.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 0.490498 28, 064 13, 765 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0. 380504 3, 025, 914 0 0 71.00 1, 151, 372 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72 00 0.450011 2, 186, 840 0 0 984, 102 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 213087 39, 735, 830 42, 381 51, 459 8, 467, 189 73.00 07400 RENAL DIALYSIS 74.00 0.608238 0 0 0 74.00 07500 ASC (NON-DISTINCT PART) 75.00 0.000000 0 75.00 0 0 03950 WOUND CARE CENTER 1, 595, 258 0 75.01 0.271620 0 433, 304 75 01 03160 CARDI OPULMONARY 689, 296 0 76.00 0. 234630 161, 730 76.00 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 11. 143, 156 0.096006 1.069.810 91.00 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92.00 0.767247 2, 398, 406 0 1, 840, 170 92.00 09201 OBSERVATION BEDS (DISTINCT PART) 0.000000 0 92.01 92.01 0 93.00 04950 OTHER OUTPATIENT SERVICES 0.000000 0 0 93.00 04951 GENESI S 0.770775 0 93 01 347, 212 267, 622 93 01 0 93.02 04952 WOMEN'S CENTER 0.000000 0 93.02 04953 RESIDENTIAL HOMES 0 93. 03 0.000000 C 0 0 O 93.03 04954 DR. STEELE 0 93.04 0.000000 93.04 C 0 04955 DIABETIC EDUCATION 0 93.05 0.000000 Λ 93.05 0 93.06 04956 HOWARD COUNTY CSS 5. 120447 52, 141 0 266, 985 93.06 93.07 04957 CLINTON COUNTY 0.859261 0 93.07 0 04968 PSYCH MEDICATION 0.000000 n 0 93.18 93.18 Λ 93.43 04993 NEW BEGINNINGS 3. 366508 0 0 93.43 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVI CES 95.00 0. 374964 95.00 51, 459 22, 239, 642 200. 00 200.00 Subtotal (see instructions) 127, 218, 504 44, 561 201.00 Less PBP Clinic Lab. Services-Program 201.00 Only Charges Net Charges (line 200 - line 201) 22, 239, 642 202. 00 202.00 127, 218, 504 44, 561 51, 459

In Lieu of Form CMS-2552-10 Health Financial Systems COMMUNITY HOWARD REGIONAL HEALTH APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0007 Peri od: Worksheet D From 01/01/2019 Part V Date/Time Prepared: 12/31/2019 8/19/2020 2:00 pm Title XVIII Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 280 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 0 0 0 53. 00 05300 ANESTHESI OLOGY 0 53 00 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 54.00 54.01 03480 ONCOLOGY 54.01 57.00 05700 CT SCAN 00000000000 0 57.00 05800 MRI 0 58.00 58.00 59.00 05900 CARDIAC CATHETERIZATION 0 59.00 06000 LABORATORY 60.00 0 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63 00 63 00 65.00 06500 RESPIRATORY THERAPY 0 65.00 66.00 06600 PHYSI CAL THERAPY 66.00 06700 OCCUPATIONAL THERAPY 67.00 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72 00 Ω 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 9,031 10, 965 73.00 07400 RENAL DIALYSIS 74.00 0 0 74.00 07500 ASC (NON-DISTINCT PART) 75.00 0 0 75.00 03950 WOUND CARE CENTER 0 75.01 0 75.01 76.00 03160 CARDI OPULMONARY 0 0 76.00 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 000000000000 0 92.00 09201 OBSERVATION BEDS (DISTINCT PART) 0 92.01 04950 OTHER OUTPATIENT SERVICES 0 93.00 93.00 04951 GENESIS 93 01 0 93 01 04952 WOMEN'S CENTER 0 93. 02 93.02 04953 RESIDENTIAL HOMES 0 93. 03 93.03 04954 DR. STEELE 0 93.04 93.04 04955 DIABETIC EDUCATION 93.05 0 93.05 93.06 04956 HOWARD COUNTY CSS 0 93.06 93.07 04957 CLINTON COUNTY 93.07 04968 PSYCH MEDICATION 93. 18 Λ 93.18 04993 NEW BEGINNINGS 93.43 93.43 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 95.00

9, 311

9, 311

10, 965

10, 965

200.00

201.00

202.00

200.00

201.00

202.00

Subtotal (see instructions)

Only Charges

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

201.00

0 202. 00

0

11, 449, 864

Health Financial Systems APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0007 Peri od: Worksheet D From 01/01/2019 Part V Date/Time Prepared: 12/31/2019 8/19/2020 2:00 pm Title XIX Hospi tal Cost Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 128454 925, 307 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.467652 0 0 0 52.00 05300 ANESTHESI OLOGY 0.000000 53 00 0 O 53 00 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 0.168798 0 575, 212 0 54.00 54.01 03480 ONCOLOGY 0. 196131 198, 151 0 54.01 57.00 05700 CT SCAN 0.033419 0 1, 276, 802 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 57.00 0 05800 MRI 259, 488 58.00 0.091585 0 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.034978 273, 315 0 59.00 06000 LABORATORY 60.00 0.110330 1, 216, 388 0 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 63 00 63 00 0 06500 RESPIRATORY THERAPY 65.00 0.230962 65, 696 0 65.00 06600 PHYSI CAL THERAPY 0. 431720 10, 308 0 66.00 66.00 06700 OCCUPATIONAL THERAPY 0.482628 67.00 67.00 0 68.00 06800 SPEECH PATHOLOGY 0.518087 0 0 68 00 69.00 06900 ELECTROCARDI OLOGY 0. 126958 170, 536 0 69.00 07000 ELECTROENCEPHALOGRAPHY 0. 490498 70.00 70.00 2,002 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0. 380504 26, 237 71.00 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 72 00 0.450011 114, 268 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 213087 1, 432, 877 0 73.00 07400 RENAL DIALYSIS 74.00 0.608238 C 0 74.00 07500 ASC (NON-DISTINCT PART) 75.00 0.000000 0 0 75.00 0 03950 WOUND CARE CENTER 75.01 0.271620 0 43, 241 Ω 75.01 03160 CARDI OPULMONARY 0. 234630 0 76.00 76.00 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0 91.00 0.096006 4, 684, 031 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0.767247 0 C 0 92.00 09201 OBSERVATION BEDS (DISTINCT PART) 0.000000 0 0 0 0 0 0 92.01 92.01 93.00 04950 OTHER OUTPATIENT SERVICES 0.000000 0 0 93.00 04951 GENESIS 0.770775 0 93 01 93 01 173, 327 Λ 04952 WOMEN'S CENTER 93.02 0.000000 C 0 93.02 04953 RESIDENTIAL HOMES 93. 03 0.000000 0 0 93.03 04954 DR. STEELE 93.04 93.04 0.000000 0 0 04955 DIABETIC EDUCATION 93.05 0.000000 0 0 93.05 93.06 04956 HOWARD COUNTY CSS 5. 120447 2,678 0 0 93.06 93.07 04957 CLINTON COUNTY 0.859261 93.07 0 93.18 04968 PSYCH MEDICATION 0.000000 C n 93.18 Λ 04993 NEW BEGINNINGS 93.43 3. 366508 0 0 93.43 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVI CES 95.00 0. 374964 0 95.00 0 0 200, 00 200.00 Subtotal (see instructions) 11, 449, 864

201.00

202.00

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

Only Charges

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0007 Peri od: Worksheet D From 01/01/2019 Part V Date/Time Prepared: 12/31/2019 8/19/2020 2:00 pm Title XIX Hospi tal Cost Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 118, 859 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 53. 00 05300 ANESTHESI OLOGY 0 53 00 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 97,095 0 54.00 54.01 03480 ONCOLOGY 38, 864 54.01 57.00 05700 CT SCAN 0 57.00 42 669 05800 MRI 0 58.00 23, 765 58.00 59.00 05900 CARDIAC CATHETERIZATION 9,560 0 59.00 06000 LABORATORY 60.00 134, 204 0 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63 00 63 00 65.00 06500 RESPIRATORY THERAPY 15, 173 0 65.00 66.00 06600 PHYSI CAL THERAPY 4, 450 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 21,651 0 69.00 982 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 9, 983 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72 00 51, 422 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 305, 327 0 73.00 07400 RENAL DIALYSIS 0 74.00 0 74.00 07500 ASC (NON-DISTINCT PART) 75.00 0 75.00 0 03950 WOUND CARE CENTER 75.01 11, 745 0 75.01 03160 CARDI OPULMONARY 0 76.00 76.00 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 449, 695 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0 92.00 09201 OBSERVATION BEDS (DISTINCT PART) 0 92.01 92.01 0 0 93.00 04950 OTHER OUTPATIENT SERVICES 93.00 04951 GENESIS 93 01 133, 596 0 93 01 04952 WOMEN'S CENTER 0 93.02 93.02 04953 RESIDENTIAL HOMES 0 0 93. 03 93.03 04954 DR. STEELE 0 93.04 0 93.04 04955 DIABETIC EDUCATION 93.05 0 0 93.05 93.06 04956 HOWARD COUNTY CSS 13, 713 0 93.06 93.07 04957 CLINTON COUNTY 0 93.07 93.18 04968 PSYCH MEDICATION 0 Λ 93.18 04993 NEW BEGINNINGS 93.43 0 93.43 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVI CES 95.00 95.00 0 200.00 200.00 Subtotal (see instructions) 1, 482, 753 201.00 Less PBP Clinic Lab. Services-Program 201.00

1, 482, 753

202.00

Only Charges

202.00

Net Charges (line 200 - line 201)

| Health Financial Systems | COMMUNITY HOWARD REGIONAL HEALTH | In Lie | u of Form CMS-2 | 2552-10 | | |
|---|----------------------------------|-----------------------------|--------------------------------|---------|--|--|
| COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0007 | Peri od: From 01/01/2019 | Worksheet D-1 | | | |
| | | To 12/31/2019 | Date/Time Pre 8/19/2020 2:0 | | | |
| | 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, excluding newborn) 19,28 | | | | | | |
| 2.00 Handling day (including private game days evaluating private had and provide days) | | | | | | |

| | Title XVIII Hospital | PPS | |
|------------------|--|--------------|------------------|
| | Cost Center Description | 1. 00 | |
| | PART I - ALL PROVIDER COMPONENTS | 1.00 | |
| | INPATI ENT DAYS | | |
| 1.00 | Inpatient days (including private room days and swing-bed days, excluding newborn) | 19, 282 | 1.00 |
| 2.00 | Inpatient days (including private room days, excluding swing-bed and newborn days) | 19, 282 | 2. 00 |
| 3.00 | Private room days (excluding swing-bed and observation bed days). If you have only private room days, | 0 | 3. 00 |
| 4. 00 | do not complete this line. | 14 770 | 4. 00 |
| 5.00 | Semi-private room days (excluding swing-bed and observation bed days) Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost | 16, 770 0 | 5. 00 |
| 3.00 | reporting period | | 3.00 |
| 6.00 | Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost | 0 | 6. 00 |
| | reporting period (if calendar year, enter 0 on this line) | | |
| 7. 00 | Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost | 0 | 7. 00 |
| 8. 00 | reporting period Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost | o | 8. 00 |
| 6.00 | reporting period (if calendar year, enter 0 on this line) | ١ | 8.00 |
| 9.00 | Total inpatient days including private room days applicable to the Program (excluding swing-bed and | 6, 057 | 9. 00 |
| | newborn days) (see instructions) | | |
| 10. 00 | Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) | 0 | 10. 00 |
| 11 00 | through December 31 of the cost reporting period (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after | | 11 00 |
| 11. 00 | December 31 of the cost reporting period (if calendar year, enter 0 on this line) | 0 | 11. 00 |
| 12. 00 | Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) | 0 | 12. 00 |
| | through December 31 of the cost reporting period | | |
| 13.00 | Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) | 0 | 13. 00 |
| 14.00 | after December 31 of the cost reporting period (if calendar year, enter 0 on this line) | | 14.00 |
| 14. 00 15. 00 | Medically necessary private room days applicable to the Program (excluding swing-bed days) Total nursery days (title V or XIX only) | 0 | 14. 00 15. 00 |
| 16. 00 | Nursery days (title V or XIX only) | 0 | 16. 00 |
| 10.00 | SWING BED ADJUSTMENT | - O | 10.00 |
| 17. 00 | Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost | 0.00 | 17. 00 |
| | reporting period | | |
| 18. 00 | Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost | 0. 00 | 18. 00 |
| 19. 00 | reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost | 0. 00 | 19. 00 |
| 19.00 | reporting period | 0.00 | 19.00 |
| 20.00 | Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost | 0.00 | 20.00 |
| | reporting period | | |
| 21. 00 | Total general inpatient routine service cost (see instructions) | 23, 543, 631 | |
| 22. 00 | Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) | 0 | 22. 00 |
| 23. 00 | Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6) | 0 | 23. 00 |
| | x line 18) | - | |
| 24.00 | Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line | 0 | 24. 00 |
| 05.00 | 7 x line 19) | | |
| 25. 00 | Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) | 0 | 25. 00 |
| 26. 00 | Total swing-bed cost (see instructions) | 0 | 26. 00 |
| 27. 00 | General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) | 23, 543, 631 | |
| | PRI VATE ROOM DI FFERENTI AL ADJUSTMENT | | |
| 28. 00 | General inpatient routine service charges (excluding swing-bed and observation bed charges) | 0 | 28. 00 |
| 29. 00 | Private room charges (excluding swing-bed charges) | 0 | 29. 00 |
| 30.00 | Semi-private room charges (excluding swing-bed charges) | 0. 000000 | 30.00 |
| 31. 00 32. 00 | General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3) | 0.000000 | 31. 00 32. 00 |
| 33. 00 | Average semi-private room per diem charge (line 30 ÷ line 4) | 0.00 | 33. 00 |
| 34. 00 | Average per diem private room charge differential (line 32 minus line 33)(see instructions) | 0. 00 | 34. 00 |
| 35.00 | Average per diem private room cost differential (line 34 x line 31) | 0.00 | 35. 00 |
| 36. 00 | Private room cost differential adjustment (line 3 x line 35) | 0 | 36. 00 |
| 37. 00 | General inpatient routine service cost net of swing-bed cost and private room cost differential (line | 23, 543, 631 | 37. 00 |
| | 27 minus line 36) | | |
| | PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS | | |
| 38. 00 | Adjusted general inpatient routine service cost per diem (see instructions) | 1, 221. 02 | 38. 00 |
| 39. 00 | Program general inpatient routine service cost (line 9 x line 38) | 7, 395, 718 | |
| 40.00 | Medically necessary private room cost applicable to the Program (line 14 x line 35) | 0 | 40. 00 |
| 41. 00 | Total Program general inpatient routine service cost (line 39 + line 40) | 7, 395, 718 | 41.00 |

| JIVIPU I | ATION OF INPATIENT OPERATING COST | | Provi der C | CN: 15-0007 | Peri od: From 01/01/2019 | w of Form CMS-2 Worksheet D-1 | |
|----------------|--|--------------------------|------------------------|--|-----------------------------|--------------------------------------|-------|
| | | | | | To 12/31/2019 | Date/Time Pre 8/19/2020 2:0 | |
| | | | Ti tl e | xVIII | Hospi tal | PPS | о ріі |
| | Cost Center Description | Total Inpatient Costl | Total npatient Days | Average Per Diem (col. 1 col. 2) | 3 | Program Cost (col. 3 x col. 4) | |
| | | 1.00 | 2. 00 | 3.00 | 4. 00 | 5. 00 | |
| 2. 00 | NURSERY (title V & XIX only) | 0 | O | 0. (| 00 | 0 | 42. |
| | Intensive Care Type Inpatient Hospital Units | 0.075.444 | | | | 1 00/ 0/0 | |
| 3. 00 4. 00 | INTENSIVE CARE UNIT | 3, 075, 414 | 1, 469 | 2, 093. | 54 624 | 1, 306, 369 | 43. |
| . 00 | BURN INTENSIVE CARE UNIT | | | | | | 45. |
| | SURGICAL INTENSIVE CARE UNIT | | | | | | 46 |
| | OTHER SPECIAL CARE (SPECIFY) | | | | | • | 47 |
| | Cost Center Description | | | | | | |
| | D | -+ D 21 2 | 1: 200) | | | 1.00 | 40 |
| . 00 | Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines | | | ine) | | 10, 217, 444 18, 919, 531 | |
| . 00 | PASS THROUGH COST ADJUSTMENTS | 41 till ough 40) (. | see mstructro | 113) | | 10, 717, 331 | 47 |
| . 00 | Pass through costs applicable to Program inp | atient routine s | services (from | Wkst. D, sur | m of Parts I and | 673, 000 | 50 |
| | 111) | | | | | | |
| . 00 | Pass through costs applicable to Program inp | atient ancillary | y services (fr | om Wkst. D, s | sum of Parts II | 493, 032 | 51 |
| . 00 | and IV) Total Program excludable cost (sum of lines | 50 and 51) | | | | 1, 166, 032 | 52 |
| 3. 00 | Total Program inpatient operating cost exclu | | ated, non-phy | sician anesti | netist, and | 17, 753, 499 | |
| | medical education costs (line 49 minus line | 9 1 | | | | ,, | |
| | TARGET AMOUNT AND LIMIT COMPUTATION | | | | | | |
| . 00 | | | | | | | 54 |
| . 00 | Target amount per discharge Target amount (line 54 x line 55) | | | | | 0. 00 0 | 1 |
| . 00 | Difference between adjusted inpatient operat | ing cost and tai | rget amount (L | ine 56 minus | line 53) | 0 | |
| . 00 | , | g | 9 (| | | 0 | 1 |
| . 00 | Lesser of lines 53/54 or 55 from the cost re | porting period (| endi ng 1996, ເ | pdated and co | ompounded by the | 0.00 | 59 |
| 00 | market basket | | | | | 0.00 | ١,, |
| . 00 | Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line | | | | the amount by | 0. 00 0 | 1 |
| . 00 | which operating costs (line 53) are less than | | | | | 0 | " |
| | amount (line 56), otherwise enter zero (see | | 3 (3 0 . x | 00), 0 0 | the target | | |
| . 00 | , , | | | | | 0 | |
| . 00 | Allowable Inpatient cost plus incentive paym | ent (see instru | ctions) | | | 0 | 63 |
| . 00 | PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos | ts through Decer | mber 31 of the | cost reporti | ng period (See | 0 | 64 |
| . 00 | instructions)(title XVIII only) | to through becch | | Cost Topol ti | ng perrod (see | Ŭ | ັ ່ |
| . 00 | Medicare swing-bed SNF inpatient routine cos | ts after Decembe | er 31 of the c | ost reporting | g period (See | 0 | 65 |
| | instructions)(title XVIII only) | | | => (| | | ١ |
| . 00 | Total Medicare swing-bed SNF inpatient routi CAH (see instructions) | ne costs (line o | 64 plus line 6 | 5)(title XVI | I only). For | 0 | 66 |
| . 00 | , | e costs through | December 31 c | of the cost re | eporting period | 0 | 67 |
| | (line 12 x line 19) | 3 | | | | Ü | " |
| . 00 | Title V or XIX swing-bed NF inpatient routin | e costs after De | ecember 31 of | the cost repo | orting period | 0 | 68 |
| | (line 13 x line 20) | | | (0) | | | 1, |
| . 00 | Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N | | | | | 0 | 69 |
| . 00 | Skilled nursing facility/other nursing facil | | | |) | | 70 |
| . 00 | Adjusted general inpatient routine service c | ost per diem (li | ne 70 ÷ line | 2) | | | 71 |
| . 00 | Program routine service cost (line 9 x line | , | | | | | 72 |
| . 00 | Medically necessary private room cost applic | 5 | • | , | | | 73 |
| . 00 | Total Program general inpatient routine serv Capital-related cost allocated to inpatient | • | , | | Part II column | | 74 |
| . 00 | 26, line 45) | . Catine Service | COSES (TIOIII W | O KSHOEL D, I | art II, Corumil | | ′ ° |
| . 00 | Per diem capital-related costs (line 75 ÷ li | , | | | | | 76 |
| 00 | Program capital-related costs (line 9 x line | | | | | | 77 |
| 00 | , | | covidor roces | le) | | | 78 |
| 00 | Aggregate charges to beneficiaries for exces Total Program routine service costs for comp | | | | nus line 79) | | 80 |
| 00 | Inpatient routine service cost per diem limi | | | (70 /// // | | | 81 |
| 00 | Inpatient routine service cost limitation (I | ine 9 x line 81) | | | | | 82 |
| 00 | Reasonable inpatient routine service costs (| | s) | | | | 83 |
| . 00 | Program inpatient ancillary services (see in | | ac) | | | | 84 |
| | Utilization review - physician compensation Total Program inpatient operating costs (sum | | | | | | 85 |
| . 00 | PART IV - COMPUTATION OF OBSERVATION BED PASS | | ough ou | | | | 1 00 |
| . 00 | Total observation bed days (see instructions | | | | | 2, 512 | 87 |
| ~~ | Adjusted general inpatient routine cost per | diem (line 27 ÷ | line 2) | | | 1, 221. 02 | 1 88 |
| . 00 | Observation bed cost (line 87 x line 88) (se | | , | | | 3, 067, 202 | |

| Health Financial Systems COM | MMUNITY HOWARD | REGIONAL HEALTI | Н | In Lie | u of Form CMS-2 | 2552-10 |
|---|----------------|-----------------|------------|----------------------------------|----------------------------------|---------|
| COMPUTATION OF INPATIENT OPERATING COST | | Provi der CO | | Peri od: | Worksheet D-1 | |
| | | | | From 01/01/2019 To 12/31/2019 | Date/Time Prep 8/19/2020 2:00 | |
| | | Title | XVIII | Hospi tal | PPS | |
| Cost Center Description | Cost | Routine Cost | column 1 ÷ | Total | Observation | |
| | | (from line 21) | column 2 | Observati on | Bed Pass | |
| | | | | Bed Cost (from | Through Cost | |
| | | | | line 89) | (col. 3 x col. | |
| | | | | | 4) (see | |
| | | | | | instructions) | |
| | 1.00 | 2.00 | 3. 00 | 4. 00 | 5. 00 | |
| COMPUTATION OF OBSERVATION BED PASS THROUGH (| COST | | | | | |
| 90.00 Capital-related cost | 1, 605, 610 | 23, 543, 631 | 0. 06819 | 7 3, 067, 202 | 209, 174 | 90.00 |
| 91.00 Nursing School cost | 0 | 23, 543, 631 | 0.00000 | 3, 067, 202 | 0 | 91.00 |
| 92.00 Allied health cost | 315, 122 | 23, 543, 631 | 0. 01338 | 5 3, 067, 202 | 41, 054 | 92.00 |
| 93.00 All other Medical Education | o | 23, 543, 631 | 0. 00000 | 3, 067, 202 | 0 | 93. 00 |

| Health Financial Systems | COMMUNITY HOWARD REG | GLONAL HEALTH | In Lie | u of Form CMS- | 2552-10 |
|---|----------------------|-----------------------|--|-----------------------------|---------|
| COMPUTATION OF INPATIENT OPERATING COST | | Provider CCN: 15-0007 | Peri od: From 01/01/2019 To 12/31/2019 | Worksheet D-1 Date/Time Pre | |
| | | | 10 12/31/2017 | 8/19/2020 2:0 | 0 pm |
| | | Title XIX | Hospi tal | Cost | |
| Cost Center Description | | | | | |
| | | | | 1. 00 | |
| PART I - ALL PROVIDER COMPONENTS | | | | | |
| I NPATI ENT DAYS | | | | | |
| | | | | | |

| | | Title XIX | Hospi tal | Cost | |
|------------------|--|-----------------------------|-----------------|------------------|------------------|
| | Cost Center Description | | | 1 00 | |
| | PART I - ALL PROVIDER COMPONENTS | | | 1. 00 | |
| | I NPATI ENT DAYS | | | | |
| 1.00 | Inpatient days (including private room days and swing-bed days, | excluding newborn) | | 19, 282 | 1.00 |
| 2.00 | Inpatient days (including private room days, excluding swing-bed | | | 19, 282 | 2.00 |
| 3.00 | Private room days (excluding swing-bed and observation bed days) | . If you have only priv | vate room days, | 0 | 3.00 |
| | do not complete this line. | | | | |
| 4.00 | Semi-private room days (excluding swing-bed and observation bed | | | 16, 770 | 4. 00 |
| 5. 00 | Total swing-bed SNF type inpatient days (including private room | days) through December | 31 of the cost | 0 | 5. 00 |
| 6. 00 | reporting period Total swing-bed SNF type inpatient days (including private room) | days) after December 2 | 1 of the cost | 0 | 6. 00 |
| 0.00 | reporting period (if calendar year, enter 0 on this line) | days) at tel becelliber 3 | i oi the cost | U | 0.00 |
| 7. 00 | Total swing-bed NF type inpatient days (including private room days) | avs) through December 3 | 31 of the cost | 0 | 7. 00 |
| | reporting period | -y-,g | | _ | |
| 8.00 | Total swing-bed NF type inpatient days (including private room d | ays) after December 31 | of the cost | 0 | 8. 00 |
| | reporting period (if calendar year, enter 0 on this line) | | | | |
| 9. 00 | Total inpatient days including private room days applicable to the | he Program (excluding s | swing-bed and | 1, 109 | 9. 00 |
| 10.00 | newborn days) (see instructions) | (i = 1 | | 0 | 10.00 |
| 10. 00 | Swing-bed SNF type inpatient days applicable to title XVIII only through December 31 of the cost reporting period (see instruction | | om days) | 0 | 10. 00 |
| 11. 00 | Swing-bed SNF type inpatient days applicable to title XVIII only | | om days) after | 0 | 11. 00 |
| 11.00 | December 31 of the cost reporting period (if calendar year, ente | | om days) arter | o . | 11.00 |
| 12.00 | Swing-bed NF type inpatient days applicable to titles V or XIX or | | room days) | 0 | 12.00 |
| | through December 31 of the cost reporting period | | | | |
| 13.00 | Swing-bed NF type inpatient days applicable to titles V or XIX or | | | 0 | 13.00 |
| 44.00 | after December 31 of the cost reporting period (if calendar year | | | | 44.00 |
| 14.00 | Medically necessary private room days applicable to the Program | (excluding swing-bed da | ays) | 0 | 14.00 |
| 15. 00 16. 00 | Total nursery days (title V or XIX only) Nursery days (title V or XIX only) | | | 834 591 | 15. 00 16. 00 |
| 16.00 | SWING BED ADJUSTMENT | | | 391 | 16.00 |
| 17. 00 | Medicare rate for swing-bed SNF services applicable to services | through December 31 of | the cost | 0.00 | 17. 00 |
| | reporting period | tiii dagii bedeiiibei di di | | 0.00 | |
| 18. 00 | Medicare rate for swing-bed SNF services applicable to services | after December 31 of t | ne cost | 0.00 | 18.00 |
| | reporting period | | | | |
| 19. 00 | Medicaid rate for swing-bed NF services applicable to services the | hrough December 31 of | the cost | 0. 00 | 19. 00 |
| 00.00 | reporting period | C. D. I. 04 C.I. | | 0.00 | 00.00 |
| 20. 00 | Medicaid rate for swing-bed NF services applicable to services a reporting period | rter becember 31 or the | e cost | 0. 00 | 20. 00 |
| 21. 00 | Total general inpatient routine service cost (see instructions) | | | 23, 543, 631 | 21. 00 |
| 22. 00 | Swing-bed cost applicable to SNF type services through December | 31 of the cost reportion | na period (line | 0 | 22. 00 |
| | 5 x line 17) | | 5 | | |
| 23. 00 | Swing-bed cost applicable to SNF type services after December 31 | of the cost reporting | period (line 6 | 0 | 23.00 |
| | x line 18) | | | | |
| 24. 00 | Swing-bed cost applicable to NF type services through December 3 | 1 of the cost reporting | g period (line | 0 | 24. 00 |
| 25. 00 | 7 x line 19) Swing-bed cost applicable to NF type services after December 31 | of the cost reporting | ported (line 9 | 0 | 25. 00 |
| 23.00 | x line 20) | of the cost reporting p | berroa (Trile 6 | 0 | 23.00 |
| 26. 00 | Total swing-bed cost (see instructions) | | | 0 | 26. 00 |
| 27. 00 | General inpatient routine service cost net of swing-bed cost (li | ne 21 minus line 26) | | 23, 543, 631 | |
| | PRIVATE ROOM DIFFERENTIAL ADJUSTMENT | | | | |
| 28. 00 | General inpatient routine service charges (excluding swing-bed a | nd observation bed cha | rges) | 0 | 28. 00 |
| 29. 00 | Pri vate room charges (excluding swing-bed charges) | | | 0 | 29. 00 |
| 30.00 | Semi-private room charges (excluding swing-bed charges) | | | 0 | 30.00 |
| 31.00 | General inpatient routine service cost/charge ratio (line 27 ÷ l | ine 28) | | 0.000000 | 31.00 |
| 32.00 | Average private room per diem charge (line 29 ÷ line 3) | | | 0.00 | 32.00 |
| 33. 00 34. 00 | Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus | line 33)(see instructi | ions) | 0. 00 0. 00 | 33. 00 34. 00 |
| 35. 00 | Average per diem private room cost differential (line 34 x line 3 | | | 0.00 | 35. 00 |
| 36. 00 | Private room cost differential adjustment (line 3 x line 35) | • , | | 0.00 | 36. 00 |
| 37. 00 | General inpatient routine service cost net of swing-bed cost and | private room cost dif | ferential (line | 23, 543, 631 | 37. 00 |
| | 27 minus line 36) | • | , | | |
| | PART II - HOSPITAL AND SUBPROVIDERS ONLY | | | | |
| | PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTI | | T | | |
| 38. 00 | Adjusted general inpatient routine service cost per diem (see in | | | 1, 221. 02 | 38. 00 |
| 39. 00 | Program general inpatient routine service cost (line 9 x line 38) | , | | 1, 354, 111 | 39.00 |
| 40. 00 41. 00 | Medically necessary private room cost applicable to the Program Total Program general inpatient routine service cost (line 39 + | • | | 0 1, 354, 111 | 40.00 |
| 41.00 | Trotal Trogram general impatrent fouttine service cost (fille 39 + | 11110 40) | | 1, 354, 111 | 41.00 |

| Heal th | Financial Systems COMMUNITY HOWARD REGIONAL HEALTH In Li | eu of Form CMS-2 | 2552-10 |
|------------------|--|-----------------------------|------------------|
| COMPUT | ATION OF INPATIENT OPERATING COST Provider CCN: 15-0007 Period: From 01/01/2019 | Worksheet D-1 | |
| | To 12/31/2019 | | |
| | Title XIX Hospital | Cost | <u> </u> |
| | Cost Center Description Total Total Average Per Program Days Inpatient Cost Inpatient Days Diem (col. 1 ÷ | Program Cost (col. 3 x col. | |
| | | 4) | |
| 42 00 | 1.00 2.00 3.00 4.00 NURSERY (title V & XIX only) 651,379 834 781.03 59 | 5. 00 461, 589 | 42 00 |
| | Intensive Care Type Inpatient Hospital Units | | |
| 43. 00 44. 00 | INTENSIVE CARE UNIT 3, 075, 414 1, 469 2, 093. 54 (CORONARY CARE UNIT | 0 | 43. 00 44. 00 |
| 45. 00 | BURN INTENSIVE CARE UNIT | | 45. 00 |
| 46.00 | SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) | | 46. 00 47. 00 |
| 47.00 | Cost Center Description | | 47.00 |
| 48. 00 | Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) | 1. 00 863, 510 | 49.00 |
| | Total Program inpatient costs (sum of lines 41 through 48)(see instructions) | 2, 679, 210 | 1 |
| 50. 00 | PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and | 0 | 50. 00 |
| 51. 00 | | 0 | 51.00 |
| | and IV) | | |
| 52. 00 53. 00 | Total Program excludable cost (sum of lines 50 and 51) Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and | 0 | |
| 33. 00 | medical education costs (line 49 minus line 52) | | 33.00 |
| 54 00 | TARGET AMOUNT AND LIMIT COMPUTATION Program discharges | 0 | 54. 00 |
| 55. 00 | | | 55. 00 |
| 56. 00 57. 00 | Target amount (line 54 x line 55) Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) | 0 | |
| 58.00 | Bonus payment (see instructions) | 0 | 58.00 |
| 59. 00 | Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the | 0.00 | 59. 00 |
| 60. 00 | market basket Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket | 0.00 | 60. 00 |
| 61. 00 | , | 0 | 61. 00 |
| | which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) | | |
| 62. 00 63. 00 | Relief payment (see instructions) Allowable Inpatient cost plus incentive payment (see instructions) | 0 | 62. 00 63. 00 |
| 03.00 | PROGRAM INPATIENT ROUTINE SWING BED COST | | 03.00 |
| 64. 00 | Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only) | 0 | 64. 00 |
| 65. 00 | Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See | 0 | 65. 00 |
| 66. 00 | instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For | 0 | 66. 00 |
| 67. 00 | CAH (see instructions) Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period | 0 | 67. 00 |
| | (line 12 x line 19) | | |
| 68. 00 | Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) | | 68. 00 |
| 69. 00 | Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY | 0 | 69. 00 |
| 70. 00 | Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) | | 70. 00 |
| 71. 00 72. 00 | Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) Program routine service cost (line 9 x line 71) | | 71. 00 72. 00 |
| 73. 00 | Medically necessary private room cost applicable to Program (line 14 x line 35) | | 73. 00 |
| 74. 00 75. 00 | Total Program general inpatient routine service costs (line 72 + line 73) | | 74. 00 75. 00 |
| | Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) | | |
| 76. 00 77. 00 | Per diem capital-related costs (line 75 ÷ line 2) Program capital-related costs (line 9 x line 76) | | 76. 00 77. 00 |
| 78. 00 | Inpatient routine service cost (line 74 minus line 77) | | 78. 00 |
| 79. 00 80. 00 | Aggregate charges to beneficiaries for excess costs (from provider records) Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) | | 79. 00 80. 00 |
| 81. 00 | Inpatient routine service costs for comparison to the cost fram tatron (frae 70 minus frae 77) | | 81. 00 |
| 82. 00 83. 00 | Inpatient routine service cost limitation (line 9 x line 81) Passonable inpatient routine service costs (see instructions) | | 82. 00 83. 00 |
| 83.00 | Reasonable inpatient routine service costs (see instructions) Program inpatient ancillary services (see instructions) | | 83.00 |
| 85.00 | Utilization review - physician compensation (see instructions) | | 85. 00 |
| 86. 00 | Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST | | 86. 00 |
| 87. 00 | Total observation bed days (see instructions) | 2, 512 | 1 |
| 88. 00 89. 00 | Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) Observation bed cost (line 87 x line 88) (see instructions) | 1, 221. 02 3, 067, 202 | 1 |
| | | | |

| Health Financial Systems C | OMMUNITY HOWARD | REGIONAL HEALT | Н | In Lie | u of Form CMS-2 | 2552-10 |
|---|-----------------|----------------|------------|----------------------------|----------------------------------|----------------|
| COMPUTATION OF INPATIENT OPERATING COST | | Provi der Co | | Period: From 01/01/2019 | Worksheet D-1 | |
| | | | | To 12/31/2019 | Date/Time Prep 8/19/2020 2:00 | pared: O pm |
| | | Ti tl | e XIX | Hospi tal | Cost | |
| Cost Center Description | Cost | Routine Cost | column 1 ÷ | Total | Observation | |
| | | (from line 21) | column 2 | Observati on | Bed Pass | |
| | | | | Bed Cost (from | Through Cost | |
| | | | | line 89) | (col. 3 x col. | |
| | | | | | 4) (see | |
| | | | | | instructions) | |
| | 1.00 | 2.00 | 3. 00 | 4. 00 | 5. 00 | |
| COMPUTATION OF OBSERVATION BED PASS THROUGH | COST | | | | | |
| 90.00 Capital-related cost | 1, 605, 610 | 23, 543, 631 | 0. 06819 | 7 3, 067, 202 | 209, 174 | 90.00 |
| 91.00 Nursing School cost | 0 | 23, 543, 631 | 0.00000 | 3, 067, 202 | 0 | 91.00 |
| 92.00 Allied health cost | 0 | 23, 543, 631 | 0.00000 | 3, 067, 202 | 0 | 92.00 |
| 93.00 All other Medical Education | 0 | 23, 543, 631 | 0. 00000 | 3, 067, 202 | 0 | 93. 00 |

| Health Financial Systems | COMMUNITY HOWARD REG | IONAL HEALT | Н | In Lie | u of Form CMS-2 | 2552-10 |
|--|----------------------|-------------|--------------|----------------------------|--------------------------------|---------|
| INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | | Provider Co | CN: 15-0007 | Period: From 01/01/2019 | Worksheet D-3 | |
| | | | | | Date/Time Pre 8/19/2020 2:0 | |
| | | Title | XVIII | Hospi tal | PPS | |
| Cost Center Description | | | Ratio of Cos | t Inpatient | Inpati ent | |
| | | | To Charges | Program | Program Costs | |

| | | | | From 01/01/2019 | Dota/Time Dro | narad. |
|---------|--|-----------|----------------------|--------------------------------|----------------|------------------|
| | | | To 12/31/2019 | Date/Time Pre 8/19/2020 2:0 | | |
| | | 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) 3. 00 | |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | 1.00 | 2100 | 0.00 | |
| 30. 00 | 03000 ADULTS & PEDIATRICS | | | 14, 539, 431 | | 30. 00 |
| | 03100 INTENSIVE CARE UNIT | | | 2, 956, 707 | | 31. 00 |
| | 04300 NURSERY | | | | | 43. 00 |
| | ANCI LLARY SERVI CE COST CENTERS | | 0.4004 | 40.754.447 | 1 (07 074 | F0 00 |
| 1 | 05000 OPERATING ROOM | | 0. 1284 | · · · · · · | | 50.00 |
| | 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY | | 0. 46765 0. 00000 | | | 52. 00 53. 00 |
| | 05300 ANESTHEST OLUGY 05400 RADI OLOGY-DI AGNOSTI C | | 0. 00000 | | - | 54.00 |
| | 03480 ONCOLOGY | | 0. 19613 | · · · · · · | | 54. 00 |
| | 05700 CT SCAN | | 0. 0334 | | | 57. 00 |
| | 05800 MRI | | 0. 09158 | | 30, 531 | 58. 00 |
| | 05900 CARDI AC CATHETERI ZATI ON | | 0. 0349 | · · | | 59. 00 |
| | 06000 LABORATORY | | 0. 11033 | | | 60.00 |
| 63.00 | 06300 BLOOD STORING, PROCESSING & TRANS. | | 0.00000 | | | 63.00 |
| | 06500 RESPI RATORY THERAPY | | 0. 23096 | 3, 160, 323 | 729, 915 | 65. 00 |
| 66. 00 | 06600 PHYSI CAL THERAPY | | 0. 43172 | 696, 870 | 300, 853 | 66. 00 |
| 67. 00 | 06700 OCCUPATI ONAL THERAPY | | 0. 48262 | 399, 424 | 192, 773 | 67. 00 |
| | 06800 SPEECH PATHOLOGY | | 0. 51808 | · · | · | 68. 00 |
| 1 | 06900 ELECTROCARDI OLOGY | | 0. 1269! | | | 69. 00 |
| | 07000 ELECTROENCEPHALOGRAPHY | | 0. 49049 | | | |
| | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | | 0. 38050 | · · · · · | | 71. 00 |
| | 07200 IMPL. DEV. CHARGED TO PATIENTS | | 0. 4500 | | 1, 794, 689 | 72.00 |
| | 07300 DRUGS CHARGED TO PATIENTS | | 0. 21308 | | | |
| | 07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART) | | 0. 60823 0. 00000 | | 217, 440 | 74. 00 75. 00 |
| | 03950 WOUND CARE CENTER | | 0. 00000 | | 1 | |
| | 03160 CARDI OPULMONARY | | 0. 27102 | | 275 | 76. 00 |
| | OUTPATIENT SERVICE COST CENTERS | | 0. 2540. | 1,172 | | 70.00 |
| | 09100 EMERGENCY | | 0. 09600 | 5, 682, 267 | 545, 532 | 91.00 |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART | | 0. 7672 | 17 0 | 0 | 92.00 |
| | 09201 OBSERVATION BEDS (DISTINCT PART) | | 0.00000 | | 0 | 92. 01 |
| | 04950 OTHER OUTPATIENT SERVICES | | 0. 00000 | | - | 93. 00 |
| | 04951 GENESI S | | 0. 7707 | | | 93. 01 |
| | 04952 WOMEN' S CENTER | | 0. 00000 | | | 93. 02 |
| | 04953 RESI DENTI AL HOMES | | 0.00000 | | - | 93. 03 |
| | 04954 DR. STEELE | | 0.00000 | | | 93. 04 |
| | 04955 DI ABETI C EDUCATION 04956 HOWARD COUNTY CSS | | 0.00000 | | | 93. 05 93. 06 |
| | 04950 HOWARD COUNTY CSS 04957 CLINTON COUNTY | | 5. 1204 0. 8592 | | - | 93.06 |
| | 04957 CETNION COUNTY 04968 PSYCH MEDICATION | | 0. 85926 | | | 93. 07 |
| | 04993 NEW BEGINNINGS | | 3. 36650 | | | 93. 43 |
| | OTHER REIMBURSABLE COST CENTERS | | 3. 55550 | | | 75. 45 |
| | 09500 AMBULANCE SERVICES | | | | | 95. 00 |
| 200.00 | Total (sum of lines 50 through 94 and 96 through 98) | | | 60, 644, 549 | 10, 217, 444 | • |
| 201.00 | Less PBP Clinic Laboratory Services-Program only charges | (line 61) | | 0 | | 201. 00 |
| 202. 00 | Net charges (line 200 minus line 201) | | | 60, 644, 549 | | 202. 00 |
| | | | | | | |

| Health Financial Systems | COMMUNITY HOWARD REG | IONAL HEALTH | | In Lieu of Form CMS-2552-10 |
|--|----------------------|-----------------------|----------|-----------------------------|
| INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | | Provider CCN: 15-0007 | Peri od: | Worksheet D-3 |

| INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Health Fir | nancial Systems COMMUNITY HOWARD REG | TONAL HEALT | Н | In Li€ | eu of Form CMS-I | 2552-10 |
|--|--------------|--|-------------|--------------|---------------|------------------|---------|
| To 12/31/2019 Date / Time Prepared to 11 to XIX Stock To Charges To Charg | I NPATI ENT | ANCILLARY SERVICE COST APPORTIONMENT | Provi der C | CN: 15-0007 | Peri od: | Worksheet D-3 | |
| Cost Center Description | | | | | | | |
| MIRATI ENT ROUTI NE SERVICE COST CENTERS 1.00 | | | | | To 12/31/2019 | | |
| INPATE ENT. ROUTH NE. SERVI CE. COST. CENTERS 1.00 2.00 3.00 | - | | | | | | 0 pm |
| NAME | | | Ti tl | | | 1' | |
| NPATLENT ROUTINE SERVICE COST CENTERS | | Cost Center Description | | Ratio of Cos | t Inpatient | | |
| NPATIENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.00 | | | | To Charges | Program | Program Costs | |
| IMPATIENT ROUTINE SERVICE COST CENTERS | | | | | Charges | (col. 1 x col. | |
| IMPATILENT ROUTINE SERVICE COST CENTERS 2,611,570 30.0 30.0 03100 MURITS A PEDIA PRICE COST CENTERS 334,899 31.0 03.0 03100 INTENSIVE CARE UNIT 43.0 030.0 03400 MURSERY 334,814 43.0 030.0 03400 MERATHESI DLOGY 0.000000 0.0 63.0 052.0 05200 DELIVERY ROUM & LABOR ROUM 0.000000 0.0 0.52.0 0.0 052.0 05200 DELIVERY ROUM & LABOR ROUM 0.000000 0.0 0.54.0 0.0 054.0 0.0 054.0 0.0 | | | | | | 2) | |
| IMPATILENT ROUTINE SERVICE COST CENTERS 2,611,570 30.0 30.0 03100 MURITS A PEDIA PRICE COST CENTERS 334,899 31.0 03.0 03100 INTENSIVE CARE UNIT 43.0 030.0 03400 MURSERY 334,814 43.0 030.0 03400 MERATHESI DLOGY 0.000000 0.0 63.0 052.0 05200 DELIVERY ROUM & LABOR ROUM 0.000000 0.0 0.52.0 0.0 052.0 05200 DELIVERY ROUM & LABOR ROUM 0.000000 0.0 0.54.0 0.0 054.0 0.0 054.0 0.0 | | | | 1, 00 | 2, 00 | 3.00 | |
| 30.00 | INP | PATIENT ROUTINE SERVICE COST CENTERS | | • | | | |
| 31.00 | | | | 1 | 2 611 570 | | 30.00 |
| | | | | | | | |
| MICLLARY SERVICE COST CENTERS | | | | | | | |
| 50,00 500,00 500,00 500,00 500,0 | | | | | 334, 014 | | 43.00 |
| 52.00 05200 DELI YERY ROOM & LABOR ROOM 0.467652 10.923 47, 197 52.00 53.00 53.00 05300 05500 | | | | 0 13041 | 54 662 024 | 05 155 | E0 00 |
| 53.00 05300 ARESTHESI OLOCY 0.000000 0 0 53.00 | | | | 1 | · · | | 1 |
| 54. 00 | | | | 1 | · · | | |
| 54. 01 03480 0NCOLOGY 0.196131 49, 997 9, 806 54. 01 57. 00 57500 CT SCAN 0.033619 310, 847 10, 88 57. 00 58. 00 05800 MR 0.033619 310, 732 2, 906 58. 00 05800 MR 0.031619 311, 732 2, 906 58. 00 05800 MR 0.031619 311, 732 2, 906 58. 00 05800 MR 0.031619 311, 732 2, 906 58. 00 05800 MR 0.031619 311, 732 2, 906 58. 00 05800 MR 0.031619 311, 732 2, 906 58. 00 05800 MR 0.031619 311, 732 2, 906 58. 00 05800 MR 0.031619 311, 732 24, 994 59. 00 05800 MR 0.031619 311, 732 24, 994 59. 00 05800 MR 0.031619 311, 732 24, 994 59. 00 05800 MR 0.031619 311, 732 24, 994 59. 00 05800 311, 732 24, 994 59. 00 05800 MR 0.031619 311, 732 24, 994 59. 00 05800 MR 0.031619 311, 732 24, 994 59. 00 0.05800 MR | | | | 1 | | _ | 1 |
| 57. 00 05700 CT SCAN 0.033419 310,847 10,388 57. 00 59. 00 | | | | | | | |
| 58.00 05800 MR | | | | 1 | · · | | 1 |
| 59.00 0.5900 0.5900 0.5700 0.5700 0.5700 0.5700 0.5900 0. | | | | 0. 0334 | 19 310, 847 | 10, 388 | 57. 00 |
| 60. 00 0.0000 LABORATORY 0. 110.330 87.5 7.33 9.6 6.20 0. 0.00000 0. 0 0. 0.000000 0. 0 0. 0.000000 0. 0 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. | 58.00 058 | 800 MRI | | 0. 09158 | 31, 732 | 2, 906 | 58. 00 |
| 63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 0 0.050 0.050 0.0500 | 59. 00 059 | 900 CARDIAC CATHETERIZATION | | 0. 0349 | 78 714, 555 | 24, 994 | 59. 00 |
| 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000 | | | | 0. 1103 | 30 875, 733 | 96, 620 | 60.00 |
| 65.00 0.05000 0.0500 0 | 63.00 063 | 300 BLOOD STORING. PROCESSING & TRANS. | | | | . 0 | 63.00 |
| 66 00 0600 | | | | | | l . | 1 |
| 67. 00 06700 0CCUPATI ONAL THERAPY 0. 482628 0 0 67. 00 68. 00 08000 SPEECH PATHOLOGY 0. 518087 0 0 68. 00 08. 00 06900 ELECTROCARDI OLOGY 0. 126958 123. 510 15, 681 69. 00 70. 00 07000 ELECTROCARDI OLOGY 0. 490498 834 409 70. 00 71. 00 1700 MOTO MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 450011 128, 355 57, 761 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 213087 954, 665 203, 427 73. 00 75. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 608238 3. 935 2. 933 74. 00 75. 00 07500 ASC (MON-DI STI NCT PART) 0. 0000000 0 0 75. 00 75. 01 0. 3950 WOUND CARE CENTER 0. 271620 10, 864 2, 951 75. 00 75. 01 0. 3950 WOUND CARE CENTER 0. 234630 0 0 76. 00 91. 00 1000 1000 MERCHICAL SERVICES 0. 090000 0 | | | | 1 | | | |
| 68.00 0690 | | | | 1 | | | 1 |
| 69. 00 06900 LELECTROCARDI OLOGY 0. 126958 123,510 15,681 69,00 70. 00 07000 DOTOG ELECTROENCEPHALOGRAPHY 0. 490498 834 409 70.00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0. 490011 128,355 57,761 72.00 72. 00 07200 INPL. DEV. CHARGED TO PATIENTS 0. 450011 128,355 57,761 72.00 74. 00 07400 RENAL DI ALYSIS 0. 608238 3,935 2,393 74.00 75. 00 07500 ASC (NON-DISTINCT PART) 0. 000000 0 0 75.00 76. 01 03950 WOUND CARE CENTER 0. 271620 10,864 2,951 75.00 76. 00 03160 CARDI OPULMONARY 0. 234630 0 0 76.00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0. 767247 0 0 92.00 92. 01 09201 OBSERVATI ON BEDS (DISTINCT PART) 0. 000000 0 0 92.00 93. 02 04952 (MERCENCY 0. 000000 0 0 92.00 93. 03 04954 (MERCENCY) 0. 000000 0 0 < | | | | | | | |
| Too On On On On On On On | | | | | | _ | 1 |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.380504 308, 977 117, 567 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.450011 128, 355 57, 761 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.213087 954, 665 203, 427 73. 00 74. 00 07400 RENAL DI ALYSIS 0.608238 3, 935 2, 393 74. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0.000000 0 0 75. 00 0.000000 0 0 0.000000 0 | | | | | | | 1 |
| 72. 00 07200 IMPL DEV. CHARGED TO PATIENTS 0.450011 128,355 57,761 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.213087 954,665 203,427 73. 00 74. 00 07400 RENAL DI ALYSIS 0.608238 3,955 2,393 74. 00 75. 00 07500 ASC (NON-DI STINCT PART) 0.0000000 0 0 0 0 0 0 0 | | | | 1 | | | 1 |
| 73. 00 | | | | 1 | | | 1 |
| 74. 00 07400 RENAL DI ALYSIS 0.608238 3,935 2,393 74. 00 75. 00 07500 ASC (NON-DI STINCT PART) 0.000000 0 0 0 75. 00 0.000000 0 0 0 0 75. 00 0.000000 0 0 0 0 0 0 | | | | | | | |
| 75. 00 07500 ASC (NON-DISTINCT PART) 0.000000 0 0.271620 10,864 2,951 75. 01 75. 00 76. 00 0.271620 10,864 2,951 75. 01 75. 00 76. 00 0.271620 10,864 2,951 75. 01 75. 00 0.271620 10,864 2,951 75. 01 75. 00 0.271620 10,864 2,951 75. 01 75. 00 0.00000 0 0.234630 0 0 0 0 0 0 0 0 0 | | | | 0. 2130 | 954, 665 | 203, 427 | 73. 00 |
| 75. 01 76. 00 03950 WOUND CARE CENTER 0. 271620 10, 864 2, 951 75. 01 76. 00 0160 CARDI OPULMONARY 0. 234630 0 0 0 76. 00 0176 00 0176 00 0176 00 0176 00 0176 00 0176 00 0176 01 01 01 01 01 01 01 0 | 74.00 074 | 400 RENAL DIALYSIS | | 0. 6082 | 38 3, 935 | 2, 393 | 74.00 |
| 76. 00 | 75. 00 075 | 500 ASC (NON-DISTINCT PART) | | 0.0000 | 00 | 0 | 75. 00 |
| 91. 00 OJPATIENT SERVICE COST CENTERS O. 096006 765, 164 73, 460 91.00 92. 00 OJPOO EMERGENCY O. 096006 765, 164 73, 460 91.00 92. 01 OJPOO OBSERVATI ON BEDS (NON-DISTINCT PART O. 000000 O. 0 O. 092.00 93. 00 OJPOO OJECT OJPOO OJPOO | 75. 01 039 | 950 WOUND CARE CENTER | | 0. 2716 | 20 10, 864 | 2, 951 | 75. 01 |
| 91. 00 O9100 EMERGENCY O. 096006 765, 164 73, 460 91. 00 92. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART O. 000000 O. 0000000 O. 0000 | 76. 00 031 | 160 CARDI OPULMONARY | | 0. 2346 | 30 0 | 0 | 76. 00 |
| 91. 00 09100 EMERGENCY 0.096006 765, 164 73, 460 91. 00 92. 00 09200 09SERVATI ON BEDS (NON-DISTINCT PART 0.767247 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000 | | | | • | | | 1 |
| 92. 00 09200 | | | | 0. 0960 | 765, 164 | 73, 460 | 91.00 |
| 92. 01 | | | | | | 1 | |
| 93. 00 04950 OTHER OUTPATIENT SERVICES 0.000000 0 0 93. 00 93. 01 04951 GENESIS 0.770775 0 0 93. 01 93. 02 04952 WOMEN'S CENTER 0.000000 0 0 0 93. 02 93. 03 04953 RESI DENTI AL HOMES 0.000000 0 0 0 93. 03 93. 04 04954 DR. STEELE 0 0.000000 0 0 0 93. 03 93. 05 04955 DI ABETI C EDUCATION 0.000000 0 0 0 93. 05 93. 06 04956 HOWARD COUNTY CSS 0.000000 0 0 93. 05 93. 07 04957 CLI NTON COUNTY 0 0.859261 0 0 0 93. 05 93. 43 04968 PSYCH MEDI CATION 0.000000 0 0 0 93. 18 93. 43 04993 NEW BEGINNINGS 0.000000 0 0 0 93. 43 04958 DABBETI C EDUCATION 0.000000 0 0 0 93. 05 95. 00 09500 AMBULANCE SERVI CES 95. 00 200. 00 201. 00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 0 000000 0 0 0 93. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | | | | | l . | |
| 93. 01 04951 GENESIS 0.770775 0 0 93. 01 93. 02 94952 WOMEN'S CENTER 0.000000 0 0 0 93. 02 93. 03 04953 RESIDENTIAL HOMES 0.000000 0 0 0 93. 03 03 04 94954 DR. STEELE 0.000000 0 0 0 0 93. 04 95. 04955 DI ABETIC EDUCATION 0.000000 0 0 0 93. 04 93. 05 04955 DI ABETIC EDUCATION 0.000000 0 0 0 93. 05 93. 06 04956 HOWARD COUNTY CSS 5.120447 0 0 93. 06 93. 07 04957 CLINTON COUNTY 0.000000 0 0 0 93. 07 93. 18 04968 PSYCH MEDICATION 0.000000 0 0 0 93. 18 93. 43 04993 NEW BEGINNINGS 0.000000 0 0 0 93. 43 04993 NEW BEGINNINGS 0.000000 0 0 0 93. 43 04993 NEW BEGINNINGS 0.000000 0 0 0 93. 43 04993 NEW BEGINNINGS 0.000000 0 0 0 0 93. 43 04993 NEW BEGINNINGS 0.000000 0 0 0 0 93. 43 04993 NEW BEGINNINGS 0.000000 0 0 0 0 93. 43 04993 NEW BEGINNINGS 0.000000 0 0 0 0 93. 43 04993 NEW BEGINNINGS 0.000000 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | | | 1 | | | |
| 93. 02 04952 WOMEN'S CENTER 0.000000 0 0 93. 02 93. 03 04953 RESIDENTIAL HOMES 0.000000 0 0 0 93. 03 04 04954 DR. STEELE 0.000000 0 0 0 93. 04 93. 05 04955 DI ABETI C EDUCATION 0.000000 0 0 0 93. 05 04955 DI ABETI C EDUCATION 0.000000 0 0 0 93. 05 04956 HOWARD COUNTY CSS 5.120447 0 0 0 93. 06 93. 07 04957 CLI NTON COUNTY 0.859261 0 0 0 93. 07 04957 CLI NTON COUNTY 0.859261 0 0 0 93. 07 04958 PSYCH MEDI CATION 0.000000 0 0 93. 18 04993 NEW BEGINNI NGS 0.000000 0 0 93. 18 04993 NEW BEGINNI NGS 0.000000 0 0 0 93. 18 05 00 0 0 93. 18 05 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | | | | | _ | |
| 93. 03 | | | | 1 | | | |
| 93. 04 04954 DR. STEELE 0.000000 0 0 93. 04 93. 05 04955 DI ABETI C EDUCATION 0.000000 0 0 93. 05 93. 06 04956 HOWARD COUNTY CSS 5.120447 0 0 93. 06 93. 07 04957 CLINTON COUNTY 0.859261 0 0 93. 07 93. 18 04968 PSYCH MEDI CATION 0.000000 0 0 93. 18 93. 18 04993 NEW BEGINNI NGS 0.000000 0 0 93. 18 95. 00 OTHER REIMBURSABLE COST CENTERS 95. 00 200. 00 Total (sum of lines 50 through 94 and 96 through 98) 5, 504, 634 863, 510 200. 00 201. 00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201. 00 | | | | | | l . | |
| 93. 05 | | | | 1 | | | 1 |
| 93. 06 04956 HOWARD COUNTY CSS 5. 120447 0 0 93. 06 93. 07 93. 18 04957 CLINTON COUNTY 0. 859261 0 0 93. 07 93. 18 04968 PSYCH MEDICATION 0. 000000 0 0 93. 18 04968 PSYCH MEDICATION 0. 000000 0 0 93. 18 04968 PSYCH MEDICATION 0. 000000 0 0 93. 18 04968 PSYCH MEDICATION 0. 000000 0 0 93. 18 04968 PSYCH MEDICATION 0. 000000 0 0 93. 18 04968 PSYCH MEDICATION 0. 000000 0 0 93. 18 04968 PSYCH MEDICATION 0. 000000 0 0 93. 18 04968 PSYCH MEDICATION 0. 000000 0 0 93. 18 04968 PSYCH MEDICATION 0. 000000 0 0 93. 18 04968 PSYCH MEDICATION 0. 000000 0 0 93. 18 04968 PSYCH MEDICATION 0. 000000 0 0 93. 18 04968 PSYCH MEDICATION 0. 000000 0 0 93. 18 04968 PSYCH MEDICATION 0. 000000 0 0 93. 18 04968 PSYCH MEDICATION 0. 000000 0 0 93. 18 04968 PSYCH MEDICATION 0. 000000 0 0 93. 18 04968 PSYCH MEDICATION 0. 0000000 0 0 93. 18 04968 PSYCH MEDICATION 0. 0000000 0 0 93. 18 04968 PSYCH MEDICATION 0. 0000000 0 0 0 93. 18 04968 PSYCH MEDICATION 0. 0000000 0. 0000000 0. 0000000 0. 00000000 | | | | 1 | | | |
| 93. 07 04957 CLINTON COUNTY 0.859261 0 0 93. 07 93. 18 04968 PSYCH MEDI CATION 0.000000 0 0 93. 18 04968 PSYCH MEDI CATION 0.000000 0 0 93. 18 04968 PSYCH MEDI CATION 0.000000 0 0 93. 18 04968 PSYCH MEDI CATION 0.000000 0 0 93. 18 04968 PSYCH MEDI CATION 0.000000 0 0 93. 18 04968 PSYCH MEDI CATION 0.000000 0 0 0 93. 18 04968 PSYCH MEDI CATION 0.000000 0 0 0 0 0 0 0 | | | | 1 | | _ | |
| 93. 18 04968 PSYCH MEDICATION 0.000000 0 0 0 93. 18 93. 43 04993 NEW BEGINNINGS 0.366508 0 0 93. 43 04993 NEW BEGINNINGS 0 0 0 93. 43 04993 NEW BEGINNINGS 0 0 04993 NEW BEGINNINGS 0 0 0 0 0 0 0 0 0 | | | | 5. 1204 | 47 C | 0 | 93. 06 |
| 93. 43 04993 NEW BEGINNINGS 0 0 93. 43 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95. 00 Total (sum of lines 50 through 94 and 96 through 98) 5, 504, 634 863, 510 200. 00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201. 00 | | | | 0. 8592 | | | 93. 07 |
| OTHER REIMBURSABLE COST CENTERS 95. 00 9500 AMBULANCE SERVICES 200. 00 Total (sum of lines 50 through 94 and 96 through 98) Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 95. 00 201. 00 201. 00 | 93. 18 049 | 968 PSYCH MEDICATION | | 0.0000 | 00 | 0 | 93. 18 |
| OTHER REIMBURSABLE COST CENTERS 95. 00 9500 AMBULANCE SERVICES 200. 00 Total (sum of lines 50 through 94 and 96 through 98) Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 95. 00 201. 00 201. 00 | | | | 1 | | 0 | 93. 43 |
| 95. 00 | | | | | | | 1 |
| 200.00 Total (sum of lines 50 through 94 and 96 through 98) 5,504,634 863,510 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00 | | | | | | | 95, 00 |
| 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00 | | | | 1 | 5 504 634 | 863 510 | 1 |
| | | | (line 61) | | | l | 1 |
| 202. 00 100 Charges (Time 200 militus Time 201) 5, 304, 034 | | | (1116 01) | 1 | _ | | 1 |
| | 202.00 | INCL Charges (Title 200 IIIThus Title 201) | | I | 5, 304, 634 | 1 | 1202.00 |

| Health Financial Systems | COMMUNITY HOWARD REGIONAL HEALTH | In Lie | u of Form CMS-2552-10 |
|---|----------------------------------|--|---|
| CALCULATION OF REIMBURSEMENT SETTLEMENT | Provi der CCN: 15-0007 | Peri od: From 01/01/2019 To 12/31/2019 | Worksheet E Part A Date/Time Prepared: 8/19/2020 2:00 pm |

| | | | 10 12/31/2019 | 8/19/2020 2:0 | |
|------------------|--|---------------------------|------------------|----------------|------------------|
| | | Title XVIII | Hospi tal | PPS | <u> </u> |
| | | | | | |
| | DART A LABORT FUT HOODI THE OFFICE OF A LINE FOR LINE FOR A LINE F | | | 1. 00 | |
| 1. 00 | PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS DRG Amounts Other than Outlier Payments | | | 0 | 1.00 |
| 1. 00 | | | | | 1. 00 |
| 1. 02 | DRG amounts other than outlier payments for discharges occurring instructions) | ing on or after October | 1 (see | 3, 791, 955 | 1. 02 |
| 1. 03 | DRG for federal specific operating payment for Model 4 BPCI for 1 (see instructions) | or discharges occurring | prior to October | 0 | 1. 03 |
| 1. 04 | DRG for federal specific operating payment for Model 4 BPCI for | or discharges occurring | on or after | 0 | 1. 04 |
| 2.00 | October 1 (see instructions) 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 instruct | | | 0 | 2. 02 |
| 2.03 | Outlier payments for discharges occurring prior to October 1 | | | 256, 796 | 2. 03 |
| 2.04 | Outlier payments for discharges occurring on or after October | I (see Instructions) | | 86, 626 | 2. 04 |
| 3.00 | Managed Care Simulated Payments | | | 1, 733, 039 | 3.00 |
| 4. 00 | Bed days available divided by number of days in the cost repollindirect Medical Education Adjustment | | | 105. 06 | 4.00 |
| 5. 00 | FTE count for allopathic and osteopathic programs for the mosor before 12/31/1996. (see instructions) | , , | | 0.00 | 5. 00 |
| 6. 00 | FTE count for allopathic and osteopathic programs that meet the new programs in accordance with 42 CFR 413.79(e) | | · | 0.00 | 6. 00 |
| 7. 00 7. 01 | MMA Section 422 reduction amount to the IME cap as specified ACA § 5503 reduction amount to the IME cap as specified under | | | 0. 00 0. 00 | 7. 00 7. 01 |
| | cost report straddles July 1, 2011 then see instructions. | | 6 | | |
| 8. 00 | Adjustment (increase or decrease) to the FTE count for allopar affiliated programs in accordance with 42 CFR 413.75(b), 413. | | | 0. 00 | 8. 00 |
| 8. 01 | 1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap slo | ots under § 5503 of the | ACA. If the cost | 0.00 | 8. 01 |
| 8. 02 | report straddles July 1, 2011, see instructions. The amount of increase if the hospital was awarded FTE cap slo | ots from a closed teachi | ng hospital | 0.00 | 8. 02 |
| 9. 00 | under § 5506 of ACA. (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line | es (8, 8,01 and 8,02) (| see | 0.00 | 9. 00 |
| 10. 00 | <pre>instructions) FTE count for allopathic and osteopathic programs in the current</pre> | ent year from your recor | ds | 0.00 | 10.00 |
| 11.00 | FTE count for residents in dental and podiatric programs. | - | | 0.00 | 11. 00 |
| 12.00 | Current year allowable FTE (see instructions) | | | 0.00 | 12.00 |
| 13.00 | Total allowable FTE count for the prior year. | | | 0.00 | 13.00 |
| 14.00 | Total allowable FTE count for the penultimate year if that year | ar ended on or after Sep | tember 30, 1997, | 0. 00 | 14. 00 |
| | otherwise enter zero. | | | | |
| 15. 00 | Sum of lines 12 through 14 divided by 3. | | | | 15. 00 |
| 16. 00 | Adjustment for residents in initial years of the program | | | | 16. 00 |
| 17. 00 | Adjustment for residents displaced by program or hospital clos | sure | | | 17. 00 |
| 18. 00 | Adjusted rolling average FTE count | | | | 18. 00 |
| 19.00 | Current year resident to bed ratio (line 18 divided by line 4) |). | | 0.000000 | |
| 20.00 | Prior year resident to bed ratio (see instructions) | | | 0.000000 | |
| 21. 00 | Enter the lesser of lines 19 or 20 (see instructions) IME payment adjustment (see instructions) | | | 0. 000000 0 | |
| 22. 00 22. 01 | IME payment adjustment (see Firstructions) IME payment adjustment - Managed Care (see instructions) | | | 0 | 22. 00 22. 01 |
| 22.01 | Indirect Medical Education Adjustment for the Add-on for § 422 | Onf the MMA | | U | 22.01 |
| 23. 00 | Number of additional allopathic and osteopathic IME FTE resid | | FR 412. 105 | 0.00 | 23. 00 |
| 24. 00 | <pre>(f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions)</pre> | | | 0.00 | 24. 00 |
| 25. 00 | If the amount on line 24 is greater than -0-, then enter the instructions) | lower of line 23 or line | 24 (see | 0.00 | 1 |
| 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 28.0 Disproportionate Share Adjustment | 1) | | 0 | 29. 01 |
| 30. 00 | Percentage of SSI recipient patient days to Medicare Part A pa | atient days (see instruc | tions) | 7. 33 | 30.00 |
| 31. 00 | Percentage of Medicaid patient days (see instructions) | attorit days (see mistrue | 5115) | 28. 55 | |
| 32. 00 | Sum of lines 30 and 31 | | | 35. 88 | |
| 33. 00 | Allowable disproportionate share percentage (see instructions |) | | 18. 82 | 1 |
| | Disproportionate share adjustment (see instructions) | , | | 661, 262 | |
| | 3 | | | | |

| CALCUL | ATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0007 | Peri od: From 01/01/2019 | Worksheet E Part A | |
|------------------|--|-------------------------------|-----------------------------|------------------------|------------------|
| | | | To 12/31/2019 | | |
| | | Title XVIII | Hospi tal | PPS | |
| | | | | On/After 10/1 | |
| | Uncompensated Care Adjustment | | 1. 00 | 2. 00 | |
| 35. 00 | Total uncompensated care amount (see instructions) | | 8, 272, 872, 447 | 8, 350, 599, 096 | 35. 00 |
| 35. 01 | Factor 3 (see instructions) | | 0. 000148500 | 0. 000193285 | |
| 35. 02 | Hospital uncompensated care payment (If line 34 is zero, ente instructions) | r zero on this line) (se | e 1, 228, 525 | 1, 614, 048 | 35. 02 |
| 35. 03 | Pro rata share of the hospital uncompensated care payment amo | , | 918, 869 | | 1 |
| 36. 00 | Total uncompensated care (sum of columns 1 and 2 on line 35.0 | | 1, 324, 586 | | 36. 00 |
| 40. 00 | Additional payment for high percentage of ESRD beneficiary dis Total Medicare discharges on Worksheet S-3, Part I excluding | | gn 46) | | 40.00 |
| 40.00 | 652, 682, 683, 684 and 685 (see instructions) | ur seriar ges i or inis bitos | | | 1 40.00 |
| 41. 00 | Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 6 instructions) | 83, 684 an 685. (see | 0 | | 41. 00 |
| 41. 01 | Total ESRD Medicare covered and paid discharges excluding MS-an 685. (see instructions) | DRGs 652, 682, 683, 684 | 0 | | 41. 01 |
| 42.00 | Divide line 41 by line 40 (if less than 10%, you do not quali | | 0.00 | | 42. 00 |
| 43. 00 | Total Medicare ESRD inpatient days excluding MS-DRGs 652, 68 instructions) | 2, 683, 684 an 685. (see | 0 | | 43. 00 |
| 44. 00 | Ratio of average length of stay to one week (line 43 divided days) | 3 | 0. 000000 | | 44. 00 |
| 45. 00 | Average weekly cost for dialysis treatments (see instructions | • | 0.00 | | 45. 00 |
| 46. 00 47. 00 | Total additional payment (line 45 times line 44 times line 41 Subtotal (see instructions) | . 01) | 16, 383, 699 | | 46. 00 47. 00 |
| 48. 00 | Hospital specific payments (to be completed by SCH and MDH, s | mall rural hospitals | 10, 363, 077 | | 48. 00 |
| | only. (see instructions) | marr rarar neepi tare | | | 10.00 |
| | | | | Amount | |
| 49. 00 | Total payment for inpatient operating costs (see instructions |) | | 1. 00 16, 383, 699 | 49. 00 |
| 50. 00 | Payment for inpatient program capital (from Wkst. L, Pt. I and | | | 1, 241, 005 | |
| 51.00 | Exception payment for inpatient program capital (Wkst. L, Pt. | III, see instructions) | | 0 | 51.00 |
| 52.00 | Direct graduate medical education payment (from Wkst. E-4, li | ne 49 see instructions). | | 0 | 52.00 |
| 53. 00 54. 00 | Nursing and Allied Health Managed Care payment Special add-on payments for new technologies | | | 25, 909 0 | 1 |
| 54. 00 | Islet isolation add-on payment | | | 0 | |
| 55. 00 | Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6 | 9) | | Ö | 55. 00 |
| 56.00 | Cost of physicians' services in a teaching hospital (see intr | uctions) | | 0 | 56. 00 |
| 57. 00 | Routine service other pass through costs (from Wkst. D, Pt. I | | nrough 35). | 98, 971 | |
| 58. 00 | Ancillary service other pass through costs from Wkst. D, Pt. | IV, col. 11 line 200) | | 0 | 58. 00 |
| 59. 00 60. 00 | Total (sum of amounts on lines 49 through 58) Primary payer payments | | | 17, 749, 584 7, 083 | |
| 61. 00 | Total amount payable for program beneficiaries (line 59 minus | line 60) | | 17, 742, 501 | |
| 62. 00 | Deductibles billed to program beneficiaries | | | 1, 539, 596 | |
| 63.00 | Coinsurance billed to program beneficiaries | | | 44, 671 | 63. 00 |
| 64. 00 | Allowable bad debts (see instructions) | | | 111, 993 | 64. 00 |
| 65. 00 | Adjusted reimbursable bad debts (see instructions) | | | 72, 795 | 1 |
| 66.00 | Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (line 61 plus line 65 minus lines 62 and 63) | ructions) | | 54, 218 | |
| 67. 00 68. 00 | Credits received from manufacturers for replaced devices for | annlicable to MS_DRGs (so | e instructions) | 16, 231, 029 0 | 67. 00 68. 00 |
| 69. 00 | Outlier payments reconciliation (sum of lines 93, 95 and 96). | | | 0 | 69.00 |
| 70. 00 | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) | (| -, | Ō | 70. 00 |
| 70. 50 | Rural Community Hospital Demonstration Project (§410A Demonst | ration) adjustment (see | nstructions) | 0 | 70. 50 |
| 70. 87 | Demonstration payment adjustment amount before sequestration | | | 0 | 70. 87 |
| 70. 88 | SCH or MDH volume decrease adjustment (contractor use only) | | | 0 | 70. 88 |
| 70.89 | Prioneer ACO demonstration payment adjustment amount (see inst | ructions) | | | 70.89 |
| 70. 90 70. 91 | HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) | | | 0 | 70. 90 70. 91 |
| 70. 91 | Bundled Model 1 discount amount (see instructions) | | | 0 | 70. 91 |
| 70. 93 | HVBP payment adjustment amount (see instructions) | | | 29, 125 | |
| 70. 94 | HRR adjustment amount (see instructions) | | | -47, 205 | 70. 94 |
| 70. 95 | Recovery of accelerated depreciation | | 0 | 70. 95 | |

| Health Financial Systems | COMMUNITY HOWARD REGIONAL HEALTH | In Lieu of Form CMS-2552-10 |
|---|----------------------------------|---|
| CALCULATION OF REIMBURSEMENT SETTLEMENT | Provi der CCN: 15-0007 | Period: Worksheet E From 01/01/2019 Part A |
| | | To 12/31/2019 Date/Time Prenared |

| | ATTON OF REIMBURSEMENT SETTLEMENT | Provider C | | From 01/01/2019 To 12/31/2019 | Part A Date/Time Pre | |
|--|--|--|---------------|----------------------------------|----------------------|---|
| | | Titl∈ | XVIII | Hospi tal | PPS | |
| | | | FFY | (yyyy) | Amount | |
| 70. 96 | Low volume adjustment for federal fiscal year (yyyy) (Enter in | n column 0 | | 0 | 1. 00 | 70. 96 |
| 70. 90 | the corresponding federal year for the period prior to 10/1) | ii coi uiiii o | | U | U | 70.90 |
| 70. 97 | Low volume adjustment for federal fiscal year (yyyy) (Enter in | n column O | | 0 | 0 | 70. 97 |
| 70. 77 | the corresponding federal year for the period ending on or after | | | ŭ | Ö | 70.77 |
| 70. 98 | Low Volume Payment-3 | | | | 0 | 70. 98 |
| 70. 99 | HAC adjustment amount (see instructions) | | | | 0 | 70. 99 |
| | Amount due provider (line 67 minus lines 68 plus/minus lines 6 | 69 & 70) | | | 16, 212, 949 | |
| 71. 01 | Sequestration adjustment (see instructions) | , | | | 324, 259 | 1 |
| 71. 02 | Demonstration payment adjustment amount after sequestration | | | | 0 | 71. 02 |
| 71. 03 | Sequestration adjustment-PARHM pass-throughs | | | | | 71. 03 |
| 72.00 | Interim payments | | | | 15, 638, 119 | 72. 00 |
| 72.01 | Interim payments-PARHM | | | | | 72. 01 |
| 73.00 | Tentative settlement (for contractor use only) | | | | 0 | 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 | 2, 72, and | | | 250, 571 | 74. 00 |
| | 73) | | | | | |
| 74. 01 | Balance due provider/program-PARHM (see instructions) | | | | | 74. 01 |
| 75. 00 | Protested amounts (nonallowable cost report items) in accordan | nce with | | | 484, 872 | 75. 00 |
| | CMS Pub. 15-2, chapter 1, §115.2 | | | | | |
| | TO BE COMPLETED BY CONTRACTOR (lines 90 through 96) | | | | | |
| 90. 00 | Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of | of 2.03 | | | 0 | 90. 00 |
| 04 00 | plus 2.04 (see instructions) | | | | 0 | 04 00 |
| 91.00 | Capital outlier from Wkst. L, Pt. I, line 2 | | | | 0 | 91.00 |
| | Operating outlier reconciliation adjustment amount (see instru | | | | 0 | 92.00 |
| 93.00 | Capital outlier reconciliation adjustment amount (see instruct | | | | 0 | 93.00 |
| | The rate used to calculate the time value of money (see instru | uctions) | | | 0.00 | |
| | Time value of money for operating expenses (see instructions) | +: ana) | | | 0 | 95.00 |
| 96. 00 | Time value of money for capital related expenses (see instruc- | LI ONS) | | Dri or to 10/1 | On/After 10/1 | 96. 00 |
| | | | | Prior to 10/1 1.00 | 2.00 | |
| | HSP Bonus Payment Amount | | | 1.00 | 2.00 | |
| 100 00 | HSP bonus amount (see instructions) | | | 0 | 0 | 100. 00 |
| .00.00 | HVBP Adjustment for HSP Bonus Payment | | | <u> </u> | 5 | 100.00 |
| 101.00 | HVBP adjustment factor (see instructions) | | | 0.000000000 | 0. 0000000000 | 101. 00 |
| | HVBP adjustment amount for HSP bonus payment (see instructions | s) | | o | 0 | 102. 00 |
| | HRR Adjustment for HSP Bonus Payment | , | | | | |
| 103.00 | HRR adjustment factor (see instructions) | | | | | |
| 104.00 | HRR adjustment amount for HSP bonus payment (see instructions) | | | 0.0000 | 0. 0000 | 103. 00 |
| | Tick adjustiller allour for his borius payliler (see fristructions, |) | | 0.0000 | | 103. 00 104. 00 |
| | Rural Community Hospital Demonstration Project (§410A Demonstr | | ıstment | | | |
| 200.00 | | ration) Adju | | | | |
| 200. 00 | Rural Community Hospital Demonstration Project (§410A Demonstr | ration) Adju | | | | 104. 00 |
| 200. 00 | Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per | ration) Adju | | | | 104. 00 |
| 201. 00 | Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line | ration) Adju riod under t | | | 0 | 104. 00 200. 00 201. 00 |
| 201. 00 202. 00 | Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) | ration) Adju riod under t | | | 0 | 104. 00 200. 00 201. 00 202. 00 |
| 201. 00 202. 00 | Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) | ration) Adju riod under t e 49) | the 21st | 0 | 0 | 104. 00 200. 00 201. 00 |
| 201. 00 202. 00 | Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in | ration) Adju riod under t e 49) | the 21st | 0 | 0 | 104. 00 200. 00 201. 00 202. 00 |
| 201. 00 202. 00 203. 00 | Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) | ration) Adju riod under t e 49) | the 21st | 0 | 0 | 104. 00 200. 00 201. 00 202. 00 203. 00 |
| 201. 00 202. 00 203. 00 204. 00 | Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) | ration) Adju riod under t e 49) | the 21st | 0 | o ration | 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 |
| 201. 00 202. 00 203. 00 204. 00 205. 00 | Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) | ration) Adju riod under t e 49) | the 21st | 0 | o ration | 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 |
| 201. 00 202. 00 203. 00 204. 00 205. 00 | Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) | ration) Adju riod under t e 49) | the 21st | 0 | o ration | 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 |
| 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 | Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement | ration) Adjuriod under t | the 21st | 0 | o ration | 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 |
| 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 | Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instruction) | ration) Adjuriod under te 49) first year | the 21st | 0 | ration | 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 |
| 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 | Rural Community Hospital Demonstration Project (§410A Demonstration Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) | ration) Adjuriod under te 49) first year | the 21st | 0 | ration | 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 |
| 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 | Rural Community Hospital Demonstration Project (§410A Demonstration Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) | ration) Adjuriod under te 49) first year | the 21st | 0 | ration | 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 |
| 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 | Rural Community Hospital Demonstration Project (§410A Demonstration Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use | ration) Adjuriod under te 49) first year | the 21st | 0 | ration | 104. 00 200. 00 201. 00 202. 00 203. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 |
| 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 | Rural Community Hospital Demonstration Project (§410A Demonstrals this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) | ration) Adjuriod under te 49) first year | the 21st | 0 | ration | 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 |
| 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00 | Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement | ration) Adjuriod under to the 49) first year ructions) line 59) | the 21st | 0 | ration | 104. 00 200. 00 201. 00 202. 00 203. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00 |
| 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00 | Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 200) | ration) Adjuriod under to the 49) first year ructions) line 59) | the 21st | 0 | ration | 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00 211. 00 |
| 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 210. 00 211. 00 212. 00 213. 00 | Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 204) Low-volume adjustment (see instructions) | ration) Adjuried under to the 49) first year ructions) line 59) | of the curren | 0 | ration | 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00 211. 00 212. 00 213. 00 |
| 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00 212. 00 213. 00 | Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 200) | ration) Adjuried under to the 49) first year ructions) line 59) | of the curren | 0 | ration | 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00 211. 00 |

| Health Financial Systems | COMMUNITY HOWARD REGIONAL HEALTH | In Lie | u of Form CMS-2552-10 |
|---|----------------------------------|--|---|
| CALCULATION OF REIMBURSEMENT SETTLEMENT | Provi der CCN: 15-0007 | Peri od: From 01/01/2019 To 12/31/2019 | Worksheet E Part B Date/Time Prepared: 8/19/2020 2:00 pm |

| | | | 10 12/31/2017 | 8/19/2020 2:0 | |
|----------------|---|---------------------------|-----------------|---------------|------------------|
| | | Title XVIII | Hospi tal | PPS | <u>- </u> |
| | | | | | |
| | | | | 1. 00 | |
| | PART B - MEDICAL AND OTHER HEALTH SERVICES | | | | |
| 1.00 | Medical and other services (see instructions) | | | 20, 276 | 1.00 |
| 2. 00 | Medical and other services reimbursed under OPPS (see instruct | i ons) | | 22, 215, 013 | 2. 00 |
| 3. 00 | OPPS payments | | | 17, 762, 067 | 3. 00 |
| 4.00 | Outlier payment (see instructions) | | | 119, 122 | 4.00 |
| 4. 01 | Outlier reconciliation amount (see instructions) | | | 0 | |
| 5.00 | Enter the hospital specific payment to cost ratio (see instruc | ctions) | | 0.000 | 1 |
| 6. 00 7. 00 | Line 2 times line 5 | | | 0 00 | |
| 8. 00 | Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions) | | | 0.00 | 8.00 |
| 9. 00 | Ancillary service other pass through costs from Wkst. D, Pt. I | V col 13 line 200 | | 24, 629 | 1 |
| 10. 00 | Organ acquisitions | v, coi : 13, 111le 200 | | 24, 029 | 10.00 |
| 11. 00 | Total cost (sum of lines 1 and 10) (see instructions) | | | 20, 276 | 1 |
| | COMPUTATION OF LESSER OF COST OR CHARGES | | | 20,2,0 | |
| | Reasonable charges | | | | |
| 12. 00 | Ancillary service charges | | | 96, 020 | 12.00 |
| 13.00 | Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii | ne 69) | | 0 | 1 |
| 14.00 | Total reasonable charges (sum of lines 12 and 13) | ŕ | | 96, 020 | 14. 00 |
| | Customary charges | | | | 1 |
| 15.00 | Aggregate amount actually collected from patients liable for p | payment for services on a | charge basis | 0 | 15. 00 |
| 16. 00 | Amounts that would have been realized from patients liable for | payment for services or | n a chargebasis | 0 | 16. 00 |
| | had such payment been made in accordance with 42 CFR §413.13(|)) | | | |
| 17. 00 | Ratio of line 15 to line 16 (not to exceed 1.000000) | | | 0. 000000 | |
| | Total customary charges (see instructions) | | | 96, 020 | 1 |
| 19. 00 | Excess of customary charges over reasonable cost (complete onl | y if line 18 exceeds lir | ne 11) (see | 75, 744 | 19. 00 |
| | instructions) | 1611 44 | 40) (| | |
| 20. 00 | Excess of reasonable cost over customary charges (complete onl | y it line il exceeds iir | ne 18) (see | 0 | 20. 00 |
| 21. 00 | instructions) Lesser of cost or charges (see instructions) | | | 20, 276 | 21.00 |
| | Interns and residents (see instructions) | | | 20, 276 | 1 |
| | Cost of physicians' services in a teaching hospital (see instr | cuctions) | | 0 | 23. 00 |
| | Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) | uctions) | | 17, 905, 818 | |
| 24.00 | COMPUTATION OF REIMBURSEMENT SETTLEMENT | | | 17, 905, 616 | 24.00 |
| 25. 00 | Deductibles and coinsurance amounts (for CAH, see instructions | :) | | 8, 912 | 25. 00 |
| 26. 00 | Deductibles and Coinsurance amounts relating to amount on line | · · | ictions) | 3, 249, 514 | • |
| 27. 00 | Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p | • | | 14, 667, 668 | 1 |
| 27.00 | instructions) | rus the sum of Times 22 | and 25] (500 | 14,007,000 | 27.00 |
| 28. 00 | Direct graduate medical education payments (from Wkst. E-4, li | ne 50) | | 0 | 28. 00 |
| | ESRD direct medical education costs (from Wkst. E-4, line 36) | , | | 0 | 1 |
| 30.00 | Subtotal (sum of lines 27 through 29) | | | 14, 667, 668 | 30.00 |
| 31.00 | Primary payer payments | | | 2, 053 | 31. 00 |
| 32.00 | Subtotal (line 30 minus line 31) | | | 14, 665, 615 | 32.00 |
| | ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE | ES) | | | |
| 33. 00 | Composite rate ESRD (from Wkst. I-5, line 11) | | | 0 | 33. 00 |
| | Allowable bad debts (see instructions) | | | 315, 841 | |
| 35. 00 | Adjusted reimbursable bad debts (see instructions) | | | 205, 297 | |
| 36. 00 | Allowable bad debts for dual eligible beneficiaries (see instr | ructions) | | 256, 568 | |
| | Subtotal (see instructions) | | | 14, 870, 912 | |
| | MSP-LCC reconciliation amount from PS&R | | | -98 | |
| | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) | _ | | 0 | |
| 39. 50 | Pioneer ACO demonstration payment adjustment (see instructions | 5) | | | 39. 50 |
| 39. 97 | Demonstration payment adjustment amount before sequestration | | | 0 | |
| 39. 98 | Partial or full credits received from manufacturers for replace | ced devices (see instruct | nons) | 0 | |
| 39. 99 | RECOVERY OF ACCELERATED DEPRECIATION | | | 0 | 39. 99 |
| 40.00 | Subtotal (see instructions) | | | 14, 871, 010 | |
| 40. 01 | Sequestration adjustment (see instructions) | | | 297, 420 | |
| 40. 02 | Demonstration payment adjustment amount after sequestration | | | 0 | |
| 40. 03 | Sequestration adjustment-PARHM pass-throughs | | | 14 510 007 | 40. 03 |
| | Interim payments | | | 14, 519, 827 | 1 |
| 41.01 | Interim payments-PARHM Tentative settlement (for contractors use only) | | | 0 | 41. 01 42. 00 |
| 42. 01 | Tentative settlement-PARHM (for contractor use only) | | | O | 42.00 |
| 43. 00 | Balance due provider/program (see instructions) | | | 53, 763 | |
| 43. 01 | Balance due provider/program-PARHM (see instructions) | | | 33, 703 | 43. 01 |
| 44. 00 | Protested amounts (nonallowable cost report items) in accordan | nce with CMS Pub 15-2 | chapter 1 | 0 | 1 |
| 00 | §115. 2 | 1 40. 10 2, | | | 55 |
| | TO BE COMPLETED BY CONTRACTOR | | | | 1 |
| 90.00 | Original outlier amount (see instructions) | | | 0 | 90.00 |
| | Outlier reconciliation adjustment amount (see instructions) | | | 0 | |
| | The rate used to calculate the Time Value of Money | | | 0.00 | 1 |
| | Time Value of Money (see instructions) | | | 0 | • |
| 94.00 | Total (sum of lines 91 and 93) | | | 0 | 94. 00 |
| | | | | | |

6.02

7.00

8.00

14, 573, 590

NPR Date (Mo/Day/Yr)

2 00

In Lieu of Form CMS-2552-10 Health Financial Systems COMMUNITY HOWARD REGIONAL HEALTH ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-0007 Peri od: Worksheet E-1 From 01/01/2019 Part I 12/31/2019 Date/Time Prepared: 8/19/2020 2:00 pm Title XVIII Hospi tal PPS Part B Inpatient Part A mm/dd/yyyy mm/dd/yyyy Amount Amount 1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 15, 638, 119 14, 519, 827 1. 00 2.00 Interim payments payable on individual bills, either 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 0 0 3.01 3.02 0 0 3.02 3.03 0 3.03 0 3.04 0 0 3.04 3.05 0 0 3.05 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0 3.50 3.51 0 3.51 0 0 3.52 3.52 0 3.53 3.53 0 0 3.54 0 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 0 Ω 3.99 3.50-3.98) 15, 638, 119 14, 519, 827 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 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) Program to Provider 5.01 5.01 TENTATIVE TO PROVIDER 0 0 5.02 0 0 5.02 0 5.03 0 5.03 Provider to Program 5.50 TENTATI VE TO PROGRAM 0 0 5.50 5.51 0 0 5. 51 0 5.52 0 5.52 0 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 5.99 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on 6.00 the cost report. (1) SETTLEMENT TO PROVIDER 6.01 250, 571 53, 763 6.01

15, 888, 690

0

Contractor

Number

1 00

SETTLEMENT TO PROGRAM

8.00 Name of Contractor

Total Medicare program liability (see instructions)

6 02

7.00

| Heal th | Financial Systems COMMUNITY HOWARD RE | GIONAL HEALTH | In Lie | u of Form CMS- | 2552-10 |
|---------|---|--------------------------|--|--|----------|
| | ATION OF REIMBURSEMENT SETTLEMENT FOR HIT | Provider CCN: 15-0007 | Peri od: From 01/01/2019 To 12/31/2019 | Worksheet E-1 Part II Date/Time Pre 8/19/2020 2:0 | pared: |
| | | Title XVIII | Hospi tal | PPS | <u> </u> |
| | | | | | |
| | | | | 1. 00 | |
| | TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS | | | | |
| | HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION | I | | | |
| 1.00 | Total hospital discharges as defined in AARA §4102 from Wkst. | S-3, Pt. I col. 15 line | 14 | | 1. 00 |
| 2.00 | Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8 | 3-12 | | | 2.00 |
| 3.00 | Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 | | | | 3. 00 |
| 4.00 | Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8 | 3-12 | | | 4. 00 |
| 5.00 | Total hospital charges from Wkst C, Pt. I, col. 8 line 200 | | | | 5. 00 |
| 6.00 | Total hospital charity care charges from Wkst. S-10, col. 3 I | ine 20 | | | 6. 00 |
| 7. 00 | CAH only - The reasonable cost incurred for the purchase of cline 168 | certified HIT technology | Wkst. S-2, Pt. I | | 7. 00 |
| 8. 00 | Calculation of the HIT incentive payment (see instructions) | | | | 8.00 |
| 9. 00 | Sequestration adjustment amount (see instructions) | | | | 9. 00 |
| 10.00 | Calculation of the HIT incentive payment after sequestration | (see instructions) | | | 10.00 |
| | I NPATI ENT HOSPI TAL SERVI CES UNDER THE I PPS & CAH | | | | 1 |
| 30.00 | Initial/interim HIT payment adjustment (see instructions) | | | | 30.00 |
| | Other Adjustment (specify) | | | | 31. 00 |
| | Balance due provider (line 8 (or line 10) minus line 30 and l | ine 31) (see instruction | 15) | | 32 00 |

32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)

32.00

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

Provider CCN: 15-0007

Peri od: Worksheet G From 01/01/2019 To 12/31/2019 Date/Time Prepared:

8/19/2020 2:00 pm Speci fi c Endowment Fund General Fund Plant Fund Purpose Fund 1.00 3.00 4.00 2.00 CURRENT ASSETS 1.00 Cash on hand in banks 30, 746 0 0 0 1.00 Temporary investments 0 0 2.00 0 2.00 0 3.00 Notes receivable 0 0 3.00 0 4 00 69, 469, 767 4 00 Accounts receivable 0 0 5.00 Other receivable 54, 415 0 0 5.00 -48, 962, 996 6.00 Allowances for uncollectible notes and accounts receivable 6.00 0 7.00 Inventory 3, 853, 600 0 0 7.00 0 8.00 Prepaid expenses 846, 802 0 8.00 0 9.00 Other current assets 207, 723 0 9.00 10 00 Due from other funds 0 0 0 10 00 25, 500, 057 Total current assets (sum of lines 1-10) 0 0 11.00 0 11 00 FIXED ASSETS 12.00 Land 4, 583, 000 0 0 0 12.00 Land improvements 0 13.00 0 0 0 0 0 0 0 0 0 0 0 0 0 13.00 4, 193, 828 οĺ Accumulated depreciation 14.00 0 14.00 15.00 Bui I di ngs 104, 778, 873 0 0 15.00 16.00 Accumulated depreciation 0 16.00 0 17.00 Leasehold improvements 17.00 139, 419 0 0 18 00 Accumulated depreciation 0 18.00 Fi xed equipment 31, 198, 040 19.00 19.00 0 20.00 Accumulated depreciation 0 20.00 0 21.00 Automobiles and trucks 364, 270 0 21.00 22.00 Accumulated depreciation 0 22.00 23.00 Major movable equipment 0 23.00 Accumulated depreciation -47, 434, 594 24.00 0 24.00 0 25.00 Mi nor equi pment depreci able Λ 25, 00 26.00 Accumulated depreciation 0 0 26.00 C 27.00 HIT designated Assets 0 0 27.00 0 28.00 Accumulated depreciation 0 0 28.00 0 29.00 Mi nor equi pment-nondepreci abl e 0 29.00 30.00 Total fixed assets (sum of lines 12-29) 97, 822, 836 0 30.00 OTHER ASSETS 31 00 Investments O 0 n 31 00 0 0 32.00 Deposits on Leases 0 0 32.00 Due from owners/officers 0 0 0 33.00 33.00 0 34.00 Other assets 85, 777, 521 0 0 34.00 0 Total other assets (sum of lines 31-34) 35.00 85, 777, 521 0 35, 00 36.00 Total assets (sum of lines 11, 30, and 35) 209, 100, 414 0 0 0 36.00 CURRENT LIABILITIES 37 00 746, 029 O 0 n 37 00 Accounts payable 0 0 38.00 Salaries, wages, and fees payable -11, 957 0 38.00 0 Payroll taxes payable 0 39.00 39.00 0 40.00 Notes and Loans payable (short term) 0 0 40.00 0 0 Deferred income 41 00 41 00 Ω 0 42.00 Accelerated payments 0 42.00 43.00 Due to other funds 0 0 0 43.00 Other current liabilities 6,015,090 0 0 44.00 0 44.00 Total current liabilities (sum of lines 37 thru 44) 0 6, 749, 162 0 45.00 0 45.00 ONG TERM LIABILITIES 46.00 Mortgage payable 0 46.00 0 0 47.00 Notes payable 0 0 47.00 48 00 Unsecured Loans 0 0 0 48 00 Other long term liabilities 936, 208 0 0 49.00 49.00 0 50 00 Total long term liabilities (sum of lines 46 thru 49) 936, 208 0 0 0 50.00 Total liabilities (sum of lines 45 and 50) 51.00 7, 685, 370 0 0 0 51.00 CAPITAL ACCOUNTS 52.00 General fund balance 201, 415, 044 52.00 53.00 Specific purpose fund 0 53.00 Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted 54.00 0 54.00 55.00 0 55.00 56.00 Governing body created - endowment fund balance 0 56.00 Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement, 57.00 0 57.00 58.00 0 58.00 replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 201, 415, 044 0 59.00 60.00 Total liabilities and fund balances (sum of lines 51 and 209, 100, 414 0 0 0 60.00

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0007

| | | | | | То | 12/31/2019 | Date/Time Prep 8/19/2020 2:00 | |
|----------------|---|----------------|------------------------|----------|-----|------------|----------------------------------|------------------|
| | | General | Fund | Speci al | Pur | pose Fund | Endowment Fund | |
| | | | | | | | | |
| | | 1.00 | 2.00 | 2.00 | | 4.00 | F 00 | |
| 1. 00 | Fund balances at beginning of period | 1.00 | 2. 00 167, 316, 048 | 3.00 | | 4. 00 | 5. 00 | 1. 00 |
| 2. 00 | Net income (loss) (from Wkst. G-3, line 29) | | 34, 098, 995 | | | U | | 2. 00 |
| 3.00 | Total (sum of line 1 and line 2) | | 201, 415, 043 | | | 0 | | 3. 00 |
| 4.00 | ROUNDI NG | 1 | 201, 110, 010 | | 0 | O | 0 | 4. 00 |
| 5. 00 | | o | | | 0 | | l ol | 5. 00 |
| 6.00 | | o | | | 0 | | ol | 6. 00 |
| 7.00 | | 0 | | | 0 | | o | 7. 00 |
| 8.00 | | O | | | 0 | | 0 | 8. 00 |
| 9.00 | | 0 | | | 0 | | 0 | 9. 00 |
| 10.00 | Total additions (sum of line 4-9) | | 1 | | | 0 | | 10.00 |
| 11. 00 | Subtotal (line 3 plus line 10) | | 201, 415, 044 | | | 0 | | 11.00 |
| 12.00 | Deductions (debit adjustments) (specify) | 0 | | | 0 | | 0 | |
| 13. 00 | | 0 | | | 0 | | 0 | 13.00 |
| 14. 00 | | 0 | | | 0 | | 0 | |
| 15. 00 | | 0 | | | 0 | | 0 | 15. 00 |
| 16.00 | | 0 | | | 0 | | 0 | 16.00 |
| 17. 00 | T-t-1 d-dti (6 li 12 17) | O O | 0 | | U | 0 | 0 | 17. 00 |
| 18.00 | Total deductions (sum of lines 12-17) Fund balance at end of period per balance | | 201 415 044 | | | 0 | | 18. 00 19. 00 |
| 19. 00 | sheet (line 11 minus line 18) | | 201, 415, 044 | | | U | | 19.00 |
| | Janear (Trite Triminas Trite To) | Endowment Fund | PI ant | Fund | | | | |
| | | | | | | | | |
| | | 6.00 | 7. 00 | 8. 00 | | | | |
| 1.00 | Fund balances at beginning of period | 0 | | | 0 | | | 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) | O | | | 0 | | | 3. 00 |
| 4.00 | ROUNDI NG | | 0 | | | | | 4. 00 |
| 5. 00 6. 00 | | | 0 | | | | | 5. 00 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) | 0 | Ŭ | | 0 | | | 10.00 |
| 11. 00 | Subtotal (line 3 plus line 10) | o | | | O | | | 11. 00 |
| 12. 00 | Deductions (debit adjustments) (specify) | | o | | | | | 12.00 |
| 13.00 | | | o | | | | | 13.00 |
| 14.00 | | | 0 | | | | | 14.00 |
| 15.00 | | | 0 | | | | | 15.00 |
| 16.00 | | | 0 | | | | | 16.00 |
| 17. 00 | | | 0 | | | | | 17. 00 |
| 18.00 | Total deductions (sum of lines 12-17) | 0 | | | 0 | | | 18.00 |
| | | 1 | | 1 | | | | |
| 19. 00 | Fund balance at end of period per balance sheet (line 11 minus line 18) | 0 | | | 0 | | | 19. 00 |

Health Financial Systems COMM STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0007

| | | | To | 12/31/2019 | Date/Time Prep 8/19/2020 2:00 | |
|--------|--|----------|--------------|---------------|----------------------------------|--------|
| | Cost Center Description | Lnna | ati ent | Outpati ent | Total | J pili |
| | oost contor boson per on | | . 00 | 2. 00 | 3. 00 | |
| | PART I - PATIENT REVENUES | | | 2.00 | 0.00 | |
| | General Inpatient Routine Services | | | | | |
| 1.00 | Hospi tal | 23 | , 104, 069 | | 23, 104, 069 | 1. 00 |
| 2.00 | SUBPROVIDER - IPF | | , , | | | 2. 00 |
| 3.00 | SUBPROVIDER - IRF | | | | | 3. 00 |
| 4. 00 | SUBPROVI DER | | | | | 4. 00 |
| 5. 00 | Swing bed - SNF | | 0 | | 0 | 5. 00 |
| 6.00 | Swing bed - NF | | 0 | | 0 | 6. 00 |
| 7. 00 | SKILLED NURSING FACILITY | | _ | | _ | 7. 00 |
| 8.00 | NURSING FACILITY | | | | | 8. 00 |
| 9. 00 | OTHER LONG TERM CARE | | | | | 9. 00 |
| 10.00 | Total general inpatient care services (sum of lines 1-9) | 23 | , 104, 069 | | 23, 104, 069 | 10. 00 |
| | Intensive Care Type Inpatient Hospital Services | 1 20 | 7 .0 .7 00 / | | 20/101/00/ | 10.00 |
| 11. 00 | INTENSIVE CARE UNIT | 6 | , 850, 681 | | 6, 850, 681 | 11. 00 |
| 12. 00 | CORONARY CARE UNIT | | ,, | | 2, 222, 22 | 12. 00 |
| 13. 00 | BURN INTENSIVE CARE UNIT | | | | | 13. 00 |
| 14. 00 | SURGICAL INTENSIVE CARE UNIT | | | | | 14. 00 |
| 15. 00 | OTHER SPECIAL CARE (SPECIFY) | | | | | 15. 00 |
| 16. 00 | Total intensive care type inpatient hospital services (sum of line | ·s 6 | , 850, 681 | | 6, 850, 681 | 16. 00 |
| 10.00 | 11-15) | .5 | , 000, 001 | | 0, 000, 001 | 10.00 |
| 17. 00 | Total inpatient routine care services (sum of lines 10 and 16) | 29 | , 954, 750 | | 29, 954, 750 | 17. 00 |
| 18. 00 | Ancillary services | • | , 160, 814 | 413, 528, 139 | 589, 688, 953 | 18. 00 |
| 19. 00 | Outpati ent servi ces | 1 | 0 | 0 | 0 | 19. 00 |
| 20. 00 | RURAL HEALTH CLINIC | | 0 | ol | 0 | 20. 00 |
| 21. 00 | FEDERALLY QUALIFIED HEALTH CENTER | | 0 | ol | 0 | 21. 00 |
| 22. 00 | HOME HEALTH AGENCY | | J | Ĭ | · · | 22. 00 |
| 23. 00 | AMBULANCE SERVI CES | | 0 | o | 0 | 23. 00 |
| 24. 00 | CMHC | | J | Ĭ | · · | 24. 00 |
| 25. 00 | AMBULATORY SURGICAL CENTER (D. P.) | | | | | 25. 00 |
| 26. 00 | HOSPI CE | | | | | 26. 00 |
| 27. 00 | OTHER (SPECIFY) | | 0 | 364, 060 | 364, 060 | 27. 00 |
| 28. 00 | Total patient revenues (sum of lines 17-27)(transfer column 3 to W | lkst 206 | , 115, 564 | 413, 892, 199 | 620, 007, 763 | |
| 20.00 | G-3, line 1) | 200 | , , | 1.0,072,177 | 020/00///00 | 20.00 |
| | PART II - OPERATING EXPENSES | ' | <u>'</u> | | | |
| 29.00 | Operating expenses (per Wkst. A, column 3, line 200) | | | 155, 420, 346 | | 29. 00 |
| 30.00 | ADD (SPECIFY) | | 0 | | | 30.00 |
| 31.00 | | | 0 | | | 31. 00 |
| 32.00 | | | 0 | | | 32.00 |
| 33.00 | | | 0 | | | 33.00 |
| 34.00 | | | 0 | | | 34.00 |
| 35.00 | | | 0 | | | 35. 00 |
| 36.00 | Total additions (sum of lines 30-35) | | | o | | 36.00 |
| 37.00 | DEDUCT (SPECIFY) | | 0 | | | 37. 00 |
| 38.00 | | | 0 | | | 38. 00 |
| 39.00 | | | 0 | | | 39. 00 |
| 40.00 | | | 0 | | | 40. 00 |
| 41.00 | | | 0 | | | 41. 00 |
| 42.00 | Total deductions (sum of lines 37-41) | | | o | | 42.00 |
| 43.00 | Total operating expenses (sum of lines 29 and 36 minus line 42)(tr | ansfer | | 155, 420, 346 | | 43.00 |
| | to Wkst. G-3, line 4) | | | | | |
| | | | | | | |

| | Financial Systems COMMUNITY HOWARD RE | | | u of Form CMS-2 | |
|--------|---|-----------------------|----------------------------------|------------------|--------|
| STATE | ENT OF REVENUES AND EXPENSES | Provider CCN: 15-0007 | Peri od: | Worksheet G-3 | |
| | | | From 01/01/2019 To 12/31/2019 | Date/Time Pre | narad. |
| | | | 10 12/31/2019 | 8/19/2020 2:00 | |
| | | | | 07 177 2020 2. 0 | , p |
| | | | | 1. 00 | |
| 1.00 | Total patient revenues (from Wkst. G-2, Part I, column 3, lir | ne 28) | | 620, 007, 763 | 1. 00 |
| 2.00 | Less contractual allowances and discounts on patients' accour | nts | | 445, 700, 743 | 2. 00 |
| 3.00 | Net patient revenues (line 1 minus line 2) | | | 174, 307, 020 | 3. 00 |
| 4.00 | Less total operating expenses (from Wkst. G-2, Part II, line | 43) | | 155, 420, 346 | 4.00 |
| 5.00 | Net income from service to patients (line 3 minus line 4) | | | 18, 886, 674 | 5. 00 |
| | OTHER INCOME | | | | |
| 6.00 | Contributions, donations, bequests, etc | | | 215, 233 | 6.00 |
| 7.00 | Income from investments | | | 0 | 7. 00 |
| 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 | | | 4, 464 | 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 | | | 372, 908 | 14. 00 |
| 15.00 | Revenue from rental of living quarters | | | 0 | 15. 00 |
| 16.00 | Revenue from sale of medical and surgical supplies to other | than patients | | 0 | 16. 00 |
| 17.00 | Revenue from sale of drugs to other than patients | · | | 0 | 17. 00 |
| 18.00 | Revenue from sale of medical records and abstracts | | | 0 | 18. 00 |
| 19.00 | Tuition (fees, sale of textbooks, uniforms, etc.) | | | 0 | 19. 00 |
| 20.00 | Revenue from gifts, flowers, coffee shops, and canteen | | | 0 | 20. 00 |
| 21.00 | Rental of vending machines | | | 6, 253 | 21. 00 |
| 22. 00 | Rental of hospital space | | | 2, 903, 079 | 22. 00 |
| 23.00 | Governmental appropriations | | | 0 | 23. 00 |
| | l | | | | l |

11, 723, 134 24. 00

15, 225, 071 25. 00 34, 111, 745 26. 00

12, 750 27. 00 12, 750 28. 00 34, 098, 995 29. 00

24.00 MISC & NON OPERATING REVENUE

27. 00 I NCOME TAX

25.00 Total other income (sum of lines 6-24)
26.00 Total (line 5 plus line 25)

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)

| | | ARD REGIONAL HEALTH | | u of Form CMS-2 | 2552-10 |
|--------------|---|--------------------------------|-----------------------------|----------------------------|---------|
| CALCUL | ATION OF CAPITAL PAYMENT | Provider CCN: 15-0007 | Peri od: From 01/01/2019 | Worksheet L Parts I-III | |
| | | | To 12/31/2019 | Date/Time Pre | pared: |
| | | T: 11 \0(1) | | 8/19/2020 2:0 | O pm |
| | | Title XVIII | Hospi tal | PPS | |
| | | | | 1. 00 | |
| | PART I - FULLY PROSPECTIVE METHOD | | | | |
| | CAPITAL FEDERAL AMOUNT | | | | 1 |
| . 00 | Capital DRG other than outlier | | | 1, 132, 086 | 1.0 |
| . 01 | Model 4 BPCI Capital DRG other than outlier | | | 0 | 1.0 |
| . 00 | Capital DRG outlier payments | | | 23, 560 | 2. 0 |
| 01 | Model 4 BPCI Capital DRG outlier payments | | | 0 | |
| 00 | Total inpatient days divided by number of days in the co | ost reporting period (see inst | ructions) | 50. 58 | |
| . 00 | Number of interns & residents (see instructions) | | | 0.00 | |
| 00 | Indirect medical education percentage (see instructions) | | | 0.00 | |
| . 00 | <pre>Indirect medical education adjustment (multiply line 5 t 1.01)(see instructions)</pre> | by the sum of lines 1 and 1.01 | , columns 1 and | 0 | 6.0 |
| 00 | Percentage of SSI recipient patient days to Medicare Par | rt A patient days (Worksheet E | , part A line | 7. 33 | 7.0 |
| 00 | 30) (see instructions) Percentage of Medicaid patient days to total days (see i | netructions) | | 28. 55 | 8.0 |
| 00 | Sum of lines 7 and 8 | | 35. 88 | | |
| 0.00 | Allowable disproportionate share percentage (see instruc | ctions) | | 7. 54 | |
| 1. 00 | Disproportionate share adjustment (see instructions) | 211 0113) | | 85, 359 | |
| 2. 00 | Total prospective capital payments (see instructions) | | | 1, 241, 005 | |
| | | | | | |
| | DART LL DAVIENT UNDER REACONABLE COOT | | | 1. 00 | |
| 00 | PART II - PAYMENT UNDER REASONABLE COST Program inpatient routine capital cost (see instructions | -) | | 0 | 1 0 |
| . 00 . 00 | Program inpatient routine capital cost (see instructions Program inpatient ancillary capital cost (see instructions | | | 0 | |
| . 00 | Total inpatient program capital cost (see instruction) | | | 0 | |
| . 00 | Capital cost payment factor (see instructions) | 2) | | 0 | 1 |
| . 00 | Total inpatient program capital cost (line 3 x line 4) | | | 0 | 1 |
| . 00 | Trotal Tripatrent program capital cost (Trile 3 x Trile 4) | | | | 3.0 |
| | | | | 1. 00 | |
| | PART III - COMPUTATION OF EXCEPTION PAYMENTS | | | | 1 |
| 00 | Program inpatient capital costs (see instructions) | | | 0 | |
| 00 | Program inpatient capital costs for extraordinary circum | | | 0 | 2. 0 |
| 00 | Net program inpatient capital costs (line 1 minus line 2 | 2) | | 0 | 0.0 |
| 00 | Applicable exception percentage (see instructions) | | | 0.00 | |
| 00 | Capital cost for comparison to payments (line 3 x line 4 | | | 0 | 0.0 |
| 00 | Percentage adjustment for extraordinary circumstances (s | | | 0.00 | |
| 00 | Adjustment to capital minimum payment level for extraord | dinary circumstances (line 2 x | (line 6) | 0 | |
| . 00 | Capital minimum payment level (line 5 plus line 7) | | | 0 | 0.0 |
| | Current year capital payments (from Part I, line 12, as | appri (capre) | | 0 | 9.0 |
| 0. 00 | Current year comparison of capital minimum payment level | | Loss Line O) | 0 | 10. C |

11.00

0 12.00

0 13.00 14.00

0

0 15.00

0 16.00 0 17.00

11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year

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

Worksheet L, Part III, line 14)

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

15.00 Current year allowable operating and capital payment (see instructions)
16.00 Current year operating and capital costs (see instructions)
17.00 Current year exception offset amount (see instructions)

13.00

14.00