This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0086 Worksheet S Peri od: From 01/01/2019 Parts I-III AND SETTLEMENT SUMMARY 12/31/2019 Date/Time Prepared: 6/3/2020 5:03 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically filed cost report Date: 6/3/2020 5:03 pm use only Manually submitted cost report] If this is an amended report enter the number of times the provider resubmitted this cost report] Medicare Utilization. Enter "F" for full or "L" for low. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Final Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. Contractor's Vendor Code:
[12] [9] If line 5, column 1 is 4: Enter
[13] NPR Date:
[14] 12. Contractor's Vendor Code:
[15] 13. NPR Date:
[16] 13. NPR Date:
[17] 14. Contractor's Vendor Code:
[18] 15. Contractor's Vendor Code:
[18] 16. NPR Date:
[18] 17. Contractor's Vendor Code:
[18] 17. Contractor's Vendor Code:
[18] 18. Contractor's Vendor Code:
[18] 19. NPR Date:
[18] 19. NPR Date:
[18] 19. NPR Date:
[18] 19. NPR Date:
[19] 19. NPR Date: Contractor use only

PART II - CERTIFICATION

(3) Settled with Audit

(4) Reopened (5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by DEARBORN COUNTY HOSPITAL (15-0086) 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.

MI CHAEL SCHWEBLER (Si gned) Officer or Administrator of Provider(s)

PRESIDENT AND CEO

Title

(Dated when report is electronically signed.)

number of times reopened = 0-9.

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 | 246, 252 | 17, 756 | 0 | -249, 224 | 1. 00 |
| 2.00 | Subprovi der - IPF | 0 | 0 | 0 | | 0 | 2. 00 |
| 3.00 | Subprovi der - I RF | 0 | 0 | 0 | | 0 | 3. 00 |
| 5.00 | Swing bed - SNF | 0 | 0 | 0 | | 0 | 5. 00 |
| 6.00 | Swing bed - NF | 0 | | | | 0 | 6. 00 |
| 7.00 | SKILLED NURSING FACILITY | 0 | 0 | 0 | | 0 | 7. 00 |
| 9.00 | HOME HEALTH AGENCY I | 0 | 0 | -1 | | 0 | 9. 00 |
| 200.00 | Total | 0 | 246, 252 | 17, 755 | 0 | -249, 224 | 200.00 |
| TL L | | Albert Control ! Albert Co. | | | | | |

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 DEARBORN COUNTY HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0086 Peri od: Worksheet S-2 From 01/01/2019 Part I Date/Time Prepared: 12/31/2019 6/3/2020 5:03 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 600 WILSON CREEK ROAD 1.00 PO Box: 1.00 State: IN 2.00 City: LAWRENCEBURG Zip Code: 47025-County: DEARBORN 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N)

/ XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 DEARBORN COUNTY 150086 17140 07/01/1966 N 3.00 HOSPI TAI Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 6.00 Subprovider - (Other) 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 HEALTH SERVICES CORP. 157055 17140 10/01/1978 Ρ Ν 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce HOSPICE OF SOUTHEASTERN 151531 14 00 17140 12/22/1994 14 00 NDI ANA Hospital-Based Health Clinic - RHC 15.00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospi tal -Based (CMHC) I 17.00 18.00 Renal Dialysis 18 00 19.00 Other 19.00 From: To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2019 12/31/2019 20 00 21.00 Type of Control (see instructions) 21.00 9 1.00 2.00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Υ Ν 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 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)

N

Ν

N

N

Ν

22 02

22 03

23.00

Ν

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

22.03 Did this hospital receive a geographic reclassification from urban to

payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after

rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for

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

below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

October 1.

yes or "N" for no.

| paid days eligible Medica unpaid paid da | | | da | ys | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|-------------|--------|------------------|--|--|--|--|--|
| days | unpai d | | | | | | | | | |
| 1.00 2.00 3.00 | | 5. 00 | 6. | | | | | | | |
| 24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column | 0 50 | 25 | 1 | 0 | 24. 00 | | | | | |
| 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5. | 0 0 | | 0 | | 25. 00 | | | | | |
| Inimo para ana errgibre bat unpara days in corumin 3. | Urban/R | ural S Da | ite of (| Geogr | | | | | | |
| 2/ 00 [nton your standard goographic closed firstless (not wage) status at the baginsing | 1. (| 00 | 2. 00 |) | 24 00 | | | | | |
| 26.00 Enter your standard geographic classification (not wage) status at the beginning cost reporting period. Enter "1" for urban or "2" for rural. 27.00 Enter your standard geographic classification (not wage) status at the end of the | | 1 | | | 26. 00 27. 00 | | | | | |
| reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable enter the effective date of the geographic reclassification in column 2. | | | | | | | | | | |
| 35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status effect in the cost reporting period. | sin | 0 | | | 35. 00 | | | | | |
| | Beginning: Ending: | | | | | | | | | |
| 36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for i | | | 2.00 | | 36. 00 | | | | | |
| | of periods in excess of one and enter subsequent dates. On If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status On 3 | | | | | | | | | |
| | 7.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see | | | | | | | | | |
| 38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. | d | | | | 38. 00 | | | | | |
| | 1. (| | Y/N 2.00 | | - | | | | | |
| 39.00 Does this facility qualify for the inpatient hospital payment adjustment for low hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for "N" for no. (see instructions) | volume Y olumn | | Y | | 39. 00 | | | | | |
| 40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for you "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "I no in column 2, for discharges on or after October 1. (see instructions) | | | Υ | | 40. 00 | | | | | |
| , and the same of | | | | XI X | | | | | | |
| Prospective Payment System (PPS)-Capital | | 1.00 | 2. 00 | 3. 00 | | | | | | |
| 45.00 Does this facility qualify and receive Capital payment for disproportionate share with 42 CFR Section §412.320? (see instructions) | in accordance | N | N | N | 45. 00 | | | | | |
| 46.00 Is this facility eligible for additional payment exception for extraordinary circupursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, I | | N | N | N | 46. 00 | | | | | |
| Pt. III. 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or 48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" | | N N | N N | N N | 47. 00 48. 00 | | | | | |
| Teachi ng Hospi tal s | | | 14 | 14 | 56. 00 | | | | | |
| is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no. If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is | | | | | | | | | | |
| | | | | | | | | | | |
| for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. Is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. 58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' service defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I. | f column 2 is | N | | | 58. 00 59. 00 | | | | | |

Health Financial Systems DEARBORN COUNTY HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0086 Peri od: Worksheet S-2 From 01/01/2019 Part I Date/Time Prepared: 12/31/2019 6/3/2020 5:03 pm NAHE 413.85 Worksheet A Pass-Through Qualification Y/N Line # Criterion Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for 60.00 any programs that meet the criteria under §413.85? (see instructions) If line 60 is yes, complete columns 2 and 3 for each program. (see 23.00 60.01 1 instructions) Y/N IME Direct GME IME Direct GME 1. 00 2.00 3.00 4.00 5.00 61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in 0.00 0. od 61.00 Ν column 1. (see instructions) Enter the average number of unweighted primary care 61.01 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61.02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61.03 Enter the base line FTE count for primary care 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) 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 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 used for cap relief and/or FTEs that are nonprimary 61.06 care or general surgery. (see instructions) Program Name Program Code Unweighted IME Unweighted Direct GME FTE FTE Count Count 4.00 1 00 2 00 3 00 61.10 Of the FTEs in line 61.05, specify each new program 0.00 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.0d 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 62.01 0.00 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions) 63.00 N Unwei ghted Unwei ghted Ratio (col. 1/ FTEs in FTES (col. 1 + col Nonprovi der Hospi tal 2)) Si te

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0086 Peri od: Worksheet S-2 From 01/01/2019 Part I Date/Time Prepared: 12/31/2019 6/3/2020 5:03 pm Program Code Unwei ghted Unwei ghted Program Name 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. 00 0. 00 0.000000 65.00 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 ghted Ratio (col. 3/ Program Code Unwei ahted 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 O 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 N 75.00 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 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 DEARBORN COUNTY H HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | IOSPI TAL Provi der CC | CN: 15-0086 | Period: From 01/01/2019 To 12/31/2019 | u of Form CMS Worksheet S Part I Date/Time P 6/3/2020 5:0 | -2 repared: |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|------------------|---------------------------------------------|-----------------------------------------------------------------------|------------------|
| | | | | 1.00 | |
| Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes an 81.00 Is this a LTCH co-located within another hospital for part or a "Y" for yes and "N" for no. | | | ng period? Enter | N N | 80. 00 81. 00 |
| TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TE 86.00 Did this facility establish a new Other subprovider (excluded u §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. | | , | | N | 85. 00 86. 00 |
| 87.00 Is this hospital an extended neoplastic disease care hospital c 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. | lassified ι | under section | ١ | N | 87. 00 |
| 1.000(0)(1)(0)(1)(1.21(0)(1.10(1)(1.10(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(| | | V 1. 00 | XI X 2. 00 | |
| Title V and XIX Services | | | 1.00 | 2.00 | |
| 90.00 Does this facility have title V and/or XIX inpatient hospital s yes or "N" for no in the applicable column. | ervi ces? Er | nter "Y" for | N | Υ | 90.00 |
| 91.00 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 applica | | | N | Y | 91. 00 |
| 92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual | certi fi cati | | | N | 92. 00 |
| instructions) Enter "Y" for yes or "N" for no in the applicable 93.00 Does this facility operate an ICF/IID facility for purposes of | | d XIX? Enter | N | N | 93. 00 |
| "Y" for yes or "N" for no in the applicable column. 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and | "N" for no | in the | N | N | 94. 00 |
| applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the applic | able columr | ٦. | 0. 00 | 0. 00 | 95. 00 |
| 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or applicable column. | | | N | N | 96. 00 |
| 97.00 If line 96 is "Y", enter the reduction percentage in the applic 98.00 Does title V or XIX follow Medicare (title XVIII) for the interstepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for | 0. 00 Y | 97. 00 98. 00 | | | |
| column 1 for title V, and in column 2 for title XIX. 98.01 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 | | | | Y | 98. 01 |
| 98.02 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 " | | | Y | Y | 98. 02 |
| for title V, and in column 2 for title XIX. 98.03 Does title V or XIX follow Medicare (title XVIII) for a critica reimbursed 101% of inpatient services cost? Enter "Y" for yes o for title V, and in column 2 for title XIX. | | | | N | 98. 03 |
| 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reioutpatient services cost? Enter "Y" for yes or "N" for no in colin column 2 for title XIX. | | | N | N | 98. 04 |
| 98.05 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. 05 |
| 98.06 Does title V or XIX follow Medicare (title XVIII) when cost reil Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 column 2 for title XIX. | | | Y | Y | 98. 06 |
| Rural Providers 105.00 Does this hospital qualify as a CAH? | | | N | | 105. 00 |
| 106.00 If this facility qualifies as a CAH, has it elected the all-inc for outpatient services? (see instructions) | lusive meth | nod of paymen | | | 106. 00 |
| 107.00 If this facility qualifies as a CAH, is it eligible for cost re training programs? Enter "Y" for yes or "N" for no in column 1. yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 | (see instr | ructions) If | | | 107. 00 |
| reimbursed. If yes complete Wkst. D-2, Pt. II. 108.00 Is this a rural hospital qualifying for an exception to the CRN. CFR Section §412.113(c). Enter "Y" for yes or "N" for no. | A fee sched | dul e? See 42 | 2 N | | 108. 00 |
| | Physi cal 1.00 | Occupation | - | Respiratory 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 | 2. 00 N | 3. 00 N | N N | 109. 00 |
| | | | | 1.00 | _ |
| 110.00 Did this hospital participate in the Rural Community Hospital D Demonstration) for the current cost reporting period? Enter "Y" complete Worksheet E, Part A, Lines 200 through 218, and Worksh | for yes or | "N" for no. | If yes, | N N | 110. 00 |

| ealth Financial Systems DEARBORN COUNTY HOSPITAL OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CO | N: 15-0086 | Peri od: | ieu of Form CM Worksheet S | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|------------------------------|-------------------------------|----------------------|
| | | From 01/01/20 To 12/31/20 | 19 Part I | repared |
| | | 1. 00 | 2.00 | |
| 11.00 If this facility qualifies as a CAH, did it participate in the Frontier Con Health Integration Project (FCHIP) demonstration for this cost reporting program "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, or 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; for tele-health services. | period? Enter enter the column 2. | N | | 111. |
| | | 1 | 00 2.00 3.0 | 00 |
| Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no ir is yes, enter the method used (A, B, or E only) in column 2. If column 2 is either "93" percent for short term hospital or "98" percent for long term psychiatric, rehabilitation and long term hospitals providers) based on the Pub. 15-1, chapter 22, §2208.1. | s "E", enter rm care (incl ne definition | in column udes in CMS | N O | |
| 16.00 Is this facility classified as a referral center? Enter "Y" for yes or "N" 17.00 Is this facility legally-required to carry malpractice insurance? Enter "No. | | | N Y | 116. 117. |
| 18.00 Is the malpractice insurance a claims-made or occurrence policy? Enter 1 iclaim-made. Enter 2 if the policy is occurrence. | f the policy | is | 1 | 118. |
| Crum made. Enter 2 11 the portey 13 decurrence. | Premi ums | Losses | Insurance | |
| | 1.00 | 2.00 | 3.00 | - |
| 18.01 List amounts of malpractice premiums and paid losses: | 302, 6 | 53 | 0 | 0 118. |
| | | 1. 00 | 2.00 | \dashv |
| 18.02 Are malpractice premiums and paid losses reported in a cost center other of Administrative and General? If yes, submit supporting schedule listing contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless proving 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 proving in ACA §3121 and applicable amendments? (see instructions) | ost centers vision in ACA ' for yes or ne Outpatient | | N | 118. 119. 120. |
| Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implantable devices | • | Y | | 121. |
| patients? Enter "Y" for yes or "N" for no. 22.00 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. | | | | 122. |
| Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" | for no. If | N | | 125. |
| yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare certified kidney transplant center, enter the certified in column 1 and termination date, if applicable, in column 2. | fication date | | | 126. |
| 27.00 If this is a Medicare certified heart transplant center, enter the certifiin column 1 and termination date, if applicable, in column 2. | cation date | | | 127. |
| 18.00 If this is a Medicare certified liver transplant center, enter the certification for column 1 and termination date, if applicable, in column 2. | cation date | | | 128. |
| 29.00 If this is a Medicare certified lung transplant center, enter the certific column 1 and termination date, if applicable, in column 2. | | n | | 129. |
| 80.00 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. |
| (21.00 If this is a Medicare certified intestinal transplant center, enter the condate in column 1 and termination date, if applicable, in column 2. (22.00 If this is a Medicare certified islet transplant center, enter the certification. | | | | 131. |
| in column 1 and termination date, if applicable, in column 2. in column 1 and termination date, if applicable, in column 2. | | | | 133. |
| in column 1 and termination date, if applicable, in column 2. 4.00 If this is an organ procurement organization (OPO), enter the OPO number i and termination date, if applicable, in column 2. | | | | 134. |
| All Providers | | | | |
| 40.00 Are there any related organization or home office costs as defined in CMS chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home | | N | | 140. |

Health Financial Systems DEARBORN COUNTY HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0086 Peri od: Worksheet S-2 From 01/01/2019 Part I Date/Time Prepared: 12/31/2019 6/3/2020 5:03 pm 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number 141 00 Name: Contractor's Name: Contractor's Number: 141 00 142.00 Street: PO Box: 142.00 143. 00 Ci ty: 143. 00 State: Zip Code:

1.00

144.00 Are provider based physicians' costs included in Worksheet A? 144. 00 γ 1. 00 2.00 145.00 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. 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 147. 00 Ν 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 155.00 Ν N 156.00 Subprovi der - IPF Ν Ν Ν Ν 156.00 157.00 Subprovi der - IRF 157 00 N Ν Ν N 158. 00 SUBPROVI DER 158. 00 Ν Ν Ν 159. 00 Ν 160.00 Ν Ν Ν Ν Ν Ν N 161. 00

159.00 SNF 160.00 HOME HEALTH AGENCY 161.00 CMHC 1.00 Mul ti campus

165.00 s this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Enter "Y" for yes or "N" for no. Name County State Zip Code CBSA FTE/Campus 0 1.00 2.00 3.00 4.00 5.00 0.00 166.00

166.00 If line 165 is yes, for each campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)

1.00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 s this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no. 167 00 168.00 of this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the 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 9. 99169. 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 0171.00 N 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)

| | Financial Systems DEARBORN COUNT TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | | CN: 15-0086 | Period: | u of Form CMS Worksheet S- | | | | |
|-------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|----------------|----------------------------------|-----------------------------------------|----------|--|--|--|
| 03111 | AL AND HOST THE HEALTH GAILE RETINDORSEMENT QUESTIONNAIRE | Trovider o | CN. 13 0000 | From 01/01/2019 To 12/31/2019 | Part II Date/Time Pr 6/3/2020 5:0 | epared | | | |
| | | | | Y/N | Date | J | | | |
| | General Instruction: Enter Y for all YES responses. Enter N | for all NO re | esnonses Ent | 1.00 | 2. 00 | | | | |
| | mm/dd/yyyy format. | 101 411 10 10 | caponaca. Enti | ci aii dates iii t | | | | | |
| | COMPLETED BY ALL HOSPITALS | | | | | _ | | | |
| 00 | Provider Organization and Operation Has the provider changed ownership immediately prior to the | beginning of | the cost | N | | 1. | | | |
| | reporting period? If yes, enter the date of the change in co | | instructions | 1 17 | | <u> </u> | | | |
| | | | 1.00 | Date 2.00 | V/I 3. 00 | | | | |
| 00 | Has the provider terminated participation in the Medicare P | rogram? If | 1.00 N | 2.00 | 3.00 | 2. | | | |
| | yes, enter in column 2 the date of termination and in column | | | | | | | | |
| 00 | voluntary or "I" for involuntary. Is the provider involved in business transactions, including | a management | N | | | 3. | | | |
| 00 | contracts, with individuals or entities (e.g., chain home of | | | | |] 3. | | | |
| | or medical supply companies) that are related to the provide | | | | | | | | |
| | officers, medical staff, management personnel, or members of directors through ownership, control, or family and othe | | | | | | | | |
| | relationships? (see instructions) | 1 311111111 | | | | | | | |
| | | | Y/N | Type | Date | | | | |
| | Financial Data and Reports | | 1.00 | 2. 00 | 3. 00 | | | | |
| 00 | Column 1: Were the financial statements prepared by a Cert | | Υ | A | | 4. | | | |
| | Accountant? Column 2: If yes, enter "A" for Audited, "C" for | | | | | | | | |
| | or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions. | ilable in | | | | | | | |
| . 00 | Are the cost report total expenses and total revenues diffe | rent from | N | | | 5. | | | |
| | those on the filed financial statements? If yes, submit rec | onciliation. | | V 40 | | | | | |
| | | | | Y/N 1. 00 | Legal Oper. 2.00 | | | | |
| | Approved Educational Activities | | | | 2.00 | | | | |
| 00 | Column 1: Are costs claimed for nursing school? Column 2: | If yes, is th | ne provider is | s N | | 6. | | | |
| 00 | the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see in: | structions | | Y | | 7. | | | |
| 00 | Were nursing school and/or allied health programs approved | | d during the | N N | | 8. | | | |
| | cost reporting period? If yes, see instructions. | | | | | | | | |
| . 00 | Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction | | car education | N | | 9. | | | |
| 0. 00 | Was an approved Intern and Resident GME program initiated o | | the current | N | | 10. | | | |
| 1 00 | cost reporting period? If yes, see instructions. | O Din on Any | a may to d | N | | 11 | | | |
| 1. 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 | orovea | N | | 11. | | | |
| | Treads in the treatment of the transfer and the treatment of the treatment | | | | Y/N | | | | |
| | | | | | 1. 00 | | | | |
| 2 00 | Bad Debts Is the provider seeking reimbursement for bad debts? If yes | . see instruct | tions. | | Υ | 12. | | | |
| | If line 12 is yes, did the provider's bad debt collection p | | | ost reporting | N | 13. | | | |
| | period? If yes, submit copy. | | s ! | -+ | N | 14. | | | |
| 3. 00 | If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions. | | | | | | | | |
| 3. 00 | | | | tructions | Υ | 15. | | | |
| 3. 00 4. 00 | Bed Complement Did total beds available change from the prior cost reporti | | | | | | | | |
| 3. 00 4. 00 | Bed Complement | Par | rt A | Par | | | | | |
| 3. 00 4. 00 | Bed Complement | Par Y/N | rt A Date | Par Y/N | Date | | | | |
| 3. 00 1. 00 | Bed Complement Did total beds available change from the prior cost reporti | Par Y/N 1.00 | Date 2.00 | Y/N 3.00 | Date 4.00 | | | | |
| 3. 00 4. 00 5. 00 | Bed Complement Did total beds available change from the prior cost reporti PS&R Data Was the cost report prepared using the PS&R Report only? | Par Y/N | rt A Date | Par Y/N | Date | 16. | | | |
| 3. 00 4. 00 5. 00 | Bed Complement Did total beds available change from the prior cost reporti | Par Y/N 1.00 | Date 2.00 | Y/N 3.00 | Date 4.00 | 16. | | | |
| 3. 00 4. 00 5. 00 | Bed Complement Did total beds available change from the prior cost reporti PS&R Data 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) | Par Y/N 1.00 | Date 2.00 | Y/N 3.00 | Date 4.00 | 16. | | | |
| 3. 00 4. 00 5. 00 | Bed Complement Did total beds available change from the prior cost reporti PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for | Par Y/N 1.00 | Date 2.00 | Y/N 3.00 | Date 4.00 | 16. | | | |
| 3. 00 4. 00 5. 00 | Bed Complement Did total beds available change from the prior cost reporti PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If | Par Y/N 1.00 | Date 2.00 | Par Y/N 3.00 | Date 4.00 | | | | |
| 3. 00 4. 00 5. 00 5. 00 | Bed Complement Did total beds available change from the prior cost reporti PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) | Y/N 1.00 Y | Date 2.00 | Y/N 3.00 | Date 4.00 | 17. | | | |
| 3. 00 4. 00 5. 00 5. 00 | PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4 .(see instructions) | Par Y/N 1.00 | Date 2.00 | Par Y/N 3.00 | Date 4.00 | 17. | | | |
| 3. 00 4. 00 5. 00 6. 00 | PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4 (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed | Y/N 1.00 Y | Date 2.00 | Y/N 3.00 | Date 4.00 | 17. | | | |
| 3. 00 4. 00 5. 00 6. 00 7. 00 | PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4 . (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. | Y/N 1.00 Y N | Date 2.00 | Par Y/N 3.00 | Date 4.00 | 17. | | | |
| 3. 00 4. 00 5. 00 6. 00 | PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4 .(see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this | Y/N 1.00 Y | Date 2.00 | Y/N 3.00 | Date 4.00 | 17. | | | |

| Heal th | Financial Systems DEARBORN COUL | NTY HOSPITAL | | In Lie | u of Form CM | S-2552-10 |
|------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|----------------|----------------------------------------------|------------------------------------------------------|------------------|
| HOSPI T | AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provi der C | CN: 15-0086 | Peri od: From 01/01/2019 To 12/31/2019 | Worksheet S Part II Date/Time F 6/3/2020 5: | repared: |
| | | | i pti on | 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 | |
| | | 1. 00 | 2.00 | 3. 00 | 4.00 | |
| 21. 00 | Was the cost report prepared only using the provider's records? If yes, see instructions. | N | | N | | 21. 00 |
| | | | | | 1. 00 | |
| | COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC | EPT CHILDRENS H | IOSPI TALS) | | | |
| 00.00 | Capital Related Cost | | | | | |
| 22. 00 23. 00 | Have assets been relifed for Medicare purposes? If yes, se Have changes occurred in the Medicare depreciation expense | | sals made dur | ing the cost | N N | 22. 00 23. 00 |
| 24. 00 | reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases enter | ed into during | this cost re | eporting period? | Y | 24. 00 |
| 25. 00 | If yes, see instructions Have there been new capitalized leases entered into during | Plf yes, see | N | 25. 00 | | |
| 26. 00 | instructions. Were assets subject to Sec. 2314 of DEFRA acquired during t | • | 0. | | N | 26. 00 |
| | instructions. | • | 3 . | 3 . | | |
| 27. 00 | Has the provider's capitalization policy changed during th copy. | e cost reportir | ng period? ii | yes, submit | N | 27. 00 |
| 28. 00 | Interest Expense Were new Loans, mortgage agreements or Letters of credit e | ntered into dur | ing the cost | reporting | Y | 28. 00 |
| 29. 00 | period? If yes, see instructions. Did the provider have a funded depreciation account and/or | bond funds (De | ebt Service F | Reserve Fund) | N | 29. 00 |
| 30. 00 | treated as a funded depreciation account? If yes, see inst Has existing debt been replaced prior to its scheduled mat | ructi ons | | • | N | 30. 00 |
| | instructions. | , | , | | | |
| 31. 00 | Has debt been recalled before scheduled maturity without i instructions. | ssuance or new | dept? IT yes | s, see | N | 31. 00 |
| 32. 00 | Purchased Services Have changes or new agreements occurred in patient care se | | ed through co | ontractual | N | 32. 00 |
| 33. 00 | arrangements with suppliers of services? If yes, see instr If line 32 is yes, were the requirements of Sec. 2135.2 ap no, see instructions. | | ng to competi | tive bidding? If | | 33. 00 |
| | Provi der-Based Physi ci ans | | | | | |
| 34. 00 | Are services furnished at the provider facility under an a | rrangement with | n provi der-ba | sed physi ci ans? | Y | 34. 00 |
| 35. 00 | If yes, see instructions. If line 34 is yes, were there new agreements or amended ex | | nts with the | provi der-based | N | 35. 00 |
| | physicians during the cost reporting period? If yes, see i | nstructions. | | Y/N | Date | |
| | | | | 1. 00 | 2. 00 | |
| | Home Office Costs | | | | | |
| 36. 00 37. 00 | Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p | repared by the | home office? | N | | 36. 00 37. 00 |
| 38. 00 | If yes, see instructions. If line 36 is yes , was the fiscal year end of the home of | fice different | from that of | - | | 38. 00 |
| 39. 00 | the provider? If yes, enter in column 2 the fiscal year en If line 36 is yes, did the provider render services to oth | | | 5, | | 39. 00 |
| 40. 00 | see instructions. If line 36 is yes, did the provider render services to the | home office? | If yes, see | | | 40. 00 |
| | instructions. | | | | | |
| | Coot Deport Droponon Contact Lafarantian | 1. | 00 | 2. | 00 | |
| 41. 00 | Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, | | 41. 00 | | | |
| 42. 00 | respectively. Enter the employer/company name of the cost report | BLUE & CO., LL | _C | | | 42. 00 |
| 43. 00 | preparer. Enter the telephone number and email address of the cost | 317-713-7957 | | KCSMI TH@BLUEAN | DCO COM | 43. 00 |
| 10.00 | report preparer in columns 1 and 2, respectively. | 7,7,57 | | ROOMI THEBEOLAN | 233. JON | 13.00 |
| | | | | | | |

| Health Financial Systems DEARBORN | COUNTY HOSPITAL | In Lie | In Lieu of Form CMS-2552-10 | | | |
|---------------------------------------------------------------|-----------------------|-----------------------------|--------------------------------|--------|--|--|
| HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0086 | Peri od: From 01/01/2019 | Worksheet S-2 | | | |
| | | | Date/Time Pre 6/3/2020 5:03 | | | |
| | | | | | | |
| | 3. 00 | | | | | |
| Cost Report Preparer Contact Information | | | | | | |
| 41.00 Enter the first name, last name and the title/position | SENI OR MANAGER | | | 41. 00 | | |
| held by the cost report preparer in columns 1, 2, and | 3, | | | | | |
| respecti vel y. | | | | | | |
| 42.00 Enter the employer/company name of the cost report | | | | 42.00 | | |
| preparer. | | | | | | |
| 43.00 Enter the telephone number and email address of the co | st | | | 43.00 | | |
| report preparer in columns 1 and 2, respectively. | | | | | | |

Health Financial Systems DEARBOOM
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-0086

| | | | | | | 10 | 12/31/2019 | 6/3/2020 5: 03 | |
|------------------|----------------------------------------------|-------------|-----|---------|--------------|----|------------|----------------|------------------|
| | | | | | | | | 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 | | 54 | 19, 7 | 10 | 0.00 | 0 | 1. 00 |
| | 8 exclude Swing Bed, Observation Bed and | | | | | | | | |
| | Hospice days)(see instructions for col. 2 | | | | | | | | |
| | for the portion of LDP room available beds) | | | | | | | | |
| 2. 00 | HMO and other (see instructions) | | | | | | | | 2. 00 |
| 3.00 | HMO IPF Subprovider | | | | | | | | 3. 00 |
| 4.00 | HMO IRF Subprovider | | | | | | | | 4. 00 |
| 5.00 | Hospital Adults & Peds. Swing Bed SNF | | | | | | | 0 | 5. 00 |
| 6.00 | Hospital Adults & Peds. Swing Bed NF | | | | | | | 0 | 6. 00 |
| 7.00 | Total Adults and Peds. (exclude observation | | | 54 | 19, 7 | 10 | 0. 00 | 0 | 7. 00 |
| | beds) (see instructions) | | | | | | | | |
| 8.00 | INTENSIVE CARE UNIT | 31. 00 | | 8 | 2, 92 | 20 | 0. 00 | 0 | 8. 00 |
| 9.00 | CORONARY CARE UNIT | | | | | | | | 9. 00 |
| 10.00 | BURN INTENSIVE CARE UNIT | | | | | | | | 10.00 |
| 11.00 | SURGICAL INTENSIVE CARE UNIT | | | | | | | | 11.00 |
| 12.00 | OTHER SPECIAL CARE (SPECIFY) | 40.00 | | | | | | | 12.00 |
| 13.00 | NURSERY | 43. 00 | | | 22.77 | 20 | 0.00 | 0 | 13.00 |
| 14.00 | Total (see instructions) | | | 62 | 22, 63 | 30 | 0. 00 | 0 | 14.00 |
| 15.00 | CAH visits | | | | | | | 0 | 15. 00 |
| 16.00 | SUBPROVI DER - I PF | | | | | | | | 16.00 |
| 17. 00 | SUBPROVIDER - I RF | | | | | | | | 17. 00 18. 00 |
| 18. 00 19. 00 | SUBPROVI DER | 44. 00 | | 0 | | 0 | | 0 | |
| 20. 00 | SKILLED NURSING FACILITY NURSING FACILITY | 44.00 | | U | | U | | U | 20. 00 |
| 21. 00 | OTHER LONG TERM CARE | | | | | | | | 21. 00 |
| 21.00 | HOME HEALTH AGENCY | 101. 00 | | | | | | 0 | 22. 00 |
| 23. 00 | AMBULATORY SURGICAL CENTER (D. P.) | 101.00 | | | | | | U | 23. 00 |
| 24. 00 | HOSPICE | 116. 00 | | 0 | | 0 | | | 24. 00 |
| 24. 00 | HOSPICE (non-distinct part) | 30.00 | 1 | U | | U | | | 24. 00 |
| 25. 00 | CMHC - CMHC | 30.00 | | | | | | | 25. 00 |
| 26. 00 | RURAL HEALTH CLINIC | | | | | | | | 26. 00 |
| 26. 25 | FEDERALLY QUALIFIED HEALTH CENTER | 89. 00 | | | | | | 0 | |
| 27. 00 | Total (sum of lines 14-26) | 07.00 | | 62 | | | | O | 27. 00 |
| 28. 00 | Observation Bed Days | | | 02 | | | | 0 | 28. 00 |
| 29. 00 | Ambul ance Tri ps | | | | | | | J | 29. 00 |
| 30.00 | Employee discount days (see instruction) | | | | | | | | 30. 00 |
| 31. 00 | Employee discount days (see Finstruction) | | | | | | | | 31. 00 |
| 32. 00 | Labor & delivery days (see instructions) | | | 0 | | 0 | | | 32. 00 |
| 32. 00 | Total ancillary labor & delivery room | | | O | | 9 | | | 32. 00 |
| JZ. 01 | outpatient days (see instructions) | | | | | | | | 52.01 |
| 33. 00 | LTCH non-covered days | | | | | | | | 33. 00 |
| | LTCH site neutral days and discharges | | | | | | | | 33. 01 |
| | | 1 | 1 | | • | 1 | | | |

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0086

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

6/3/2020 5:03 pm Full Time Equivalents I/P Days / O/P Visits / Trips Title XVIII Component Title XIX Total All Total Interns Employees On Pati ents & Residents Payrol I 6.00 7.00 8.00 9.00 10.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 3,604 169 7, 135 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) 914 2 00 1,656 3.00 HMO IPF Subprovider 3.00 HMO IRF Subprovider 4.00 0 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 0 0 5.00 Hospital Adults & Peds. Swing Bed NF 6.00 C 0 6.00 7.00 Total Adults and Peds. (exclude observation 3,604 169 7, 135 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 734 1,807 8.00 CORONARY CARE UNIT 9.00 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 587 13.00 14.00 Total (see instructions) 4,338 169 9,529 0.00 552.17 14.00 CAH visits 15.00 15.00 SUBPROVIDER - IPF 16.00 16.00 SUBPROVIDER - IRF 17.00 17.00 18.00 SUBPROVI DER 18.00 19.00 SKILLED NURSING FACILITY 0 0 0 0.00 0.00 19.00 20 00 NURSING FACILITY 20 00 21.00 OTHER LONG TERM CARE 21.00 22.00 HOME HEALTH AGENCY 4,094 725 7, 938 0.00 14. 20 22.00 23.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 HOSPI CE 24 00 0 Ω 0 0 00 4.41 24.00 24. 10 HOSPICE (non-distinct part) 0 24.10 CMHC - CMHC 25.00 25.00 26, 00 RURAL HEALTH CLINIC 26, 00 0.00 FEDERALLY QUALIFIED HEALTH CENTER 26.25 0 Ω 0 0.00 26.25 27.00 Total (sum of lines 14-26) 0.00 570.78 27.00 28.00 Observation Bed Days 2,068 28.00 29.00 Ambul ance Trips 29.00 0 30.00 Employee discount days (see instruction) 0 30.00 31.00 Employee discount days - IRF 0 31.00 Labor & delivery days (see instructions) 10 45 32.00 32.00 0 Total ancillary labor & delivery room 32.01 0 32.01 outpatient days (see instructions) 33.00 LTCH non-covered days 33.00 33.01 LTCH site neutral days and discharges 33.01

| Period: | Worksheet S-3 | From 01/01/2019 | Part | To 12/31/2019 | Date/Time Prepared: Health Financial Systems DEARBOR HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provi der CCN: 15-0086

| | | | | | То | 12/31/2019 | Date/Time Pre 6/3/2020 5:03 | |
|------------------|----------------------------------------------|---------------------|-------------|----------|---------------|------------|-----------------------------|------------------|
| | | Full Time | Di scharges | | | | 107072020 0.00 | piii |
| | | Equi val ents | T' 11 1/ | | T' 11 \0.0111 | T' 11 VIV | T | |
| | Component | Nonpai d Workers | Title V | | Title XVIII | Title XIX | Total All Patients | |
| | | 11. 00 | 12. 00 | \dashv | 13. 00 | 14.00 | 15. 00 | |
| 1. 00 | Hospital Adults & Peds. (columns 5, 6, 7 and | 11.00 | 12.00 | 0 | 1, 280 | 14.00 | 2, 931 | 1. 00 |
| 1.00 | 8 exclude Swing Bed, Observation Bed and | | | ۷ | 1, 200 | 43 | 2, 931 | 1.00 |
| | Hospice days) (see instructions for col. 2 | | | | | | | |
| | for the portion of LDP room available beds) | | | | | | | |
| 2.00 | HMO and other (see instructions) | | | İ | 252 | 527 | | 2. 00 |
| 3.00 | HMO IPF Subprovider | | | İ | | 0 | | 3. 00 |
| 4.00 | HMO IRF Subprovider | | | İ | | o | | 4. 00 |
| 5.00 | Hospital Adults & Peds. Swing Bed SNF | | | İ | | | | 5. 00 |
| 6.00 | Hospital Adults & Peds. Swing Bed NF | | | i | | | | 6. 00 |
| 7.00 | Total Adults and Peds. (exclude observation | | | | | | | 7. 00 |
| | beds) (see instructions) | | | | | | | |
| 8.00 | INTENSIVE CARE UNIT | | | | | | | 8. 00 |
| 9.00 | CORONARY CARE UNIT | | | | | | | 9. 00 |
| 10.00 | BURN INTENSIVE CARE UNIT | | | | | | | 10.00 |
| 11. 00 | SURGICAL INTENSIVE CARE UNIT | | | | | | | 11. 00 |
| 12.00 | OTHER SPECIAL CARE (SPECIFY) | | | | | | | 12.00 |
| 13. 00 | NURSERY | | | | | | | 13. 00 |
| 14. 00 | Total (see instructions) | 0. 00 | | 0 | 1, 280 | 43 | 2, 931 | |
| 15. 00 | CAH visits | | | l | | | | 15. 00 |
| 16.00 | SUBPROVI DER - I PF | | | l | | | | 16. 00 |
| 17. 00 | SUBPROVI DER - I RF | | | ł | | | | 17. 00 |
| 18.00 | SUBPROVI DER | 0.00 | | ł | | | | 18.00 |
| 19.00 | SKILLED NURSING FACILITY | 0. 00 | | ł | | | | 19.00 |
| 20.00 | NURSING FACILITY | | | ł | | | | 20. 00 21. 00 |
| 21. 00 | OTHER LONG TERM CARE | 0.00 | | ł | | | | 21.00 |
| 22. 00 23. 00 | HOME HEALTH AGENCY | 0. 00 | | ł | | | | 23. 00 |
| 24. 00 | AMBULATORY SURGICAL CENTER (D. P.) HOSPICE | 0. 00 | | ł | | | | 24.00 |
| 24. 00 | HOSPICE (non-distinct part) | 0.00 | | ł | | | | 24. 10 |
| 25. 00 | CMHC - CMHC | | | ł | | | | 25. 00 |
| 26. 00 | RURAL HEALTH CLINIC | | | ł | | | | 26. 00 |
| 26. 25 | FEDERALLY QUALIFIED HEALTH CENTER | 0.00 | | l | | | | 26. 25 |
| 27. 00 | Total (sum of lines 14-26) | 0. 00 | | l | | | | 27. 00 |
| 28. 00 | Observation Bed Days | | | İ | | | | 28. 00 |
| 29. 00 | Ambul ance Trips | | | l | | | | 29. 00 |
| 30.00 | Employee discount days (see instruction) | | | İ | | | | 30.00 |
| 31.00 | Employee discount days - IRF | | | | | | | 31. 00 |
| 32.00 | Labor & delivery days (see instructions) | | | | | | | 32.00 |
| 32. 01 | Total ancillary labor & delivery room | | | | | | | 32. 01 |
| | outpatient days (see instructions) | | | | | | | |
| | LTCH non-covered days | | | | 0 | | | 33. 00 |
| 33. 01 | LTCH site neutral days and discharges | | | | 0 | | | 33. 01 |

| Peri od: | Worksheet S-3 | From 01/01/2019 | Part II | To 12/31/2019 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0086

| | | | | | To | 12/31/2019 | Date/Time Prep 6/3/2020 5:03 | |
|------------------|------------------------------------------------------------------------------|------------------------|-------------------------|-------------------------------------------------|------------------------------|-----------------------------|---------------------------------------------|------------------|
| | | Wkst. A Line Number | | Reclassificati on of Salaries (from Wkst. | Sal ari es (col. 2 ± col. | Salaries in | Average Hourly Wage (col. 4 ÷ col. 5) | |
| | | 1. 00 | 2. 00 | A-6) 3. 00 | 3) 4.00 | <u>col . 4</u> 5. 00 | 6. 00 | |
| | PART II - WAGE DATA SALARIES | | | | | | | |
| 1.00 | Total salaries (see | 200. 00 | 34, 176, 147 | 0 | 34, 176, 147 | 1, 187, 244. 00 | 28. 79 | 1. 00 |
| 2. 00 | instructions) Non-physician anesthetist Part | | 0 | 0 | 0 | 0.00 | 0.00 | 2. 00 |
| 3. 00 | A Non-physician anesthetist Part | | 0 | 0 | 0 | 0.00 | 0. 00 | 3. 00 |
| 4. 00 | B Physician-Part A - | | 0 | 0 | 0 | 0.00 | 0. 00 | 4. 00 |
| 4. 01 | Administrative Physicians - Part A - Teaching | | 0 | 0 | | 0. 00 | | 4. 01 |
| 5. 00 | Physician and Non Physician-Part B | | 0 | 0 | | 0. 00 | | |
| 6. 00 | Non-physician-Part B for hospital-based RHC and FQHC | | 0 | 0 | 0 | 0. 00 | 0. 00 | 6. 00 |
| 7.00 | services Interns & residents (in an | 21. 00 | 0 | 0 | 0 | 0. 00 | 0. 00 | 7. 00 |
| 7. 01 | approved program) Contracted interns and residents (in an approved programs) | | 0 | 0 | 0 | 0.00 | 0. 00 | 7. 01 |
| 8.00 | Home office and/or related organization personnel | | 0 | 0 | 0 | 0.00 | 0. 00 | 8. 00 |
| 9. 00 10. 00 | SNF Excluded area salaries (see | 44. 00 | 0 1, 803, 243 | 0 249, 142 | 0 2, 052, 385 | 0. 00 62, 180. 00 | | 9. 00 10. 00 |
| 10.00 | instructions) OTHER WAGES & RELATED COSTS | | 1,003,243 | 247, 142 | 2,002,000 | 02, 100. 00 | 33.01 | 10.00 |
| 11. 00 | Contract labor: Direct Patient Care | | 767, 824 | 0 | 767, 824 | 9, 820. 00 | 78. 19 | 11. 00 |
| 12. 00 | Contract Labor: Top Level | | 0 | 0 | 0 | 0. 00 | 0. 00 | 12. 00 |
| | management and administrative services | | | | | | | |
| 13. 00 | Contract Labor: Physician-Part A - Administrative | | 458, 333 | 0 | 458, 333 | 2, 031. 00 | 225. 67 | 13. 00 |
| 14. 00 | Home office and/or related organization salaries and wage-related costs | | 0 | 0 | 0 | 0.00 | 0. 00 | 14. 00 |
| 14. 01 14. 02 | Home office salaries Related organization salaries | | 0 | 0 | 0 | 0. 00 0. 00 | | 14. 01 14. 02 |
| 15. 00 | Home office: Physician Part A - Administrative | | 0 | 0 | 0 | 0. 00 | | |
| 16. 00 | Home office and Contract Physicians Part A - Teaching | | 0 | 0 | 0 | 0.00 | 0. 00 | 16. 00 |
| 17. 00 | WAGE-RELATED COSTS Wage-related costs (core) (see | | 6, 769, 968 | 0 | 6, 769, 968 | | | 17. 00 |
| 18. 00 | instructions) Wage-related costs (other) | | | | | | | 18. 00 |
| 19. 00 | (see instructions) Excluded areas | | 374, 166 | | | | | 19. 00 |
| 20. 00 | Non-physician anesthetist Part | | 0 | 0 | | | | 20.00 |
| 21. 00 | Non-physician anesthetist Part B | | 0 | 0 | | | | 21. 00 |
| 22. 00 | Physician Part A - Administrative | | 0 | _ | | | | 22. 00 |
| 22. 01 23. 00 | Physician Part A - Teaching Physician Part B | | 0 | 0 | 0 | | | 22. 01 23. 00 |
| 24. 00 25. 00 | Wage-related costs (RHC/FQHC) Interns & residents (in an | | 0 | 0 | 0 | | | 24. 00 25. 00 |
| 25. 50 | approved program) Home office wage-related | | 0 | 0 | 0 | | | 25. 50 |
| 25. 51 | (core) Related organization | | 0 | 0 | 0 | | | 25. 51 |
| 25. 52 | wage-related (core) Home office: Physician Part A | | 0 | 0 | 0 | | | 25. 52 |
| | - Administrative - wage-related (core) | | | | | | | a= |
| 25. 53 | Home office & Contract Physicians Part A - Teaching - | | 0 | 0 | 0 | | | 25. 53 |
| | wage-related (core) OVERHEAD COSTS - DIRECT SALARIE | S | | | | | | |
| | Employee Benefits Department Administrative & General | 4. 00 5. 00 | 364, 635 5, 707, 463 | | | 11, 105. 00 184, 913. 00 | | 26. 00 27. 00 |
| | | , | | | , | | | |

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

| | | | | | '' | 0 12/31/2019 | 6/3/2020 5:03 | |
|--------|--------------------------------|--------------|-------------|------------------|---------------|--------------|----------------|--------|
| | | Wkst. A Line | Amount | Reclassi fi cati | Adj usted | Pai d Hours | Average Hourly | |
| | | Number | Reported | on of Salaries | Sal ari es | Related to | Wage (col. 4 ÷ | |
| | | | | (from Wkst. | (col.2 ± col. | Salaries in | col . 5) | |
| | | | | A-6) | 3) | col. 4 | | |
| | | 1.00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | 6. 00 | |
| 28. 00 | Administrative & General under | | 709, 018 | 0 | 709, 018 | 5, 717. 00 | 124. 02 | 28. 00 |
| | contract (see inst.) | | | | | | | |
| 29. 00 | Maintenance & Repairs | 6. 00 | | 0 | 0 | 0.00 | | 29. 00 |
| 30.00 | Operation of Plant | 7. 00 | | -50, 771 | | | 28. 72 | 30.00 |
| 31. 00 | Laundry & Linen Service | 8. 00 | · · | 0 | 88, 573 | | | 31.00 |
| 32.00 | Housekeepi ng | 9. 00 | 879, 516 | 0 | 879, 516 | 63, 771. 00 | | 32.00 |
| 33.00 | Housekeeping under contract | | 0 | 0 | 0 | 0. 00 | 0.00 | 33. 00 |
| | (see instructions) | | | | | | | |
| 34.00 | Di etary | 10. 00 | 893, 698 | -680, 819 | 212, 879 | 12, 303. 00 | 17. 30 | 34.00 |
| 35.00 | Di etary under contract (see | | 0 | 0 | 0 | 0. 00 | 0.00 | 35.00 |
| | instructions) | | | | | | | |
| 36. 00 | Cafeteri a | 11. 00 | | 680, 819 | 680, 819 | 39, 347. 00 | 17. 30 | 36. 00 |
| 37.00 | Maintenance of Personnel | 12. 00 | 0 | 0 | 0 | 0. 00 | | 37.00 |
| 38. 00 | Nursing Administration | 13. 00 | 745, 701 | 0 | 745, 701 | 19, 843. 00 | 37. 58 | 38. 00 |
| 39. 00 | Central Services and Supply | 14. 00 | 293, 621 | 0 | 293, 621 | 15, 763. 00 | 18. 63 | 39. 00 |
| 40.00 | Pharmacy | 15. 00 | 1, 483, 275 | -198, 371 | 1, 284, 904 | 29, 417. 00 | 43. 68 | 40.00 |
| 41.00 | Medical Records & Medical | 16. 00 | 669, 923 | 0 | 669, 923 | 30, 555. 00 | 21. 93 | 41.00 |
| | Records Library | | | | | | | |
| 42.00 | Social Service | 17. 00 | · · | 0 | 171, 579 | 6, 395. 00 | 26. 83 | 42.00 |
| 43.00 | Other General Service | 18. 00 | 0 | 0 | 0 | 0.00 | 0.00 | 43.00 |

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

| | | | | | ' | 0 12/31/2019 | 6/3/2020 5:03 | | | | | |
|-------|----------------------------------------|-------------|--------------|------------------|---------------|-----------------|----------------|-------|--|--|--|--|
| | | Worksheet A | Amount | Reclassi fi cati | Adj usted | Pai d Hours | Average Hourly | | | | | |
| | | Line Number | Reported | on of Salaries | Sal ari es | Related to | Wage (col. 4 ÷ | | | | | |
| | | | | (from | (col.2 ± col. | Salaries in | col. 5) | | | | | |
| | | | | Worksheet A-6) | 3) | col. 4 | | | | | | |
| | | 1. 00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | 6. 00 | | | | | |
| | PART III - HOSPITAL WAGE INDEX SUMMARY | | | | | | | | | | | |
| 1.00 | Net salaries (see | | 34, 885, 165 | 0 | 34, 885, 165 | 1, 192, 961. 00 | 29. 24 | 1. 00 | | | | |
| | instructions) | | | | | | | l | | | | |
| 2.00 | Excluded area salaries (see | | 1, 803, 243 | 249, 142 | 2, 052, 385 | 62, 180. 00 | 33. 01 | 2. 00 | | | | |
| | instructions) | | | | | | | l | | | | |
| 3.00 | Subtotal salaries (line 1 | | 33, 081, 922 | -249, 142 | 32, 832, 780 | 1, 130, 781. 00 | 29. 04 | 3. 00 | | | | |
| | minus line 2) | | | | | | | l | | | | |
| 4.00 | Subtotal other wages & related | | 1, 226, 157 | 0 | 1, 226, 157 | 11, 851. 00 | 103. 46 | 4. 00 | | | | |
| | costs (see inst.) | | | | | | | l | | | | |
| 5. 00 | Subtotal wage-related costs | | 6, 769, 968 | 0 | 6, 769, 968 | 0.00 | 20. 62 | 5. 00 | | | | |
| | (see inst.) | | | | | | | l | | | | |
| 6.00 | Total (sum of lines 3 thru 5) | | 41, 078, 047 | -249, 142 | 40, 828, 905 | 1, 142, 632. 00 | 35. 73 | 6. 00 | | | | |
| 7.00 | Total overhead cost (see | | 13, 124, 595 | -249, 142 | 12, 875, 453 | 462, 674. 00 | 27. 83 | 7. 00 | | | | |
| | instructions) | | | | | | | l | | | | |

| Health Financial Systems | DEARBORN COUNTY HOSPITAL | In Lieu of Form CMS-2552-10 |
|-----------------------------|--------------------------|-------------------------------------------------------------------------------------------|
| HOSPITAL WAGE RELATED COSTS | Provi der CCN: 15-0086 | Peri od: Worksheet S-3 From 01/01/2019 To 12/31/2019 Date/Time Prepared: 6/3/2020 5:03 pm |

| | To 12/31/201 | 9 Date/Time Prep 6/3/2020 5:03 | |
|--------|-------------------------------------------------------------------------------------------------------|-----------------------------------|--------|
| | | Amount | |
| | | Reported | |
| | | 1. 00 | |
| | PART IV - WAGE RELATED COSTS | • | |
| | Part A - Core List | | |
| | RETI REMENT COST | | |
| 1.00 | 401K Employer Contributions | 813, 788 | 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) | 2, 958, 549 | 8. 02 |
| 8.03 | Health Insurance (Purchased) | 0 | 8. 03 |
| 9.00 | Prescription Drug Plan | 0 | 9. 00 |
| 10.00 | Dental, Hearing and Vision Plan | 234, 534 | 10.00 |
| 11. 00 | Life Insurance (If employee is owner or beneficiary) | 50, 620 | 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) | 94, 927 | |
| 14.00 | | 0 | 14.00 |
| 15.00 | | 220, 100 | 15.00 |
| 16.00 | Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. | 0 | 16.00 |
| | Non cumulative portion) | | |
| | TAXES | | |
| | FICA-Employers Portion Only | 2, 012, 244 | |
| | Medicare Taxes - Employers Portion Only | 478, 923 | |
| 19. 00 | Unemployment Insurance | 27, 387 | |
| 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 | e 0 | 21. 00 |
| | <pre>instructions))</pre> | | |
| 22. 00 | Day Care Cost and Allowances | 0 | 22. 00 |
| | Tuition Reimbursement | 253, 062 | |
| 24. 00 | Total Wage Related cost (Sum of lines 1 -23) | 7, 144, 134 | 24. 00 |
| 25 62 | Part B - Other than Core Related Cost | | 25 00 |
| 25.00 | OTHER WAGE RELATED COSTS (SPECIFY) | 1 | 25. 00 |

| | | READDORN CONNEY HOOD, TAI | | 6.5. 0110.4 | |
|---------|------------------------------------------------|---------------------------|----------------|-----------------|-------|
| | Financial Systems | DEARBORN COUNTY HOSPITAL | | u of Form CMS-2 | |
| HOSPI 7 | TAL CONTRACT LABOR AND BENEFIT COST | | eri od: | Worksheet S-3 | |
| | | | rom 01/01/2019 | | |
| | | | o 12/31/2019 | Date/Time Pre | |
| | | | | 6/3/2020 5: 03 | pm |
| | Cost Center Description | | Contract Labor | Benefit Cost | |
| | | | 1. 00 | 2.00 | |
| | PART V - Contract Labor and Benefit Cost | | | | |
| | Hospital and Hospital-Based Component Identif | i cati on: | | | |
| 1.00 | Total facility's contract labor and benefit of | cost | 767, 824 | 7, 144, 134 | 1.00 |
| 2.00 | Hospi tal | | 767, 824 | 7, 144, 134 | 2. 00 |
| 3.00 | Subprovi der - IPF | | | | 3. 00 |
| 4.00 | Subprovi der - IRF | | | | 4. 00 |
| 5.00 | Subprovider - (Other) | | 0 | 0 | 5. 00 |
| 6.00 | Swing Beds - SNF | | 0 | 0 | 6. 00 |
| 7.00 | Swing Beds - NF | | 0 | 0 | 7. 00 |
| 0 00 | Hospi tal Pasad SNE | | | 0 | 0 00 |

8.00

9.00

10.00

11.00

12.00

13.00 14. 00 15.00

16.00 17.00

0 18.00

0

0

8.00

9.00

10.00

11.00

12.00

18.00 Other

Hospi tal -Based SNF

Hospi tal -Based NF Hospi tal -Based OLTC Hospi tal -Based HHA

16.00 Hospi tal -Based-CMHC 17.00 Renal Dialysis

Separately Certified ASC

13.00 Hospital -Based Hospice
14.00 Hospital -Based Health Clinic RHC
15.00 Hospital -Based Health Clinic FQHC

| Heal th | Financial Systems | DEARBORN COUN | ITY HOSPITAL | | In Li∈ | eu of Form CMS-: | 2552-10 |
|------------------|---------------------------------------------------------------------------------------|---------------------|---------------|--------------|-----------------------------|----------------------|---------|
| | BEALTH AGENCY STATISTICAL DATA | | Provi der C | CN: 15-0086 | Peri od: From 01/01/2019 | Worksheet S-4 | |
| | | | Component | CCN: 15-7055 | To 12/31/2019 | | |
| | | | | | Home Health | PPS | |
| | | | | | Agency I | | |
| 0.00 | I Country | | | | 1. | 00 | 0.00 |
| 0. 00 | County | Title V | Title XVIII | Title XIX | Other | Total | 0. 00 |
| | HOME HEALTH AGENCY STATISTICAL DATA | 1. 00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | |
| 1. 00 | Home Health Aide Hours | 0 | С | | 0 0 | 0 | 1. 00 |
| 2. 00 | Unduplicated Census Count (see instructions) | 0.00 | 299.00 | | 0.00 ployees (Full Ti | | 2. 00 |
| | | | | Number of Em | proyecs (ruit ii | me Equi vai cirt) | |
| | | | | | | | |
| | | Enter the numb | | Staff | Contract | Total | |
| | | your normal | work week | | | | |
| | | | | | | | |
| | | (| 0 | 1.00 | 2. 00 | 3.00 | |
| 3. 00 | HOME HEALTH AGENCY - NUMBER OF EMPLOYEES Administrator and Assistant Administrator(s) | | 40. 00 | 3. 0 | 99 0.00 | 3. 99 | 3.00 |
| 4.00 | Director(s) and Assistant Director(s) | | .0.00 | 0.0 | 0.00 | 0.00 | 4. 00 |
| 5. 00 6. 00 | Other Administrative Personnel Direct Nursing Service | | | 0.0 | | | 1 |
| 7.00 | Nursi ng Supervi sor | | | 0.0 | 0.00 | 0.00 | 7. 00 |
| 8. 00 9. 00 | Physical Therapy Service Physical Therapy Supervisor | | | 2.7 | | | 1 |
| 10.00 | Occupational Therapy Service | | | 0. 0 | | | 1 |
| 11. 00 12. 00 | Occupational Therapy Supervisor Speech Pathology Service | | | 0.0 | | | 1 |
| 13.00 | Speech Pathology Supervisor | | | 0.0 | | | 1 |
| 14. 00 15. 00 | Medical Social Service Medical Social Service Supervisor | | | 0.0 | | | 1 |
| 16.00 | Home Heal th Aide | | | 0. 0 | 67 0.00 | 0. 67 | 1 |
| 17. 00 18. 00 | Home Health Aide Supervisor Other (specify) | | | 0.0 | | | 1 |
| 10.00 | HOME HEALTH AGENCY CBSA CODES | | | | | | 10.00 |
| 19. 00 | Enter in column 1 the number of CBSAs where you provided services during the cost | | | | 2 | | 19. 00 |
| 20. 00 | reporting period. List those CBSA code(s) in column 1 serviced | | | 17140 | | | 20. 00 |
| 20.00 | during this cost reporting period (line 20 | | | 17140 | | | 20.00 |
| 20. 01 | contains the first code). | | | 99915 | | | 20. 01 |
| | | Full Ep | | | DED 0 1 | T | |
| | | Without Outliers | With Outliers | LUPA EDISOGE | PEP Only Epi sodes | Total (cols. 1-4) | |
| | DDC ACTIVITY DATA | 1. 00 | 2.00 | 3. 00 | 4. 00 | 5.00 | |
| 21. 00 | PPS ACTIVITY DATA Skilled Nursing Visits | 1, 806 | 234 | | 63 43 | 2, 146 | 21. 00 |
| 22. 00 23. 00 | Skilled Nursing Visit Charges Physical Therapy Visits | 362, 464 1, 285 | | 1 | 44 8, 630 44 26 | | |
| 24. 00 | Physical Therapy Visit Charges | 283, 002 | | | | | |
| 25. 00 26. 00 | Occupational Therapy Visits Occupational Therapy Visit Charges | 322 70, 921 | 441 | 1, 98 | 9 7 32 1, 542 | 340 74, 886 | 1 |
| 27. 00 | Speech Pathology Visits | 12 | 2 | | 1 0 | 15 | 27. 00 |
| 28. 00 29. 00 | Speech Pathology Visit Charges Medical Social Service Visits | 2, 643 | 441 C | 1 | 20 0 0 0 | 3, 304 0 | 1 |
| 30.00 | Medical Social Service Visit Charges | 0 | C | | 0 0 | 0 | 30. 00 |
| 31. 00 32. 00 | Home Health Aide Visits Home Health Aide Visit Charges | 204 42, 982 | 3 701 | 1 | 0 0 | | 1 |
| 33. 00 | Total visits (sum of lines 21, 23, 25, 27, | 3, 629 | | | 17 76 | | 1 |
| 34. 00 | 29, and 31) Other Charges | 0 | c | | 0 0 | 0 | 34.00 |
| 35. 00 | Total Charges (sum of lines 22, 24, 26, 28, | 762, 012 | - | 1 | | l . | 1 |
| 36. 00 | 30, 32, and 34) Total Number of Episodes (standard/non | 291 | | | 41 8 | 340 | 36. 00 |
| 37. 00 | outlier) Total Number of Outlier Episodes | | 10 | | 1 | 11 | 37. 00 |
| | Total Non-Routine Medical Supply Charges | 23, 863 | ł . | 1 | 45 666 | | 38.00 |
| | | | | | | | |

| Heal th | Financial Systems | | DEARBORN COUN | ITY HOSPITAL | | In Lie | eu of Form CMS-2 | 2552-10 |
|---------|-----------------------------------------------|------------------|-------------------|------------------|--------------|----------------------------------|-----------------------------|--------------|
| HOSPI T | AL-BASED HOSPICE IDENTIFICATION | DATA | | Provi der C | CN: 15-0086 | Peri od: | Worksheet S-9 | |
| | | | | Heeni ee CC | N: 15-1531 | From 01/01/2019 To 12/31/2019 | PARTS I THROU | GH IV |
| | | | | HOSPI CE CC | N: 15-1531 | 10 12/31/2019 | Date/Time Pre 6/3/2020 5:03 | pareu: nm |
| | | | | | | Hospi ce I | 0, 0, 2020 0, 00 | |
| | | Undupl i cated | | | | | | |
| | | Days | | | | | | |
| | | Title XVIII | Title XIX | Title XVIII | Title XIX | All Other | Total (sum of | |
| | | | | Skilled | Nursi ng | | col s. 1, 2 & | |
| | | | | Nursing | Facility | | 5) | |
| | | 1. 00 | 2.00 | Facility 3.00 | 4.00 | 5. 00 | 6. 00 | |
| | PART I - ENROLLMENT DAYS FOR CO | | | | | 3.00 | 0.00 | |
| 1.00 | Hospice Continuous Home Care | OST REFORTING T | EKTODS BEGINNI | THO BETOKE OCTO | DER 1, 2013 | | | 1.00 |
| 2.00 | Hospice Routine Home Care | | | | | | | 2.00 |
| 3.00 | Hospice Inpatient Respite Care | | | | | | | 3. 00 |
| 4.00 | Hospice General Inpatient Care | | | | | | | 4. 00 |
| 5.00 | Total Hospice Days | | | | | | | 5. 00 |
| | Part II - CENSUS DATA FOR COST | REPORTING PERI | ODS BEGINNING | BEFORE OCTOBER | 1, 2015 | | | |
| 6.00 | Number of patients receiving | | | | | | | 6. 00 |
| | hospi ce care | | | | | | | |
| 7. 00 | Total number of unduplicated | | | | | | | 7. 00 |
| | Continuous Care hours billable | | | | | | | |
| 8. 00 | to Medicare Average Length of Stay (line 5 | | | | | | | 8. 00 |
| 8.00 | / line 6) | | | | | | | 0.00 |
| 9. 00 | Unduplicated census count | | | | | | | 9. 00 |
| | Parts I and II, columns 1 and 2 | also include : | the days renort | ted in columns | 3 and 4 | | | 7.00 |
| MOTE. | Tarts Fand FF, Corumns Fand 2 | ar so Ther due | the days report | | | | | |
| | | | | Title XVIII | Title XIX | Other | Total (sum of | |
| | | | | | | | col s. 1 | |
| | | | | 1.00 | 2.00 | 3. 00 | through 3) 4.00 | |
| | PART III - ENROLLMENT DAYS FOR | COST DEDODTING | DEDIANS REGIN | | | | 4.00 | |
| 10. 00 | Hospice Continuous Home Care | COST KEI OKTTING | J I EKI ODS DEGIN | INTING ON OR ALL | LK OCTOBER 1 | 0 0 | 0 | 10.00 |
| 11. 00 | Hospice Routine Home Care | | | 2, 277 | | 64 425 | 1 | 11. 00 |
| 12. 00 | Hospice Inpatient Respite Care | | | 2,2,, | 1 | 0 0 | | 12.00 |
| 13. 00 | | | | 133 | | 7 56 | | 13. 00 |
| 14.00 | Total Hospice Days | | | 2, 410 | | 71 481 | l e | 14. 00 |
| | PART IV - CONTRACTED STATISTICA | AL DATA FOR COS | ST REPORTING PE | RIODS BEGINNIN | G ON OR AFTE | R OCTOBER 1, 2015 | | |
| 15.00 | Hospice Inpatient Respite Care | | | 0 | | 0 0 | | 15. 00 |
| 16.00 | Hospice General Inpatient Care | | | (|) | 0 | 0 | 16. 00 |
| | | | | | | | | |

| ים פר | Financial Systems DEARBORN COUNTY HOS | | | u of Form CMS-2 | |
|-------------------------|---------------------------------------------------------------------------------------------------------------------------------------|---------------------------|-----------------------------|-------------------------|------------|
| JSPI I | AL UNCOMPENSATED AND INDIGENT CARE DATA | ovider CCN: 15-0086 | Peri od: From 01/01/2019 | Worksheet S-10 | U |
| | | | To 12/31/2019 | Date/Time Pre | pared |
| | | | | 6/3/2020 5: 03 | pm |
| | | | | 1. 00 | |
| | Uncompensated and indigent care cost computation | | | | |
| 00 | Cost to charge ratio (Worksheet C, Part I line 202 column 3 divid | led by line 202 colum | nn 8) | 0. 322496 | 1. (|
| 00 | Medicaid (see instructions for each line) Net revenue from Medicaid | | | -934, 391 | 2. (|
| 00 | Did you receive DSH or supplemental payments from Medicaid? | | | Υ | 3. (|
| 00 | If line 3 is yes, does line 2 include all DSH and/or supplemental | payments from Medic | cai d? | Υ | 4. (|
| 00 | If line 4 is no, then enter DSH and/or supplemental payments from | Medicaid | | 0 | |
| 00 | Medi cai d charges | | | 16, 844, 808 | 1 |
| 00 | Medicaid cost (line 1 times line 6) | no 7 minus sum of Li | noc 2 and E. if | 5, 432, 383 | 1 |
| 00 | Difference between net revenue and costs for Medicaid program (li < zero then enter zero) | THE / IIITHUS SUIII OT TT | nes 2 and 5, 11 | 6, 366, 774 | 0. (|
| | Children's Health Insurance Program (CHIP) (see instructions for | each line) | | | |
| 00 | Net revenue from stand-alone CHIP | · | | 0 | 9.1 |
| 0. 00 | Stand-alone CHIP charges | | | 0 | |
| 1.00 | Stand-alone CHIP cost (line 1 times line 10) | 44 ' 1' 0 | . 6 | 0 | |
| 2. 00 | Difference between net revenue and costs for stand-alone CHIP (lienter zero) | ne II minus II ne 9; | IT < zero then | 0 | 12. |
| | Other state or local government indigent care program (see instru | ctions for each line | e) | | |
| 3. 00 | Net revenue from state or local indigent care program (Not include | | | 0 | 13. |
| 1. 00 | Charges for patients covered under state or local indigent care p | program (Not included | d in lines 6 or | 0 | 14. |
| - 00 | 10) | | | | 4.5 |
| 5. 00 5. 00 | State or local indigent care program cost (line 1 times line 14) Difference between net revenue and costs for state or local indic | uont caro program (Li | no 15 minus Lino | 0 | 15. 16. |
| 5. 00 | 13; if < zero then enter zero) | jent care program (11 | ne is illinus iine | U | 10. |
| | Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) | and state/local indi | gent care program | ns (see | |
| 7. 00 | 1 | | | 0 | |
| 3. 00 | Government grants, appropriations or transfers for support of hos | | (6.11 | 0 | |
| 9. 00 | Total unreimbursed cost for Medicaid , CHIP and state and local i 8, 12 and 16) | ndigent care program | ns (sum of lines | 6, 366, 774 | 19. |
| | 0, 12 did 10) | Uni nsured | Insured | Total (col. 1 | |
| | | pati ents | | + col . 2) | |
| | | 1.00 | 2. 00 | 3. 00 | |
| 0. 00 | Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil | ity 202, 7 | 709 204, 521 | 407, 230 | 20 |
|). 00 | (see instructions) | 202, | 204, 321 | 407, 230 | 20. |
| 1. 00 | Cost of patients approved for charity care and uninsured discount | s (see 65, 3 | 373 204, 521 | 269, 894 | 21. |
| | instructions) | | | | |
| 2. 00 | Payments received from patients for amounts previously written of | f as | 0 0 | 0 | 22. |
| 3. 00 | charity care [Cost of charity care (line 21 minus line 22) | 65, 3 | 373 204, 521 | 269, 894 | 23 |
| J. 00 | post of charty care (fine 21 minus fine 22) | 00, | 204, 321 | 207, 074 | 25. |
| | | | | 1.00 | |
| 1. 00 | Does the amount on line 20 column 2, include charges for patient | | n of stay limit | N | 24. |
| 5. 00 | imposed on patients covered by Medicaid or other indigent care pr If line 24 is yes, enter the charges for patient days beyond the | | am's length of | 0 | 25. |
| | stay limit | rusti ons) | | 4 / 57 244 | 24 |
| 6. 00 7. 00 | Total bad debt expense for the entire hospital complex (see instrumedicare reimbursable bad debts for the entire hospital complex (| | | 4, 657, 214 181, 658 | ı |
| . 00 | Medicare allowable bad debts for the entire hospital complex (see | | | 279, 475 | 1 |
| 7. 01 | | | | 4, 377, 739 | 1 |
| 7. 01 3. 00 | Non-Medicare bad debt expense (see instructions) | | | | |
| | Non-Medicare bad debt expense (see instructions) Cost of non-Medicare and non-reimbursable Medicare bad debt exper | se (see instructions | s) | 1, 509, 620 | 1 |
| 3. 00 9. 00 0. 00 | 1 , , , , , , , , , , , , , , , , , , , | · | 5) | | 29. 30. |

| | FINANCIAL SYSTEMS | DEARBURN COUNTY | | CN 15 000/ | | U OF FORM CMS- | 2332-10 |
|------------------|----------------------------------------------------------------------|-------------------------|----------------------------|-----------------|-----------------------------------------|-------------------------------|------------------|
| RECLAS | SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O | F EXPENSES | Provi der C | | Period: From 01/01/2019 | Worksheet A | |
| | | | | | Γο 12/31/2019 | Date/Time Pre | |
| | 0 1 0 1 0 1 | 6.1. | | T (a | D 1 .C. 11 | 6/3/2020 5: 03 | pm |
| | Cost Center Description | Sal ari es | Other | | Reclassificati | Reclassified Trial Balance | |
| | | | | + col . 2) | ons (See A-6) | (col. 3 +- | |
| | | | | | | col . 4) | |
| | | 1.00 | 2. 00 | 3.00 | 4. 00 | 5. 00 | |
| | GENERAL SERVICE COST CENTERS | 1100 | 2.00 | 0.00 | | 0.00 | |
| 1.00 | 00100 NEW CAP REL COSTS-BLDG & FIXT | | 3, 867, 978 | 3, 867, 978 | 138, 774 | 4, 006, 752 | 1.00 |
| 2.00 | 00200 NEW CAP REL COSTS-MVBLE EQUIP | | 1, 815, 698 | 1, 815, 698 | 0 | 1, 815, 698 | 2. 00 |
| 3.00 | 00300 OTHER CAPITAL RELATED COSTS | | 0 |) | 0 | 0 | 3. 00 |
| 4.00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | 364, 635 | 7, 325, 404 | | | 7, 690, 039 | 4. 00 |
| 5. 01 | 01160 COMMUNI CATI ONS | 106, 872 | 145, 603 | 1 | | 252, 475 | |
| 5. 02 | 00550 DATA PROCESSING | 1, 227, 075 | 2, 054, 819 | | | 3, 281, 894 | |
| 5. 03 | 00560 PURCHASING RECEIVING AND STORES | 180, 932 | 147, 376 | | | 328, 394 | 5. 03 |
| 5.04 | 00570 ADMI TTI NG 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE | 580, 279 | 66, 344 | | | 646, 623 | |
| 5. 05 5. 06 | 00591 OTHER ADMINISTRATIVE AND GENERAL | 723, 694 2, 888, 611 | 1, 048, 893 7, 233, 349 | | | 1, 772, 587 9, 972, 580 | |
| 7. 00 | 00700 OPERATION OF PLANT | 1, 117, 593 | 1, 857, 574 | | | 2, 920, 893 | 1 |
| 8. 00 | 00800 LAUNDRY & LINEN SERVICE | 88, 573 | 330, 566 | | | 419, 139 | 1 |
| 9. 00 | 00900 HOUSEKEEPI NG | 879, 516 | 236, 657 | | 1 | 1, 137, 787 | 1 |
| 10.00 | 01000 DI ETARY | 893, 698 | 638, 388 | | | 364, 944 | |
| 11.00 | 01100 CAFETERI A | 0 | 0 | | 1, 167, 142 | 1, 167, 142 | 11. 00 |
| 13.00 | 01300 NURSING ADMINISTRATION | 745, 701 | 71, 592 | | | 817, 293 | 13. 00 |
| 14.00 | 01400 CENTRAL SERVICE & SUPPLY | 293, 621 | 375, 200 | | | 468, 066 | |
| 15. 00 | 01500 PHARMACY | 1, 483, 275 | 262, 025 | | | 1, 467, 199 | 1 |
| 16. 00 | 01600 MEDICAL RECORDS & LIBRARY | 669, 923 | 114, 727 | 1 | | 783, 057 | 1 |
| 17. 00 | 01700 SOCIAL SERVICE | 171, 579 | 10, 887 | | | 182, 466 | 1 |
| 23. 00 | 02300 PHARMACY RESIDENCY | 0 | 0 |) (| 234, 770 | 234, 770 | 23. 00 |
| 00.00 | I NPATI ENT ROUTI NE SERVI CE COST CENTERS | F 700 070 | 4 404 407 | / 000 40 | 054 000 | F 070 047 | 00.00 |
| 30.00 | 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT | 5, 732, 278 | 1, 101, 126 | | | 5, 979, 316 | |
| 31. 00 43. 00 | 04300 NURSERY | 1, 288, 220 0 | 179, 305 | | 5 129 521, 681 | 1, 467, 654 521, 681 | |
| 44. 00 | 04400 SKILLED NURSING FACILITY | | 0 | 1 | 0 521,001 | 0 321,001 | 1 |
| 44.00 | ANCI LLARY SERVI CE COST CENTERS | <u> </u> | | 1 | 9 | | 1 44. 00 |
| 50. 00 | 05000 OPERATING ROOM | 2, 049, 149 | 5, 864, 411 | 7, 913, 560 | -1, 131, 349 | 6, 782, 211 | 50.00 |
| 51. 00 | 05100 RECOVERY ROOM | 658, 546 | 92, 111 | | | 747, 728 | |
| 52.00 | 05200 DELIVERY ROOM & LABOR ROOM | o | 0 | | 314, 609 | 314, 609 | |
| 53.00 | 05300 ANESTHESI OLOGY | o | 2, 135, 998 | 2, 135, 998 | -35, 996 | 2, 100, 002 | 53. 00 |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 1, 348, 393 | 613, 205 | 1, 961, 598 | -4, 316 | 1, 957, 282 | |
| 54. 01 | 05401 ULTRASOUND | 242, 089 | 71, 325 | | | 285, 883 | |
| 55. 00 | 05500 RADI OLOGY-THERAPEUTI C | 479, 161 | 227, 377 | | | 645, 700 | |
| 57. 00 | 05700 CT SCAN | 572, 762 | 334, 629 | | | 863, 458 | |
| 58. 00 | 05800 MAGNETIC RESONANCE IMAGING (MRI) | 280, 160 | 300, 003 | 580, 16 | | 579, 323 | 1 |
| 59.00 | 05900 CARDI AC CATHETERI ZATI ON | 2 202 070 | 2 072 020 | 5 25 (20) | 0 | 0 | 07.00 |
| 60. 00 60. 01 | 06000 LABORATORY 06001 BLOOD LABORATORY | 2, 283, 078 | 3, 073, 830 | 5, 356, 908 | -133 | 5, 356, 775 | 60. 00 60. 01 |
| 65. 00 | 06500 RESPIRATORY THERAPY | 800, 947 | 150, 728 | 951, 67! | -38, 855 | 912, 820 | |
| 65. 01 | 03950 SLEEP CLINIC | 000, 747 | 212, 509 | | | 212, 509 | |
| 66. 00 | | 1, 444, 440 | 105, 550 | | | 1, 545, 603 | |
| | 06700 OCCUPATI ONAL THERAPY | 256, 249 | 10, 865 | | | 264, 709 | |
| | 06800 SPEECH PATHOLOGY | 185, 587 | 3, 128 | | | 188, 715 | |
| 69. 00 | 06900 ELECTROCARDI OLOGY | 711, 097 | 361, 661 | 1, 072, 758 | -777 | 1, 071, 981 | 69. 00 |
| 71.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 |) | 1, 658, 015 | 1, 658, 015 | 71. 00 |
| 72.00 | 07200 IMPL. DEV. CHARGED TO PATIENT | 0 | 165, 305 | | | 165, 305 | |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 0 | 2, 750, 578 | 2, 750, 578 | 0 | 2, 750, 578 | 73. 00 |
| | OUTPATIENT SERVICE COST CENTERS | | | | 1 | | |
| 91.00 | | 1, 625, 171 | 648, 730 | 2, 273, 90° | -3, 733 | 2, 270, 168 | |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | | | | | 92.00 |
| 101 00 | OTHER REIMBURSABLE COST CENTERS | 004 143 | 100 200 | 1 174 54 | -6, 104 | 1, 170, 439 | 101 00 |
| 101.00 | 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS | 996, 163 | 180, 380 | 1, 176, 54 | -0, 104 | 1, 170, 439 | 101.00 |
| 113 00 | 11300 INTEREST EXPENSE | | 0 | | | 0 | 113. 00 |
| | 11600 HOSPI CE | 294, 238 | 358, 222 | 652, 460 | -32, 284 | 620, 176 | |
| 118.00 | | 33, 663, 305 | 46, 544, 056 | 1 | | | |
| | NONREI MBURSABLE COST CENTERS | 00,000,000 | 10, 0 1 1, 000 | , 30, 20, 7, 00 | ., .,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | 00, 102, 100 | |
| 190.00 | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | 0 |) | 0 | 0 | 190. 00 |
| 192.00 | 19200 PHYSICIANS' PRIVATE OFFICES | 7, 367 | 237, 714 | 245, 08° | 1 44, 688 | 289, 769 | 192. 00 |
| 192. 01 | 19201 PHYSICIAN CLINIC | 9, 597 | 33, 486 | 43, 083 | 0 | 43, 083 | 192. 01 |
| 192. 02 | 19202 LI FELI NE | 0 | 1, 888 | 1, 888 | 0 | 1, 888 | 192. 02 |
| | 19203 CREDIT UNION | 0 | 0 | | 0 | | 192. 03 |
| | 19204 ENT | 0 | 299, 300 | | | 299, 300 | |
| | 19205 HOSPI TALI ST | 0 | 2, 049, 099 | | | 2, 049, 099 | |
| | 19206 ORTHO | 0 | 682, 787 | | | 682, 787 | |
| | 07950 COMMUNITY MENTAL HEALTH | 170 004 | 174 201 | | 0 | | 194.00 |
| | 07951 MARKETI NG | 178, 934 | 176, 291 | | | 355, 225 | |
| | 07953 OCCUPATIONAL HEALTH 07952 PATHS EDUCATION | 198, 064 | 64, 595 54, 621 | | | 262, 894 54, 621 | 194. 02 |
| | 07952 PATHS EDUCATION 07954 FOUNDATION | 118, 880 | 25, 653 | | | 144, 533 | |
| 174.04 | JOT TO THE BOTTON | 110,000 | 25, 003 | 1 144, 55. | <u> </u> | 144, 333 | 1177.04 |
| | | | | | | | |

| Heal th Financial | Systems | DEARBORN COUNT | Y HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|--------------------|--------------------------------------|----------------|--------------|---------------|--------------------------------|--------------------------------|---------|
| RECLASSI FI CATI O | N AND ADJUSTMENTS OF TRIAL BALANCE O | F EXPENSES | Provi der CC | | eri od: | Worksheet A | |
| | | | | | rom 01/01/2019 o 12/31/2019 | Date/Time Pre 6/3/2020 5:03 | |
| Cos | t Center Description | Sal ari es | 0ther | Total (col. 1 | Recl assi fi cati | Recl assi fi ed | |
| | | | | + col . 2) | ons (See A-6) | Trial Balance | |
| | | | | | | (col. 3 +- | |
| | | | | | | col. 4) | |
| | | 1.00 | 2.00 | 3. 00 | 4. 00 | 5. 00 | |
| 200. 00 TOT | AL (SUM OF LINES 118 through 199) | 34, 176, 147 | 50, 169, 490 | 84, 345, 637 | 0 | 84, 345, 637 | 200.00 |

| Period: | Worksheet A | From 01/01/2019 | To 12/31/2019 | Date/Time Prepared: 6/3/2020 5:03 pm

| | | | | | 6/3/2020 5: 03 pm |
|------------------|----------------------------------------------------------------------------|----------------------|----------------------------|--------------|--------------------|
| | Cost Center Description | Adjustments | Net Expenses | | |
| | | | For Allocation | 1 | |
| | T | 6. 00 | 7. 00 | | |
| 1 00 | GENERAL SERVICE COST CENTERS | 21/ 251 | 2 700 501 | .1 | 1 00 |
| 1. 00 2. 00 | 00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP | -216, 251 -3, 718 | 3, 790, 501 1, 811, 980 | | 1.00 |
| 3. 00 | 00300 OTHER CAPITAL RELATED COSTS | -3,710 | 1, 611, 960 | 1 | 3.00 |
| 4. 00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | -12, 371 | 7, 677, 668 | 1 | 4.00 |
| 5. 01 | 01160 COMMUNI CATI ONS | -7, 138 | 245, 337 | • | 5. 01 |
| 5. 02 | 00550 DATA PROCESSING | 0 | 3, 281, 894 | • | 5. 02 |
| 5.03 | 00560 PURCHASING RECEIVING AND STORES | 0 | 328, 394 | • | 5. 03 |
| 5.04 | 00570 ADMITTING | 0 | 646, 623 | 3 | 5. 04 |
| 5.05 | 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE | -4, 463 | 1, 768, 124 | 1 | 5. 05 |
| 5.06 | 00591 OTHER ADMINISTRATIVE AND GENERAL | -5, 277, 085 | 4, 695, 495 | 5 | 5. 06 |
| 7.00 | 00700 OPERATION OF PLANT | -109, 696 | 2, 811, 197 | 7 | 7. 00 |
| 8.00 | 00800 LAUNDRY & LINEN SERVICE | 0 | 419, 139 | 1 | 8. 00 |
| 9. 00 | 00900 HOUSEKEEPI NG | 0 | 1, 137, 787 | • | 9. 00 |
| 10.00 | 01000 DI ETARY | -6, 166 | 358, 778 | • | 10.00 |
| 11. 00 | 01100 CAFETERI A | -497, 842 | 669, 300 | • | 11.00 |
| 13.00 | 01300 NURSI NG ADMI NI STRATI ON | 0 | 817, 293 | • | 13.00 |
| 14.00 | 01400 CENTRAL SERVICE & SUPPLY | 0 | 468, 066 | | 14.00 |
| 15. 00 16. 00 | 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY | 0 -20, 963 | 1, 467, 199 | | 15. 00 16. 00 |
| 17. 00 | 01700 SOCIAL SERVICE | -20, 903 | 762, 094 182, 466 | • | 17. 00 |
| 23. 00 | 02300 PHARMACY RESIDENCY | 0 | 234, 770 | | 23. 00 |
| 23.00 | I NPATI ENT ROUTI NE SERVI CE COST CENTERS | <u> </u> | 254, 110 | <u>/</u> | 23. 00 |
| 30. 00 | 03000 ADULTS & PEDIATRICS | -381, 338 | 5, 597, 978 | 3 | 30.00 |
| 31. 00 | 03100 I NTENSI VE CARE UNI T | 0 | 1, 467, 654 | • | 31.00 |
| 43.00 | 04300 NURSERY | 0 | 521, 681 | • | 43. 00 |
| 44.00 | 04400 SKILLED NURSING FACILITY | 0 | 0 | | 44. 00 |
| | ANCILLARY SERVICE COST CENTERS | | | | |
| 50.00 | 05000 OPERATI NG ROOM | -58, 310 | 6, 723, 901 | • | 50.00 |
| 51. 00 | 05100 RECOVERY ROOM | 0 | 747, 728 | • | 51.00 |
| 52. 00 | 05200 DELIVERY ROOM & LABOR ROOM | 0 | 314, 609 | • | 52.00 |
| 53.00 | 05300 ANESTHESI OLOGY | -2, 008, 922 | 91, 080 | • | 53.00 |
| 54.00 | 05400 RADI OLOGY - DI AGNOSTI C | -4, 524 | 1, 952, 758 | | 54.00 |
| 54. 01 55. 00 | 05401 ULTRASOUND | 0 | 285, 883 | • | 54. 01 55. 00 |
| 55.00 | 05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN | -2, 776 | 645, 700 860, 682 | • | 57.00 |
| 58. 00 | 05800 MAGNETIC RESONANCE I MAGING (MRI) | -2,770 | 579, 323 | | 58.00 |
| 59. 00 | 05900 CARDI AC CATHETERI ZATI ON | 0 | 379, 323 | 1 | 59.00 |
| 60. 00 | 06000 LABORATORY | -164, 614 | 5, 192, 161 | | 60.00 |
| 60. 01 | 06001 BLOOD LABORATORY | 104, 014 | 3, 172, 101 | | 60. 01 |
| 65. 00 | 06500 RESPI RATORY THERAPY | -16, 739 | 896, 081 | | 65. 00 |
| 65. 01 | 03950 SLEEP CLINIC | 0 | 212, 509 | • | 65. 01 |
| 66.00 | 06600 PHYSI CAL THERAPY | 0 | 1, 545, 603 | • | 66. 00 |
| 67.00 | 06700 OCCUPATI ONAL THERAPY | 0 | 264, 709 | | 67. 00 |
| 68.00 | 06800 SPEECH PATHOLOGY | 0 | 188, 715 | 5 | 68. 00 |
| 69. 00 | 06900 ELECTROCARDI OLOGY | -236, 197 | 835, 784 | 1 | 69. 00 |
| | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 1, 658, 015 | • | 71.00 |
| | 07200 I MPL. DEV. CHARGED TO PATIENT | 0 | 165, 305 | • | 72. 00 |
| 73. 00 | 07300 DRUGS CHARGED TO PATIENTS | -909, 425 | 1, 841, 153 | 3 | 73. 00 |
| 01 00 | OUTPATIENT SERVICE COST CENTERS | 00.224 | 2 100 024 | 1 | 91.00 |
| 91.00 | 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) | -89, 334 | 2, 180, 834 | ! | 92.00 |
| 72.00 | OTHER REIMBURSABLE COST CENTERS | | | 1 | 72.00 |
| 101.00 | 10100 HOME HEALTH AGENCY | 0 | 1, 170, 439 | | 101. 00 |
| | SPECIAL PURPOSE COST CENTERS | -1 | .,, | | |
| 113.00 | 11300 NTEREST EXPENSE | 0 | 0 | | 113. 00 |
| 116.00 | 11600 HOSPI CE | -4, 187 | 615, 989 | | 116. 00 |
| 118.00 | SUBTOTALS (SUM OF LINES 1 through 117) | -10, 032, 059 | 70, 130, 379 | | 118. 00 |
| | NONREI MBURSABLE COST CENTERS | | | , | |
| | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | 0 | 1 | 190. 00 |
| | 19200 PHYSI CI ANS' PRI VATE OFFI CES | 0 | 289, 769 | | 192. 00 |
| | 19201 PHYSI CI AN CLI NI C | 0 | 43, 083 | | 192. 01 |
| | 19202 LI FELI NE | 0 | 1, 888 | 3 | 192. 02 |
| | 19203 CREDIT UNION | 0 | 200, 200 |) | 192. 03 |
| | 19204 ENT | 0 | 299, 300 | • | 192. 04 |
| | 19205 HOSPI TALI ST | 0 | 2, 049, 099 | | 192. 05 |
| | 19206 ORTHO 07950 COMMUNI TY MENTAL HEALTH | 0 | 682, 787 0 | 1 | 192. 06 194. 00 |
| | 07950 COMMUNITY MENTAL HEALTH | | 355, 225 | 1 | 194. 00 |
| | 207953 OCCUPATI ONAL HEALTH | | 355, 225 262, 894 | | 194. 01 |
| | 07955 OCCUPATIONAL HEALTH | 0 | 54, 621 | • | 194. 02 |
| | 07954 FOUNDATION | 0 | 144, 533 | • | 194. 04 |
| 200.00 | | -10, 032, 059 | | • | 200. 00 |
| | | | , ., . | • | 1 |
| | | | | | |

| | | | | | 10 12/31/2019 | Date/IIme Prepare 6/3/2020 5:03 pm |
|----------------|---------------------------|----------------|-------------|------------------|---------------|-----------------------------------------|
| | | Increases | | | | |
| | Cost Center | Li ne # | Salary | 0ther | | |
| | 2.00 | 3. 00 | 4. 00 | 5. 00 | | |
| | CAFETERI A | 11 00 | 400 010 | 407 222 | | 1 |
| . 00 CAF | ETERI A | | 680, 819 | 48 <u>6, 323</u> | | 1. |
| D | NURSERY | | 680, 819 | 486, 323 | | |
| | SERY | 43.00 | 445, 363 | 76, 318 | | 1. |
| • | I VERY ROOM & LABOR ROOM | 52.00 | 268, 584 | 46, 025 | | 2. |
| 00 022 | VERT ROOM & EADOR ROOM | | 713, 947 | 122, 343 | | 2. |
| C - | UTILIZATION REVIEW COST | | 710, 717 | 122, 010 | | |
| | ER ADMINISTRATIVE AND | 5. 06 | 0 | 1, 593 | | 1. |
| | ERAL | | | , | | |
| 0 | | - $ +$ | | <u> 1, 5</u> 93 | | |
| D - | SECURI TY GUARD | | | | | |
| . 00 PHY | SICIANS' PRIVATE OFFICES | 192. 00 | 50, 771 | 139 | | 1. |
| 0 | | | 50, 771 | 139 | | |
| | MED SUPPLY RECLASS | | | | | |
| | I CAL SUPPLIES CHARGED TO | 71. 00 | 0 | 1, 658, 015 | | 1. |
| | I ENTS | | | | | |
| | CHASING RECEIVING AND | 5. 03 | 0 | 86 | | 2. |
| ST0 | - | 24 22 | | 400 | | |
| | ENSIVE CARE UNIT | 31.00 | 0 | 129 | | 3. |
| | UPATI ONAL HEALTH | 194. 02 | 0 | 235 | | 4. |
| 00 | | 0.00 | 0 | 0 | | 5 |
| 00 | | 0.00 | 0 | 0 | | 6 |
| 00 | | 0.00 | 0 | 0 | | 7 |
| 00 | | 0.00 | 0 | 0 | | 8 |
| 00 | | 0.00 | 0 | 0 | | 9 |
| 0. 00 | | 0.00 | 0 | 0 | | 10 |
| 1. 00 | | 0. 00 0. 00 | 0 | 0 | | 11 |
| 2. 00 | | | | - | | |
| 3. 00 | | 0. 00 0. 00 | 0 | 0 | | 13 |
| 1.00 | | 1 | ol ol | 0 | | 14 |
| 5. 00 | | 0.00 | ol ol | 0 | | |
| 5. 00 7. 00 | | 0. 00 0. 00 | ol ol | 0 | | 16 17 |
| 3. 00 | | 0.00 | 0 | 0 | | 18 |
| 9. 00 | | 0.00 | o | 0 | | 19 |
| 0. 00 | | 0.00 | o | 0 | | 20 |
|). 00 | | | | 1, 658, 465 | | 20 |
| F - | POB HOUSEKEEPING | | <u> </u> | 1,030,403 | | |
| | SEKEEPI NG | 9.00 | 0 | 21, 614 | | 1 |
| 00 | SEREE! 1110 | 0.00 | | 0 | | 2 |
| 0 | | | 0 | <u>21, 614</u> | | - |
| G - | I NSURANCE | | <u> </u> | 2., 0 | | |
| | CAP REL COSTS-BLDG & | 1.00 | 0 | 138, 774 | | 1 |
| FIX | | 55 | 9 | . = = , | | ' |
| | SICIANS' PRIVATE OFFICES | 192.00 | 0 | 12, 199 | | 2 |
| 0 | | + | | 150, 973 | | - |
| Н - | PHARMACY RESIDENCY RECLAS | S | | 1 | | |
| | RMACY RESIDENCY | 23.00 | 198, 371 | 36, 399 | | 1 |
| TOT | ALS — — — — | | 198, 371 | 36, 399 | | |
| 00.00 Gra | nd Total: Increases | | 1, 643, 908 | 2, 477, 849 | | 500 |

| | | | | | | | e/IIme Prepared /2020 5:03 pm |
|------|----------------------------------|-------------------------|------------------------------|-------------------|----------------|---|----------------------------------|
| | | Decreases | | · | | | |
| | Cost Center | Li ne # | Sal ary | 0ther | Wkst. A-7 Ref. | | |
| | 6. 00 | 7. 00 | 8. 00 | 9. 00 | 10. 00 | | |
| | A - CAFETERIA | | | | | | |
| . 00 | DI ETARY | <u>10.</u> 00 | 680, 819 | 48 <u>6, 3</u> 23 | | | 1. |
| ŀ | 0 | | 680, 819 | 486, 323 | | | |
| | B - NURSERY | | | | | | |
| . 00 | ADULTS & PEDIATRICS | 30.00 | 713, 947 | 122, 343 | C | | 1. |
| 00 | | 0.00 | 0 | 0 | (| | 2. |
| | 0 | | 713, 947 | 122, 343 | | | |
| Ī | C - UTILIZATION REVIEW COST | | | | | | |
| 00 | MEDICAL RECORDS & LIBRARY | 16.00 | 0 | 1, 593 | (| | 1. |
| Ī | 0 — — — — — | — — T | | 1, 593 | | 1 | |
| İ | D - SECURITY GUARD | · | | • | • | • | |
| | OPERATION OF PLANT | 7. 00 | 50, 771 | 139 |) | | 1. |
| 1 | | + | 50, 771 | 139 | | | |
| t | E - MED SUPPLY RECLASS | | | | | 1 | |
| 00 | OPERATION OF PLANT | 7. 00 | 0 | 171 | | | 1. |
| | CENTRAL SERVICE & SUPPLY | 14.00 | Ö | 200, 755 | | | 2. |
| | PHARMACY | 15. 00 | o | 43, 331 | | | 3. |
| | ADULTS & PEDIATRICS | 30.00 | 0 | 17, 798 | | | 4. |
| | OPERATING ROOM | 50.00 | 0 | 1, 131, 349 | 1 | 1 | 5. |
| | RECOVERY ROOM | 51.00 | 0 | | | 1 | 6. |
| | | | 0 | 2, 929 35, 996 | | 1 | |
| | ANESTHESI OLOGY | 53.00 | U | · | | 1 | 7. |
| | RADI OLOGY-DI AGNOSTI C | 54.00 | 0 | 4, 316 | | 1 | 8. |
| | ULTRASOUND | 54. 01 | 0 | 27, 531 | | 1 | 9. |
| | RADI OLOGY-THERAPEUTI C | 55.00 | 0 | 60, 838 | | 1 | 10. |
| | CT SCAN | 57. 00 | 0 | 43, 933 | | 1 | 11. |
| | MAGNETIC RESONANCE IMAGING (MRI) | 58. 00 | 0 | 840 | (|) | 12. |
| | LABORATORY | 60.00 | 0 | 133 | | 1 | 13. |
| | RESPI RATORY THERAPY | 65.00 | 0 | 38, 855 | C | | 14. |
| . 00 | PHYSI CAL THERAPY | 66.00 | 0 | 4, 387 | ď | | 15. |
| . 00 | OCCUPATI ONAL THERAPY | 67.00 | 0 | 2, 405 | C | | 16. |
| . 00 | ELECTROCARDI OLOGY | 69.00 | 0 | 777 | (| | 17. |
| . 00 | EMERGENCY | 91.00 | o | 3, 733 | C | | 18. |
| . 00 | HOME HEALTH AGENCY | 101.00 | o | 6, 104 | | | 19. |
| . 00 | HOSPI CE | 116.00 | o | 32, 284 | | | 20. |
| Ī | $\overline{_{0}}$ $$ $$ $$ $$ | T | | 1, 658, 465 | | | |
| İ | F - POB HOUSEKEEPING | <u> </u> | | | • | ' | |
| | OPERATION OF PLANT | 7, 00 | 0 | 3, 193 | C | | 1. |
| | PHYSICIANS' PRIVATE OFFICES | 192.00 | o | 18, 421 | | | 2. |
| | 0 | — — 172. 00 | | 21, 614 | | 1 | 2. |
| 1 | G - INSURANCE | | <u> </u> | 21,017 | | | |
| | OTHER ADMINISTRATIVE AND | 5. 06 | 0 | 150, 973 | 12 | | 1. |
| | GENERAL GENERAL | 5.00 | ٩ | 150, 973 | 12 | - | ['' |
| 00 | DEIVENAL | 0.00 | | 0 | | | 2. |
| ,, | lacksquare $ +$ | — — " 0. 00 | — — — ; | 150, 973 | | 4 | 2. |
| ŀ | U | <u> </u> | U | 130, 973 | ' | | |
| | | | 100 274 | 27 200 | | | 1 |
| 00 | PHARMACY TOTALS | 15.00 | 19 <u>8, 371</u> 198, 371 | 3 <u>6, 3</u> 99 | | 4 | 1. |
| Į. | | | 102 7/11 | 46 300 | 11 | 1 | 1 |

| Period: | Worksheet A-7 | From 01/01/2019 | Part | To 12/31/2019 | Date/Time Prepared:

| | | | | To | 12/31/2019 | Date/Time Prep | |
|-------|-----------------------------------------------|------------------|--------------|-----------------|-------------|----------------|-------|
| | | | | Acqui si ti ons | | 6/3/2020 5: 03 | pili |
| | | Begi nni ng | Purchases | Donati on | Total | Disposals and | |
| | | Bal ances | i ui chases | Donation | iotai | Retirements | |
| | | 1.00 | 2.00 | 3.00 | 4. 00 | 5. 00 | |
| | PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET | T BALANCES | | | | | |
| 1.00 | Land | 1, 408, 112 | 0 | 0 | 0 | 0 | 1.00 |
| 2.00 | Land Improvements | 2, 615, 940 | o | 0 | 0 | ol | 2.00 |
| 3.00 | Buildings and Fixtures | 74, 554, 397 | 480, 823 | 0 | 480, 823 | ol | 3.00 |
| 4.00 | Building Improvements | 0 | o | 0 | 0 | ol | 4. 00 |
| 5.00 | Fi xed Equipment | 0 | o | 0 | 0 | 0 | 5. 00 |
| 6.00 | Movable Equipment | 62, 752, 321 | 6, 694, 210 | 0 | 6, 694, 210 | 1, 390, 037 | 6.00 |
| 7.00 | HIT designated Assets | 0 | o | 0 | 0 | ol | 7. 00 |
| 8.00 | Subtotal (sum of lines 1-7) | 141, 330, 770 | 7, 175, 033 | 0 | 7, 175, 033 | 1, 390, 037 | 8. 00 |
| 9.00 | Reconciling Items | 0 | 0 | 0 | 0 | ol | 9. 00 |
| 10.00 | Total (line 8 minus line 9) | 141, 330, 770 | 7, 175, 033 | 0 | 7, 175, 033 | 1, 390, 037 | 10.00 |
| | | Endi ng Bal ance | Fully | | | | |
| | | | Depreci ated | | | | |
| | | | Assets | | | | |
| | | 6.00 | 7. 00 | | | | |
| | PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET | | | | | | |
| 1.00 | Land | 1, 408, 112 | 0 | | | | 1. 00 |
| 2.00 | Land Improvements | 2, 615, 940 | 0 | | | | 2. 00 |
| 3.00 | Buildings and Fixtures | 75, 035, 220 | 0 | | | | 3. 00 |
| 4.00 | Building Improvements | 0 | 0 | | | | 4. 00 |
| 5.00 | Fixed Equipment | 0 | 0 | | | | 5. 00 |
| 6.00 | Movable Equipment | 68, 056, 494 | 0 | | | | 6. 00 |
| 7. 00 | HIT designated Assets | 0 | 0 | | | | 7. 00 |
| 8.00 | Subtotal (sum of lines 1-7) | 147, 115, 766 | 0 | | | | 8. 00 |
| 9.00 | Reconciling Items | 0 | 0 | | | | 9. 00 |
| 10.00 | Total (line 8 minus line 9) | 147, 115, 766 | 0 | | | | 10.00 |

| Health Financial Systems DEARBORN COUNTY HOSPITAL In Lieu of Form CMS-25 | | | | | | | |
|--------------------------------------------------------------------------|-----------------------------------------------|-------------------|------------------------|----------------|---------------------------------------------------------------------------------|--------|--------|
| | CILIATION OF CAPITAL COSTS CENTERS | BEARBORN GOON | Provi der CCN: 15-0086 | | Peri od: From 01/01/2019 Part II To 12/31/2019 Date/Time P 6/3/2020 5: | | pared: |
| | | | Sl | JMMARY OF CAPI | ΓAL | | |
| | Cost Center Description | Depreciation | Lease | Interest | Insurance (see instructions) | | |
| | | 9. 00 | 10.00 | 11. 00 | 12.00 | 13. 00 | |
| | PART II - RECONCILIATION OF AMOUNTS FROM WOR | KSHEET A, COLUM | N 2, LINES 1 a | nd 2 | | | |
| 1.00 | NEW CAP REL COSTS-BLDG & FIXT | 2, 890, 424 | 0 | 977, 554 | 1 0 | 0 | 1. 00 |
| 2.00 | NEW CAP REL COSTS-MVBLE EQUIP | 0 | 1, 815, 698 | (| 0 | 0 | 2. 00 |
| 3.00 | Total (sum of lines 1-2) | 2, 890, 424 | 1, 815, 698 | 977, 554 | 1 0 | 0 | 3. 00 |
| | | SUMMARY O | F CAPITAL | | | | |
| | Cost Center Description | Other | Total (1) (sum | | | | |
| | | Capi tal -Rel ate | of cols. 9 | | | | |
| | | d Costs (see | through 14) | | | | |
| | | instructions) | | | | | |
| | | 14. 00 | 15. 00 | | | | |
| | PART II - RECONCILIATION OF AMOUNTS FROM WORL | KSHEET A, COLUM | | | | | |
| 4 00 | NEW CAR REL COCTO DI DO A FLYT | | 0 0/7 070 | I | | | 1 4 00 |

0 0 0

3, 867, 978 1, 815, 698 5, 683, 676

1. 00 2. 00 3. 00

1.00 NEW CAP REL COSTS-BLDG & NEW CAP REL COSTS-MVBLE E 3.00 Total (sum of lines 1-2)

NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-MVBLE EQUIP

| Heal th | n Financial Systems | DEARBORN COUN | ITY HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|-----------------------------------------|-----------------------------------------------|--------------------------------------------|------------------------------------------------|-----------------------|------------------|--------------------------------------------------------------|---------|
| RECONCILIATION OF CAPITAL COSTS CENTERS | | | Provi der C | Provider CCN: 15-0086 | | Worksheet A-7 Part III Date/Time Prep 6/3/2020 5:03 | pared: |
| | | COMI | COMPUTATION OF RATIOS ALLOCATION OF OTHER CAPI | | | | |
| | Cost Center Description | Gross Assets | Capi tal i zed | Gross Assets | | 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 CI | | 2.00 | 0.00 | | 0.00 | |
| 1.00 | NEW CAP REL COSTS-BLDG & FIXT | 147, 115, 766 | C | 147, 115, 76 | 6 1.000000 | 0 | 1. 00 |
| 2.00 | NEW CAP REL COSTS-MVBLE EQUIP | 0 | O | | 0. 000000 | | 2. 00 |
| 3.00 | Total (sum of lines 1-2) | 147, 115, 766 | | 147, 115, 76 | | | 3. 00 |
| | | ALLOCATION OF OTHER CAPITAL SUMMARY OF CAP | | | | F CAPITAL | |
| | Cost Center Description | Taxes | 0ther | Total (sum o | f Depreciation | Lease | |
| | | | Capi tal -Relate | | | | |
| | | 6. 00 | d Costs 7.00 | through 7) 8.00 | 9, 00 | 10.00 | |
| | PART III - RECONCILIATION OF CAPITAL COSTS CI | | 7.00 | 8.00 | 9.00 | 10.00 | |
| 1.00 | NEW CAP REL COSTS-BLDG & FLXT | 1 0 | |) | 0 2, 715, 773 | 0 | 1. 00 |
| 2.00 | NEW CAP REL COSTS-MVBLE EQUIP | 0 | | | 0 -3, 718 | | 2. 00 |
| 3.00 | Total (sum of lines 1-2) | 0 | Ö | | 0 2, 712, 055 | | 3. 00 |
| | | | Sl | JMMARY OF CAPI | | | |
| | Cost Center Description | Interest | Insurance (see | Taxes (see | 0ther | Total (2) (sum | |
| | | | instructions) | instructions | Capi tal -Relate | | |
| | | | | | d Costs (see | through 14) | |
| | | 11.00 | 10.00 | 10.00 | instructions) | 45.00 | |
| | PART III - RECONCILIATION OF CAPITAL COSTS CI | 11.00 | 12.00 | 13. 00 | 14. 00 | 15. 00 | |
| 1. 00 | NEW CAP REL COSTS-BLDG & FIXT | 935, 954 | 138, 774 | | 0 0 | 3, 790, 501 | 1. 00 |
| 2.00 | NEW CAP REL COSTS-BEDG & TTXT | 733, 734 | | | 0 0 | 1, 811, 980 | 2.00 |
| 3.00 | Total (sum of lines 1-2) | 935, 954 | ١ | | 0 0 | 5, 602, 481 | |
| 0.00 | 1.2.2. (22 0. 1.1.00 1 2) | , , , , , , , , | 1 .55,771 | 1 | -1 | 3, 332, 101 | 0.00 |

| | | | | | 0 12/31/2019 | Date/lime Prep 6/3/2020 5:03 | |
|------------------|-------------------------------------------------------------|----------------|----------------|-------------------------------------|-----------------|---------------------------------|------------------|
| | | | | Expense Classification on | | | 1 |
| | | | | To/From Which the Amount is | to be Adjusted | | |
| | | | | | | | |
| | | | | | | | |
| | Cost Center Description | Basis/Code (2) | Amount | Cost Center | Li ne # | Wkst. A-7 Ref. | |
| | | 1.00 | 2.00 | 3.00 | 4. 00 | 5. 00 | |
| 1.00 | Investment income - NEW CAP | | | NEW CAP REL COSTS-BLDG & FLXT | 1. 00 | 0 | 1. 00 |
| | REL COSTS-BLDG & FIXT (chapter 2) | | | FIXI | | | |
| 2.00 | Investment income - NEW CAP | | | NEW CAP REL COSTS-MVBLE | 2. 00 | 0 | 2. 00 |
| | REL COSTS-MVBLE EQUIP (chapter | | | EQUI P | | | |
| 3.00 | 2) Investment income - other | | 0 | | 0. 00 | 0 | 3. 00 |
| | (chapter 2) | _ | | | | _ | |
| 4.00 | Trade, quantity, and time discounts (chapter 8) | В | -7, 594 | OTHER ADMINISTRATIVE AND GENERAL | 5. 06 | 0 | 4. 00 |
| 5.00 | Refunds and rebates of | | 0 | | 0.00 | 0 | 5. 00 |
| 4 00 | expenses (chapter 8) | | 0 | | 0.00 | | 4 00 |
| 6. 00 | Rental of provider space by suppliers (chapter 8) | | U | | 0. 00 | 0 | 6. 00 |
| 7.00 | Tel ephone servi ces (pay | A | -7, 138 | COMMUNI CATI ONS | 5. 01 | 0 | 7. 00 |
| | stations excluded) (chapter 21) | | | | | | |
| 8. 00 | Television and radio service | A | -3, 718 | NEW CAP REL COSTS-MVBLE | 2. 00 | 9 | 8. 00 |
| | (chapter 21) | | | EQUI P | | | |
| 9. 00 10. 00 | Parking Lot (chapter 21) Provider-based physician | A-8-2 | -2, 920, 433 | | 0. 00 | 0 | 9. 00 10. 00 |
| 10.00 | adjustment | N 0 2 | 2, 720, 433 | | | | 10.00 |
| 11. 00 | Sale of scrap, waste, etc. | | 0 | | 0. 00 | 0 | 11. 00 |
| 12. 00 | (chapter 23) Related organization | A-8-1 | 0 | | | 0 | 12. 00 |
| | transactions (chapter 10) | | J | | | | |
| 13. 00 14. 00 | Laundry and linen service Cafeteria-employees and guests | В | 407.043 | CAFETERI A | 0. 00 11. 00 | 0 | 13. 00 14. 00 |
| 15. 00 | Rental of quarters to employee | | -497, 642 0 | CAPETERIA | 0.00 | 0 | 15. 00 |
| | and others | | | | | | |
| 16. 00 | Sale of medical and surgical supplies to other than | | 0 | | 0. 00 | 0 | 16. 00 |
| | patients | | | | | | |
| 17. 00 | Sale of drugs to other than | В | -909, 425 | DRUGS CHARGED TO PATIENTS | 73. 00 | o | 17. 00 |
| 18. 00 | patients Sale of medical records and | В | -20 963 | MEDICAL RECORDS & LIBRARY | 16. 00 | 0 | 18. 00 |
| 10.00 | abstracts | | 20, 700 | MEDIONE RESONDS & ELDIVINI | 10.00 | Ĭ | 10.00 |
| 19. 00 | Nursing and allied health | | 0 | | 0. 00 | 0 | 19. 00 |
| | education (tuition, fees, books, etc.) | | | | | | |
| 20. 00 | Vending machines | | 0 | | 0.00 | 0 | 20.00 |
| 21. 00 | Income from imposition of | | 0 | | 0. 00 | 0 | 21. 00 |
| | interest, finance or penalty charges (chapter 21) | | | | | | |
| 22. 00 | Interest expense on Medicare | | 0 | | 0.00 | o | 22. 00 |
| | overpayments and borrowings to repay Medicare overpayments | | | | | | |
| 23. 00 | Adjustment for respiratory | A-8-3 | 0 | RESPI RATORY THERAPY | 65.00 | | 23. 00 |
| | therapy costs in excess of | | | | | | |
| 24. 00 | limitation (chapter 14) Adjustment for physical | A-8-3 | 0 | PHYSICAL THERAPY | 66. 00 | | 24. 00 |
| | therapy costs in excess of | | | | | | |
| 25. 00 | limitation (chapter 14) Utilization review - | | 0 | *** Cost Center Deleted *** | 114. 00 | | 25. 00 |
| 25.00 | physicians' compensation | | 0 | cost center bereted | 114.00 | | 25.00 |
| | (chapter 21) | | _ | | | _ | |
| 26. 00 | Depreciation - NEW CAP REL COSTS-BLDG & FLXT | | | NEW CAP REL COSTS-BLDG & FLXT | 1. 00 | 0 | 26. 00 |
| 27. 00 | Depreciation - NEW CAP REL | | 0 | NEW CAP REL COSTS-MVBLE | 2. 00 | О | 27. 00 |
| 20 00 | COSTS-MVBLE EQUIP | | | EQUIP | 10.00 | | 20 00 |
| 28. 00 29. 00 | Non-physician Anesthetist Physicians' assistant | | 0 | *** Cost Center Deleted *** | 19. 00 0. 00 | o | 28. 00 29. 00 |
| 30. 00 | Adjustment for occupational | A-8-3 | 0 | OCCUPATI ONAL THERAPY | 67. 00 | | 30. 00 |
| | therapy costs in excess of limitation (chapter 14) | | | | | | |
| 30. 99 | Hospice (non-distinct) (see | | 0 | ADULTS & PEDIATRICS | 30.00 | | 30. 99 |
| | instructions) | | | | | | |
| 31. 00 | Adjustment for speech pathology costs in excess of | A-8-3 | 0 | SPEECH PATHOLOGY | 68. 00 | | 31. 00 |
| | limitation (chapter 14) | | | | | | |
| | | | | | | | |

| | | | | To | 12/31/2019 | Date/Time Pre 6/3/2020 5:03 | pared: |
|--------|-----------------------------------|----------------|---------------|----------------------------------|-----------------|-----------------------------|--------|
| | | | | Expense Classification on | Worksheet A | 07 07 2020 0. 00 | Pili |
| | | | | To/From Which the Amount is | | | |
| | | | | To Troil will ell the Allourt 13 | to be haj astea | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | Cost Center Description | Basis/Code (2) | Amount | Cost Center | Li ne # | Wkst. A-7 Ref. | |
| | cost center bescription | 1.00 | 2.00 | 3.00 | 4. 00 | 5, 00 | |
| 32. 00 | CAH HIT Adjustment for | 1.00 | 2.00 | | 0.00 | 0.00 | 32. 00 |
| 32.00 | Depreciation and Interest | | U | | 0.00 | U | 32.00 |
| 33. 00 | | | 10 071 | EMPLOYEE DENEELTS DEDARTMENT | 4. 00 | 0 | 33. 00 |
| | REV - FITNESS CENTER | В | | EMPLOYEE BENEFITS DEPARTMENT | | 0 | |
| 35. 00 | SISIC BILLING SERVICES | В | | CASHI ERI NG/ACCOUNTS | 5. 05 | 0 | 35. 00 |
| 04 00 | LIEAL THE CERVANNES MANAGAMET FEE | | | RECEI VABLE | F 0/ | | 0, 00 |
| 36. 00 | HEALTH SERV/WIC MANAGMNT FEE | В | | OTHER ADMINISTRATIVE AND | 5. 06 | 0 | 36. 00 |
| | DENT LUBION LILL OLLOW | | | GENERAL | / | | |
| 37. 00 | RENT - LUDLOW HILL CLINIC | В | | OTHER ADMINISTRATIVE AND | 5. 06 | 0 | 37. 00 |
| | | _ | | GENERAL | | _ | |
| 39. 00 | DIET - NUTRITION COUNSELING | В | | DI ETARY | 10. 00 | 0 | |
| 40.00 | REV - COMMUNITY EDUCATION | В | -37, 812 | ADULTS & PEDIATRICS | 30. 00 | 0 | 40. 00 |
| | PROGRAM | | | | | | |
| 40. 01 | MI SCELLANEOUS I NCOME | В | | RADI OLOGY-DI AGNOSTI C | 54. 00 | 0 | |
| 42.00 | ADVERTI SI NG | A | | OTHER ADMINISTRATIVE AND | 5. 06 | 0 | 42. 00 |
| | | | | GENERAL | | | |
| 43.00 | AHA & IHA DUES | A | | OTHER ADMINISTRATIVE AND | 5. 06 | 0 | 43.00 |
| | | | | GENERAL | | | |
| 44.00 | MI SC. OFFSET | A | | OTHER ADMINISTRATIVE AND | 5. 06 | 0 | 44. 00 |
| | | | | GENERAL | | | |
| 45.00 | MISC. NONALLOWABLE | A | -4, 187 | HOSPI CE | 116.00 | 0 | 45. 00 |
| 45.01 | ADVERTISING STAFF | A | -13, 040 | OTHER ADMINISTRATIVE AND | 5. 06 | 0 | 45. 01 |
| | | | | GENERAL | | | |
| 45.02 | NON ALLOWABLE REPAIRS | A | -75, 890 | OPERATION OF PLANT | 7.00 | 0 | 45. 02 |
| 45.03 | PHYSICIAN RECRUITMENT & HSC | A | -80, 967 | OTHER ADMINISTRATIVE AND | 5.06 | 0 | 45. 03 |
| | LOSS | | | GENERAL | | | |
| 45.04 | MENTAL HEALTH UTILITIES | A | -33, 806 | OPERATION OF PLANT | 7. 00 | 0 | 45. 04 |
| 45.05 | NON-ALLOWABLE DEPRECIATION | l A | -174, 651 | NEW CAP REL COSTS-BLDG & | 1.00 | 9 | 45. 05 |
| | | | ., | FLXT | | | |
| 45.06 | NON ALLOWABLE INTEREST | l A | -41, 600 | NEW CAP REL COSTS-BLDG & | 1. 00 | 11 | 45. 06 |
| | | | | FLXT | | | |
| 45. 07 | HAF OFFSET | A | | OTHER ADMINISTRATIVE AND | 5. 06 | 0 | 45. 07 |
| | | '' | -,, . 02 | GENERAL | 3.00 | | |
| 50. 00 | TOTAL (sum of lines 1 thru 49) | | -10, 032, 059 | 1.7 | | | 50. 00 |
| 30.00 | (Transfer to Worksheet A, | | .0,002,007 | | | | 50.00 |
| | | | | | | | |
| | 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.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0086

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

6/3/2020 5:03 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 30. 00 ADULTS & PEDIATRICS 1. 00 1.00 343, 526 343, 526 0 0 0 2.00 50.00 OPERATING ROOM 58, 310 58, 310 0 0 2.00 3.00 53. 00 ANESTHESI OLOGY 2,008,922 0 3.00 2,008,922 0 4.00 54. 00 RADI OLOGY-DI AGNOSTI C 0 C 0 4.00 15 15 57. 00 CT SCAN 0 5.00 2,776 2, 776 n 5.00 6.00 60. 00 LABORATORY 245, 833 245, 833 260, 300 6.00 7.00 65. 00 RESPIRATORY THERAPY 23, 101 13, 101 10,000 197, 500 67 7.00 8.00 69. OO ELECTROCARDI OLOGY 236, 197 236, 197 0 8.00 1, 315 9.00 91. 00 EMERGENCY 202, 500 202, 500 179,000 9.00 10.00 0.00 10.00 458<u>, 333</u> 3, 121, 180 2, 662, 847 2,031 200.00 200.00 Cost Center/Physician Unadjusted RCE Wkst. A Line # 5 Percent of Cost of Provi der Physician Cost I denti fi er Limit Unadjusted RCE Memberships & Component of Malpractice Limit Conti nui ng Share of col. Insurance Educati on 12 1.00 2.00 8.00 9.00 13.00 14.00 12.00 30.00 ADULTS & PEDIATRICS 1.00 0 0 0 1.00 2.00 50.00 OPERATING ROOM 0 0 0 0 0 2.00 3.00 53. 00 ANESTHESI OLOGY 0 0 0 3.00 0 54. 00 RADI OLOGY-DI AGNOSTI C 0 0 0 0 4.00 0 0 4.00 57.00 CT SCAN 5.00 0 0 5 00 6.00 60. 00 LABORATORY 81, 219 4,061 6.00 7.00 65. 00 RESPIRATORY THERAPY 6, 362 318 0 0 0 7.00 69. 00 ELECTROCARDI OLOGY 0 8.00 0 8.00 0 91. 00 EMERGENCY 0 9.00 113, 166 5, 658 9.00 0 10.00 0.00 10.00 200, 747 10, 037 200.00 200.00 Wkst. A Line # Cost Center/Physician Provi der Adjusted RCE RCE Adjustment I denti fi er Component Limit Di sal I owance Share of col. 14 1. 00 2.00 15. 00 16. 00 17. 00 18. 00 30. 00 ADULTS & PEDIATRICS 1. 00 1.00 0 0 0 343, 526 2.00 50.00 OPERATING ROOM 0 0 0 58, 310 2.00 3.00 53. 00 ANESTHESI OLOGY 0 0 2,008,922 3.00 4.00 54. 00 RADI OLOGY-DI AGNOSTI C 0 4.00 0 0 15 57. 00 CT SCAN 5.00 0 0 2,776 5 00 6.00 60. 00 LABORATORY 0 81, 219 164, 614 164, 614 6.00 7.00 65. 00 RESPIRATORY THERAPY 0 6, 362 3,638 16, 739 7.00 69. 00 ELECTROCARDI OLOGY 0 236, 197 8.00 8.00 91. 00 EMERGENCY 0 9.00 113, 166 89, 334 89, 334 9.00 10.00 0.00 0 10.00 200.00 200, 747 257, 586 2, 920, 433 200.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0086

| | | | | | Т | o 12/31/2019 | Date/Time Prep 6/3/2020 5:03 | |
|--------------------|--------|--------------------------------------------------------------------|----------------------------|------------------------|----------------------------------------|------------------|---------------------------------|--------------------|
| | | | CAPI TAL REL | ATED COSTS | | 07 37 2020 3. 03 | Pili | |
| | | Cost Center Description | Net Expenses | NEW BLDG & | NEW MVBLE | EMPLOYEE | COMMUNI CATI ONS | |
| | | oost conten bescription | for Cost | FIXT | EQUI P | BENEFITS | O MINIOTET OF THE OILS | |
| | | | Allocation (from Wkst A | | | DEPARTMENT | | |
| | | | col. 7) | | | | | |
| | CENED | AL CEDIUSE COCT CENTEDO | 0 | 1. 00 | 2. 00 | 4. 00 | 5. 01 | |
| 1. 00 | | AL SERVICE COST CENTERS NEW CAP REL COSTS-BLDG & FIXT | 3, 790, 501 | 3, 790, 501 | | | | 1. 00 |
| 2.00 | | NEW CAP REL COSTS-MVBLE EQUIP | 1, 811, 980 | 2, 1, 1, 2, 1, 2, 2, 1 | 1, 811, 980 | | | 2. 00 |
| 4.00 | | EMPLOYEE BENEFITS DEPARTMENT | 7, 677, 668 | 26, 038 | | | | 4. 00 |
| 5. 01 5. 02 | 1 | COMMUNI CATI ONS DATA PROCESSI NG | 245, 337 3, 281, 894 | 3, 713 43, 088 | 1, 805 20, 947 | | 275, 245 16, 084 | 5. 01 5. 02 |
| 5.03 | 00560 | PURCHASING RECEIVING AND STORES | 328, 394 | 78, 054 | 37, 946 | 41, 292 | 2, 945 | 5. 03 |
| 5. 04 5. 05 | 1 | ADMITTING CASHIERING/ACCOUNTS RECEIVABLE | 646, 623 | 42, 196 32, 926 | | | | 5. 04 5. 05 |
| 5. 06 | | OTHER ADMINISTRATIVE AND GENERAL | 1, 768, 124 4, 695, 495 | 152, 101 | 16, 007 73, 945 | | | 5. 06 |
| 7.00 | 00700 | OPERATION OF PLANT | 2, 811, 197 | 1, 191, 885 | 579, 443 | 243, 467 | 8, 608 | 7. 00 |
| 8. 00 9. 00 | | LAUNDRY & LINEN SERVICE HOUSEKEEPING | 419, 139 1, 137, 787 | 19, 443 14, 387 | 9, 452 6, 994 | | 453 4, 531 | 8. 00 9. 00 |
| 10.00 | | DI ETARY | 358, 778 | 48, 852 | | | | |
| 11. 00 | | CAFETERI A | 669, 300 | 34, 648 | | | | 11. 00 |
| 13. 00 14. 00 | | NURSING ADMINISTRATION CENTRAL SERVICE & SUPPLY | 817, 293 468, 066 | 7, 328 86, 566 | | | | |
| 15. 00 | | PHARMACY | 1, 467, 199 | 18, 112 | | | 6, 796 | |
| 16.00 | | MEDICAL RECORDS & LIBRARY | 762, 094 | 58, 708 | | | | 16.00 |
| 17. 00 23. 00 | | SOCIAL SERVICE PHARMACY RESIDENCY | 182, 466 234, 770 | 2, 748 3, 578 | | | | 17. 00 23. 00 |
| 20.00 | I NPAT | IENT ROUTINE SERVICE COST CENTERS | | 0,0,0 | .,,,,, | | | |
| 30.00 | | ADULTS & PEDIATRICS INTENSIVE CARE UNIT | 5, 597, 978 | 817, 089 | | | | |
| 31. 00 43. 00 | 1 | NURSERY | 1, 467, 654 521, 681 | 90, 377 4, 885 | | | | 31. 00 43. 00 |
| 44. 00 | 04400 | SKILLED NURSING FACILITY | 0 | 0 | | | | 44. 00 |
| 50. 00 | | LARY SERVICE COST CENTERS OPERATING ROOM | 6, 723, 901 | 314, 926 | 153, 103 | 467, 651 | 10, 421 | 50. 00 |
| 51. 00 | | RECOVERY ROOM | 747, 728 | 14, 204 | 6, 905 | | 3, 851 | 51.00 |
| 52. 00 | | DELIVERY ROOM & LABOR ROOM | 314, 609 | 6, 155 | | 61, 295 | 0 | 52. 00 |
| 53. 00 54. 00 | | ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C | 91, 080 1, 952, 758 | 195 143, 222 | 95 69, 628 | | 1, 812 14, 952 | • |
| 54. 01 | | ULTRASOUND | 285, 883 | 7, 572 | | | | |
| 55. 00 | | RADI OLOGY-THERAPEUTI C | 645, 700 | 14, 106 | | | | • |
| 57. 00 58. 00 | | CT SCAN MAGNETIC RESONANCE IMAGING (MRI) | 860, 682 579, 323 | 0 9, 807 | (4, 768 | , | 0 | 57. 00 58. 00 |
| 59. 00 | 05900 | CARDI AC CATHETERI ZATI ON | 0 | 0 | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | 0 | 0 | 59. 00 |
| 60.00 | | LABORATORY | 5, 192, 161 | 82, 072 | 39, 900 | 521, 037 | 8, 835 | 60.00 |
| 60. 01 65. 00 | | BLOOD LABORATORY RESPI RATORY THERAPY | 896, 081 | 14, 216 | 6, 911 | 182, 790 | 0 1, 586 | 60. 01 65. 00 |
| 65. 01 | 03950 | SLEEP CLINIC | 212, 509 | 0 | C | 0 | 1, 133 | 65. 01 |
| 66. 00 67. 00 | | PHYSI CAL THERAPY OCCUPATI ONAL THERAPY | 1, 545, 603 | 92, 379 | | | 4, 078 2, 492 | |
| 68. 00 | | SPEECH PATHOLOGY | 264, 709 188, 715 | 9, 697 5, 178 | 4, 714 2, 517 | | | |
| 69. 00 | | ELECTROCARDI OLOGY | 835, 784 | 52, 040 | | | 9, 288 | 69. 00 |
| 71. 00 72. 00 | | MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENT | 1, 658, 015 165, 305 | 0 | | 0 | 0 | 71. 00 72. 00 |
| | 07300 | DRUGS CHARGED TO PATIENTS | 1, 841, 153 | 0 | | _ | Ö | 73. 00 |
| | OUTPA | TIENT SERVICE COST CENTERS | | 110 071 | | 070 000 | 7.040 | |
| 91. 00 92. 00 | | EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART) | 2, 180, 834 | 118, 271 | 57, 498 | 370, 892 | 7, 249 | 91. 00 92. 00 |
| | OTHER | REIMBURSABLE COST CENTERS | | | | | | 72.00 |
| 101.00 | | HOME HEALTH AGENCY | 1, 170, 439 | 37, 677 | 18, 317 | 227, 341 | 1, 359 | 101. 00 |
| 113 00 | | AL PURPOSE COST CENTERS INTEREST EXPENSE | | | | | | 113. 00 |
| | | HOSPI CE | 615, 989 | 3, 847 | 1, 870 | 67, 150 | | 116. 00 |
| 118.00 | | SUBTOTALS (SUM OF LINES 1 through 117) | 70, 130, 379 | 3, 702, 286 | 1, 799, 886 | 7, 587, 739 | 208, 191 | 118. 00 |
| 190.00 | | IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN | ol | 29, 800 | C | 0 | 1, 133 | 190. 00 |
| 192.00 | 19200 | PHYSICIANS' PRIVATE OFFICES | 289, 769 | 0 | C | , | 59, 125 | 192. 00 |
| | | PHYSICIAN CLINIC LIFELINE | 43, 083 | 20, 762 | C | 2, 190 | | 192. 01 192. 02 |
| | 1 | CREDIT UNION | 1, 888 0 | 12, 775 | | 0 | | 192. 02 |
| 192. 04 | 19204 | ENT | 299, 300 | 0 | C | 0 | 0 | 192. 04 |
| 192. 05 192. 06 | 1 | HOSPI TALI ST | 2, 049, 099 682, 787 | 4, 788 | 2, 327 | 0 | | 192. 05 192. 06 |
| | | COMMUNITY MENTAL HEALTH | 002, 787 | 0 | C | 0 | 0 | 194. 00 |
| 194. 01 | 07951 | MARKETI NG | 355, 225 | 13, 190 | | | | 194. 01 |
| 194. 02 | 107953 | OCCUPATI ONAL HEALTH | 262, 894 | 0 | [C | 45, 202 | 906 | 194. 02 |
| | | | | | | | | |

| Health Fina | ncial Systems | DEARBORN COUNTY HOSPITAL | | | In Lieu of Form CMS-2552-10 | | | |
|-----------------------------------------|-----------------------------------|----------------------------|--------------|------------|----------------------------------|------------------|---------|--|
| COST ALLOCATION - GENERAL SERVICE COSTS | | | Provi der CC | | Peri od: | Worksheet B | | |
| | | | | | From 01/01/2019 To 12/31/2019 | | nared: | |
| | | | | | 10 12/31/2019 | 6/3/2020 5: 03 | _pm | |
| | | | CAPI TAL REL | ATED COSTS | | | | |
| | | | | | | | | |
| | Cost Center Description | Net Expenses | NEW BLDG & | NEW MVBLE | | COMMUNI CATI ONS | | |
| | | for Cost | FLXT | EQUI P | BENEFITS | | | |
| | | Allocation (from Wkst A | | | DEPARTMENT | | | |
| | | col. 7) | | | | | | |
| | | 0 | 1.00 | 2. 00 | 4. 00 | 5. 01 | | |
| 194. 03 0795 | 2 PATHS EDUCATION | 54, 621 | 0 | | 0 0 | 0 | 194. 03 | |
| 194. 04 0795 | 4 FOUNDATION | 144, 533 | 6, 900 | 3, 35 | 5 27, 130 | 453 | 194. 04 | |
| 200. 00 | Cross Foot Adjustments | | | | | | 200. 00 | |
| 201. 00 | Negative Cost Centers | | 0 | | 0 0 | 0 | 201. 00 | |
| 202. 00 | TOTAL (sum lines 118 through 201) | 74, 313, 578 | 3, 790, 501 | 1, 811, 98 | 0 7, 716, 365 | 275, 245 | 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:
6/3/2020 5:03 pm

| | | | | ' | 0 12/31/2019 | 6/3/2020 5:03 | |
|------------------|-------------------------------------------------------------------------|------------------------|------------------|----------------------|----------------------|-------------------------|----------------|
| | Cost Center Description | DATA | PURCHASI NG | ADMI TTI NG | CASHI ERI NG/ACC | Subtotal | |
| | | PROCESSI NG | RECEIVING AND | | OUNTS | | |
| | | 5. 02 | STORES 5. 03 | 5. 04 | RECEI VABLE 5. 05 | 5A. 05 | |
| | GENERAL SERVICE COST CENTERS | 0.02 | 0.00 | 0.01 | 0.00 | 0,11 00 | |
| 1.00 | 00100 NEW CAP REL COSTS-BLDG & FIXT | | | | | | 1.00 |
| 2.00 | 00200 NEW CAP REL COSTS-MVBLE EQUIP | | | | | | 2. 00 |
| 4.00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | | | | | | 4. 00 |
| 5. 01 | 01160 COMMUNI CATI ONS | 0 (40 050 | | | | | 5. 01 |
| 5. 02 5. 03 | 00550 DATA PROCESSING 00560 PURCHASING RECEIVING AND STORES | 3, 642, 052 43, 574 | | | | | 5. 02 5. 03 |
| 5. 04 | 00570 ADMITTING | 119, 828 | | 971, 991 | | | 5. 03 |
| 5. 05 | 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE | 188, 820 | | 771, 771 | | | 5. 05 |
| 5.06 | 00591 OTHER ADMINISTRATIVE AND GENERAL | 196, 083 | | d | | 5, 795, 341 | 5. 06 |
| 7.00 | 00700 OPERATION OF PLANT | 50, 836 | 6, 063 | C | 0 | 4, 891, 499 | 7. 00 |
| 8.00 | 00800 LAUNDRY & LINEN SERVICE | 0 | | C | 0 | 485, 394 | 1 |
| 9. 00 | 00900 HOUSEKEEPI NG | 18, 156 | | C | 0 | 1, 390, 527 | 9. 00 |
| 10.00 | 01000 DI ETARY | 116, 197 | 5, 147 | | | 602, 440 | 1 |
| 11. 00 13. 00 | 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON | 61, 730 | 1, 524 | | | 880, 017 1, 065, 017 | 1 |
| 14. 00 | 01400 CENTRAL SERVICE & SUPPLY | 76, 254 | | | | 758, 752 | 1 |
| 15. 00 | 01500 PHARMACY | 94, 410 | | | o o | 1, 892, 304 | 1 |
| 16. 00 | 01600 MEDICAL RECORDS & LIBRARY | 196, 083 | | d | o | 1, 215, 452 | |
| 17.00 | 01700 SOCIAL SERVICE | 32, 680 | 457 | C | 0 | 262, 016 | 17. 00 |
| 23. 00 | 02300 PHARMACY RESIDENCY | 18, 156 | 741 | (| 0 | 305, 616 | 23. 00 |
| | I NPATI ENT ROUTI NE SERVI CE COST CENTERS | | | | 150 (00) | 0.517.014 | |
| 30.00 | 03000 ADULTS & PEDI ATRI CS | 646, 347 | 22, 553 | | | 9, 517, 814 | 1 |
| 31. 00 43. 00 | 03100 INTENSIVE CARE UNIT 04300 NURSERY | 98, 041 0 | 6, 664 | 161, 210 105, 008 | | 2, 222, 952 740, 825 | 1 |
| 44. 00 | 04400 SKILLED NURSING FACILITY | 0 | | 103,000 | | 740, 823 | 1 |
| 11.00 | ANCI LLARY SERVICE COST CENTERS | | | | , | | 11.00 |
| 50.00 | 05000 OPERATI NG ROOM | 228, 763 | 108, 649 | C | 367, 347 | 8, 374, 761 | 50.00 |
| 51.00 | 05100 RECOVERY ROOM | 0 | 4, 203 | C | 36, 068 | 963, 250 | 51.00 |
| 52.00 | 05200 DELIVERY ROOM & LABOR ROOM | 0 | 0 | C | | 401, 600 | 1 |
| 53. 00 | 05300 ANESTHESI OLOGY | 0 | 6, 299 | C | 1 .0, 0, . | 148, 155 | 1 |
| 54. 00 | O5400 RADI OLOGY - DI AGNOSTI C | 174, 296 | | | 1 | 2, 819, 255 | 1 |
| 54. 01 55. 00 | 05401 ULTRASOUND 05500 RADI OLOGY-THERAPEUTI C | 36, 312 | 1, 653 5, 937 | | , | 386, 870 866, 207 | 1 |
| 57. 00 | 05700 CT SCAN | 0 30,312 | | | | 1, 213, 592 | 1 |
| 58. 00 | 05800 MAGNETIC RESONANCE IMAGING (MRI) | 0 | | | | 693, 259 | 1 |
| 59.00 | 05900 CARDI AC CATHETERI ZATI ON | 0 | 0 | Ċ | 1 | 0 | 1 |
| 60.00 | 06000 LABORATORY | 246, 919 | 88, 085 | C | 339, 392 | 6, 518, 401 | 60.00 |
| 60. 01 | 06001 BLOOD LABORATORY | 0 | 0 | C | 1 1 | 0 | |
| 65. 00 | 06500 RESPI RATORY THERAPY | 130, 722 | 3, 267 | | | 1, 291, 994 | 1 |
| 65. 01 66. 00 | 03950 SLEEP CLINIC 06600 PHYSI CAL THERAPY | 79, 885 | 168 2, 064 | | 1 9, . , 9 | 222, 005 2, 169, 313 | 1 |
| 67. 00 | 06700 OCCUPATIONAL THERAPY | /9, 003 0 | 334 | | 1 | 2, 169, 313 351, 754 | 1 |
| 68. 00 | 06800 SPEECH PATHOLOGY | 0 | 72 | | | 245, 106 | 1 |
| 69. 00 | 06900 ELECTROCARDI OLOGY | Ö | 1, 131 | d | | 1, 177, 119 | 1 |
| 71.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | C | 13, 736 | 1, 671, 751 | |
| | 07200 IMPL. DEV. CHARGED TO PATIENT | 0 | | | | 412, 974 | |
| 73. 00 | 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | (| 102, 742 | 1, 943, 895 | 73. 00 |
| 01 00 | OUTPATIENT SERVICE COST CENTERS | 122 450 | 0.710 | | 220 ((7 | 2 007 502 | 01 00 |
| | O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT PART) | 123, 459 | 9, 712 | C | 229, 667 | 3, 097, 582 0 | 1 |
| 92.00 | OTHER REIMBURSABLE COST CENTERS | | | | | 0 | 72.00 |
| 101.00 | 10100 HOME HEALTH AGENCY | 148, 877 | 2, 145 | C | 12, 813 | 1, 618, 968 | 101. 00 |
| | SPECIAL PURPOSE COST CENTERS | | | | | | |
| | 11300 I NTEREST EXPENSE | | | | | | 113. 00 |
| | 11600 H0SPI CE | 0 | 2, 562 | | 10, 857 | 702, 275 | |
| 118. 00 | | 3, 126, 428 | 530, 386 | 971, 991 | 2, 182, 711 | 69, 316, 052 | 1118. 00 |
| 100 00 | NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | 0 | | | 20 022 | 190. 00 |
| | 19200 PHYSI CLANS' PRI VATE OFFI CES | 464, 788 | | | | 827, 624 | |
| | 19201 PHYSI CI AN CLI NI C | 32, 680 | | | | 100, 555 | |
| | 19202 LI FELI NE | 0 | | | 0 | | 192. 02 |
| 192. 03 | 19203 CREDIT UNION | 0 | 0 | C | 0 | 15, 267 | 192. 03 |
| | 19204 ENT | 0 | 0 | C | 0 | 299, 300 | |
| | 19205 HOSPI TALI ST | 14, 525 | | | 0 | 2, 070, 852 | |
| | 19206 ORTHO | 0 | 0 | | | 682, 787 | |
| | 07950 COMMUNITY MENTAL HEALTH 07951 MARKETING | 3, 631 | 668 | | | 421, 095 | 194.00 |
| | 07953 OCCUPATI ONAL HEALTH | 3,631 | i e | | 895 | 309, 972 | |
| | 07952 PATHS EDUCATION | o | | | | | 194. 03 |
| 194.04 | 07954 FOUNDATI ON | 0 | | d | o | 182, 628 | 194. 04 |
| 200.00 | | | | | | | 200. 00 |
| 201.00 | Negative Cost Centers | 0 | 0 | (| 0 | 0 | 201. 00 |
| | | | | | | | |

| Health Financial Systems | DEARBORN COUN | ITY HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|-----------------------------------------|---------------|--------------|-----------|---------------------------------------------|----------------------------------------------------------|---------|
| COST ALLOCATION - GENERAL SERVICE COSTS | | Provider CO | | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I Date/Time Prep 6/3/2020 5:03 | |
| Cost Center Description | DATA | PURCHASI NG | ADMITTING | CASHI ERI NG/ACC | Subtotal | |

| | | | | | | 6/3/2020 5: 03 | pm |
|--------|-----------------------------------|-------------|---------------|-------------|------------------|----------------|---------|
| | Cost Center Description | DATA | PURCHASI NG | ADMI TTI NG | CASHI ERI NG/ACC | Subtotal | |
| | | PROCESSI NG | RECEIVING AND | | OUNTS | | |
| | | | STORES | | RECEI VABLE | | |
| | | 5. 02 | 5. 03 | 5. 04 | 5. 05 | 5A. 05 | |
| 202.00 | TOTAL (sum lines 118 through 201) | 3, 642, 052 | 532, 205 | 971, 991 | 2, 183, 606 | 74, 313, 578 | 202. 00 |

Provider CCN: 15-0086

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

| | | | To | 12/31/2019 | Date/Time Pre 6/3/2020 5:03 | |
|---------------------------------------------------------------------------------------|----------------------------|-------------------------|----------------------------|---------------------|-----------------------------|--------------------|
| Cost Center Description | OTHER ADMI NI STRATI VE | OPERATION OF PLANT | LAUNDRY & LINEN SERVICE | HOUSEKEEPI NG | DI ETARY | piii |
| | AND GENERAL 5.06 | 7. 00 | 8. 00 | 9. 00 | 10.00 | |
| GENERAL SERVICE COST CENTERS | 3.00 | 7.00 | 0.00 | 7. 00 | 10.00 | |
| 1. 00 00100 NEW CAP REL COSTS-BLDG & FIXT | | | | | | 1.00 |
| 2. 00 00200 NEW CAP REL COSTS-MVBLE EQUI P | | | | | | 2.00 |
| 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.01 01160 COMMUNI CATIONS | | | | | | 4. 00 5. 01 |
| 5. 02 00550 DATA PROCESSING | | | | | | 5. 02 |
| 5. 03 00560 PURCHASING RECEIVING AND STORES | | | | | | 5. 03 |
| 5. 04 00570 ADMI TTI NG | | | | | | 5. 04 |
| 5. 05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE | F 70F 044 | | | | | 5. 05 |
| 5.06 00591 OTHER ADMINISTRATIVE AND GENERAL 7.00 00700 OPERATION OF PLANT | 5, 795, 341 413, 728 | 5, 305, 227 | | | | 5. 06 7. 00 |
| 8.00 00800 LAUNDRY & LINEN SERVICE | 41, 055 | 46, 454 | 572, 903 | | | 8. 00 |
| 9. 00 00900 HOUSEKEEPI NG | 117, 612 | 34, 373 | | 1, 542, 512 | | 9. 00 |
| 10. 00 01000 DI ETARY | 50, 955 | 116, 718 | | 34, 461 | 807, 853 | 10. 00 |
| 11. 00 01100 CAFETERI A | 74, 433 | 82, 782 | | 24, 442 | 0 | 11. 00 |
| 13. 00 01300 NURSI NG ADMI NI STRATI ON | 90, 080 | 17, 508 | | 5, 169 | 0 | 13.00 |
| 14. 00 01400 CENTRAL SERVI CE & SUPPLY 15. 00 01500 PHARMACY | 64, 176 160, 053 | 206, 824 43, 273 | 5, 026 0 | 61, 065 12, 776 | 0 | 14. 00 15. 00 |
| 16. 00 01600 MEDICAL RECORDS & LIBRARY | 102, 804 | 140, 265 | Ö | 41, 414 | 0 | 16. 00 |
| 17. 00 01700 SOCIAL SERVICE | 22, 162 | 6, 565 | 0 | 1, 938 | 0 | 17. 00 |
| 23. 00 O2300 PHARMACY RESIDENCY | 25, 849 | 8, 550 | 0 | 2, 524 | 0 | 23. 00 |
| I NPATI ENT ROUTI NE SERVI CE COST CENTERS | 005 022 | 1 052 100 | 210 105 | F7/ 207 | E42, 2E0 | 20.00 |
| 30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 NTENSI VE CARE UNI T | 805, 023 188, 020 | 1, 952, 188 215, 928 | | 576, 387 63, 753 | 542, 358 61, 572 | 30. 00 31. 00 |
| 43. 00 04300 NURSERY | 62, 660 | 11, 672 | 0 | 3, 446 | 01, 372 | 43. 00 |
| 44.00 04400 SKILLED NURSING FACILITY | 0 | 0 | Ō | 0 | 0 | 44. 00 |
| ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50. 00 05000 OPERATI NG ROOM | 708, 346 | 752, 421 | 70, 021 | 222, 153 | 0 | 50.00 |
| 51.00 05100 RECOVERY ROOM 52.00 05200 DELI VERY ROOM & LABOR ROOM | 81, 473 33, 968 | 33, 936 14, 706 | 0 | 10, 020 4, 342 | 841 0 | 51. 00 52. 00 |
| 53. 00 05300 ANESTHESI OLOGY | 12, 531 | 14, 706 467 | 0 | 138 | 0 | 53. 00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 238, 455 | 342, 187 | 33, 884 | 101, 031 | 0 | 54. 00 |
| 54. 01 05401 ULTRASOUND | 32, 722 | 18, 091 | 11, 697 | 5, 341 | 0 | 54. 01 |
| 55. 00 05500 RADI OLOGY-THERAPEUTI C | 73, 265 | 33, 702 | 3, 936 | 9, 951 | 0 | 55. 00 |
| 57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) | 102, 647 | 0 | 0 | (010 | 0 | 57. 00 58. 00 |
| 59. 00 05900 CARDI AC CATHETERI ZATI ON | 58, 637 | 23, 431 | 0 | 6, 918 0 | 0 | 59. 00 |
| 60. 00 06000 LABORATORY | 551, 333 | 196, 086 | 187 | 57, 895 | 0 | 60.00 |
| 60. 01 06001 BLOOD LABORATORY | 0 | 0 | 0 | O | 0 | 60. 01 |
| 65. 00 06500 RESPI RATORY THERAPY | 109, 278 | 33, 965 | 10, 444 | 10, 028 | 0 | 65. 00 |
| 65. 01 03950 SLEEP CLINIC | 18, 777 | 220.712 | 0 | 0 45 144 | 0 | 65. 01 66. 00 |
| 66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY | 183, 483 29, 752 | 220, 713 23, 168 | | 65, 166 6, 841 | 0 | 67.00 |
| 68. 00 06800 SPEECH PATHOLOGY | 20, 731 | 12, 372 | | 3, 653 | 0 | 68. 00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 99, 562 | 124, 334 | 2, 180 | 36, 710 | 0 | 69. 00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 141, 398 | 0 | 0 | 0 | 0 | 71. 00 |
| 72. 00 07200 IMPL. DEV. CHARGED TO PATIENT | 34, 930 | 0 | 0 | 0 | 0 | 72. 00 |
| 73. 00 O7300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS | 164, 417 | 0 | 0 | 0 | 0 | 73. 00 |
| 91. 00 09100 EMERGENCY | 261, 997 | 282, 574 | 132, 091 | 83, 430 | 16, 118 | 91. 00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | , | , , | , | | -, | 92.00 |
| OTHER REIMBURSABLE COST CENTERS | | | | | | |
| 101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS | 136, 934 | 90, 019 | 0 | 26, 578 | 0 | 101. 00 |
| 113.00 11300 INTEREST EXPENSE | | | | | | 113. 00 |
| 116. 00 11600 HOSPI CE | 59, 399 | 9, 192 | 0 | 2, 714 | 0 | 116. 00 |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117) | 5, 372, 645 | 5, 094, 464 | | 1, 480, 284 | 620, 889 | |
| NONREI MBURSABLE COST CENTERS | | | | | | |
| 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 2, 616 | 71, 198 | | 21, 021 | | 190. 00 |
| 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 192. 01 19201 PHYSI CI AN CLI NI C | 70, 001 8, 505 | 49, 605 | 308 | 14, 646 | | 192. 00 192. 01 |
| 192. 02 19202 LI FELI NE | 160 | 47, 003 | 0 | 14, 040 | | 192. 02 |
| 192. 03 19203 CREDIT UNION | 1, 291 | 30, 522 | 0 | 9, 012 | | 192. 03 |
| 192. 04 19204 ENT | 25, 315 | 0 | 0 | 0 | | 192. 04 |
| 192. 05 19205 HOSPI TALI ST | 175, 155 | 11, 438 | 0 | 3, 377 | | 192. 05 |
| 192. 06 19206 0RTH0 194. 00 07950 COMMUNITY MENTAL HEALTH | 57, 751 0 | 0 | 0 19, 298 | 0 | 0 186, 964 | 192.06 |
| 194.00 07930 COMMONT IT MENTAL HEALTH | 35, 617 | 31, 514 | | 9, 304 | | 194. 00 |
| 194. 02 07953 OCCUPATI ONAL HEALTH | 26, 218 | 0 | o | 0 | 0 | 194. 02 |
| 194.03 07952 PATHS EDUCATION | 4, 620 | 0 | 0 | o | | 194. 03 |
| 194. 04 07954 FOUNDATION | 15, 447 | 16, 486 | 0 | 4, 868 | | 194. 04 |
| 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers | 0 | 0 | 0 | 0 | | 200. 00 201. 00 |
| 201.00 negative cost centers | ı V | U | ı | પ | 0 | 1201.00 |

| Health Financial Systems | | DEARBORN COUN | TY HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|-----------------------------------------|---------|-------------------|--------------|--------------|-----------------|-----------------|---------|
| COST ALLOCATION - GENERAL SERVICE COSTS | 5 | | Provi der | CCN: 15-0086 | Peri od: | Worksheet B | |
| | | | | | From 01/01/2019 | | |
| | | | | | To 12/31/2019 | | |
| | | | | | | 6/3/2020 5: 03 | pm |
| Cost Center Description | | OTHER | OPERATION OF | LAUNDRY & | HOUSEKEEPI NG | DI ETARY | |
| | | ADMI NI STRATI VE | PLANT | LINEN SERVIC | E | | |
| | | AND GENERAL | | | | | |
| | | 5.06 | 7. 00 | 8.00 | 9. 00 | 10.00 | |
| 202.00 TOTAL (sum lines 118 throu | gh 201) | 5, 795, 341 | 5, 305, 22 | 7 572, 90 | 1, 542, 512 | 807, 853 | 202. 00 |

Provider CCN: 15-0086

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2019 Part I
To 12/31/2019 Date/Time Prepared:
6/3/2020 5:03 pm

| | | | | | 12/31/2019 | 6/3/2020 5:03 | |
|-----------------------------------------------------------|----------------------------------------------|--------------------|-------------------|---------------------|-----------------|-----------------------|--------------------|
| Cost Cent | er Description | CAFETERI A | NURSI NG | CENTRAL | PHARMACY | MEDI CAL | |
| | | | ADMI NI STRATI ON | SERVICE & SUPPLY | | RECORDS & LI BRARY | |
| | | 11. 00 | 13. 00 | 14. 00 | 15. 00 | 16. 00 | |
| GENERAL SERVICE | COST CENTERS | | | | | | |
| 1 1 | EL COSTS-BLDG & FIXT | | | | | | 1. 00 |
| | EL COSTS-MVBLE EQUI P | | | | | | 2.00 |
| | BENEFITS DEPARTMENT | | | | | | 4.00 |
| 5. 01 01160 COMMUNI CA 5. 02 00550 DATA PROC | | | | | | | 5. 01 5. 02 |
| 1 1 | G RECEIVING AND STORES | | | | | | 5. 02 |
| 5. 04 00570 ADMI TTI NG | 1 | | | | | | 5. 04 |
| 1 1 | G/ACCOUNTS RECEIVABLE | | | | | | 5. 05 |
| | INISTRATIVE AND GENERAL | | | | | | 5. 06 |
| 7. 00 00700 OPERATI ON | OF PLANT | | | | | | 7. 00 |
| 8.00 00800 LAUNDRY & | | | | | | | 8. 00 |
| 9. 00 00900 HOUSEKEEP | I NG | | | | | | 9. 00 |
| 10. 00 01000 DI ETARY | | 4 070 4/0 | | | | | 10.00 |
| 11. 00 01100 CAFETERI A | 1 | 1, 072, 163 | l e | | | | 11.00 |
| 13. 00 01300 NURSI NG A 14. 00 01400 CENTRAL S | ERVICE & SUPPLY | 27, 641 21, 958 | 1 | | | | 13. 00 14. 00 |
| 15. 00 01500 PHARMACY | LRVICE & SUFFEI | 40, 978 | | 1, 105, 540 | 2, 149, 384 | | 15.00 |
| | ECORDS & LIBRARY | 42, 563 | l e | 0 | 2, 117, 001 | 1, 542, 498 | 16.00 |
| 17. 00 01700 SOCIAL SE | | 8, 908 | l e | o | o | 0 | 17. 00 |
| 23. 00 02300 PHARMACY | | 8, 111 | 0 | 0 | О | 0 | 23. 00 |
| | NE SERVICE COST CENTERS | | | | | | |
| 30. 00 03000 ADULTS & | | 247, 918 | 1 | | 0 | 105, 700 | 30. 00 |
| 31. 00 03100 NTENSI VE | CARE UNIT | 56, 883 | 123, 686 | 0 | 0 | 39, 945 | 31.00 |
| 43. 00 04300 NURSERY | LIDOLNIO, FACILILITY | 19, 183 | 1 | 0 | 0 | 3, 728 | 43.00 |
| | URSING FACILITY | 0 | 0 | 0 | 0 | 0 | 44. 00 |
| 50. 00 05000 OPERATING | CE COST CENTERS | 94, 409 | 205, 282 | O | ol | 261, 437 | 50.00 |
| 51. 00 05000 0FERATTING | | 27, 205 | 1 | | 0 | 25, 679 | 51.00 |
| | ROOM & LABOR ROOM | 11, 569 | 25, 155 | | 0 | 11, 638 | ł |
| 53. 00 05300 ANESTHESI | | 11, 307 | 25, 155 | 0 | 0 | 34, 654 | 53.00 |
| 54. 00 05400 RADI OLOGY | 1 | 65, 571 | o o | Ö | o | 104, 338 | 54.00 |
| 54. 01 05401 ULTRASOUN | | 9, 433 | Ō | 0 | O | 23, 052 | 54. 01 |
| 55. 00 05500 RADI OLOGY | -THERAPEUTI C | 17, 283 | 0 | 0 | 0 | 33, 003 | 55. 00 |
| 57.00 05700 CT SCAN | | 0 | 0 | 0 | o | 153, 586 | 57. 00 |
| | RESONANCE IMAGING (MRI) | 0 | 0 | 0 | 0 | 23, 895 | 58. 00 |
| 59. 00 05900 CARDI AC C | | 0 | 0 | 0 | 0 | 0 | 59. 00 |
| 60. 00 06000 LABORATOR | | 128, 023 | 0 | 0 | 0 | 241, 630 | 60.00 |
| 60. 01 06001 BL00D LAB | 1 | 0 | 0 | 0 | 0 | 0 | 60. 01 |
| 65. 00 06500 RESPIRATO | | 34, 786 | 0 | 0 | O O | 39, 521 | 65. 00 65. 01 |
| 65. 01 03950 SLEEP CLI 66. 00 06600 PHYSI CAL | 1 | 63, 984 | 0 | 0 | 0 | 5, 834 50, 368 | |
| 67. 00 06700 OCCUPATI 0 | | 8, 572 | 0 | 0 | 0 | 8, 065 | 1 |
| 68. 00 06800 SPEECH PA | | 5, 703 | 0 | 0 | 0 | 4, 302 | 68. 00 |
| 69. 00 06900 ELECTROCA | | 31, 673 | Ö | Ö | o | 59, 098 | 1 |
| | UPPLIES CHARGED TO PATIENTS | 0 | 0 | 1, 165, 546 | O | 9, 779 | |
| 72.00 07200 IMPL. DEV | . CHARGED TO PATIENT | 0 | 0 | 0 | 0 | | 72. 00 |
| 73. 00 07300 DRUGS CHA | RGED TO PATIENTS | 0 | 0 | 0 | 2, 149, 384 | 73, 147 | 73. 00 |
| | ICE COST CENTERS | | | | | | |
| 91. 00 09100 EMERGENCY | | 75, 245 | 163, 613 | 0 | 0 | 163, 499 | 91.00 |
| 92. 00 09200 0BSERVATI | ON BEDS (NON-DISTINCT PART) BLE COST CENTERS | | | | | | 92. 00 |
| 101. 00 10100 HOME HEAL | | 0 | 0 | | o | 0.122 | 101. 00 |
| SPECIAL PURPOSE | | | | 0 | <u></u> სე | 9, 122 | 101.00 |
| 113. 00 11300 I NTEREST | | | | | | | 113. 00 |
| 116. 00 11600 HOSPI CE | EXI ENGE | 0 | 0 | 0 | 0 | 7 730 | 116.00 |
| | (SUM OF LINES 1 through 117) | 1, 047, 599 | 1, 205, 415 | 1, 165, 546 | 2, 149, 384 | 1, 542, 498 | |
| NONREI MBURSABLE | COST CENTERS | | ,, | ,, | , , , , , , , , | | |
| 190. 00 19000 GIFT, FLO | WER, COFFEE SHOP & CANTEEN | 0 | | 0 | 0 | 0 | 190. 00 |
| 192. 00 19200 PHYSI CI AN | | 2, 758 | 0 | 0 | 0 | | 192. 00 |
| 192. 01 19201 PHYSI CI AN | CLINIC | 804 | ł | 0 | 0 | | 192. 01 |
| 192. 02 19202 LI FELI NE | | 0 | 0 | 0 | 0 | | 192. 02 |
| 192. 03 19203 CREDIT UN | ION | 0 | 0 | 0 | 0 | | 192. 03 |
| 192. 04 19204 ENT | CT | 0 | 0 | 0 | 0 | | 192. 04 |
| 192. 05 19205 HOSPI TALI | 31 | 0 | 0 | 0 | 0 | | 192. 05 192. 06 |
| 192. 06 19206 ORTHO 194. 00 07950 COMMUNI TY | MENTAL HEALTH | 0 | | | o o | | 194. 00 |
| 194. 01 07951 MARKETI NG | | 7, 213 | 0 | | 0 | | 194. 00 |
| 194. 02 07953 OCCUPATI 0 | | 8, 000 | | | 0 | | 194. 02 |
| 194. 03 07952 PATHS EDU | | 0,000 | i e | ا | ol | | 194. 03 |
| 194. 04 07954 FOUNDATI 0 | | 5, 789 | | Ö | Ö | | 194. 04 |
| | t Adjustments | | | | | | 200. 00 |
| | Cost Centers | 0 | 0 | 0 | o | 0 | 201. 00 |
| | | | | | | | |

| Health Fina | ncial Systems | DEARBORN COUN | ITY HOSPITAL | | In Lie | eu of Form CMS- | 2552-10 |
|-------------|-----------------------------------|---------------|-------------------|------------|----------------------------|-----------------------|---------|
| COST ALLOCA | TION - GENERAL SERVICE COSTS | | Provi der C | | Period: From 01/01/2019 | Worksheet B Part I | |
| | | | | | To 12/31/2019 | | |
| | Cost Center Description | CAFETERI A | NURSI NG | CENTRAL | PHARMACY | MEDI CAL | |
| | | | ADMI NI STRATI ON | SERVICE & | | RECORDS & | |
| | | | | SUPPLY | | LI BRARY | |
| | | 11.00 | 13. 00 | 14.00 | 15. 00 | 16.00 | |
| 202.00 | TOTAL (sum lines 118 through 201) | 1, 072, 163 | 1, 205, 415 | 1, 165, 54 | 6 2, 149, 384 | 1, 542, 498 | 202. 00 |

| | Financial Systems | DEARBORN COUNT | | | | u of Form CMS- | <u> 2552-10</u> |
|-----------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|------------------------|-------------------------------------------------------|-----------------------------------------------------|---------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| COST A | LLOCATION - GENERAL SERVICE COSTS | | Provi der CC | | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I Date/Time Pre 6/3/2020 5:03 | |
| | Cost Center Description | SOCI AL SERVI CE | PHARMACY RESI DENCY | Subtotal | Intern & Residents Cost & Post Stepdown Adjustments | Total | |
| | | 17. 00 | 23. 00 | 24. 00 | 25. 00 | 26.00 | |
| 1 00 | GENERAL SERVICE COST CENTERS | 1 | T | | 1 | | 1 00 |
| 1.00 2.00 4.00 5.01 5.02 5.03 5.04 5.05 7.00 8.00 9.00 10.00 11.00 14.00 15.00 16.00 17.00 23.00 | 00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 01160 COMMUNI CATIONS 00550 DATA PROCESSING 00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING 00580 CASHIERING/ACCOUNTS RECEIVABLE 00591 OTHER ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICE & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE | 301, 589 0 | 350, 650 | | | | 1. 00 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 5. 05 5. 06 7. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 |
| | I NPATI ENT ROUTI NE SERVI CE COST CENTERS | 050.070 | ما | 11 7/5 50 | | 44.7/5.500 | |
| 30. 00 31. 00 | 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT | 259, 872 11, 689 | 0 | 14, 765, 523 3, 017, 130 | | 14, 765, 523 3, 017, 130 | 1 |
| 43. 00 | 04300 NURSERY | 0 | o | 883, 22! | | 883, 225 | 1 |
| 44.00 | 04400 SKILLED NURSING FACILITY | 0 | 0 | (| 0 | 0 | 44. 00 |
| FO 00 | ANCI LLARY SERVI CE COST CENTERS | 12 201 | ol | 10 702 12: | ıl ol | 10 702 121 | FO 00 |
| 50. 00 51. 00 | 05000 OPERATI NG ROOM 05100 RECOVERY ROOM | 13, 301 202 | 0 | 10, 702, 13 ⁻¹ 1, 201, 76 ⁻¹ | | 10, 702, 131 1, 201, 761 | 1 |
| 52. 00 | 05200 DELIVERY ROOM & LABOR ROOM | 0 | o | 502, 978 | | 502, 978 | 1 |
| 53.00 | 05300 ANESTHESI OLOGY | 0 | 0 | 195, 94 | 5 0 | 195, 945 | 53. 00 |
| 54.00 | 05400 RADI OLOGY - DI AGNOSTI C | 0 | 0 | 3, 704, 72 | | 3, 704, 721 | 1 |
| 54. 01 55. 00 | 05401 ULTRASOUND 05500 RADI OLOGY-THERAPEUTI C | 0 | 0 | 487, 200 1, 037, 34 | | 487, 206 1, 037, 347 | 1 |
| 57. 00 | 05700 CT SCAN | | 0 | 1, 469, 82! | | 1, 469, 825 | 1 |
| 58. 00 | 05800 MAGNETIC RESONANCE IMAGING (MRI) | 0 | 0 | 806, 140 | | 806, 140 | • |
| 59. 00 | 05900 CARDI AC CATHETERI ZATI ON | 0 | 0 | 7 (00 55) | 0 | 0 | |
| 60. 00 60. 01 | 06000 LABORATORY 06001 BLOOD LABORATORY | 0 | O | 7, 693, 55! | | 7, 693, 555 0 | 1 |
| 65. 00 | 06500 RESPIRATORY THERAPY | | 0 | 1, 530, 01 | - | 1, 530, 016 | 1 |
| 65. 01 | 03950 SLEEP CLINIC | 0 | 0 | 246, 610 | 5 0 | 246, 616 | • |
| | 06600 PHYSI CAL THERAPY | 0 | 0 | 2, 768, 150 | | 2, 768, 150 | |
| 68.00 | 06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY | | 0 | 431, 19! 291, 86 | | 431, 195 291, 867 | 1 |
| | 06900 ELECTROCARDI OLOGY | o | Ö | 1, 530, 67 | | 1, 530, 676 | 1 |
| 71. 00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | 2, 988, 47 | | 2, 988, 474 | |
| | 07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 350, 650 | 497, 652 4, 681, 493 | | 497, 652 4, 681, 493 | |
| 73.00 | OUTPATIENT SERVICE COST CENTERS | J O | 330, 030[| 4, 001, 47. | <u> </u> | 4, 001, 493 | 73.00 |
| | 09100 EMERGENCY | 6, 650 | 0 | 4, 282, 79 | | 4, 282, 799 | |
| 92. 00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | | | 0 | | 92. 00 |
| 101 00 | OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY | 302 | ol | 1, 881, 92 | 3 0 | 1, 881, 923 | 101 00 |
| 101.00 | SPECIAL PURPOSE COST CENTERS | 302 | <u> </u> | 1,001,72 | <u> </u> | 1,001,720 | 101.00 |
| | 11300 I NTEREST EXPENSE | | | | | | 113. 00 |
| 116. 00 118. 00 | 11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) | 9, 573 301, 589 | 0 350, 650 | 790, 883 68, 389, 23 | | 790, 883 68, 389, 231 | |
| 110.00 | NONREI MBURSABLE COST CENTERS | 301, 309 | 330, 030 | 00, 307, 23 | ij Oj | 00, 307, 231 | 1110.00 |
| | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | 0 | 125, 768 | | 125, 768 | 190. 00 |
| | 19200 PHYSI CLANS' PRI VATE OFFI CES | 0 | 0 | 900, 69 | | 900, 691 | |
| | 19201 PHYSI CI AN CLI NI C 19202 LI FELI NE | | 0 | 174, 11! 2, 048 | | 174, 115 2 048 | 192. 01 |
| | 19203 CREDIT UNION | o | Ö | 56, 092 | | | 192. 03 |
| | 19204 ENT | 0 | 0 | 324, 61! | | 324, 615 | • |
| | 19205 HOSPI TALI ST 19206 ORTHO | 0 | 0 | 2, 260, 822 740, 538 | | 2, 260, 822 740, 538 | 1 |
| | 07950 COMMUNITY MENTAL HEALTH | | 0 | 740, 538 206, 262 | | 740, 538 206, 262 | 1 |
| 194. 01 | 07951 MARKETI NG | | o | 504, 743 | 3 o | 504, 743 | 194. 01 |
| | 07953 OCCUPATI ONAL HEALTH | 0 | O | 344, 190 | | 344, 190 | |
| | 07952 PATHS EDUCATI ON 07954 FOUNDATI ON | 0 | 0 | 59, 24! 225, 218 | | 59, 245 225, 218 | 194. 03 194. 04 |
| 1 7 7 . 04 | 10.70.11.0000011.00 | <u>ı</u> 9 | <u> </u> | 220, 210 | - ₁ | 223, 210 | 1177.04 |

| Heal th Fina | ncial Systems | DEARBORN COUN | DEARBORN COUNTY HOSPITAL | | | In Lieu of Form CMS-2552-10 | | | |
|--------------|-----------------------------------|------------------|--------------------------|-------------|----------------------------------|-----------------------------|---------|--|--|
| COST ALLOCA | ATION - GENERAL SERVICE COSTS | | Provi der CO | | Peri od: | Worksheet B | | | |
| | | | | | From 01/01/2019 To 12/31/2019 | | narod: | | |
| | | | | | 10 12/31/2019 | 6/3/2020 5: 03 | pm | | |
| | Cost Center Description | SOCI AL SERVI CE | PHARMACY | Subtotal | Intern & | Total | | | |
| | | | RESI DENCY | | Residents Cost | | | | |
| | | | | | & Post | | | | |
| | | | | | Stepdown | | | | |
| | | | | | Adjustments | | | | |
| | | 17. 00 | 23. 00 | 24. 00 | 25.00 | 26. 00 | | | |
| 200. 00 | Cross Foot Adjustments | | 0 | | 0 0 | 0 | 200. 00 | | |
| 201. 00 | Negative Cost Centers | 0 | 0 | | 0 0 | 0 | 201. 00 | | |
| 202. 00 | TOTAL (sum lines 118 through 201) | 301, 589 | 350, 650 | 74, 313, 57 | 0 8 | 74, 313, 578 | 202. 00 | | |

| Peri od: | Worksheet B | From 01/01/2019 | Part | I | To | 12/31/2019 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0086

| | | | 1 | o 12/31/2019 | Date/Time Pre 6/3/2020 5:03 | |
|--------------------------------------------------------------------------------------------------|--------------------------|---------------------|--------------------------|-------------------|--------------------------------|--------------------|
| | | CAPI TAL REI | ATED COSTS | | 0/3/2020 3.03 | Pili |
| Cost Center Description | Directly Assigned New | NEW BLDG & FIXT | NEW MVBLE EQUI P | Subtotal | EMPLOYEE BENEFITS | |
| | Capital Related Costs | | | | DEPARTMENT | |
| | 0 | 1.00 | 2.00 | 2A | 4. 00 | |
| 1. 00 GENERAL SERVICE COST CENTERS 1. 00 00100 NEW CAP REL COSTS-BLDG & FIXT | | | | | | 1.00 |
| 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP | | | | | | 2. 00 |
| 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT | 0 | 26, 038 | 12, 659 | | 38, 697 | 4.00 |
| 5. 01 01160 COMMUNI CATI ONS 5. 02 00550 DATA PROCESSI NG | 0 | 3, 713 43, 088 | 1, 805 20, 947 | | 122 1, 404 | 5. 01 5. 02 |
| 5.03 00560 PURCHASING RECEIVING AND STORES | 0 | 78, 054 | 37, 946 | 116, 000 | 207 | 5. 03 |
| 5. 04 00570 ADMI TTI NG | 0 | 42, 196 | 20, 514 | | 664 | 5. 04 |
| 5. 05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5. 06 00591 OTHER ADMINI STRATI VE AND GENERAL | 0 | 32, 926 152, 101 | 16, 007 73, 945 | | 828 3, 305 | 5. 05 5. 06 |
| 7.00 O0700 OPERATION OF PLANT | 0 | 1, 191, 885 | 579, 443 | 1, 771, 328 | 1, 220 | 7. 00 |
| 8. 00 00800 LAUNDRY & LINEN SERVICE 9. 00 00900 HOUSEKEEPING | 0 | 19, 443 14, 387 | 9, 452 6, 994 | | 101 1, 006 | 8. 00 9. 00 |
| 10. 00 01000 DI ETARY | 0 | 48, 852 | | | 244 | 10.00 |
| 11. 00 01100 CAFETERI A | O | 34, 648 | 16, 844 | 51, 492 | 779 | 11. 00 |
| 13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CE & SUPPLY | 0 | 7, 328 86, 566 | 3, 562 42, 085 | | 853 336 | 13. 00 14. 00 |
| 15. 00 01500 PHARMACY | 0 | 18, 112 | 8, 805 | | 1, 470 | 15. 00 |
| 16. 00 01600 MEDICAL RECORDS & LIBRARY | 0 | 58, 708 | | | 766 | 16. 00 |
| 17. 00 01700 SOCIAL SERVICE 23. 00 02300 PHARMACY RESIDENCY | 0 | 2, 748 3, 578 | 1, 33 <i>6</i> 1, 740 | | 196 227 | 17. 00 23. 00 |
| I NPATIENT ROUTINE SERVICE COST CENTERS | <u> </u> | 3,370 | 1, 740 | 3,310 | 221 | 25.00 |
| 30. 00 03000 ADULTS & PEDIATRICS | 0 | 817, 089 | 397, 232 | | 5, 758 | 30.00 |
| 31. 00 03100 INTENSI VE CARE UNI T 43. 00 04300 NURSERY | 0 | 90, 377 4, 885 | 43, 937 2, 375 | | 1, 474 509 | 31. 00 43. 00 |
| 44. 00 04400 SKI LLED NURSING FACILITY | 0 | 0 | 2, 3/3 | | 0 | 44. 00 |
| ANCILLARY SERVICE COST CENTERS | | 214 027 | 152 102 | 4/0.020 | 2 244 | 1 50 00 |
| 50. 00 05000 0PERATING ROOM 51. 00 05100 RECOVERY ROOM | 0 | 314, 926 14, 204 | 153, 103 6, 905 | | 2, 344 753 | 50. 00 51. 00 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 0 | 6, 155 | 2, 992 | 9, 147 | 307 | 52. 00 |
| 53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 0 | 195 | 95 | | 1 543 | 53. 00 54. 00 |
| 54. 00 05400 RADI OLOGI - DI AGNOSTI C 54. 01 05401 ULTRASOUND | 0 | 143, 222 7, 572 | 69, 628 3, 681 | | 1, 543 277 | 54. 00 |
| 55. 00 05500 RADI OLOGY-THERAPEUTI C | 0 | 14, 106 | 6, 858 | | 548 | 55. 00 |
| 57. 00 05700 CT SCAN 58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI) | 0 | 0 9, 807 | 4, 768 | - | 655 321 | 57. 00 58. 00 |
| 59. 00 05900 CARDI AC CATHETERI ZATI ON | 0 | 9, 807 | 4, 700 | | 0 | 59.00 |
| 60. 00 06000 LABORATORY | 0 | 82, 072 | 39, 900 | 121, 972 | 2, 612 | 60. 00 |
| 60. 01 06001 BL00D LABORATORY 65. 00 06500 RESPI RATORY THERAPY | 0 | 0 14, 216 | 6, 911 | 0 21, 127 | 0 916 | 60. 01 65. 00 |
| 65. 01 03950 SLEEP CLINIC | 0 | 14, 210 | 0, 91 | 0 | 0 | 65. 01 |
| 66. 00 06600 PHYSI CAL THERAPY | 0 | 92, 379 | 44, 911 | | 1, 652 | 66. 00 |
| 67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY | 0 | 9, 697 5, 178 | 4, 714 2, 517 | 14, 411 7, 695 | 293 212 | 67. 00 68. 00 |
| 69. 00 06900 ELECTROCARDI OLOGY | o o | 52, 040 | | 77, 339 | 813 | |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | (| 0 | 0 | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | (| | 0 | 72. 00 73. 00 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 91. 00 | 0 | 118, 271 | 57, 498 | 175, 769 | 1, 859 | 91. 00 92. 00 |
| OTHER REIMBURSABLE COST CENTERS | | | |) U | | 92.00 |
| 101.00 10100 HOME HEALTH AGENCY | 0 | 37, 677 | 18, 317 | 55, 994 | 1, 140 | 101. 00 |
| SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE | | | | | | 113. 00 |
| 116. 00 11600 HOSPI CE | 0 | 3, 847 | 1, 870 | 5, 717 | 337 | 116. 00 |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117) | 0 | 3, 702, 286 | 1, 799, 886 | 5, 502, 172 | 38, 051 | 118. 00 |
| NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | O | 29, 800 | (| 29, 800 | 0 | 190. 00 |
| 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES | 0 | 27, 800 | | 0 | | 192. 00 |
| 192. 01 19201 PHYSI CI AN CLINI C | 0 | 20, 762 | (| 20, 762 | | 192. 01 |
| 192. 02 19202 LI FELI NE 192. 03 19203 CREDI T UNI ON | 0 | 0 12, 775 | (| 0 12, 775 | | 192. 02 192. 03 |
| 192. 04 19204 ENT | 0 | 12, 773 | | 0 | 0 | 192. 04 |
| 192. 05 19205 HOSPI TALI ST | 0 | 4, 788 | 2, 327 | 7, 115 | | 192. 05 |
| 192.06 19206 0RTH0 194.00 07950 COMMUNITY MENTAL HEALTH | 0 | 0 | (|) 0 | | 192. 06 194. 00 |
| 194. 01 07951 MARKETI NG | O | 13, 190 | 6, 412 | 19, 602 | 205 | 194. 01 |
| 194. 02 07953 OCCUPATI ONAL HEALTH | 0 | 0 | | 0 | | 194. 02 |
| 194. 03 07952 PATHS EDUCATI ON | 0 | 0 | 1 | O | 0 | 194. 03 |

| Health Financial Systems | DEARBORN COUN | DEARBORN COUNTY HOSPITAL | | | In Lieu of Form CMS-2552-10 | | | |
|--------------------------------------------|---------------------------------------------|--------------------------|--------------------|---------------------------------------------|------------------------------------|---------|--|--|
| ALLOCATION OF CAPITAL RELATED COSTS | | Provider CC | | Period: From 01/01/2019 To 12/31/2019 | | | | |
| | | CAPI TAL REL | ATED COSTS | | 07372020 3.03 | Į į | | |
| Cost Center Description | Directly Assigned New Capital Related Costs | NEW BLDG & FIXT | NEW MVBLE EQUIP | Subtotal | EMPLOYEE BENEFITS DEPARTMENT | | | |
| | 0 | 1. 00 | 2.00 | 2A | 4. 00 | | | |
| 194. 04 07954 FOUNDATI ON | 0 | 6, 900 | 3, 35 | 5 10, 255 | 136 | 194. 04 | | |
| 200.00 Cross Foot Adjustments | | | | 0 | | 200. 00 | | |
| 201.00 Negative Cost Centers | | 0 | | 0 | | 201. 00 | | |
| 202.00 TOTAL (sum lines 118 through 201) | 0 | 3, 790, 501 | 1, 811, 98 | 0 5, 602, 481 | 38, 697 | 202. 00 | | |

Provider CCN: 15-0086

| | | | | 10 | J 12/31/201 9 | Date/lime Pre 6/3/2020 5:03 | |
|------------------|--------------------------------------------------------------------------------------|------------------|------------------|------------------|--------------------------|--------------------------------|--------------------|
| | Cost Center Description | COMMUNI CATI ONS | DATA | PURCHASI NG | ADMITTI NG | CASHI ERI NG/ACC | |
| | | | PROCESSI NG | RECEIVING AND | | OUNTS | |
| | | 5. 01 | 5. 02 | STORES 5. 03 | 5. 04 | RECEI VABLE 5. 05 | |
| | GENERAL SERVICE COST CENTERS | 0.01 | 0.02 | 0.00 | 0.01 | 0.00 | |
| 1.00 | 00100 NEW CAP REL COSTS-BLDG & FIXT | | | | | | 1. 00 |
| 2.00 | 00200 NEW CAP REL COSTS-MVBLE EQUIP | | | | | | 2.00 |
| 4.00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | E 440 | | | | | 4.00 |
| 5. 01 5. 02 | O1160 COMMUNI CATI ONS O0550 DATA PROCESSI NG | 5, 640 330 | 65, 769 | | | | 5. 01 5. 02 |
| 5. 03 | 00560 PURCHASING RECEIVING AND STORES | 60 | 787 | | | | 5. 03 |
| 5.04 | 00570 ADMI TTI NG | 186 | 2, 164 | | 66, 018 | | 5. 04 |
| 5.05 | 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE | 246 | 3, 410 | | 0 | 53, 541 | 1 |
| 5. 06 | 00591 OTHER ADMINISTRATIVE AND GENERAL | 186 | 3, 541 | 2, 073 | 0 | 0 | |
| 7. 00 8. 00 | 00700 OPERATION OF PLANT | 176 | 918 0 | | 0 | 0 | 1 |
| 9. 00 | O0800 LAUNDRY & LINEN SERVICE O0900 HOUSEKEEPING | 93 | 328 | 3, 671 1, 749 | 0 | 0 | |
| 10. 00 | 01000 DI ETARY | 23 | 2, 098 | · | 0 | 0 | |
| 11. 00 | 01100 CAFETERI A | 79 | 0 | 0 | 0 | 0 | 11. 00 |
| 13. 00 | 01300 NURSING ADMINISTRATION | 70 | 1, 115 | | 0 | 0 | |
| 14. 00 | 01400 CENTRAL SERVI CE & SUPPLY | 84 | 1, 377 | 3, 232 | 0 | 0 | |
| 15. 00 16. 00 | 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY | 139 339 | 1, 705 3, 541 | 824 132 | 0 | 0 | |
| 17. 00 | 01700 SOCIAL SERVICE | 65 | 590 | | 0 | 0 | |
| 23. 00 | 02300 PHARMACY RESIDENCY | 28 | 328 | | 0 | Ö | |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30.00 | 03000 ADULTS & PEDI ATRI CS | 655 | 11, 672 | | | | 1 |
| 31. 00 | 03100 I NTENSI VE CARE UNI T | 79 | 1, 770 | | 10, 949 | | 1 |
| 43. 00 44. 00 | 04300 NURSERY 04400 SKILLED NURSING FACILITY | 0 | 0 | _ | 7, 132 | 129 | 1 |
| 44.00 | ANCI LLARY SERVI CE COST CENTERS | l ol | | 0 | 0 | 0 | 44.00 |
| 50.00 | 05000 OPERATI NG ROOM | 214 | 4, 131 | 23, 896 | 0 | 8, 921 | 50. 00 |
| 51.00 | 05100 RECOVERY ROOM | 79 | 0 | 924 | 0 | 886 | 51.00 |
| 52. 00 | 05200 DELIVERY ROOM & LABOR ROOM | 0 | 0 | 0 | 0 | | |
| 53. 00 | 05300 ANESTHESI OLOGY | 37 | 0 | 1, 385 | 0 | 1, 196 | |
| 54. 00 54. 01 | 05400 RADI OLOGY-DI AGNOSTI C 05401 ULTRASOUND | 306 | 3, 147 | 2, 226 364 | 0 | 3, 600 795 | 1 |
| 55. 00 | 05500 RADI OLOGY-THERAPEUTI C | 32 | 656 | | 0 | 1, 139 | 1 |
| 57. 00 | 05700 CT SCAN | 0 | 0 | 1, 423 | 0 | 5, 300 | 1 |
| 58. 00 | 05800 MAGNETIC RESONANCE IMAGING (MRI) | O | 0 | 343 | 0 | 832 | 58. 00 |
| 59. 00 | 05900 CARDI AC CATHETERI ZATI ON | 0 | 0 | 0 | 0 | 0 | |
| 60.00 | 06000 LABORATORY | 181 | 4, 459 | | 0 | 8, 338 | 1 |
| 60. 01 65. 00 | 06001 BLOOD LABORATORY 06500 RESPI RATORY THERAPY | 0 32 | 2, 361 | 0 719 | 0 | 0 1, 386 | |
| 65. 01 | 03950 SLEEP CLINIC | 23 | 2, 301 | 37 | 0 | 201 | 1 |
| 66. 00 | 06600 PHYSI CAL THERAPY | 84 | 1, 443 | | 0 | 1, 738 | 1 |
| 67.00 | 06700 OCCUPATI ONAL THERAPY | 51 | 0 | 73 | 0 | 278 | 1 |
| 68. 00 | 06800 SPEECH PATHOLOGY | 5 | 0 | 16 | 0 | 148 | 1 |
| 69. 00 | 06900 ELECTROCARDI OLOGY | 190 | 0 | 249 | 0 | 2, 243 | 1 |
| | O7100 MEDICAL SUPPLIES CHARGED TO PATIENTS O7200 IMPL. DEV. CHARGED TO PATIENT | 0 | 0 | 0 39, 105 | 0 | 337 | 71. 00 72. 00 |
| | 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | | 0 | | |
| 70.00 | OUTPATIENT SERVICE COST CENTERS | <u> </u> | | <u> </u> | | 2,021 | 70.00 |
| 91. 00 | 09100 EMERGENCY | 149 | 2, 229 | 2, 136 | 0 | 5, 642 | 91. 00 |
| 92. 00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | | | | | 92. 00 |
| 101 00 | OTHER REIMBURSABLE COST CENTERS | 20 | 2 (00 | 470 | | 1 245 | 101 00 |
| 101.00 | 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS | 28 | 2, 688 | 472 | 0 | 315 | 101. 00 |
| 113 00 | 11300 INTEREST EXPENSE | | | | | | 113. 00 |
| | 11600 HOSPI CE | o | 0 | 563 | 0 | 267 | 116.00 |
| 118.00 | SUBTOTALS (SUM OF LINES 1 through 117) | 4, 267 | 56, 458 | 116, 653 | 66, 018 | 53, 519 | 118. 00 |
| | NONREI MBURSABLE COST CENTERS | | | | | | |
| | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 23 | 0 | 0 | 0 | | 190. 00 |
| | 19200 PHYSICIANS' PRIVATE OFFICES | 1, 211 37 | 8, 393 590 | | 0 | | 192. 00 192. 01 |
| | 19201 PHTSI CLAIN CLINIC | 0 | 390 | 6 | 0 | | 192. 01 |
| | 19203 CREDIT UNION | 51 | 0 | ő | 0 | | 192. 03 |
| | 19204 ENT | o | 0 | 0 | 0 | | 192. 04 |
| | 19205 HOSPI TALI ST | 0 | 262 | 1 | 0 | l . | 192. 05 |
| | 19206 ORTHO | 0 | 0 | 0 | 0 | | 192. 06 |
| | 07950 COMMUNITY MENTAL HEALTH 07951 MARKETING | 23 | 66 | 0 147 | 0 | | 194. 00 194. 01 |
| | 07951 MARKETTING 07953 OCCUPATI ONAL HEALTH | 19 | 00 | 147 | 0 | | 194. 01 |
| | 07952 PATHS EDUCATION | 0 | 0 | '1 | 0 | | 194. 02 |
| | 07954 FOUNDATION | 9 | 0 | 57 | 0 | | 194. 04 |
| 200.00 | | | | | | | 200. 00 |
| 201.00 | Negative Cost Centers | 0 | 0 | 0 | 0 | 0 | 201. 00 |
| | | | | | | | |

| Health Financial Systems | DEARBORN COUN | TY HOSPITAL | | In Lie | eu of Form CMS- | 2552-10 |
|------------------------------------------|------------------|-------------|--------------|-----------------|------------------|---------|
| ALLOCATION OF CAPITAL RELATED COSTS | | Provi der C | | Peri od: | Worksheet B | |
| | | | | From 01/01/2019 | | |
| | | | | To 12/31/2019 | Date/Time Pre | pared: |
| | | | | | 6/3/2020 5: 03 | pm |
| Cost Center Description | COMMUNI CATI ONS | DATA | PURCHASI NG | ADMI TTI NG | CASHI ERI NG/ACC | |
| | | PROCESSI NG | RECEIVING AN | D | OUNTS | |
| | | | STORES | | RECEI VABLE | |
| | 5. 01 | 5. 02 | 5. 03 | 5. 04 | 5. 05 | |
| 202.00 TOTAL (sum lines 118 through 201) | 5, 640 | 65, 769 | 117, 05 | 66, 018 | 53, 541 | 202. 00 |
| | | | | | | |
| | | | | | | |

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0086

| | | | | | 1 | 0 12/31/2019 | Date/lime Pre 6/3/2020 5:03 | |
|------------------|-------|--------------------------------------------------------------------|----------------------------|--------------------|----------------------------|-------------------|--------------------------------|--------------------|
| | | Cost Center Description | OTHER ADMI NI STRATI VE | OPERATION OF PLANT | LAUNDRY & LINEN SERVICE | HOUSEKEEPI NG | DI ETARY | |
| | | | AND GENERAL | | | | | |
| | CENED | AL SERVICE COST CENTERS | 5. 06 | 7. 00 | 8. 00 | 9. 00 | 10. 00 | |
| 1.00 | | NEW CAP REL COSTS-BLDG & FIXT | | | | | | 1.00 |
| 2.00 | 1 | NEW CAP REL COSTS-MVBLE EQUIP | | | | | | 2. 00 |
| 4.00 | 00400 | EMPLOYEE BENEFITS DEPARTMENT | | | | | | 4. 00 |
| 5. 01 | 1 | COMMUNI CATI ONS | | | | | | 5. 01 |
| 5. 02 5. 03 | 1 | DATA PROCESSING PURCHASING RECEIVING AND STORES | | | | | | 5. 02 5. 03 |
| 5. 03 | | ADMITTING | | | | | | 5. 03 |
| 5. 05 | 1 | CASHI ERI NG/ACCOUNTS RECEI VABLE | | | | | | 5. 05 |
| 5.06 | 1 | OTHER ADMINISTRATIVE AND GENERAL | 235, 151 | | | | | 5. 06 |
| 7. 00 | 1 | OPERATION OF PLANT | 16, 788 | 1, 791, 763 | | | | 7. 00 |
| 8. 00 9. 00 | 1 | LAUNDRY & LINEN SERVICE HOUSEKEEPING | 1, 666 4, 772 | 15, 689 11, 609 | | 40, 938 | | 8. 00 9. 00 |
| 10. 00 | | DI ETARY | 2, 068 | 39, 420 | | 915 | 118, 788 | |
| 11. 00 | | CAFETERI A | 3, 020 | 27, 958 | | 649 | 0 | 1 |
| 13. 00 | 1 | NURSING ADMINISTRATION | 3, 655 | 5, 913 | | 137 | 0 | 1 |
| 14.00 | | CENTRAL SERVICE & SUPPLY | 2, 604 | 69, 852 | 439 | 1, 621 | 0 | 14.00 |
| 15. 00 16. 00 | 1 | PHARMACY MEDICAL RECORDS & LIBRARY | 6, 494 4, 171 | 14, 615 47, 373 | | 339 1, 099 | 0 | 15. 00 16. 00 |
| 17. 00 | | SOCIAL SERVICE | 899 | 2, 217 | | 51 | 0 | 17. 00 |
| 23. 00 | 1 | PHARMACY RESIDENCY | 1, 049 | 2, 887 | 0 | 67 | 0 | 23. 00 |
| | | IENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30. 00 31. 00 | | ADULTS & PEDIATRICS INTENSIVE CARE UNIT | 32, 667 | 659, 326 | | 15, 297 1, 692 | 79, 748 | 1 |
| 43. 00 | | NURSERY | 7, 629 2, 543 | 72, 926 3, 942 | | 91 | 9, 054 0 | 1 |
| 44. 00 | | SKILLED NURSING FACILITY | 0 | 0 | | Ö | 0 | 44. 00 |
| | | LARY SERVICE COST CENTERS | | | | | | |
| 50.00 | | OPERATI NG ROOM | 28, 742 | 254, 119 | | l | 0 | |
| 51. 00 52. 00 | 1 | RECOVERY ROOM DELIVERY ROOM & LABOR ROOM | 3, 306 1, 378 | 11, 461 4, 967 | 0 | 266 115 | 124 0 | 1 |
| 53. 00 | | ANESTHESI OLOGY | 508 | 158 | | 4 | 0 | 1 |
| 54. 00 | 1 | RADI OLOGY-DI AGNOSTI C | 9, 676 | 115, 569 | | 2, 681 | 0 | |
| 54. 01 | 1 | ULTRASOUND | 1, 328 | 6, 110 | | 142 | 0 | 54. 01 |
| 55. 00 | | RADI OLOGY-THERAPEUTI C | 2, 973 | 11, 382 | 1 | 264 | 0 | 55. 00 |
| 57. 00 58. 00 | | CT SCAN MAGNETIC RESONANCE IMAGING (MRI) | 4, 165 2, 379 | 0 7, 914 | | 0 184 | 0 | 57. 00 58. 00 |
| 59. 00 | | CARDI AC CATHETERI ZATI ON | 2, 3, 7 | 0 | 1 | 0 | 0 | 59. 00 |
| 60.00 | | LABORATORY | 22, 371 | 66, 225 | 16 | 1, 537 | 0 | 60.00 |
| 60. 01 | | BLOOD LABORATORY | 0 | 0 | 0 | 0 | 0 | |
| 65. 00 65. 01 | | RESPI RATORY THERAPY SLEEP CLINIC | 4, 434 762 | 11, 471 0 | 912 0 | 266 | 0 | 65. 00 65. 01 |
| 66. 00 | | PHYSI CAL THERAPY | 7, 445 | 74, 543 | 1 | 1, 729 | 0 | 66. 00 |
| 67. 00 | | OCCUPATI ONAL THERAPY | 1, 207 | 7, 825 | | 182 | 0 | 67. 00 |
| 68. 00 | 1 | SPEECH PATHOLOGY | 841 | 4, 178 | | 97 | 0 | 68. 00 |
| 69. 00 | | ELECTROCARDI OLOGY | 4, 040 | 41, 992 | i e | 974 | 0 | |
| | | MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENT | 5, 737 1, 417 | 0 | | 0 | 0 | |
| | | DRUGS CHARGED TO PATIENTS | 6, 671 | 0 | 1 | o o | 0 | |
| | | TIENT SERVICE COST CENTERS | · | | | | | |
| | | EMERGENCY | 10, 631 | 95, 435 | 11, 535 | 2, 214 | 2, 370 | |
| 92. 00 | | OBSERVATION BEDS (NON-DISTINCT PART) REIMBURSABLE COST CENTERS | | | | | | 92.00 |
| 101.00 | | HOME HEALTH AGENCY | 5, 556 | 30, 402 | 0 | 705 | 0 | 101. 00 |
| | | AL PURPOSE COST CENTERS | 5,755 | 33, 132 | _ | | | |
| | | INTEREST EXPENSE | | | | | | 113. 00 |
| | 1 | HOSPICE | 2, 410 | 3, 104 | | 72 | | 116. 00 |
| 118. 00 | | SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS | 218, 002 | 1, 720, 582 | 48, 319 | 39, 286 | 91, 296 | 118. 00 |
| 190.00 | 19000 | GIFT, FLOWER, COFFEE SHOP & CANTEEN | 106 | 24, 046 | 0 | 558 | 0 | 190. 00 |
| | | PHYSICIANS' PRIVATE OFFICES | 2, 840 | 0 | 1 | 0 | 0 | 192. 00 |
| | 1 | PHYSICIAN CLINIC | 345 | 16, 753 | 0 | 389 | | 192. 01 |
| | | LIFELINE CREDIT UNION | 6 | 10.200 | 0 | 0 239 | | 192. 02 192. 03 |
| 192. 03 | | | 52 1, 027 | 10, 308 0 | 1 | 239 | | 192. 03 |
| | | HOSPI TALI ST | 7, 107 | 3, 863 | | 90 | 0 | 192. 05 |
| 192.06 | 19206 | ORTHO | 2, 343 | 0 | 0 | O | 0 | 192. 06 |
| | | COMMUNITY MENTAL HEALTH | 0 | 0 | 1, 685 | 0 | 27, 492 | |
| | | MARKETI NG OCCUPATI ONAL HEALTH | 1, 445 1, 064 | 10, 643 0 | 0 | 247 | | 194. 01 194. 02 |
| | | PATHS EDUCATION | 1, 064 | 0 | 0 | 0 | | 194. 02 |
| 194. 04 | 07954 | FOUNDATION | 627 | 5, 568 | 1 | 129 | | 194. 04 |
| 200.00 | 1 | Cross Foot Adjustments | | | | | | 200. 00 |
| 201.00 | ון | Negative Cost Centers | 0 | 0 | 0 | 0 | 0 | 201. 00 |
| | | | | | | | | |

| Health Financial Systems | DEARBORN COUN | TY HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|------------------------------------------|-------------------------------------------|-----------------------|----------------------------|---------------------------------------------|-----------------|---------|
| ALLOCATION OF CAPITAL RELATED COSTS | | Provider CO | | Period: From 01/01/2019 Fo 12/31/2019 | | |
| Cost Center Description | OTHER ADMI NI STRATI VE AND GENERAL | OPERATION OF PLANT | LAUNDRY & LINEN SERVICE | HOUSEKEEPI NG | DI ETARY | |
| | 5. 06 | 7. 00 | 8. 00 | 9. 00 | 10.00 | |
| 202.00 TOTAL (sum lines 118 through 201) | 235, 151 | 1, 791, 763 | 50, 03 | 1 40, 938 | 118, 788 | 202. 00 |

| Peri od: | Worksheet B | From 01/01/2019 | Part | I | To | 12/31/2019 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0086

| | | | | To | 12/31/2019 | Date/Time Pre 6/3/2020 5:03 | |
|--------------------|-----------------------------------------------------------------------------------|-------------------|-------------------------------|-----------------------|--------------|--------------------------------|--------------------|
| | Cost Center Description | CAFETERI A | NURSI NG ADMI NI STRATI ON | CENTRAL SERVI CE & | PHARMACY | MEDI CAL RECORDS & | Pill |
| | | 11. 00 | 13.00 | SUPPLY 14.00 | 15. 00 | LI BRARY 16. 00 | |
| | GENERAL SERVICE COST CENTERS | | 10.00 | | 10.00 | 10.00 | |
| 1. 00 2. 00 | 00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP | | | | | | 1. 00 2. 00 |
| 4. 00 5. 01 | OO4OO | | | | | | 4. 00 5. 01 |
| 5. 02 5. 03 | 00550 DATA PROCESSING 00560 PURCHASING RECEIVING AND STORES | | | | | | 5. 02 5. 03 |
| 5. 04 5. 05 | 00570 ADMITTING 00580 CASHIERING/ACCOUNTS RECEIVABLE | | | | | | 5. 04 5. 05 |
| 5.06 | 00591 OTHER ADMINISTRATIVE AND GENERAL | | | | | | 5. 06 |
| 7. 00 8. 00 | OO7OO OPERATION OF PLANT OO8OO LAUNDRY & LINEN SERVICE | | | | | | 7. 00 8. 00 |
| 9. 00 10. 00 | 00900 HOUSEKEEPI NG 01000 DI ETARY | | | | | | 9.00 |
| 11. 00 13. 00 | 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON | 84, 893 2, 189 | | | | | 11. 00 13. 00 |
| 14.00 | 01400 CENTRAL SERVI CE & SUPPLY | 1, 739 | | 210, 931 | | | 14. 00 |
| 15. 00 16. 00 | 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY | 3, 245 3, 370 | | 0 | 55, 748 0 | 148. 040 | 15. 00 16. 00 |
| 17. 00 | 01700 SOCIAL SERVICE | 705 | o | 0 | 0 | 0 | 17. 00 |
| 23. 00 | 02300 PHARMACY RESIDENCY NPATIENT ROUTINE SERVICE COST CENTERS | 642 | 0 | 0 | 0 | 0 | 23. 00 |
| 30. 00 | 03000 ADULTS & PEDI ATRI CS | 19, 630 | | 0 | 0 | 10, 143 | 1 |
| 31. 00 43. 00 | 03100 INTENSIVE CARE UNIT 04300 NURSERY | 4, 504 1, 519 | | 0 | 0 | 3, 833 358 | 1 |
| 44. 00 | 04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS | 0 | o | 0 | 0 | 0 | 44. 00 |
| 50. 00 | 05000 OPERATING ROOM | 7, 475 | 4, 284 | 0 | 0 | 25, 112 | 50. 00 |
| 51.00 | 05100 RECOVERY ROOM | 2, 154 | | 0 | 0 | 2, 464 | 1 |
| 52. 00 53. 00 | 05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY | 916 0 | 525 0 | 0 | 0 | 1, 117 3, 325 | 1 |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 5, 192 | 1 | 0 | 0 | 10, 012 | 54. 00 |
| 54. 01 55. 00 | 05401 ULTRASOUND 05500 RADI OLOGY-THERAPEUTI C | 747 1, 368 | 0 | 0 | 0 0 | 2, 212 3, 167 | 1 |
| 57. 00 58. 00 | 05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI) | 0 | 0 | 0 | 0 | 14, 738 2, 293 | |
| 59. 00 | 05900 CARDI AC CATHETERI ZATI ON | 0 | o | 0 | 0 | 2, 243 | 1 |
| 60. 00 60. 01 | 06000 LABORATORY 06001 BLOOD LABORATORY | 10, 137 | 0 | 0 | 0 | 23, 186 0 | 1 |
| 65. 00 | 06500 RESPI RATORY THERAPY | 2, 754 | o | 0 | 0 | 3, 792 | 65. 00 |
| 65. 01 66. 00 | 03950 SLEEP CLINIC 06600 PHYSI CAL THERAPY | 0 5, 066 | 0 | 0 | 0 | 560 4, 833 | |
| 67. 00 | 06700 OCCUPATI ONAL THERAPY | 679 | | 0 | 0 | 774 | 1 |
| 68. 00 69. 00 | 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY | 452 2, 508 | | 0 | 0 | 413 5, 671 | 1 |
| 71.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT | 0 | 1 | 210, 931 0 | 0 | 938 4, 774 | 1 |
| | 07300 DRUGS CHARGED TO PATIENTS | 0 | | Ö | 55, 748 | 7, 019 | |
| 91. 00 | OUTPATIENT SERVICE COST CENTERS 09100 EMERGENCY | 5, 958 | 3, 415 | 0 | 0 | 15, 689 | 91. 00 |
| 92. 00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS | | | | | | 92.00 |
| 101.00 | 10100 HOME HEALTH AGENCY | 0 | 0 | 0 | 0 | 875 | 101. 00 |
| 113. 00 | SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE | | | | | | 113. 00 |
| 116. 00 118. 00 | 11600 HOSPI CE | 0 82, 949 | 0 | 0 | 0 EE 740 | | 116.00 |
| | NONREI MBURSABLE COST CENTERS | 82, 949 | 25, 157 | 210, 931 | 55, 748 | | |
| | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES | 0 218 | | 0 | 0 | | 190. 00 192. 00 |
| 192. 01 | 19201 PHYSICIAN CLINIC | 64 | | Ö | 0 | 0 | 192. 01 |
| | 19202 LI FELI NE 19203 CREDI T UNI ON | 0 | 0 | 0 | 0 | | 192. 02 192. 03 |
| 192. 04 | 19204 ENT | 0 | 0 | 0 | 0 | 0 | 192. 04 |
| | 19205 HOSPI TALI ST 19206 ORTHO | 0 | 0 0 | 0 | 0 0 | | 192. 05 192. 06 |
| 194.00 | 07950 COMMUNITY MENTAL HEALTH | 0 | | O | 0 | 0 | 194. 00 |
| | 07951 MARKETI NG 07953 0CCUPATI ONAL HEALTH | 571 633 | | 0 | 0) 0l | | 194. 01 194. 02 |
| 194. 03 | 07952 PATHS EDUCATION | 0 | o | 0 | 0 | 0 | 194. 03 |
| 200.00 | | 458 | | 0 | U | | 194. 04 200. 00 |
| 201.00 | Negative Cost Centers | 0 | O | 0 | 0 | 0 | 201. 00 |

| Health Financial Systems | DEARBORN COUN | NTY HOSPITAL | | In Lie | u of Form CMS- | 2552-10 |
|------------------------------------------|---------------|-------------------------------|----------------------|---------------------------------------------|-----------------------------------------|---------|
| ALLOCATION OF CAPITAL RELATED COSTS | | Provider CC | | Period: From 01/01/2019 To 12/31/2019 | Date/Time Pre | |
| Cost Center Description | CAFETERI A | NURSI NG ADMI NI STRATI ON | CENTRAL SERVICE & | PHARMACY | 6/3/2020 5: 03 MEDI CAL RECORDS & | pm |
| | | | SUPPLY | | LI BRARY | |
| | 11. 00 | 13.00 | 14. 00 | 15. 00 | 16. 00 | |
| 202.00 TOTAL (sum lines 118 through 201) | 84, 893 | 25, 157 | 210, 93 | 1 55, 748 | 148, 040 | 202. 00 |

| ALLOCATION OF CAPITAL RELATED COSTS | DEARBORN COUNT | Provi der CC | F | Peri od: From 01/01/2019 To 12/31/2019 | | pared: |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|------------------------|--------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Cost Center Description | SOCI AL SERVI CE | PHARMACY RESI DENCY | Subtotal | Intern & Residents Cost & Post Stepdown Adjustments | Total | • |
| OFNEDAL CEDILLOG COCT OFNITEDO | 17. 00 | 23. 00 | 24. 00 | 25. 00 | 26. 00 | |
| GENERAL SERVICE COST CENTERS 1. 00 | | 20,00 | | 25.100 | 20.00 | 1. 00 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 5. 05 5. 06 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 |
| 17. 00 01700 SOCI AL SERVI CE 23. 00 02300 PHARMACY RESI DENCY I NPATI ENT ROUTI NE SERVI CE COST CENTERS | 8, 908 0 | 10, 709 | | | | 17. 00 |
| 30. 00 | 7, 676 345 0 0 | | 2, 143, 957 256, 878 24, 354 | 0 0 | 2, 143, 957 256, 878 24, 354 0 | 30. 00 31. 00 43. 00 44. 00 |
| 50. 00 05000 OPERATING ROOM 51. 00 05100 RECOVERY ROOM 52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C 57. 00 05700 CT SCAN 58. 00 05800 MAGNETI C RESONANCE MAGING (MRI) 59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY | 393 6 0 0 0 0 0 0 0 0 | | 839, 671 44, 767 18, 879 6, 903 369, 761 24, 258 44, 143 26, 281 28, 841 | | 839, 671 44, 767 18, 879 6, 903 369, 761 24, 258 44, 143 26, 281 28, 841 0 280, 407 | 54. 00 54. 01 55. 00 57. 00 58. 00 59. 00 60. 00 60. 01 |
| 65. 00 | 0 0 0 0 0 0 0 0 0 | | 50, 170 1, 583 237, 598 26, 039 14, 057 136, 209 217, 943 47, 013 71, 962 | | 50, 170 1, 583 237, 598 26, 039 14, 057 136, 209 217, 943 47, 013 71, 962 | 65. 01 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 |
| 92.00 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY | 9 | | 98, 184 | 0 | 98, 184 | 92. 00 101. 00 |
| SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 116. 00 11600 HOSPI CE 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS | 283 8, 908 | 0 | 13, 495 5, 358, 580 | | 13, 495 5, 358, 580 | 113. 00 116. 00 118. 00 |
| 190.00 19000 G FT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 192.01 19201 PHYSI CI AN CLI NI C 192.02 19202 LI FELI NE 192.03 19203 CREDI T UNI ON 192.04 19204 ENT 192.05 19205 HOSPI TALI ST 192.06 19206 ORTHO 194.00 07950 COMMUNI TY MENTAL HEALTH 194.01 07951 MARKETI NG 194.02 07953 OCCUPATI ONAL HEALTH 194.03 07952 PATHS EDUCATI ON | 0 0 0 0 0 0 0 0 0 | | 54, 533 12, 904 38, 957 6 23, 425 1, 027 18, 465 2, 343 29, 177 32, 949 1, 982 188 17, 239 | | 6 23, 425 1, 027 18, 462 2, 343 29, 177 32, 949 1, 982 | 192. 00 192. 01 192. 02 192. 03 192. 04 192. 05 192. 06 194. 00 194. 01 194. 02 194. 03 |

| Health Financial Systems | DEARBORN COUNT | TY HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|------------------------------------------|----------------|--------------|------------|-----------------|-----------------|---------|
| ALLOCATION OF CAPITAL RELATED COSTS | | Provi der CO | | Peri od: | Worksheet B | |
| | | | | From 01/01/2019 | Part II | |
| | | | | To 12/31/2019 | Date/Time Pre | |
| | | | | | 6/3/2020 5:03 | pm |
| Cost Center Description | SOCIAL SERVICE | PHARMACY | Subtotal | Intern & | Total | |
| | | RESI DENCY | | Residents Cost | | |
| | | | | & Post | | |
| | | | | Stepdown | | |
| | | | | Adjustments | | |
| | 17. 00 | 23. 00 | 24.00 | 25. 00 | 26. 00 | |
| 200.00 Cross Foot Adjustments | | 10, 709 | 10, 70 | 9 0 | 10, 709 | 200. 00 |
| 201.00 Negative Cost Centers | 0 | 0 | | 0 | 0 | 201.00 |
| 202.00 TOTAL (sum lines 118 through 201) | 8, 908 | 10, 709 | 5, 602, 48 | 1 0 | 5, 602, 481 | 202. 00 |

| | ALLOCATION - STATISTICAL BASIS | DEARBORN COONT | Provi der CO | CN: 15-0086 F | eri od: | Worksheet B-1 | |
|------------------|-------------------------------------------------------------------------------|-------------------|--------------------|-------------------------|------------------|---------------------|--------------------|
| | | | | F | rom 01/01/2019 | Date/Time Pre | |
| | | CAPITAL RELA | ATED COSTS | | | 6/3/2020 5: 03 | pm |
| | | | | | | | |
| | Cost Center Description | NEW BLDG & FIXT | NEW MVBLE EQUIP | EMPLOYEE BENEFITS | COMMUNI CATI ONS | DATA PROCESSI NG | |
| | | (SQUARE | (SQUARE | DEPARTMENT | (PHONES) | (DP EQUIPMENT) | |
| | | FEET) | FEET) | (GROSS | , | | |
| | | 1.00 | 2. 00 | SALARI ES) 4. 00 | 5. 01 | 5. 02 | |
| | GENERAL SERVICE COST CENTERS | | | | | | |
| 1. 00 2. 00 | OO100 NEW CAP REL COSTS-BLDG & FIXT OO200 NEW CAP REL COSTS-MVBLE EQUIP | 310, 365 | 305, 179 | | | | 1. 00 2. 00 |
| 4. 00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | 2, 132 | 2, 132 | 33, 811, 512 | 2 | | 4.00 |
| 5. 01 | 01160 COMMUNI CATI ONS | 304 | 304 | · · | | | 5. 01 |
| 5. 02 5. 03 | OO550 DATA PROCESSING OO560 PURCHASING RECEIVING AND STORES | 3, 528 6, 391 | 3, 528 6, 391 | | | 1, 003 12 | 1 |
| 5. 04 | 00570 ADMITTING | 3, 455 | 3, 455 | | | 33 | 5. 04 |
| 5.05 | 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE | 2, 696 | 2, 696 | 723, 694 | 53 | 52 | 5. 05 |
| 5.06 | 00591 OTHER ADMINISTRATIVE AND GENERAL | 12, 454 | 12, 454 | | | 54 | 1 |
| 7. 00 8. 00 | OO7OO OPERATION OF PLANT OO8OO LAUNDRY & LINEN SERVICE | 97, 591 1, 592 | 97, 591 1, 592 | | | 14 | 1 |
| 9. 00 | 00900 HOUSEKEEPI NG | 1, 178 | 1, 178 | | | 5 | |
| 10.00 | 01000 DI ETARY | 4,000 | 4, 000 | | | 32 | 1 |
| 11. 00 13. 00 | 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON | 2, 837 600 | 2, 837 600 | | | 0 17 | |
| 14. 00 | 01400 CENTRAL SERVICE & SUPPLY | 7, 088 | 7, 088 | · · | | 21 | 1 |
| 15.00 | 01500 PHARMACY | 1, 483 | 1, 483 | | | 26 | 1 |
| 16.00 | 01600 MEDICAL RECORDS & LIBRARY | 4, 807 | 4, 807 | · · | | 54 | |
| 23. 00 | 01700 SOCI AL SERVI CE 02300 PHARMACY RESI DENCY | 225 293 | 225 293 | 171, 579 198, 371 | | 9 | 17. 00 23. 00 |
| 20.00 | INPATIENT ROUTINE SERVICE COST CENTERS | 270 | 270 | 170, 071 | | | 20.00 |
| 30.00 | 03000 ADULTS & PEDIATRICS | 66, 903 | 66, 903 | | | 178 | 1 |
| 31. 00 43. 00 | 03100 INTENSIVE CARE UNIT 04300 NURSERY | 7, 400 400 | 7, 400 400 | 1, 288, 220 445, 363 | | 27 0 | 1 |
| | 04400 SKILLED NURSING FACILITY | 0 | 0 | 1 10, 000 | | | 1 |
| | ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50.00 | O5000 OPERATI NG ROOM O5100 RECOVERY ROOM | 25, 786 1, 163 | 25, 786 1, 163 | | | 63 0 | 1 |
| 52. 00 | 05200 DELIVERY ROOM & LABOR ROOM | 504 | 504 | | | | |
| 53.00 | 05300 ANESTHESI OLOGY | 16 | 16 | c | 8 | 0 | 53. 00 |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 11, 727 | 11, 727 | | | 48 | 1 |
| 54. 01 55. 00 | 05401 ULTRASOUND 05500 RADI OLOGY-THERAPEUTI C | 620 1, 155 | 620 1, 155 | 242, 089 479, 161 | | 0 10 | |
| 57. 00 | 05700 CT SCAN | 0 | 0 | 572, 762 | | 0 | 1 |
| 58.00 | 05800 MAGNETIC RESONANCE I MAGING (MRI) | 803 | 803 | 280, 160 | | 0 | |
| 59. 00 60. 00 | 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY | 6, 720 | 6, 720 | 2, 283, 078 | 0 39 | 0 68 | |
| 60. 01 | 06001 BLOOD LABORATORY | 0,720 | 0,720 | 2, 200, 070 | 0 | 0 | 1 |
| 65. 00 | | 1, 164 | 1, 164 | 800, 947 | 7 | 36 | 65. 00 |
| | 03950 SLEEP CLINIC 06600 PHYSI CAL THERAPY | 7, 564 | 0 7, 564 | 1, 444, 440 | 5 | 0 22 | 65. 01 66. 00 |
| 67. 00 | 06700 OCCUPATI ONAL THERAPY | 7,304 | 7, 304 | 256, 249 | | 0 | |
| 68. 00 | 06800 SPEECH PATHOLOGY | 424 | 424 | · · | | 0 | |
| 69. 00 71. 00 | 06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS | 4, 261 | 4, 261 | 711, 097 0 | | 0 | |
| | 07200 IMPL. DEV. CHARGED TO PATIENT | | 0 | | - | 0 | 1 |
| | 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | C | 0 | 0 | • |
| 01 00 | OUTPATIENT SERVICE COST CENTERS O9100 EMERGENCY | 0.404 | 0 494 | 1 405 171 | 20 | 24 | 01 00 |
| | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 9, 684 | 9, 684 | 1, 625, 171 | 32 | 34 | 91. 00 92. 00 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | |
| 101.00 | 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS | 3, 085 | 3, 085 | 996, 163 | 6 | 41 | 101. 00 |
| 113.00 | 11300 INTEREST EXPENSE | | | | | | 113. 00 |
| 116.00 | 11600 HOSPI CE | 315 | 315 | 294, 238 | | | 116. 00 |
| 118.00 | 3 / | 303, 142 | 303, 142 | 33, 247, 899 | 919 | 861 | 118. 00 |
| 190.00 | NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 2, 440 | 0 | | 5 | 0 | 190. 00 |
| | 19200 PHYSICIANS' PRIVATE OFFICES | 0 | 0 | 58, 138 | | 128 | 192. 00 |
| | 19201 PHYSICIAN CLINIC | 1, 700 | 0 | 9, 597 | | | 192. 01 |
| | 19202 LI FELI NE 19203 CREDI T UNI ON | 1, 046 | 0 | | 0 | | 192. 02 192. 03 |
| | 19204 ENT | 0 | 0 | | 0 | | 192. 04 |
| 192.05 | 19205 HOSPI TALI ST | 392 | 392 | C | 0 | 4 | 192. 05 |
| | 19206 ORTHO 07950 COMMUNITY MENTAL HEALTH | 0 | 0 | | | | 192. 06 194. 00 |
| | 07950 COMMONTY MENTAL HEALTH | 1, 080 | 1, 080 | 178, 934 | 5 | | 194. 00 |
| | 07953 OCCUPATI ONAL HEALTH | 0 | 0 | 198, 064 | | | 194. 02 |
| | | <u> </u> | | | · | | |

| Health Financial S | ystems | DEARBORN COUNTY | HOSPI TAL | | In Lieu | u of Form CMS-2552-10 |
|--------------------|-------------------|-----------------|-----------|--------------|-----------------|-----------------------|
| COST ALLOCATION - | STATISTICAL BASIS | | Provi der | CCN: 15-0086 | | Worksheet B-1 |
| | | | | | From 01/01/2019 | Nate/Time Prepared: |

| | | | | ' | 0 12/31/2019 | 6/3/2020 5:03 | |
|-----------|--------------------------------------------|-------------|-------------|---------------------|------------------|----------------|---------|
| | | CAPITAL REL | ATED COSTS | | | | |
| | | NEW DI DO 0 | NEW MADE | EMBL OVEE | COMMUNICATIONS | DATA | |
| | Cost Center Description | NEW BLDG & | NEW MVBLE | EMPLOYEE | COMMUNI CATI ONS | | |
| | | FLXT | EQUI P | BENEFITS | (DUONEC) | PROCESSI NG | |
| | | (SQUARE | (SQUARE | DEPARTMENT | (PHONES) | (DP EQUIPMENT) | |
| | | FEET) | FEET) | (GROSS | | | |
| | | 1. 00 | 2.00 | SALARI ES) 4. 00 | 5. 01 | 5. 02 | |
| 104 02 07 | 952 PATHS EDUCATION | 1.00 | 2.00 | 4.00 | 3.01 | | 194. 03 |
| | 954 FOUNDATION | 565 | 565 | 118, 880 | 3 | | 194. 03 |
| 1 | I | 303 | 505 | 110,000 | 2 | | 200. 00 |
| 200.00 | Cross Foot Adjustments | | | | | | |
| 201.00 | Negative Cost Centers | 0 700 504 | 4 044 000 | 7 74/ 0/5 | 075 045 | | 201. 00 |
| 202. 00 | Cost to be allocated (per Wkst. B, Part I) | 3, 790, 501 | 1, 811, 980 | 7, 716, 365 | 275, 245 | 3, 642, 052 | 202.00 |
| 203. 00 | Unit cost multiplier (Wkst. B, Part I) | 12. 213043 | 5. 937433 | 0. 228217 | 226. 539095 | 3, 631. 158524 | 203. 00 |
| 204. 00 | Cost to be allocated (per Wkst. B, | | 51.151.155 | 38, 697 | | | |
| | Part II) | | | • | | | |
| 205. 00 | Unit cost multiplier (Wkst. B, Part | | | 0. 001144 | 4. 641975 | 65. 572283 | 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
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0086

| | | | | 10 |) 12/31/2019 | Date/lime Pre 6/3/2020 5:03 | |
|------------------|--------------------------------------------------------------------------------------------|------------------------|----------------|-----------------------------|--------------|--------------------------------|--------------------|
| | Cost Center Description | PURCHASI NG | | CASHI ERI NG/ACC | | OTHER | |
| | | RECEIVING AND STORES | (ADMI SSI ONS) | OUNTS | | ADMI NI STRATI VE | |
| | | (SUPPLY | | RECEI VABLE (GROSS | | AND GENERAL (ACCUM. | |
| | | EXPENSE) | | CHARGES) | | COST) | |
| | | 5. 03 | 5. 04 | 5. 05 | 5A. 06 | 5. 06 | |
| 4 00 | GENERAL SERVICE COST CENTERS | T T | | | | | 1 4 00 |
| 1. 00 2. 00 | 00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP | | | | | | 1. 00 2. 00 |
| 4.00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | | | | | | 4.00 |
| 5. 01 | 01160 COMMUNI CATI ONS | | | | | | 5. 01 |
| 5.02 | 00550 DATA PROCESSING | | | | | | 5. 02 |
| 5.03 | 00560 PURCHASING RECEIVING AND STORES | 10, 227, 366 | 0.004 | | | | 5. 03 |
| 5.04 | OO570 ADMITTING | 25, 705 | 3, 286 0 | | | | 5.04 |
| 5. 05 5. 06 | OO580 CASHI ERI NG/ACCOUNTS RECEI VABLE OO591 OTHER ADMI NI STRATI VE AND GENERAL | 10, 820 181, 123 | 0 | 213, 715, 121 0 | -5, 795, 341 | 68, 518, 237 | 5. 05 5. 06 |
| 7. 00 | 00700 OPERATION OF PLANT | 116, 510 | 0 | Ö | 0, 7,0, 011 | 4, 891, 499 | 7. 00 |
| 8.00 | 00800 LAUNDRY & LINEN SERVICE | 320, 785 | 0 | 0 | 0 | 485, 394 | 8. 00 |
| 9.00 | 00900 HOUSEKEEPI NG | 152, 788 | 0 | 0 | 0 | 1, 390, 527 | 9. 00 |
| 10.00 | 01000 DI ETARY | 98, 907 | 0 | 0 | 0 | 602, 440 | 1 |
| 11. 00 13. 00 | O1100 CAFETERI A O1300 NURSI NG ADMI NI STRATI ON | 29, 291 | 0 | 0 | 0 | 880, 017 1, 065, 017 | 11. 00 13. 00 |
| 14. 00 | 01400 CENTRAL SERVICE & SUPPLY | 282, 384 | 0 | 0 | 0 | 758, 752 | 14.00 |
| 15. 00 | 01500 PHARMACY | 71, 961 | 0 | Ö | Ö | 1, 892, 304 | 1 |
| 16.00 | 01600 MEDICAL RECORDS & LIBRARY | 11, 551 | 0 | 0 | 0 | 1, 215, 452 | 16. 00 |
| 17. 00 | 01700 SOCIAL SERVICE | 8, 788 | 0 | 0 | 0 | 262, 016 | 1 |
| 23. 00 | O2300 PHARMACY RESI DENCY | 14, 244 | 0 | 0 | 0 | 305, 616 | 23. 00 |
| 30. 00 | INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS | 433, 410 | 2, 386 | 15, 036, 510 | ol | 9, 517, 814 | 30.00 |
| 31. 00 | 03100 NTENSI VE CARE UNI T | 128, 063 | 545 | | o | 2, 222, 952 | 1 |
| 43.00 | 04300 NURSERY | 0 | 355 | | o | 740, 825 | |
| 44. 00 | 04400 SKILLED NURSING FACILITY | 0 | 0 | 0 | 0 | 0 | 44. 00 |
| FO 00 | ANCI LLARY SERVI CE COST CENTERS | 2 007 022 | ٥ | 25 047 10/ | ما | 0 274 7/1 | |
| 50. 00 51. 00 | O5000 OPERATI NG ROOM O5100 RECOVERY ROOM | 2, 087, 922 80, 768 | 0 | 35, 947, 106 3, 530, 213 | 0 | 8, 374, 761 963, 250 | 1 |
| 52. 00 | 05200 DELIVERY ROOM & LABOR ROOM | 00, 700 | 0 | 1, 619, 766 | o | 401, 600 | |
| 53. 00 | 05300 ANESTHESI OLOGY | 121, 053 | 0 | 4, 764, 041 | Ō | 148, 155 | |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 194, 495 | 0 | 14, 343, 926 | o | 2, 819, 255 | 1 |
| 54. 01 | 05401 ULTRASOUND | 31, 767 | 0 | 3, 169, 142 | 0 | 386, 870 | 1 |
| 55. 00 57. 00 | O5500 RADI OLOGY-THERAPEUTI C O5700 CT SCAN | 114, 087 | 0 | 4, 537, 076 | 0 | 866, 207 | 55. 00 57. 00 |
| 58. 00 | 05800 MAGNETIC RESONANCE I MAGING (MRI) | 124, 356 29, 991 | 0 | 21, 114, 315 3, 314, 365 | 0 | 1, 213, 592 693, 259 | 1 |
| 59. 00 | 05900 CARDI AC CATHETERI ZATI ON | 0 | 0 | 0 | o | 0 | 59. 00 |
| 60.00 | 06000 LABORATORY | 1, 692, 740 | 0 | 33, 218, 317 | 0 | 6, 518, 401 | 60.00 |
| 60. 01 | 06001 BLOOD LABORATORY | 0 | 0 | 0 | 0 | 0 | 60. 01 |
| 65. 00 | 06500 RESPI RATORY THERAPY 03950 SLEEP CLINIC | 62, 779 | 0 | 5, 522, 226 | 0 | 1, 291, 994 222, 005 | 65. 00 |
| 65. 01 66. 00 | 06600 PHYSI CAL THERAPY | 3, 219 39, 669 | 0 | 802, 090 6, 924, 454 | 0 | 2, 169, 313 | |
| 67. 00 | 06700 OCCUPATI ONAL THERAPY | 6, 412 | 0 | 1, 108, 710 | ő | 351, 754 | 1 |
| 68. 00 | 06800 SPEECH PATHOLOGY | 1, 376 | 0 | | o | 245, 106 | 1 |
| | 06900 ELECTROCARDI OLOGY | 21, 732 | 0 | ., | 0 | 1, 177, 119 | |
| | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | | 0 | 1, 671, 751 | |
| | O7200 IMPL. DEV. CHARGED TO PATIENT O7300 DRUGS CHARGED TO PATIENTS | 3, 416, 610 0 | 0 | 6, 839, 181 10, 055, 942 | 0 | 412, 974 1, 943, 895 | 72. 00 73. 00 |
| 73.00 | OUTPATIENT SERVICE COST CENTERS | <u> </u> | <u> </u> | 10, 055, 942 | <u> </u> | 1, 743, 073 | 73.00 |
| 91.00 | 09100 EMERGENCY | 186, 628 | 0 | 22, 478, 866 | 0 | 3, 097, 582 | 91.00 |
| 92. 00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | | | | | 92. 00 |
| 101 00 | OTHER REIMBURSABLE COST CENTERS | 41 220 | ٥ | 1 254 042 | ما | 1 (10 0(0 | 101 00 |
| 101.00 | 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS | 41, 230 | 0 | 1, 254, 042 | 0 | 1, 618, 968 | 101.00 |
| 113.00 | 11300 I NTEREST EXPENSE | | | | | | 113. 00 |
| | 11600 H0SPI CE | 49, 228 | 0 | 1, 062, 666 | О | 702, 275 | |
| 118.00 | 9 / | 10, 192, 392 | 3, 286 | 213, 627, 540 | -5, 795, 341 | 63, 520, 711 | 118. 00 |
| 400.00 | NONREI MBURSABLE COST CENTERS | I al | ما | ام | ما | 22.222 | |
| | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 12.054 | 0 | 0 | 0 | 30, 933 | 1 |
| | 19200 PHYSICIANS' PRIVATE OFFICES 19201 PHYSICIAN CLINIC | 12, 956 540 | 0 | 0 | 0 | 827, 624 100, 555 | 1 |
| | 19202 LI FELI NE | 0 | 0 | Ö | ő | | 192. 02 |
| | 19203 CREDIT UNION | O | 0 | 0 | o | 15, 267 | |
| 192. 04 | 19204 ENT | 0 | 0 | o | O | 299, 300 | 192. 04 |
| | 19205 HOSPI TALI ST | 2, 170 | 0 | 0 | 0 | 2, 070, 852 | |
| | 19206 ORTHO | 0 | 0 | 0 | 0 | 682, 787 | |
| | 07950 COMMUNITY MENTAL HEALTH 07951 MARKETING | 12, 840 | 0 | | 0 | 0 421, 095 | 194. 00 194. 01 |
| | 07951 MARKETTING 07953 OCCUPATI ONAL HEALTH | 1, 449 | 0 | 87, 581 | ol Ol | 309, 972 | |
| | 07952 PATHS EDUCATION | 77 | 0 | | ő | | 194. 03 |
| 194.04 | 07954 FOUNDATI ON | 4, 942 | O | O | o | 182, 628 | |
| | | | | | | | |

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS DEARBORN COUNTY HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-0086

| | | | | | | 6/3/2020 5:03 | _pm |
|---------|----------------------------------------|---------------|--------------|------------------|----------------|-------------------|---------|
| | Cost Center Description | PURCHASI NG | ADMI TTI NG | CASHI ERI NG/ACC | Reconciliation | OTHER | |
| | | RECEIVING AND | (ADMISSIONS) | OUNTS | | ADMI NI STRATI VE | |
| | | STORES | | RECEI VABLE | | AND GENERAL | |
| | | (SUPPLY | | (GROSS | | (ACCUM. | |
| | | EXPENSE) | | CHARGES) | | COST) | |
| | | 5. 03 | 5. 04 | 5. 05 | 5A. 06 | 5. 06 | |
| 200.00 | Cross Foot Adjustments | | | | | | 200. 00 |
| 201. 00 | Negative Cost Centers | | | | | | 201. 00 |
| 202.00 | Cost to be allocated (per Wkst. B, | 532, 205 | 971, 991 | 2, 183, 606 | | 5, 795, 341 | 202. 00 |
| | Part I) | | | | | | |
| 203. 00 | Unit cost multiplier (Wkst. B, Part I) | 0. 052037 | 295. 797626 | 0. 010217 | | 0. 084581 | 203. 00 |
| 204.00 | Cost to be allocated (per Wkst. B, | 117, 054 | 66, 018 | 53, 541 | | 235, 151 | 204. 00 |
| | Part II) | | | | | | |
| 205. 00 | Unit cost multiplier (Wkst. B, Part | 0. 011445 | 20. 090688 | 0.000251 | | 0.003432 | 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) | | | | | | |

| | Financial Systems | DEARBORN COUN | | | | u of Form CMS- | |
|--------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|-----------------------------|---------------------------|--------------------------|-----------------------------|--------------------|
| COST A | ALLOCATION - STATISTICAL BASIS | | Provi der Co | F | eriod: rom 01/01/2019 | Worksheet B-1 | |
| | | | | | o 12/31/2019 | Date/Time Pre 6/3/2020 5:03 | |
| | Cost Center Description | OPERATION OF | LAUNDRY & | HOUSEKEEPI NG | DIETARY | CAFETERI A | |
| | | PLANT (SQUARE | LINEN SERVICE (POUNDS OF | (SQUARE FEET) | (MEALS SERVED) | (MAN HOURS) | |
| | | FEET) | LAUNDRY) | 1221) | JERVED) | | |
| | JOSUS DA LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLONIA DE LA COLO | 7. 00 | 8. 00 | 9. 00 | 10.00 | 11. 00 | |
| 1. 00 | GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT | | | | | | 1.00 |
| 2.00 | 00200 NEW CAP REL COSTS-MVBLE EQUIP | | | | | | 2. 00 |
| 4.00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | | | | | | 4. 00 |
| 5. 01 5. 02 | O1160 COMMUNI CATI ONS O0550 DATA PROCESSI NG | | | | | | 5. 01 5. 02 |
| 5. 02 | 00560 PURCHASING RECEIVING AND STORES | | | | | | 5. 02 |
| 5.04 | 00570 ADMI TTI NG | | | | | | 5. 04 |
| 5.05 | 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE | | | | | | 5. 05 |
| 5. 06 7. 00 | 00591 OTHER ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT | 181, 814 | | | | | 5. 06 7. 00 |
| 8. 00 | 00800 LAUNDRY & LINEN SERVICE | 1, 592 | 468, 576 | | | | 8. 00 |
| 9. 00 | 00900 HOUSEKEEPI NG | 1, 178 | 0 | 179, 044 | | | 9. 00 |
| 10. 00 11. 00 | 01000 DI ETARY 01100 CAFETERI A | 4, 000 2, 837 | 2, 682 8, 579 | | | 769, 682 | 10.00 |
| 13. 00 | 01300 NURSING ADMINISTRATION | 600 | 0, 3/4 | 600 | | 19, 843 | |
| 14. 00 | 01400 CENTRAL SERVICE & SUPPLY | 7, 088 | 4, 111 | 7, 088 | | 15, 763 | 1 |
| 15. 00 | 01500 PHARMACY | 1, 483 | 0 | 1, 483 | | 29, 417 | 1 |
| 16. 00 17. 00 | 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE | 4, 807 225 | 0 | 4, 807 225 | | 30, 555 6, 395 | 1 |
| 23. 00 | 02300 PHARMACY RESIDENCY | 293 | 0 | 293 | | 5, 823 | 1 |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30. 00 31. 00 | 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT | 66, 903 7, 400 | 179, 278 26, 747 | 66, 903 7, 400 | | 177, 974 40, 835 | 1 |
| 43. 00 | 04300 NURSERY | 400 | 20, 747 | | | 13, 771 | |
| 44. 00 | 04400 SKILLED NURSING FACILITY | 0 | 0 | C | 0 | 0 | 44. 00 |
| FO 00 | ANCI LLARY SERVI CE COST CENTERS | 25 70/ | F7 270 | 25 70/ | l ol | 47.774 | FO 00 |
| 50. 00 51. 00 | 05000 OPERATING ROOM 05100 RECOVERY ROOM | 25, 786 1, 163 | 57, 270 0 | 25, 78 <i>6</i> 1, 163 | | 67, 774 19, 530 | 1 |
| 52. 00 | 05200 DELIVERY ROOM & LABOR ROOM | 504 | 0 | 504 | | 8, 305 | 1 |
| 53.00 | 05300 ANESTHESI OLOGY | 16 | 07.714 | 16 | 0 | 0 | 1 |
| 54. 00 54. 01 | 05400 RADI OLOGY-DI AGNOSTI C 05401 ULTRASOUND | 11, 727 620 | 27, 714 9, 567 | | 0 | 47, 072 6, 772 | 1 |
| 55. 00 | 05500 RADI OLOGY-THERAPEUTI C | 1, 155 | 3, 219 | | | 12, 407 | 1 |
| 57. 00 | 05700 CT SCAN | 0 | 0 | C | | 0 | 1 |
| 58. 00 59. 00 | 05800 MAGNETI C RESONANCE I MAGING (MRI) 05900 CARDI AC CATHETERI ZATI ON | 803 | 0 | 803 | | 0 | |
| 60.00 | 06000 LABORATORY | 6, 720 | 153 | 1 | | 91, 905 | |
| 60. 01 | 06001 BLOOD LABORATORY | 0 | 0 | C | 0 | 0 | 1 |
| 65. 00 65. 01 | 06500 RESPI RATORY THERAPY 03950 SLEEP CLINIC | 1, 164 | 8, 542 | 1, 164 | | 24, 972 0 | 1 |
| 66. 00 | 06600 PHYSI CAL THERAPY | 7, 564 | 12, 369 | | | 45, 933 | 1 |
| 67. 00 | 06700 OCCUPATI ONAL THERAPY | 794 | 2, 489 | | | 6, 154 | 67. 00 |
| 68. 00 | 06800 SPEECH PATHOLOGY | 424 | 1 700 | 424 | | 4, 094 | |
| 69. 00 71. 00 | 06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS | 4, 261 | 1, 783 0 | 4, 261 | 0 | 22, 737 0 | 1 |
| 72. 00 | 07200 I MPL. DEV. CHARGED TO PATIENT | 0 | 0 | ď | Ö | 0 | 1 |
| 73. 00 | 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | C | 0 | 0 | 73. 00 |
| 91. 00 | OUTPATIENT SERVICE COST CENTERS 09100 EMERGENCY | 9, 684 | 108, 037 | 9, 684 | 767 | 54, 017 | 91.00 |
| | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 7,004 | 100, 037 | 7, 004 | 707 | 34, 017 | 92.00 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | 1 |
| 101.00 | 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS | 3, 085 | 0 | 3, 085 | 0 | 0 | 101. 00 |
| 113.00 | 11300 I NTEREST EXPENSE | | | | | | 113. 00 |
| 116.00 | 11600 HOSPI CE | 315 | 0 | 315 | | | 116. 00 |
| 118.00 | 9 / | 174, 591 | 452, 540 | 171, 821 | 29, 546 | 752, 048 | 118. 00 |
| 190.00 | NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 2, 440 | 0 | 2, 440 | O | 0 | 190. 00 |
| 192.00 | 19200 PHYSICIANS' PRIVATE OFFICES | 0 | 252 | | | 1, 980 | 192. 00 |
| | 19201 PHYSI CI AN CLI NI C | 1, 700 | 0 | 1, 700 | 0 | | 192. 01 |
| | 2 19202 LI FELI NE 3 19203 CREDIT UNI ON | 1, 046 | 0 | 1, 046 | 0 | | 192. 02 192. 03 |
| | 19204 ENT | 0 | 0 | 1, 046 | o | | 192. 03 |
| 192. 05 | 19205 HOSPI TALI ST | 392 | 0 | 392 | 0 | 0 | 192. 05 |
| | 5 19206 ORTHO 07950 COMMUNITY MENTAL HEALTH | 0 | 15 704 | | 0 8, 897 | | 192. 06 194. 00 |
| | 07950 COMMUNITY MENTAL HEALTH | 1, 080 | 15, 784 0 | 1, 080 | | | 194. 00 |
| 194. 02 | 07953 OCCUPATI ONAL HEALTH | 0 | Ö | 1, 300 | o | 5, 743 | 194. 02 |
| | 07952 PATHS EDUCATION | 0 | 0 | C | 0 | | 194. 03 |
| 194. 0 ² 200. 00 | O7954 FOUNDATION Cross Foot Adjustments | 565 | 0 | 565 | | 4, 156 | 194. 04 200. 00 |
| | 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | 1 | I | 1 | <u> </u> | | |

| Heal th F | nancial Systems | DEARBORN COUN | TY HOSPITAL | | In Lie | u of Form CMS-: | 2552-10 |
|-----------|--------------------------------------------------------|---------------|---------------|---------------|----------------------------------|--------------------------------|---------|
| COST ALL | OCATION - STATISTICAL BASIS | | Provi der Co | | Peri od: | Worksheet B-1 | |
| | | | | | From 01/01/2019 To 12/31/2019 | Date/Time Pre 6/3/2020 5:03 | |
| | Cost Center Description | OPERATION OF | LAUNDRY & | HOUSEKEEPI NG | | CAFETERI A | |
| | | | LINEN SERVICE | (SQUARE | (MEALS | (MAN HOURS) | |
| | | (SQUARE | (POUNDS OF | FEET) | SERVED) | | |
| | | FEET) | LAUNDRY) | 0.00 | 10.00 | 11 00 | |
| 221 22 | | 7. 00 | 8. 00 | 9. 00 | 10.00 | 11. 00 | 201 20 |
| 201. 00 | Negative Cost Centers | | | | | | 201. 00 |
| 202.00 | Cost to be allocated (per Wkst. B, Part I) | 5, 305, 227 | 572, 903 | 1, 542, 51 | 2 807, 853 | 1, 072, 163 | 202. 00 |
| 203.00 | Unit cost multiplier (Wkst. B, Part I) | 29. 179420 | 1. 222647 | 8. 61526 | 8 21. 014307 | 1. 392995 | 203. 00 |
| 204.00 | Cost to be allocated (per Wkst. B, Part II) | 1, 791, 763 | 50, 031 | 40, 93 | 118, 788 | 84, 893 | 204. 00 |
| 205. 00 | Unit cost multiplier (Wkst. B, Part | 9. 854923 | 0. 106772 | 0. 22864 | 3. 089977 | 0. 110296 | 205. 00 |
| 206. 00 | NAHE adjustment amount to be allocated (per Wkst. B-2) | | | | | | 206. 00 |
| 207. 00 | NAHE unit cost multiplier (Wkst. D, Parts III and IV) | | | | | | 207. 00 |

| | LLOCATION - STATISTICAL BASIS | DEARBORN COUNT | Provider CC | CN: 15-0086 | Peri od: | Worksheet B-1 | |
|------------------|----------------------------------------------------------------------------------------|-------------------------------|-----------------------|--------------------|---------------------------------|--------------------------------|--------------------|
| | | | | | | Date/Time Pre 6/3/2020 5:03 | pm |
| | Cost Center Description | NURSI NG ADMI NI STRATI ON | CENTRAL SERVI CE & | PHARMACY (100%) | MEDICAL RECORDS & | SOCIAL SERVICE | |
| | | | SUPPLY | (1221) | LI BRARY | (TIME | |
| | | (GROSS HOURS) | (100%) | | (ADJUSTED CHARGES) | SPENT) | |
| | | 13. 00 | 14. 00 | 15. 00 | 16. 00 | 17. 00 | |
| 1 00 | GENERAL SERVICE COST CENTERS | | | | | | 1 1 00 |
| 1. 00 2. 00 | OO100 NEW CAP REL COSTS-BLDG & FIXT OO200 NEW CAP REL COSTS-MVBLE EQUIP | | | | | | 1. 00 2. 00 |
| 4.00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | | | | | | 4. 00 |
| 5. 01 5. 02 | O1160 COMMUNI CATI ONS O0550 DATA PROCESSI NG | | | | | | 5. 01 5. 02 |
| 5. 02 | 00560 PURCHASING RECEIVING AND STORES | | | | | | 5. 02 |
| 5.04 | 00570 ADMITTING | | | | | | 5. 04 |
| 5. 05 5. 06 | OO580 CASHI ERI NG/ACCOUNTS RECEI VABLE OO591 OTHER ADMINI STRATI VE AND GENERAL | | | | | | 5. 05 5. 06 |
| 7. 00 | 00700 OPERATION OF PLANT | | | | | | 7. 00 |
| 8.00 | 00800 LAUNDRY & LINEN SERVICE | | | | | | 8.00 |
| 9. 00 10. 00 | 00900 HOUSEKEEPI NG 01000 DI ETARY | | | | | | 9.00 |
| | 01100 CAFETERI A | | | | | | 11. 00 |
| 13.00 | 01300 NURSI NG ADMI NI STRATI ON | 397, 969 | 100 | | | | 13.00 |
| | O1400 CENTRAL SERVI CE & SUPPLY O1500 PHARMACY | 15, 763 | 100 | 10 | 00 | | 14. 00 15. 00 |
| 16.00 | 01600 MEDICAL RECORDS & LIBRARY | Ö | Ö | | 0 212, 062, 128 | | 16. 00 |
| | 01700 SOCIAL SERVICE 02300 PHARMACY RESIDENCY | 0 | 0 | | 0 0 | 2, 993 | |
| 23.00 | I NPATI ENT ROUTI NE SERVI CE COST CENTERS |) U | U | | 0 0 | 0 | 23.00 |
| 30.00 | 03000 ADULTS & PEDIATRICS | 177, 974 | 0 | | 0 14, 531, 180 | 2, 579 | |
| 31. 00 43. 00 | 03100 INTENSI VE CARE UNIT 04300 NURSERY | 40, 835 13, 771 | 0 | | 0 5, 491, 473 0 512, 529 | 116 0 | 1 |
| | 04400 SKILLED NURSING FACILITY | 0 | 0 | | 0 512, 529 | 0 | |
| 50.00 | ANCILLARY SERVICE COST CENTERS | (= == | ام | | 05 047 404 | 400 | |
| 50. 00 51. 00 | O5000 OPERATI NG ROOM O5100 RECOVERY ROOM | 67, 774 19, 530 | 0 | | 0 35, 947, 106 0 3, 530, 213 | 132 2 | 1 |
| 52. 00 | 05200 DELIVERY ROOM & LABOR ROOM | 8, 305 | o | | 0 1, 599, 989 | 0 | 1 |
| | 05300 ANESTHESI OLOGY | 0 | o | | 0 4, 764, 041 | 0 | |
| 54. 00 54. 01 | 05400 RADI OLOGY-DI AGNOSTI C 05401 ULTRASOUND | 0 | 0 | | 0 14, 343, 926 0 3, 169, 142 | 0 | |
| 55.00 | 05500 RADI OLOGY-THERAPEUTI C | | o | | 0 4, 537, 076 | 0 | |
| 57. 00 | 05700 CT SCAN | 0 | 0 | | 0 21, 114, 315 | 0 | |
| 58. 00 59. 00 | 05800 MAGNETIC RESONANCE I MAGING (MRI) 05900 CARDIAC CATHETERIZATION | | 0 | | 0 3, 285, 007 | 0 | 58. 00 59. 00 |
| 60.00 | 06000 LABORATORY | O | Ō | | 0 33, 218, 317 | 0 | 60.00 |
| 60. 01 | 06001 BLOOD LABORATORY | 0 | 0 | | 0 0 0 | 0 | 60. 01 |
| 65. 00 | 06500 RESPI RATORY THERAPY 03950 SLEEP CLINIC | | 0 | | 0 5, 433, 161 0 802, 090 | 0 | |
| 66.00 | 06600 PHYSI CAL THERAPY | 0 | 0 | | 0 6, 924, 454 | 0 | 1 |
| | 06700 OCCUPATI ONAL THERAPY | 0 | 0 | | 0 1, 108, 710 | 0 | |
| 69.00 | 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY | | 0 0 | | 0 591, 457 0 8, 124, 514 | 0 | |
| 71.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 100 | | 0 1, 344, 407 | 0 | 71. 00 |
| | 07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | 10 | 0 6, 839, 181 | 0 | |
| 73.00 | OUTPATIENT SERVICE COST CENTERS | J U | | | 00 10, 055, 942 | 0 | 73.00 |
| | 09100 EMERGENCY | 54, 017 | 0 | | 0 22, 477, 190 | 66 | |
| 92. 00 | O9200 OBSERVATI ON BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS | | | | | | 92.00 |
| 101.00 | 10100 HOME HEALTH AGENCY | 0 | 0 | | 0 1, 254, 042 | 3 | 101. 00 |
| 112 00 | SPECIAL PURPOSE COST CENTERS | 1 | | | | | 112 00 |
| | 11300 INTEREST EXPENSE 11600 HOSPICE | 0 | 0 | | 0 1, 062, 666 | 95 | 113. 00 116. 00 |
| 118.00 | SUBTOTALS (SUM OF LINES 1 through 117) | 397, 969 | 100 | 10 | 212, 062, 128 | | 118. 00 |
| 100.00 | NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | l | O | | | 0 | 190. 00 |
| | 19000 GIFT, PLOWER, COFFEE SHOP & CANTEEN | | o | | 0 0 | | 190.00 |
| 192. 01 | 19201 PHYSI CI AN CLI NI C | 0 | 0 | | 0 0 | | 192. 01 |
| | 19202 LI FELI NE 19203 CREDI T UNI ON | 0 | 0 | | 0 0 | | 192. 02 192. 03 |
| | 19203 CREDIT ONTON | | 0 | | | | 192. 03 |
| 192. 05 | 19205 HOSPI TALI ST | 0 | o | | 0 0 | 0 | 192. 05 |
| | 19206 ORTHO | 0 | 0 | | 0 0 | | 192. 06 194. 00 |
| | 07950 COMMUNITY MENTAL HEALTH 07951 MARKETING | | 0 | | 0 0 | | 194. 00 |
| 194. 02 | 07953 OCCUPATI ONAL HEALTH | 0 | o | | 0 0 | 0 | 194. 02 |
| | 07952 PATHS EDUCATION 07954 FOUNDATION | 0 | 0 | | 0 0 | | 194. 03 194. 04 |
| 174.04 | 10775 ITT CONDITT ON | <u> </u> | <u> </u> | | <u>σ</u> | 0 | 1177.04 |

| Health Fi | nancial Systems | DEARBORN COUN | TY HOSPITAL | | In Lie | eu of Form CMS-: | 2552-10 |
|-----------|----------------------------------------|-------------------|-----------------|----------------|---------------------------------------------|------------------|---------|
| COST ALLO | CATION - STATISTICAL BASIS | | Provider CC | | Period: From 01/01/2019 To 12/31/2019 | Date/Time Pre | pared: |
| | | | | | | 6/3/2020 5:03 | |
| | Cost Center Description | NURSI NG | CENTRAL | PHARMACY | | SOCIAL SERVICE | |
| | | ADMI NI STRATI ON | | (100%) | RECORDS & | | |
| | | | SUPPLY | | LI BRARY | (TIME | |
| | | (GROSS HOURS) | (100%) | | (ADJUSTED | SPENT) | |
| | | | | | CHARGES) | | |
| | | 13.00 | 14.00 | 15.00 | 16.00 | 17. 00 | |
| 200.00 | Cross Foot Adjustments | | | | | | 200.00 |
| 201.00 | Negative Cost Centers | | | | | | 201. 00 |
| 202.00 | Cost to be allocated (per Wkst. B, | 1, 205, 415 | 1, 165, 546 | 2, 149, 38 | 4 1, 542, 498 | 301, 589 | 202. 00 |
| | Part I) | | | | | · | |
| 203.00 | Unit cost multiplier (Wkst. B, Part I) | 3. 028917 | 11, 655. 460000 | 21, 493. 84000 | 0. 007274 | 100. 764784 | 203. 00 |
| 204.00 | Cost to be allocated (per Wkst. B, | 25, 157 | 210, 931 | 55, 74 | 148, 040 | 8, 908 | 204. 00 |
| | Part II) | | , | , | , | -, | |
| 205.00 | Unit cost multiplier (Wkst. B, Part | 0. 063213 | 2, 109. 310000 | 557. 48000 | 0. 000698 | 2, 976278 | 205 00 |
| 200.00 | | 0.000210 | 2, 107, 010000 | 0071 10000 | 0.000070 | 2.770270 | 200.00 |
| 206.00 | NAHE adjustment amount to be allocated | | | | | | 206. 00 |
| 200.00 | (per Wkst. B-2) | | | | | | 200.00 |
| 207. 00 | NAHE unit cost multiplier (Wkst. D, | | | | | | 207. 00 |
| 207.00 | Parts III and IV) | | | | | | 207.00 |
| ļ | parts in and iv) | 1 | | l | I | I | I |

Health Financial Systems DEARBORN COUNTY HOSPITAL In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0086 Period: Worksheet B-1

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0086 From 01/01/2019 12/31/2019 Date/Time Prepared: 6/3/2020 5:03 pm Cost Center Description **PHARMACY** RESI DENCY (ASSI GNED TIME) 23.00 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.00 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.01 01160 COMMUNI CATI ONS 5.01 00550 DATA PROCESSING 5.02 5.02 00560 PURCHASING RECEIVING AND STORES 5.03 5.03 00570 ADMITTING 5.04 5.04 5.05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.05 00591 OTHER ADMINISTRATIVE AND GENERAL 5.06 5.06 7 00 00700 OPERATION OF PLANT 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 01100 CAFETERI A 11.00 11.00 13. 00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICE & SUPPLY 14.00 14.00 01500 PHARMACY 15 00 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 17.00 01700 SOCIAL SERVICE 17.00 02300 PHARMACY RESIDENCY 23.00 100 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 30.00 03100 INTENSIVE CARE UNIT 31.00 0 31.00 0 43 00 04300 NURSERY 43 00 04400 SKILLED NURSING FACILITY 44.00 0 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 000000000000000000 05100 RECOVERY ROOM 51 00 51 00 52.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 05300 ANESTHESI OLOGY 53.00 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 54.01 05401 ULTRASOUND 54 01 55.00 05500 RADI OLOGY-THERAPEUTI C 55.00 05700 CT SCAN 57.00 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 05900 CARDIAC CATHETERIZATION 59 00 59 00 60.00 06000 LABORATORY 60.00 60.01 06001 BLOOD LABORATORY 60.01 06500 RESPIRATORY THERAPY 65.00 65.00 03950 SLEEP CLINIC 65.01 65.01 66.00 06600 PHYSI CAL THERAPY 66.00 67.00 06700 OCCUPATIONAL THERAPY 67.00 06800 SPEECH PATHOLOGY 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENT 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 100 73.00 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 100 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190 00 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 192.00 192. 01 19201 PHYSICIAN CLINIC 000000000 192.01 192, 02 19202 LI FELI NE 192. 02 192. 03 19203 CREDIT UNION 192.03 192. 04 19204 ENT 192.04 192. 05 19205 HOSPI TALI ST 192. 05 192.06 19206 ORTHO 192 06 194. 00 07950 COMMUNITY MENTAL HEALTH 194.00 194. 01 07951 MARKETI NG 194. 01 194. 02 07953 OCCUPATIONAL HEALTH 194. 02 194. 03 07952 PATHS EDUCATION 194. 03 194. 04 07954 FOUNDATI ON 194.04 200.00 Cross Foot Adjustments 200.00

| Heal th Finar | ncial Systems | DEARBORN COUNTY | Y HOSPITAL | | In Lie | u of Form CMS-2552-10 |
|---------------|----------------------------------------|-----------------|---------------|---------|----------------------------------|--------------------------------------|
| COST ALLOCA | TION - STATISTICAL BASIS | | Provider CCN: | 15-0086 | Peri od: | Worksheet B-1 |
| | | | | | From 01/01/2019 To 12/31/2019 | Date/Time Prepared: 6/3/2020 5:03 pm |
| | Cost Center Description | PHARMACY | | | | |
| | | RESI DENCY | | | | |
| | | (ASSI GNED | | | | |
| | | TIME) | | | | |
| | | 23. 00 | | | | |
| 201. 00 | Negative Cost Centers | | | | | 201. 00 |
| 202. 00 | Cost to be allocated (per Wkst. B, | 350, 650 | | | | 202. 00 |
| | Part I) | | | | | |
| 203. 00 | Unit cost multiplier (Wkst. B, Part I) | 3, 506. 500000 | | | | 203. 00 |
| 204. 00 | Cost to be allocated (per Wkst. B, | 10, 709 | | | | 204. 00 |
| | Part II) | | | | | |
| 205.00 | Unit cost multiplier (Wkst. B, Part | 107. 090000 | | | | 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) | | | | | |

| Health Financial Systems | DEARBORN COUNTY HOSPITAL | In Lieu of Form CMS-2552-10 |
|------------------------------------------|--------------------------|-----------------------------|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | Provi der CCN: 15-0086 | Peri od: Worksheet C |
| | | From 01/01/2019 Part I |
| | | T- 10/01/0010 D-+-/T: D |

| | | | | | From 01/01/2019 To 12/31/2019 | Part I Date/Time Pre 6/3/2020 5:03 | pared: |
|------------|-----------------------------------------|----------------|---------------|--------------|----------------------------------|------------------------------------------|---------|
| | | | Title | XVIII | Hospi tal | PPS | Pili |
| | | | | <u>'</u> | Costs | | |
| | Cost Center Description | Total Cost | Therapy Limit | Total Costs | RCE | Total Costs | |
| | , , , , , , , , , , , , , , , , , , , | (from Wkst. B, | Adj . | | Di sal I owance | | |
| | | Part I, col. | | | | | |
| | | 26) | | | | | |
| | | 1. 00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | |
| I NP | ATIENT ROUTINE SERVICE COST CENTERS | <u> </u> | <u> </u> | • | | | |
| 30. 00 030 | 000 ADULTS & PEDIATRICS | 14, 765, 523 | | 14, 765, 523 | 3 0 | 14, 765, 523 | 30.00 |
| | 00 INTENSIVE CARE UNIT | 3, 017, 130 | | 3, 017, 130 | o | 3, 017, 130 | 31. 00 |
| | NURSERY | 883, 225 | | 883, 225 | | 883, 225 | |
| | OO SKILLED NURSING FACILITY | 0 | | | 0 | 0 | 1 |
| | ILLARY SERVICE COST CENTERS | | | | | - | |
| | 000 OPERATING ROOM | 10, 702, 131 | | 10, 702, 131 | 0 | 10, 702, 131 | 50.00 |
| | OO RECOVERY ROOM | 1, 201, 761 | | 1, 201, 76 | | 1, 201, 761 | 51.00 |
| | OO DELIVERY ROOM & LABOR ROOM | 502, 978 | | 502, 978 | | 502, 978 | |
| | OO ANESTHESI OLOGY | 195, 945 | ł . | 195, 945 | | 195, 945 | 1 |
| | OO RADI OLOGY-DI AGNOSTI C | 3, 704, 721 | | 3, 704, 72 | | 3, 704, 721 | 1 |
| | 01 ULTRASOUND | 487, 206 | | 487, 206 | | 487, 206 | |
| | OO RADI OLOGY-THERAPEUTI C | 1, 037, 347 | | 1, 037, 347 | | 1, 037, 347 | 55. 00 |
| | OO CT SCAN | 1, 469, 825 | | 1, 469, 825 | | 1, 469, 825 | 1 |
| | MAGNETIC RESONANCE IMAGING (MRI) | 806, 140 | | 806, 140 | | 806, 140 | 1 |
| | OOO CARDI AC CATHETERI ZATI ON | 800, 140 | | 000, 140 | | 000, 140 | 59.00 |
| | OOO LABORATORY | 7, 693, 555 | | 7, 693, 555 | , i | 7, 858, 169 | |
| | 001 BLOOD LABORATORY | 7,043,555 | | 1,093,555 | 104, 014 | 7, 838, 109 | 60.00 |
| | 00 RESPI RATORY THERAPY | 1, 530, 016 | | 1, 530, 016 | ار ا | 1, 533, 654 | 65.00 |
| | PSO SLEEP CLINIC | | | | | | |
| | 000 PHYSI CAL THERAPY | 246, 616 | | , | | 246, 616 | 1 |
| | | 2, 768, 150 | | _, | | 2, 768, 150 | 1 |
| | OO OCCUPATIONAL THERAPY | 431, 195 | 0 | | | 431, 195 | |
| | SOO SPEECH PATHOLOGY | 291, 867 | 0 | 291, 867 | | 291, 867 | 68. 00 |
| | OOO ELECTROCARDI OLOGY | 1, 530, 676 | | 1, 530, 676 | | 1, 530, 676 | |
| | 00 MEDICAL SUPPLIES CHARGED TO PATIENTS | 2, 988, 474 | | 2, 988, 474 | | 2, 988, 474 | |
| | OO IMPL. DEV. CHARGED TO PATIENT | 497, 652 | | 497, 652 | | 497, 652 | |
| | DRUGS CHARGED TO PATIENTS | 4, 681, 493 | | 4, 681, 493 | 3 0 | 4, 681, 493 | 73. 00 |
| | PATIENT SERVICE COST CENTERS | 1 000 700 | ı | | 00.004 | | |
| | OO EMERGENCY | 4, 282, 799 | | 4, 282, 799 | | 4, 372, 133 | |
| | 00 OBSERVATION BEDS (NON-DISTINCT PART) | 3, 317, 941 | | 3, 317, 94 | | 3, 317, 941 | 92.00 |
| | ER REI MBURSABLE COST CENTERS | | T | | .1 | | |
| | OO HOME HEALTH AGENCY | 1, 881, 923 | | 1, 881, 923 | 3 | 1, 881, 923 | 101.00 |
| | CIAL PURPOSE COST CENTERS | T | T | T | T | | |
| | OO INTEREST EXPENSE | | | | | | 113. 00 |
| | HOSPI CE | 790, 883 | | 790, 883 | | 790, 883 | |
| 200.00 | Subtotal (see instructions) | 71, 707, 172 | l e | , , | | | 1 |
| 201.00 | Less Observation Beds | 3, 317, 941 | | 3, 317, 94 | | 3, 317, 941 | |
| 202. 00 | Total (see instructions) | 68, 389, 231 | 0 | 68, 389, 231 | 257, 586 | 68, 646, 817 | 202. 00 |
| | | | | | | | |

| Health Financial Systems | DEARBORN COUNTY HOSPITAL | In Lie | u of Form CMS-2552-10 |
|------------------------------------------|--------------------------|-----------------------------|-----------------------|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | Provi der CCN: 15-0086 | Peri od: From 01/01/2019 | Worksheet C |

To 12/31/2019 Date/Time Prepared: 6/3/2020 5:03 pm Title XVIII Hospi tal Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** + col . 7) Ratio I npati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 11, 840, 528 03000 ADULTS & PEDIATRICS 11, 840, 528 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 5, 491, 473 5, 491, 473 31.00 512, 529 43.00 43.00 04300 NURSERY 512, 529 44.00 04400 SKILLED NURSING FACILITY 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 12, 900, 405 23, 046, 701 35, 947, 106 0. 297719 0.000000 50.00 51.00 05100 RECOVERY ROOM 745, 854 2, 784, 359 3, 530, 213 0.340422 0.000000 51.00 05200 DELIVERY ROOM & LABOR ROOM 1, 599, 989 0.314363 0.000000 52.00 52.00 1, 485, 607 114, 382 53.00 05300 ANESTHESI OLOGY 1, 751, 160 3, 012, 881 4, 764, 041 0.041130 0.000000 53 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 921, 484 12, 422, 442 14, 343, 926 0. 258278 0.000000 54.00 54.01 05401 ULTRASOUND 293, 419 2, 875, 723 3, 169, 142 0.153734 0.000000 54.01 2, 095, 599 05500 RADI OLOGY-THERAPEUTI C 55.00 2, 441, 477 4, 537, 076 0.228638 0.000000 55, 00 57.00 05700 CT SCAN 3, 926, 289 17, 188, 026 21, 114, 315 0.069613 0.000000 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 209, 858 3, 285, 007 0.245400 0.000000 3, 075, 149 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.000000 0.000000 59.00 06000 LABORATORY 26, 031, 939 60.00 7, 186, 378 33, 218, 317 0.231606 0.000000 60.00 60.01 06001 BLOOD LABORATORY 0.000000 0.000000 60.01 06500 RESPIRATORY THERAPY 1, 247, 942 0. 281607 65.00 4, 185, 219 5, 433, 161 0.000000 65.00 03950 SLEEP CLINIC 772, 090 802, 090 0.307467 0.000000 30,000 65.01 65.01 06600 PHYSI CAL THERAPY 66.00 1,045,465 5, 878, 989 6, 924, 454 0.399764 0.000000 66.00 67.00 06700 OCCUPATI ONAL THERAPY 493,030 615, 680 1, 108, 710 0.388916 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 149, 935 441, 522 591, 457 0.493471 0.000000 68.00 69 00 06900 ELECTROCARDI OLOGY 1, 981, 875 6, 142, 639 8, 124, 514 0 188402 0 000000 69 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 731, 486 612, 921 1, 344, 407 2. 222894 0.000000 71.00 07200 I MPL. DEV. CHARGED TO PATIENT 4, 590, 497 2, 248, 684 6, 839, 181 0.072765 0.000000 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 5, 914, 669 4, 141, 273 10, 055, 942 0.465545 0.000000 73.00 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 3, 885, 040 18, 592, 150 22, 477, 190 0. 190540 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 225,000 2, 465, 652 1.233136 0.000000 92.00 2, 690, 652 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 1, 254, 042 1, 254, 042 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 1, 062, 666 1 062 666 116.00 200.00 Subtotal (see instructions) 73, 592, 799 138, 469, 329 212, 062, 128 200.00 201.00 Less Observation Beds 201. 00 202.00 Total (see instructions) 73, 592, 799 138, 469, 329 212, 062, 128 202.00

| Health Financial Systems | DEARBORN COUNTY HOSPITAL | In Lieu of Form CMS-2552-10 |
|------------------------------------------|--------------------------|-------------------------------------------------------------------------------------|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | Provi der CCN: 15-0086 | Peri od: Worksheet C From 01/01/2019 Part I To 12/31/2019 Date/Time Prepared: |

| 6/3/ | 2020 5: 03 pm |
|---------------------------------------------------------------------|---------------|
| Title XVIII Hospital | PPS |
| Cost Center Description PPS Inpatient | |
| Rati o | |
| 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 |
| 44.00 04400 SKILLED NURSING FACILITY | 44. 00 |
| ANCI LLARY SERVI CE COST CENTERS | |
| 50. 00 05000 OPERATI NG ROOM 0. 297719 | 50.00 |
| 51. 00 05100 RECOVERY ROOM 0.340422 | 51.00 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.314363 | 52. 00 |
| 53. 00 05300 ANESTHESI OLOGY | 53. 00 |
| 54. 00 05400 RADI 0LOGY-DI AGNOSTI C 0. 258278 | 54.00 |
| 54. 01 05401 ULTRASOUND 0. 153734 | 54. 01 |
| 55. 00 05500 RADI OLOGY-THERAPEUTI C 0. 228638 | 55. 00 |
| 57. 00 05700 CT SCAN 0. 069613 | 57. 00 |
| 58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0. 245400 | 58. 00 |
| 59. 00 05900 CARDI AC CATHETERI ZATI ON 0. 000000 | 59. 00 |
| 60. 00 06000 LABORATORY | 60.00 |
| 60. 01 06001 BLOOD LABORATORY 0. 000000 | 60. 01 |
| 65. 00 06500 RESPI RATORY THERAPY | 65. 00 |
| 65. 01 03950 SLEEP CLINIC 0. 307467 | 65. 01 |
| 66. 00 06600 PHYSI CAL THERAPY 0. 399764 | 66. 00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY 0. 388916 | 67. 00 |
| 68. 00 06800 SPEECH PATHOLOGY 0. 493471 | 68. 00 |
| 69. 00 06900 ELECTROCARDI OLOGY 0. 188402 | 69. 00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 2.222894 | 71. 00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0.072765 | 72. 00 |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 465545 | 73. 00 |
| OUTPATIENT SERVICE COST CENTERS | |
| 91. 00 09100 EMERGENCY 0. 194514 | 91. 00 |
| 92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 1. 233136 | 92.00 |
| OTHER REIMBURSABLE COST CENTERS | |
| 101. 00 10100 HOME HEALTH AGENCY | 101. 00 |
| SPECIAL PURPOSE COST CENTERS | |
| 113. 00 11300 I NTEREST EXPENSE | 113. 00 |
| 116. 00 11600 HOSPI CE | 116. 00 |
| 200.00 Subtotal (see instructions) | 200. 00 |
| 201.00 Less Observation Beds | 201. 00 |
| 202.00 Total (see instructions) | 202. 00 |

| Health Financial Systems | DEARBORN COUNTY HOSPITAL | In Lie | u of Form CMS-2552-10 |
|------------------------------------------|--------------------------|-----------------------------|-----------------------|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | Provi der CCN: 15-0086 | Peri od: From 01/01/2019 | |

| | | | | | o 12/31/2019 | Date/Time Pre 6/3/2020 5:03 | |
|--------|--------------------------------------------|----------------|---------------|--------------|-----------------|--------------------------------|-------------|
| - | | | Ti tl | e XIX | Hospi tal | Cost | |
| | | | | | Costs | | |
| | Cost Center Description | Total Cost | Therapy Limit | Total Costs | RCE | Total Costs | |
| | · | (from Wkst. B, | Ādj. | | Di sal I owance | | |
| | | Part I, col. | | | | | |
| | | 26) | | | | | |
| | | 1.00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| | 03000 ADULTS & PEDIATRICS | 14, 765, 523 | | 14, 765, 523 | | 14, 765, 523 | |
| | 03100 INTENSIVE CARE UNIT | 3, 017, 130 | | 3, 017, 130 | | -, , | |
| | 04300 NURSERY | 883, 225 | l e | 883, 225 | | 883, 225 | |
| | 04400 SKILLED NURSING FACILITY | 0 | | (| 0 | 0 | 44. 00 |
| | ANCILLARY SERVICE COST CENTERS | | | | | | |
| | 05000 OPERATING ROOM | 10, 702, 131 | | 10, 702, 131 | | 10, 702, 131 | 1 |
| | 05100 RECOVERY ROOM | 1, 201, 761 | | 1, 201, 761 | | 1, 201, 761 | 1 |
| | 05200 DELIVERY ROOM & LABOR ROOM | 502, 978 | | 502, 978 | | 502, 978 | |
| | 05300 ANESTHESI OLOGY | 195, 945 | | 195, 945 | | 195, 945 | 1 |
| 1 | 05400 RADI OLOGY-DI AGNOSTI C | 3, 704, 721 | | 3, 704, 721 | 0 | 3, 704, 721 | 1 |
| | 05401 ULTRASOUND | 487, 206 | | 487, 206 | 0 | 487, 206 | |
| | 05500 RADI OLOGY-THERAPEUTI C | 1, 037, 347 | | 1, 037, 347 | 0 | 1, 037, 347 | 55. 00 |
| | 05700 CT SCAN | 1, 469, 825 | | 1, 469, 825 | 0 | 1, 469, 825 | 57. 00 |
| | 05800 MAGNETIC RESONANCE IMAGING (MRI) | 806, 140 | | 806, 140 | 0 | 806, 140 | 58. 00 |
| | 05900 CARDI AC CATHETERI ZATI ON | 0 | | (| 0 | 0 | 59. 00 |
| | 06000 LABORATORY | 7, 693, 555 | | 7, 693, 555 | 164, 614 | 7, 858, 169 | 60.00 |
| | 06001 BLOOD LABORATORY | 0 | | (| 0 | 0 | 60. 01 |
| | 06500 RESPI RATORY THERAPY | 1, 530, 016 | 0 | 1, 530, 016 | 3, 638 | 1, 533, 654 | 65. 00 |
| 65. 01 | 03950 SLEEP CLINIC | 246, 616 | 0 | 246, 616 | 0 | 246, 616 | 65. 01 |
| 66.00 | 06600 PHYSI CAL THERAPY | 2, 768, 150 | 0 | 2, 768, 150 | 0 | 2, 768, 150 | 66. 00 |
| 67.00 | 06700 OCCUPATI ONAL THERAPY | 431, 195 | 0 | 431, 195 | 0 | 431, 195 | 67. 00 |
| 68. 00 | 06800 SPEECH PATHOLOGY | 291, 867 | 0 | 291, 867 | 0 | 291, 867 | 68. 00 |
| 69.00 | 06900 ELECTROCARDI OLOGY | 1, 530, 676 | | 1, 530, 676 | 0 | 1, 530, 676 | 69. 00 |
| 71. 00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 2, 988, 474 | | 2, 988, 474 | 0 | 2, 988, 474 | 71. 00 |
| 72.00 | 07200 IMPL. DEV. CHARGED TO PATIENT | 497, 652 | | 497, 652 | 0 | 497, 652 | 72. 00 |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 4, 681, 493 | | 4, 681, 493 | 0 | 4, 681, 493 | 73. 00 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 91.00 | 09100 EMERGENCY | 4, 282, 799 | | 4, 282, 799 | 89, 334 | 4, 372, 133 | 91. 00 |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 3, 317, 941 | | 3, 317, 941 | | 3, 317, 941 | 92.00 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | 1 |
| 101.00 | 10100 HOME HEALTH AGENCY | 1, 881, 923 | | 1, 881, 923 | 3 | 1, 881, 923 | 101. 00 |
| (| SPECIAL PURPOSE COST CENTERS | | | | | | 1 |
| 113.00 | 11300 I NTEREST EXPENSE | | | | | | 113. 00 |
| 116.00 | 11600 HOSPI CE | 790, 883 | | 790, 883 | 3 | 790, 883 | 116. 00 |
| 200.00 | Subtotal (see instructions) | 71, 707, 172 | | 71, 707, 172 | 257, 586 | 71, 964, 758 | 200. 00 |
| 201.00 | Less Observation Beds | 3, 317, 941 | | 3, 317, 941 | | 3, 317, 941 | 201. 00 |
| 202.00 | Total (see instructions) | 68, 389, 231 | 0 | 68, 389, 231 | 257, 586 | 68, 646, 817 | 202. 00 |
| | | • | | • | • | | - |

| Health Financial Systems | DEARBORN COUNTY HOSPITAL | In Lie | u of Form CMS-2552-10 |
|------------------------------------------|--------------------------|-----------------------------|-----------------------|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | Provi der CCN: 15-0086 | Peri od: From 01/01/2019 | Worksheet C Part I |

| | | | | - | -rom 01/01/2019 Го 12/31/2019 | Part I Date/Time Pre 6/3/2020 5:03 | |
|---------|--------------------------------------------|--------------|------------------------|----------------------------|----------------------------------|------------------------------------------|---------|
| | | _ | | e XIX | Hospi tal | Cost | |
| | Cost Center Description | I npati ent | Charges Outpati ent | Total (col. 6 + col. 7) | Cost or Other Ratio | TEFRA I npati ent Rati o | |
| | | 6. 00 | 7. 00 | 8. 00 | 9. 00 | 10.00 | |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30.00 | 03000 ADULTS & PEDIATRICS | 11, 840, 528 | | 11, 840, 52 | 3 | | 30.00 |
| 31.00 | 03100 INTENSIVE CARE UNIT | 5, 491, 473 | | 5, 491, 47 | 3 | | 31.00 |
| 43.00 | 04300 NURSERY | 512, 529 | | 512, 52 | 9 | | 43.00 |
| 44.00 | 04400 SKILLED NURSING FACILITY | 0 | | (|) | | 44.00 |
| | ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50.00 | 05000 OPERATI NG ROOM | 12, 900, 405 | 23, 046, 701 | 35, 947, 10 | 0. 297719 | 0. 000000 | 50.00 |
| 51.00 | 05100 RECOVERY ROOM | 745, 854 | 2, 784, 359 | 3, 530, 21 | 0. 340422 | 0.000000 | 51.00 |
| 52.00 | 05200 DELIVERY ROOM & LABOR ROOM | 1, 485, 607 | 114, 382 | 1, 599, 989 | 9 0. 314363 | 0.000000 | 52. 00 |
| 53.00 | 05300 ANESTHESI OLOGY | 1, 751, 160 | 3, 012, 881 | 4, 764, 04 | 0. 041130 | 0.000000 | 53. 00 |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 1, 921, 484 | 12, 422, 442 | 14, 343, 92 | 0. 258278 | 0.000000 | 54.00 |
| 54. 01 | 05401 ULTRASOUND | 293, 419 | 2, 875, 723 | 3, 169, 142 | 0. 153734 | 0.000000 | 54. 01 |
| 55.00 | 05500 RADI OLOGY-THERAPEUTI C | 2, 095, 599 | 2, 441, 477 | 4, 537, 07 | 0. 228638 | 0.000000 | 55. 00 |
| 57.00 | 05700 CT SCAN | 3, 926, 289 | 17, 188, 026 | 21, 114, 31 | 0. 069613 | 0.000000 | 57. 00 |
| 58.00 | 05800 MAGNETIC RESONANCE IMAGING (MRI) | 209, 858 | 3, 075, 149 | 3, 285, 00° | 0. 245400 | 0.000000 | 58. 00 |
| 59.00 | 05900 CARDI AC CATHETERI ZATI ON | O | 0 | | 0. 000000 | 0.000000 | 59. 00 |
| 60.00 | 06000 LABORATORY | 7, 186, 378 | 26, 031, 939 | 33, 218, 31 ⁻ | 0. 231606 | 0.000000 | 60.00 |
| 60. 01 | 06001 BLOOD LABORATORY | 0 | 0 | | 0. 000000 | 0.000000 | 60. 01 |
| 65.00 | 06500 RESPI RATORY THERAPY | 4, 185, 219 | 1, 247, 942 | 5, 433, 16 ⁻ | 0. 281607 | 0.000000 | 65. 00 |
| 65. 01 | 03950 SLEEP CLINIC | 30,000 | 772, 090 | 802, 090 | 0. 307467 | 0.000000 | 65. 01 |
| 66.00 | 06600 PHYSI CAL THERAPY | 1, 045, 465 | 5, 878, 989 | 6, 924, 45 | 0. 399764 | 0.000000 | 66. 00 |
| 67.00 | 06700 OCCUPATI ONAL THERAPY | 493, 030 | 615, 680 | 1, 108, 710 | 0. 388916 | 0.000000 | 67. 00 |
| 68.00 | 06800 SPEECH PATHOLOGY | 149, 935 | 441, 522 | 591, 45 | 0. 493471 | 0.000000 | 68. 00 |
| 69.00 | 06900 ELECTROCARDI OLOGY | 1, 981, 875 | 6, 142, 639 | 8, 124, 51 | 0. 188402 | 0.000000 | 69. 00 |
| 71.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 731, 486 | 612, 921 | 1, 344, 40 | 7 2. 222894 | 0.000000 | 71. 00 |
| 72.00 | 07200 I MPL. DEV. CHARGED TO PATIENT | 4, 590, 497 | 2, 248, 684 | 6, 839, 18 | 0. 072765 | 0.000000 | |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 5, 914, 669 | 4, 141, 273 | 10, 055, 94 | 0. 465545 | 0.000000 | 73.00 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 91.00 | 09100 EMERGENCY | 3, 885, 040 | 18, 592, 150 | 22, 477, 190 | 0. 190540 | 0.000000 | 91. 00 |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 225, 000 | 2, 465, 652 | 2, 690, 65 | 1. 233136 | 0.000000 | 92.00 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | |
| 101.00 | 10100 HOME HEALTH AGENCY | 0 | 1, 254, 042 | 1, 254, 04 | 2 | | 101. 00 |
| | SPECIAL PURPOSE COST CENTERS | , | | | | | |
| | 11300 INTEREST EXPENSE | | | | | | 113. 00 |
| | 11600 H0SPI CE | 0 | 1, 062, 666 | | | | 116. 00 |
| 200.00 | | 73, 592, 799 | 138, 469, 329 | 212, 062, 12 | 3 | | 200. 00 |
| 201.00 | 1 1 | [| | | | | 201. 00 |
| 202. 00 | Total (see instructions) | 73, 592, 799 | 138, 469, 329 | 212, 062, 12 | 3 | | 202. 00 |

| Health Financial Systems | | DEARBORN COUNTY | HOSPI TAL | | In Lie | u of Form CMS-2552-10 |
|---------------------------|-----------------|-----------------|-----------|--------------|----------------------------------------------|----------------------------------------|
| COMPUTATION OF RATIO OF C | OSTS TO CHARGES | | Provi der | CCN: 15-0086 | Peri od: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: |

| | | | 10 12/31/2019 | Date/II me Prepared: 6/3/2020 5:03 pm |
|-----------------------------------------------------------------|---------------|-----------|---------------|--------------------------------------------|
| | | Title XIX | Hospi tal | Cost |
| Cost Center Description | PPS Inpatient | | | |
| | 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 |
| 44.00 O4400 SKILLED NURSING FACILITY | | | | 44. 00 |
| ANCILLARY SERVICE COST CENTERS | | | | |
| 50. 00 05000 OPERATI NG ROOM | 0. 000000 | | | 50. 00 |
| 51. 00 05100 RECOVERY ROOM | 0. 000000 | | | 51.00 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 0. 000000 | | | 52. 00 |
| 53. 00 05300 ANESTHESI OLOGY | 0. 000000 | | | 53. 00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 0. 000000 | | | 54.00 |
| 54. 01 05401 ULTRASOUND | 0. 000000 | | | 54. 01 |
| 55. 00 05500 RADI OLOGY-THERAPEUTI C | 0. 000000 | | | 55. 00 |
| 57. 00 05700 CT SCAN | 0. 000000 | | | 57. 00 |
| 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) | 0. 000000 | | | 58. 00 |
| 59. 00 05900 CARDI AC CATHETERI ZATI ON | 0. 000000 | | | 59. 00 |
| 60. 00 06000 LABORATORY | 0. 000000 | | | 60. 00 |
| 60. 01 06001 BLOOD LABORATORY | 0. 000000 | | | 60. 01 |
| 65. 00 06500 RESPI RATORY THERAPY | 0. 000000 | | | 65. 00 |
| 65. 01 03950 SLEEP CLINIC | 0. 000000 | | | 65. 01 |
| 66. 00 06600 PHYSI CAL THERAPY | 0. 000000 | | | 66. 00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | 0. 000000 | | | 67. 00 |
| 68. 00 06800 SPEECH PATHOLOGY | 0. 000000 | | | 68. 00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0. 000000 | | | 69. 00 |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0. 000000 | | | 71. 00 |
| 72. 00 07200 I MPL. DEV. CHARGED TO PATIENT | 0. 000000 | | | 72. 00 |
| 73. 00 O7300 DRUGS CHARGED TO PATIENTS | 0. 000000 | | | 73. 00 |
| OUTPATIENT SERVICE COST CENTERS | 0.000000 | | | 01.00 |
| 91. 00 09100 EMERGENCY | 0.000000 | | | 91.00 |
| 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) | 0. 000000 | | | 92. 00 |
| OTHER REIMBURSABLE COST CENTERS | | | | 101 00 |
| 101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS | | | | 101.00 |
| 113. 00 11300 NTEREST EXPENSE | | | | 113. 00 |
| 116. 00 11600 HOSPI CE | | | | 116.00 |
| | | | | 200. 00 |
| 200.00 Subtotal (see instructions) 201.00 Less Observation Beds | | | | 200.00 |
| | | | | 201.00 |
| 202.00 Total (see instructions) | 1 | | | J202. 00 |

| Health Financial Systems | DEARBORN COUN | DEARBORN COUNTY HOSPITAL | | In Lieu of Form CMS-2552-10 | | |
|--------------------------------------------------|----------------|--------------------------|------------------------|-----------------------------|------------------------------------------------------------------|---------|
| APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPIT | AL COSTS | | Provi der CCN: 15-0086 | | Worksheet D Part I Date/Time Prepared: 6/3/2020 5:03 pm | |
| | | | Title XVIII | | 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 | 2, 143, 957 | 0 | 2, 143, 95 | 7 9, 203 | 232. 96 | 30. 00 |
| 31.00 INTENSIVE CARE UNIT | 256, 878 | | 256, 87 | 1, 807 | 142. 16 | 31.00 |
| 43. 00 NURSERY | 24, 354 | | 24, 35 | 4 587 | 41. 49 | 43.00 |
| 44.00 SKILLED NURSING FACILITY | 0 | | | 0 | 0.00 | 44. 00 |
| 200.00 Total (lines 30 through 199) | 2, 425, 189 | | 2, 425, 18 | 9 11, 597 | | 200. 00 |
| Cost Center Description | I npati ent | Inpati ent | | | | |
| · · | Program days | Program | | | | |
| | | Capital Cost | | | | |
| | | (col. 5 x col. | | | | |
| | | 6) | | | | |
| | 6.00 | 7.00 | | | | |
| INPATIENT ROUTINE SERVICE COST CENTERS | · | | | | | |
| 30. 00 ADULTS & PEDIATRICS | 3, 604 | 839, 588 | | | | 30.00 |
| 31.00 INTENSIVE CARE UNIT | 734 | | | | | 31. 00 |
| 43. 00 NURSERY | 0 | | | | | 43. 00 |
| 44.00 SKILLED NURSING FACILITY | 0 | | , | | | 44.00 |
| 200.00 Total (lines 30 through 199) | 4, 338 | 943, 933 | | | | 200. 00 |

| Health Financial Systems | DEARBORN COUN | ITY HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|-----------------------------------------------------|----------------|----------------|----------------|-----------------------------|------------------------|---------|
| APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA | L COSTS | Provider C | | Peri od: From 01/01/2019 | Worksheet D Part II | |
| | | | | To 12/31/2019 | Date/Time Pre | |
| | | Ti +l c | XVIII | Hospi tal | 6/3/2020 5: 03 PPS | pm |
| Cost Center Description | Capi tal | Total Charges | | | Capital Costs | |
| cost center bescription | | (from Wkst. C, | | Program | (column 3 x | |
| | (from Wkst. B, | Part I, col. | (col . 1 ÷ col | 9 | column 4) | |
| | Part II, col. | 8) | 2) | . onal goo | 001 4 | |
| | 26) | ", | | | | |
| | 1.00 | 2.00 | 3.00 | 4. 00 | 5. 00 | |
| ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50.00 05000 OPERATING ROOM | 839, 671 | 35, 947, 106 | 0. 02335 | 5, 389, 067 | 125, 883 | 50.00 |
| 51.00 05100 RECOVERY ROOM | 44, 767 | 3, 530, 213 | 0. 01268 | 294, 528 | 3, 735 | 51.00 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 18, 879 | 1, 599, 989 | 0. 01179 | 7, 349 | 87 | 52.00 |
| 53. 00 05300 ANESTHESI OLOGY | 6, 903 | 4, 764, 041 | 0. 00144 | 739, 964 | 1, 072 | 53.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 369, 761 | 14, 343, 926 | 0. 02577 | 1, 063, 255 | 27, 409 | 54.00 |
| 54. 01 05401 ULTRASOUND | 24, 258 | 3, 169, 142 | 0.00765 | 92, 021 | 704 | 54. 01 |
| 55. 00 05500 RADI OLOGY-THERAPEUTI C | 44, 143 | 4, 537, 076 | 0.00972 | 931, 937 | 9, 067 | 55.00 |
| 57. 00 05700 CT SCAN | 26, 281 | | 0. 00124 | 2, 318, 685 | 2, 887 | 57. 00 |
| 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) | 28, 841 | 3, 285, 007 | 0. 00878 | 123, 634 | 1, 086 | 58. 00 |
| 59. 00 05900 CARDI AC CATHETERI ZATI ON | 0 | 0 | 0.00000 | 00 | 0 | 59. 00 |
| 60. 00 06000 LABORATORY | 280, 407 | 33, 218, 317 | 0. 00844 | 3, 830, 817 | 32, 336 | 60.00 |
| 60. 01 06001 BLOOD LABORATORY | 0 | 0 | 0.00000 | 0 0 | 0 | 60. 01 |
| 65. 00 06500 RESPI RATORY THERAPY | 50, 170 | 5, 433, 161 | 0.00923 | 3, 007, 473 | 27, 771 | 65. 00 |
| 65. 01 03950 SLEEP CLINIC | 1, 583 | 802, 090 | 0. 00197 | 28, 592 | 56 | 65. 01 |
| 66. 00 06600 PHYSI CAL THERAPY | 237, 598 | 6, 924, 454 | 0. 03431 | 609, 633 | 20, 918 | 66. 00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | 26, 039 | 1, 108, 710 | 0. 02348 | 36 294, 825 | 6, 924 | 67.00 |
| 68. 00 06800 SPEECH PATHOLOGY | 14, 057 | 591, 457 | 0. 02376 | 7 100, 227 | 2, 382 | 68. 00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 136, 209 | 8, 124, 514 | 0. 01676 | 1, 075, 686 | 18, 034 | 69. 00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 217, 943 | 1, 344, 407 | 0. 16211 | 161, 147 | 26, 124 | 71. 00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | 47, 013 | 6, 839, 181 | 0.00687 | 1, 610, 061 | 11, 068 | 72. 00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 71, 962 | 10, 055, 942 | 0.00715 | 3, 229, 269 | 23, 109 | 73. 00 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 91. 00 09100 EMERGENCY | 335, 227 | | | | | |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 481, 765 | 2, 690, 652 | 0. 17905 | 224, 585 | | |
| 200.00 Total (lines 50 through 199) | 3, 303, 477 | 191, 900, 890 | 1 | 27, 249, 201 | 412, 429 | 200. 00 |

| Health Financial Systems | DEARBORN COUN | | | | eu of Form CMS-2 | 2552-10 |
|-----------------------------------------------------|-----------------|-------------------|---------------|-----------------|-----------------------------|---------|
| APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA | SS THROUGH COST | TS Provi der Co | | Peri od: | Worksheet D | |
| | | | | From 01/01/2019 | Part III | |
| | | | | To 12/31/2019 | Date/Time Pre 6/3/2020 5:03 | pared: |
| | | Title | : XVIII | Hospi tal | PPS | рш |
| Cost Center Description | Nursing School | Nursing School | Allied Health | Allied Health | All Other | |
| · · | Post-Stepdown | | Post-Stepdowr | | Medi cal | |
| | Adjustments | | Adjustments | | Education Cost | |
| | 1A | 1.00 | 2A | 2. 00 | 3. 00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30. 00 03000 ADULTS & PEDIATRICS | 0 | 0 | | 0 | 0 | 30. 00 |
| 31.00 03100 INTENSIVE CARE UNIT | 0 | 0 | | 0 | 0 | 31. 00 |
| 43. 00 04300 NURSERY | 0 | 0 | | 0 | 0 | 43.00 |
| 44.00 04400 SKILLED NURSING FACILITY | 0 | 0 | | 0 | 1 | 44.00 |
| 200.00 Total (lines 30 through 199) | 0 | 0 | | 0 | 0 | 200. 00 |
| Cost Center Description | Swi ng-Bed | Total Costs | Total Patient | Per Diem (col. | I npati ent | |
| | Adjustment | (sum of cols. | Days | 5 ÷ col. 6) | Program Days | |
| | Amount (see | 1 through 3, | | | | |
| | instructions) | | | | | |
| | 4. 00 | 5. 00 | 6. 00 | 7. 00 | 8. 00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30. 00 03000 ADULTS & PEDI ATRI CS | 0 | 0 | 9, 20 | | | |
| 31.00 03100 INTENSIVE CARE UNIT | | 0 | 1, 80 | | | |
| 43. 00 04300 NURSERY | | 0 | 58 | | | 1 .0.00 |
| 44.00 04400 SKILLED NURSING FACILITY | | 0 | | 0. 00 | | 1 |
| 200.00 Total (lines 30 through 199) | | 0 | 11, 59 | 7 | 4, 338 | 200. 00 |
| Cost Center Description | I npati ent | | | | | |
| | Program | | | | | |
| | Pass-Through | | | | | |
| | Cost (col. 7 x | | | | | |
| | col. 8) | | | | | |

30. 00 31. 00

43. 00 44. 00 200. 00

30. 00 | 03000 | ADULTS & PEDI ATRI CS | 03100 | INTENSI VE CARE UNIT | 43. 00 | 04300 | NURSERY | 44. 00 | 04400 | SKILLED NURSI NG FACILITY | Total (lines 30 through 199)

| Health Financial Systems | DEARBORN COUNTY HOSPITAL | In Lieu of Form CMS-2552-10 |
|---------------------------------------|----------------------------------------------------|-----------------------------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT | ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0086 | Peri od: Worksheet D |
| THROUGH COSTS | | From 01/01/2019 Part IV |

| | | | | 0 12/31/2019 | Date/lime Pre 6/3/2020 5:03 | |
|-------------------------------------------------|---------------|----------------|----------------|---------------|--------------------------------|---------|
| | | Ti tl e | XVIII | Hospi tal | PPS | |
| Cost Center Description | Non Physician | Nursing School | Nursing School | Allied Health | Allied Health | |
| | Anestheti st | Post-Stepdown | | Post-Stepdown | | |
| | Cost | Adjustments | | Adjustments | | |
| | 1.00 | 2A | 2.00 | 3A | 3. 00 | |
| ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50. 00 05000 OPERATI NG ROOM | C | 0 | (| 0 | 0 | 50. 00 |
| 51.00 05100 RECOVERY ROOM | C | 0 | (| 0 | 0 | 51. 00 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | C | 0 |) c | 0 | 0 | 52.00 |
| 53. 00 05300 ANESTHESI OLOGY | C | 0 | (| 0 | 0 | 53.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | C | 0 | (| 0 | 0 | 54. 00 |
| 54. 01 05401 ULTRASOUND | C | 0 | (| 0 | 0 | 54. 01 |
| 55. 00 05500 RADI OLOGY-THERAPEUTI C | C | 0 | (| 0 | 0 | 55. 00 |
| 57. 00 05700 CT SCAN | C | 0 | (| 0 | 0 | 57. 00 |
| 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) | C | 0 | (| 0 | 0 | 58. 00 |
| 59. 00 05900 CARDI AC CATHETERI ZATI ON | C | 0 | (| 0 | 0 | 59. 00 |
| 60. 00 06000 LABORATORY | C | 0 | (| 0 | 0 | 60.00 |
| 60. 01 06001 BLOOD LABORATORY | C | 0 | (| 0 | 0 | 60. 01 |
| 65. 00 06500 RESPIRATORY THERAPY | C | 0 | (| 0 | 0 | 65. 00 |
| 65. 01 03950 SLEEP CLINIC | C | 0 | (| 0 | 0 | 65. 01 |
| 66. 00 06600 PHYSI CAL THERAPY | C | 0 | (| 0 | 0 | 66. 00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | C | 0 | (| 0 | 0 | 67. 00 |
| 68. 00 06800 SPEECH PATHOLOGY | C | 0 | (| 0 | 0 | 68. 00 |
| 69. 00 06900 ELECTROCARDI OLOGY | C | 0 | (| 0 | 0 | 69. 00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | S C | 0 | (| 0 | 0 | 71. 00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | C | 0 | (| 0 | 0 | 72. 00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | C | 0 | (| 0 | 350, 650 | 73. 00 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 91. 00 09100 EMERGENCY | C | 0 | (| 0 | 0 | 91. 00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART |) 0 |) | (| | 0 | 92. 00 |
| 200.00 Total (lines 50 through 199) | C |) O | (| 0 | 350, 650 | 200. 00 |

| Health Financial Systems | DEARBORN COUNTY | HOSPI TAL | In Lie | u of Form CMS-2552-10 |
|--------------------------------------|--------------------------------|-----------------------|-----------------|-----------------------|
| APPORTIONMENT OF INPATIENT/OUTPATIEN | T ANCILLARY SERVICE OTHER PASS | Provider CCN: 15-0086 | Peri od: | Worksheet D |
| TURQUOU GOOTO | | | Erom 01/01/2010 | Dort IV |

THROUGH COSTS From 01/01/2019 | Part IV To 12/31/2019 | Date/Time Prepared: 6/3/2020 5:03 pm Title XVIII Hospi tal All Other Ratio of Cost Cost Center Description Total Cost Total Total Charges to Charges Medi cal (from Wkst. C, (sum of cols. Outpati ent Education Cost 1, 2, 3, and Cost (sum of Part I, col. (col. 5 ÷ col 4) col s. 2, 3, 8) and 4) 4.00 5.00 6.00 7.00 8.00 ANCILLARY SERVICE COST CENTERS 35, 947, 106 50.00 05000 OPERATING ROOM 0.000000 50.00 000000000000000000000 51.00 05100 RECOVERY ROOM 3, 530, 213 0.00000051.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 1, 599, 989 0.000000 52.00 52.00 05300 ANESTHESI OLOGY 0 0 4, 764, 041 0.000000 53.00 53.00 05400 RADI OLOGY-DI AGNOSTI C 14, 343, 926 0.000000 54.00 54.00 54.01 05401 ULTRASOUND 0 0 3, 169, 142 0.000000 54.01 55.00 05500 RADI OLOGY-THERAPEUTI C 4, 537, 076 0.000000 55.00 21, 114, 315 05700 CT SCAN 0 0 0.000000 57 00 57 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 58.00 3, 285, 007 0.000000 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.000000 59.00 0 0.000000 60.00 06000 LABORATORY 33, 218, 317 60.00 06001 BLOOD LABORATORY 0 0.000000 60 01 60 01 65.00 06500 RESPIRATORY THERAPY 0 5, 433, 161 0.000000 65.00 03950 SLEEP CLINIC 0.000000 65.01 802, 090 65.01 06600 PHYSI CAL THERAPY 6, 924, 454 0.000000 66 00 66 00 67.00 06700 OCCUPATI ONAL THERAPY 1, 108, 710 0.000000 67.00 06800 SPEECH PATHOLOGY 0 591, 457 0.000000 68.00 06900 ELECTROCARDI OLOGY 69.00 8, 124, 514 0.000000 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 Ω 0 0.000000 71.00 1.344.407 07200 I MPL. DEV. CHARGED TO PATIENT 72.00 0 6, 839, 181 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 350, 650 350, 650 10, 055, 942 0. 034870 73.00 OUTPATIENT SERVICE COST CENTERS 91. 00 09100 EMERGENCY 0 22, 477, 190 0.000000 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 2, 690, 652 0.000000 92.00

350, 650

350, 650

191, 900, 890

200.00

200.00

Total (lines 50 through 199)

| Health Financial Systems | | DEARBORN C | COUNTY HOS | SPI TAL | | In Lie | u of Form CMS-2552-10 |
|--------------------------------|-------------------|-----------------|------------|-------------|---------|----------|-----------------------|
| APPORTIONMENT OF INPATIENT/OUT | PATIENT ANCILLARY | SERVICE OTHER F | PASS Pr | ovider CCN: | 15-0086 | Peri od: | Worksheet D |

| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SETTHROUGH COSTS | RVICE OTHER PASS | | 1 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV Date/Time Pre 6/3/2020 5:03 | |
|------------------------------------------------------------------|------------------|--------------|---------------|---------------------------------------------|----------------------------------------------------------|--------|
| | | Title | XVIII | Hospi tal | PPS | |
| Cost Center Description | Outpati ent | I npati ent | I npati ent | Outpati ent | Outpati ent | |
| | Ratio of Cost | Program | Program | Program | Program | |
| | to Charges | Charges | Pass-Through | Charges | Pass-Through | |
| | (col. 6 ÷ col. | | Costs (col. 8 | 3 | Costs (col. 9 | |
| | 7) | | x col. 10) | | x col. 12) | |
| | 9. 00 | 10. 00 | 11. 00 | 12.00 | 13. 00 | |
| ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50.00 05000 OPERATING ROOM | 0. 000000 | 5, 389, 067 | | 4, 671, 225 | 0 | 50. 00 |
| 51.00 05100 RECOVERY ROOM | 0. 000000 | 294, 528 | | 0 851, 318 | 0 | 51.00 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 0. 000000 | 7, 349 | | 0 | 0 | 52.00 |
| 53. 00 05300 ANESTHESI OLOGY | 0. 000000 | 739, 964 | | 672, 238 | 0 | 53.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 0. 000000 | 1, 063, 255 | | 3, 822, 672 | 0 | 54.00 |
| 54. 01 05401 ULTRASOUND | 0. 000000 | 92, 021 | | 503, 023 | 0 | 54. 01 |
| 55. 00 05500 RADI OLOGY-THERAPEUTI C | 0. 000000 | 931, 937 | | 1, 706, 232 | 0 | 55. 00 |
| 57. 00 05700 CT SCAN | 0. 000000 | 2, 318, 685 | | 5, 367, 822 | 0 | 57. 00 |
| 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) | 0. 000000 | 123, 634 | | 836, 731 | 0 | 58. 00 |
| 59. 00 05900 CARDI AC CATHETERI ZATI ON | 0. 000000 | 0 | | 0 | 0 | 59. 00 |
| 60. 00 06000 LABORATORY | 0. 000000 | 3, 830, 817 | | 2, 485, 695 | 0 | 60.00 |
| 60. 01 06001 BLOOD LABORATORY | 0. 000000 | 0 | | 0 | 0 | 60. 01 |
| 65. 00 06500 RESPIRATORY THERAPY | 0. 000000 | 3, 007, 473 | | 639, 650 | 0 | 65.00 |
| 65. 01 03950 SLEEP CLINIC | 0. 000000 | 28, 592 | | 207, 644 | 0 | 65. 01 |
| 66. 00 06600 PHYSI CAL THERAPY | 0. 000000 | 609, 633 | | 305, 222 | 0 | 66. 00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | 0. 000000 | 294, 825 | | 14, 608 | 0 | 67. 00 |
| 68. 00 06800 SPEECH PATHOLOGY | 0. 000000 | 100, 227 | | 5, 187 | 0 | 68. 00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0. 000000 | 1, 075, 686 | | 1, 795, 938 | 0 | 69. 00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0. 000000 | 161, 147 | | 54, 081 | 0 | 71. 00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | 0. 000000 | 1, 610, 061 | • | 0 487, 441 | 0 | 72. 00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 0. 034870 | 3, 229, 269 | | | 52, 740 | 73. 00 |
| OUTPATIENT SERVICE COST CENTERS | | ., ==., ==. | | | | |
| 91. 00 09100 EMERGENCY | 0. 000000 | 2, 116, 446 | | 3, 682, 488 | 0 | 91.00 |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0. 000000 | 224, 585 | | 1, 478, 149 | | 92.00 |
| 200.00 Total (lines 50 through 199) | | 27, 249, 201 | • | | | |

| Health Financial Systems | DEARBORN COUN | ITY HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|-----------------------------------------------------|----------------|----------------|---------------|---------------------------------------------|--------------------------------|---------|
| APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND | O VACCINE COST | Provi der Co | | Period: From 01/01/2019 To 12/31/2019 | Date/Time Pre 6/3/2020 5:03 | |
| | | Title | XVIII | Hospi tal | PPS | |
| | | | Charges | | Costs | |
| Cost Center Description | | PPS Reimbursed | | Cost | PPS Services | |
| | Ratio From | Services (see | Reimbursed | Rei mbursed | (see inst.) | |
| | Worksheet C, | inst.) | Servi ces | Services Not | | |
| | Part I, col. 9 | 1 | Subject To | Subject To | | |
| | | | Ded. & Coins. | Ded. & Coins. | | |
| | | | (see inst.) | (see inst.) | | |
| | 1.00 | 2.00 | 3. 00 | 4. 00 | 5. 00 | |
| ANCI LLARY SERVICE COST CENTERS | | | 1 | | | 1 |
| 50. 00 05000 OPERATI NG ROOM | 0. 297719 | | | 0 | 1, 390, 712 | 1 |
| 51. 00 05100 RECOVERY ROOM | 0. 340422 | | | 0 | 289, 807 | 51. 00 |
| 52.00 O5200 DELIVERY ROOM & LABOR ROOM | 0. 314363 | | | 0 | 0 | 52. 00 |
| 53. 00 05300 ANESTHESI OLOGY | 0. 041130 | | | 0 | 27, 649 | |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 0. 258278 | | | 0 0 | 987, 312 | |
| 54. 01 05401 ULTRASOUND | 0. 153734 | | | 0 | 77, 332 | 1 |
| 55. 00 05500 RADI OLOGY-THERAPEUTI C | 0. 228638 | | | 0 | 390, 109 | |
| 57. 00 05700 CT SCAN | 0. 069613 | | | 0 | 373, 670 | |
| 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) | 0. 245400 | | | 0 | 205, 334 | |
| 59. 00 05900 CARDI AC CATHETERI ZATI ON | 0. 000000 | 0 | | 0 | 0 | 59. 00 |
| 60. 00 06000 LABORATORY | 0. 231606 | | 18, 05 | 0 | 575, 702 | 60.00 |
| 60. 01 06001 BLOOD LABORATORY | 0. 000000 | | | 0 | 0 | 60. 01 |
| 65. 00 06500 RESPI RATORY THERAPY | 0. 281607 | | | 0 | 180, 130 | |
| 65. 01 03950 SLEEP CLI NI C | 0. 307467 | | | 0 | 63, 844 | 65. 01 |
| 66. 00 06600 PHYSI CAL THERAPY | 0. 399764 | | | 0 | 122, 017 | 66. 00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | 0. 388916 | | | 0 | 5, 681 | |
| 68. 00 06800 SPEECH PATHOLOGY | 0. 493471 | 5, 187 | | 0 | 2, 560 | 68. 00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0. 188402 | 1, 795, 938 | | 0 | 338, 358 | 69. 00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 2. 222894 | 54, 081 | | 0 0 | 120, 216 | 71. 00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | 0. 072765 | 487, 441 | | 0 0 | 35, 469 | 72. 00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 0. 465545 | 1, 512, 485 | | 1, 233 | 704, 130 | 73. 00 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 91. 00 09100 EMERGENCY | 0. 190540 | 3, 682, 488 | | 0 0 | 701, 661 | 91. 00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 1. 233136 | 1, 478, 149 | | 0 0 | 1, 822, 759 | 92.00 |
| 200.00 Subtotal (see instructions) | | 31, 099, 849 | 18, 05 | 1, 233 | 8, 414, 452 | 200.00 |
| 201.00 Less PBP Clinic Lab. Services-Program | | | | 0 | | 201. 00 |
| Only Charges | | | | | | |
| 202.00 Net Charges (line 200 - line 201) | | 31, 099, 849 | 18, 05 | 1, 233 | 8, 414, 452 | 202. 00 |

| Health Financial Systems | | DEARBORN COUNTY | HOSPI TAL | In Lieu | u of Form CMS-25 | 52-10 |
|---------------------------|---------------------------|-----------------|---------------|----------------------------------------------|-------------------------------------------------------------|-------|
| APPORTIONMENT OF MEDICAL, | OTHER HEALTH SERVICES AND | VACCINE COST | Provider CCN: | Peri od: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepa 6/3/2020 5:03 p | |

| | | | | | To 12/31/20 | 019 Date/Time Pr 6/3/2020 5:0 | |
|-----------|---------------------------------------------------|-------------|--------------|-------|-------------|----------------------------------|---------|
| | | | Title | XVIII | Hospi tal | PPS | |
| | | Cost | S | | <u> </u> | ., | |
| | Cost Center Description | Cost | Cost | | | | |
| | | Rei mbursed | Rei mbursed | | | | |
| | | | Services Not | | | | |
| | | | Subj ect To | | | | |
| | | | ed. & Coins. | | | | |
| | | | (see inst.) | | | | |
| 0.014 | OLLIADV CEDVICE COCT CENTEDO | 6. 00 | 7. 00 | | | | |
| | CILLARY SERVICE COST CENTERS OOO OPERATING ROOM | | | I | | | 50.00 |
| | 100 RECOVERY ROOM | | 0 | | | | 50.00 |
| | 200 DELIVERY ROOM & LABOR ROOM | | 0 | | | | 52.00 |
| | 300 ANESTHESI OLOGY | | 0 | | | | 53. 00 |
| | 400 RADI OLOGY-DI AGNOSTI C | | 0 | | | | 54. 00 |
| | 401 ULTRASOUND | | 0 | | | | 54. 01 |
| | 500 RADI OLOGY-THERAPEUTI C | | 0 | | | | 55. 00 |
| | 700 CT SCAN | 0 | 0 | | | | 57. 00 |
| | 800 MAGNETIC RESONANCE IMAGING (MRI) | 0 | 0 | | | | 58. 00 |
| | 900 CARDI AC CATHETERI ZATI ON | o | 0 | | | | 59. 00 |
| | 000 LABORATORY | 4, 180 | 0 | | | | 60.00 |
| 60. 01 06 | 001 BLOOD LABORATORY | 0 | 0 | | | | 60. 01 |
| 65. 00 06 | 500 RESPIRATORY THERAPY | O | 0 | | | | 65. 00 |
| 65. 01 03 | 950 SLEEP CLINIC | 0 | 0 | | | | 65. 01 |
| 66. 00 06 | 600 PHYSI CAL THERAPY | 0 | 0 | | | | 66. 00 |
| | 700 OCCUPATI ONAL THERAPY | 0 | 0 | | | | 67. 00 |
| | 800 SPEECH PATHOLOGY | 0 | 0 | | | | 68. 00 |
| | 900 ELECTROCARDI OLOGY | 0 | 0 | | | | 69. 00 |
| | 100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | | | | 71. 00 |
| | 200 IMPL. DEV. CHARGED TO PATIENT | 0 | 0 | | | | 72. 00 |
| | 300 DRUGS CHARGED TO PATIENTS | 0 | 574 | | | | 73. 00 |
| | TPATIENT SERVICE COST CENTERS | | | T | | | |
| | 100 EMERGENCY | 0 | 0 | 1 | | | 91. 00 |
| | 200 OBSERVATION BEDS (NON-DISTINCT PART) | 0 | 0 | ı | | | 92. 00 |
| 200.00 | Subtotal (see instructions) | 4, 180 | 574 | | | | 200. 00 |
| 201. 00 | Less PBP Clinic Lab. Services-Program | 0 | | | | | 201. 00 |
| 202. 00 | Only Charges Net Charges (line 200 - line 201) | 4, 180 | 574 | | | | 202. 00 |
| 202.00 | inet charges (Title 200 - Title 201) | 4, 100 | 374 | I | | | 1202.00 |

| Health Financial Systems | DEARBORN COUNTY HOSPITAL | In Lie | u of Form CMS-2552-10 |
|-----------------------------------------|--------------------------|----------------------------------------------|----------------------------------------------------|
| COMPUTATION OF INPATIENT OPERATING COST | Provi der CCN: 15-0086 | Peri od: From 01/01/2019 To 12/31/2019 | Worksheet D-1 Date/Time Prepared: 6/3/2020 5:03 pm |
| | Title XVIII | Hospi tal | PPS |

| Cost Center Description PRET ALL_FROUTERC CORPORENTS | | | | | 6/3/2020 5:03 | pm |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|----------------------------------------------------------------|------------------------------|------------------|---------------|--------|
| PART 1 - ALL PROVIDER COMPONENTS | | | Title XVIII | Hospi tal | PPS | |
| INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED IMPS INSMITTED | | Cost Center Description | | | 1 00 | |
| INPARTENT MAYS | | DADT I _ ALL DROVENED COMPONENTS | | | 1.00 | |
| Impatient days (including private room days and swing-bed days, excluding newborn) | | | | | | |
| Inpatient days (including private room days, excluding swing-bed and newborn days) 9,203 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 2,00 | 1.00 | | s. excludina newborn) | | 9, 203 | 1.00 |
| do not complete this line. 4. 00 Semi-private room days (sectualing swing-bed and observation bed days) Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 7. 00 Iotal swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 8. 00 Iotal swing-bed SNF type inpatient days (including private room days) after December 31 of the cost period (if callendar year, enter 0 on this line) 9. 00 Iotal swing-bed SNF type inpatient days (including private room days) after December 31 of the cost period (including private room days) after December 31 of the cost period (including private room days) after December 31 of the cost period (including private room days) after December 31 of the cost period (including private room days) after December 31 of the cost period (including private room days) after December 31 of the cost period (including private room days) after December 31 of the cost period (including private room days) after December 31 of the cost period (including private room days) after December 31 of the cost reporting period (see instruction) (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including | 2.00 | | | | 9, 203 | 2. 00 |
| 5.00 Total swin,p-ted Str type inpatient days (including private room days) after December 31 of the cost reporting period of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of the swin of | 3.00 | Private room days (excluding swing-bed and observation bed day | s). If you have only pr | ivate room days, | 0 | 3.00 |
| 10 10 10 10 10 10 10 10 | | · · | | | | |
| reporting period (1º Calendar year, enter 0 on this line) 7.00 Total swing-bed SWT type inpatient days (including private room days) after December 31 of the cost reporting period (1º Calendar year, enter 0 on this line) 8.00 Total swing-bed Nr type inpatient days (including private room days) after December 31 of the cost reporting period (1º Calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 10.00 Swing-bed SWT type inpatient days applicable to this line) 10.00 Swing-bed SWT type inpatient days applicable to the Program (excluding private room days) 11.00 Swing-bed SWT type inpatient days applicable to the Program (excluding private room days) 12.00 Swing-bed SWT type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 13.00 Swing-bed SWT type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 13.00 Swing-bed SWT type inpatient days applicable to title XVIII only (including private room days) 14.00 Swing-bed SWT type inpatient days applicable to title XVIII only (including private room days) 15.00 Swing-bed SWT type inpatient days applicable to title XVIII only (including private room days) 16.00 SWT type bed WT type inpatient days applicable to title XVIII only (including private room days) 17.00 Swing-bed WT type inpatient days applicable to title XVIII only (including private room days) 18.00 SWT type bed WT type inpatient days applicable to title XVIII only (including private room days) 18.00 WT type bed WT type inpatient days applicable to title XVIII only (including private room days) 18.00 WE type bed WT type inpatient days applicable to title XVIII only (including private room days) 18.00 WE type bed WT type inpatient days applicable to title XVIII only (including private room days) 18.00 WE typ | | | | | | |
| Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) parter December 31 of the cost reporting period (if year) Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if year) Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (in patient days including private room days) No | 5.00 | | om days) through Decembe | r 31 of the cost | 0 | 5.00 |
| 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 reporting period 8.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost 9.00 Total inpatient days including private room days apricable to the Program (excluding swing-bed and newborn days) 10.00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and newborn days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Through December 31 of the cost reporting period (inclendar year, enter 0 on this line) 12.00 Inclendar year, enter 0 on this line) 13.00 Swing-bed NF type inpatient days applicable to title XV or XX only (including private room days) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 15.00 Iotal nursery days (title V or XX only) 16.00 Iotal nursery days (title V or XX only) 17.00 Total nursery days (title V or XX only) 18.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost program (excluding swing-bed days) 18.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost program (in the cost program of the cost program (excluding swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (in the program of the program of the cost applicable to SNF type services through December 31 of the cost re | 4 00 | | om days) after December | 21 of the cost | 0 | 4 00 |
| Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost | 0.00 | | olli days) ai tei becellibei | 31 OF THE COST | U | 6.00 |
| reporting period 8. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 10. 00 Swing-bed SWI type inpatient days applicable to title XVIII only (including private room days) 11. 00 Swing-bed SWI type inpatient days applicable to title XVIII only (including private room days) after 0 becember 31 of the cost reporting period (see instructions) 12. 00 Swing-bed SWI type inpatient days applicable to title XVIII only (including private room days) after 0 becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 13. 00 Swing-bed SWI 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 (if calendar year, enter 0 on this line) 14. 00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 0 13. 00 after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 16. 00 Inclair nursery days (if let V or XIX only) 0 15. 00 10 10 nursery days (if let V or XIX only) 0 15. 00 10 10 nursery days (if let V or XIX only) 0 15. 00 10 10 nursery days (if let V or XIX only) 0 15. 00 10 10 nursery days (if let V or XIX only) 0 15. 00 10 10 nursery days (if let V or XIX only) 0 15. 00 10 10 nursery days (if let V or XIX only) 0 15. 00 10 10 nursery days (if let V or XIX only) 0 15. 00 10 10 nursery days (if let V or XIX only) 0 15. 00 10 10 10 nursery days (if let V or XIX only) 0 15. 00 10 10 10 10 10 10 10 10 10 10 10 10 | 7. 00 | | days) through December | 31 of the cost | 0 | 7.00 |
| reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after supplied (see instructions) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only 0 on this line) 12.00 Swing-bed SNF type inpatient days applicable to title XVIII only 0 on this line) 13.00 Swing-bed SNF type inpatient days applicable to title SV or XIX only (including private room days) 13.00 Swing-bed SNF type inpatient days applicable to title SV or XIX only (including private room days) 13.00 Swing-bed SNF type inpatient days applicable to title SV or XIX only (including private room days) 13.00 Swing-bed SNF type inpatient days applicable to title SV or XIX only (including private room days) 14.00 Medically necessary private room days applicable to the Program (excluding Swing-bed days) 15.00 Notes in ursery days (title V or XIX only) 16.00 Notes in ursery days (title V or XIX only) 17.00 Notes in Set On ADUSTRIAN 18.00 Medically necessary private room days applicable to services through December 31 of the cost reporting period (including private room days) 18.00 Notes in Set On ADUSTRIAN 18.00 Notes in Set On ADUSTRIAN 18.00 Notes in Set On ADUSTRIAN 18.00 Notes in Set On ADUSTRIAN 18.00 Notes in Set On ADUSTRIAN 18.00 Notes in Set On ADUSTRIAN 18.00 Notes in Set On ADUSTRIAN 18.00 Notes in Set On ADUSTRIAN 18.00 Notes in Set On ADUSTRIAN 18.00 Notes in Set On ADUSTRIAN 18.00 Notes in Set On ADUSTRIAN 18.00 Notes in Set On ADUSTRIAN 18.00 Notes in Set On ADUSTRIAN 18.00 Notes in Set On ADUSTRIAN 18.00 Notes in Set On ADUSTRIAN 18.00 Notes in Set On ADUSTRIAN 18.00 Notes in Set On ADUSTRIAN 18.00 Notes in Set On ADUSTRIAN 18.00 Notes in Set On ADUSTRIAN 18.00 Notes in Set On ADUSTRIAN 18.00 Notes in Set On ADUS | | | ,., | | | |
| 10.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) 10.00 10.00 | 8.00 | Total swing-bed NF type inpatient days (including private room | n days) after December 3 | 1 of the cost | 0 | 8. 00 |
| newborn days 10.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10. | | | | | | |
| 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) on through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) on after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 0.14.00 15.00 Total nursery days (title V or XIX only) 0.15.00 16.00 Nursery days (title V or XIX only) 0.16.00 17.00 SMIM BED ADUSTINEN 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost 0.00 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost 0.00 18.00 reporting period 0.00 19.00 Medicald rate for swing-bed NF services applicable to services through December 31 of the cost 0.00 19.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 19.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 19.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 19.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 19.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 19.00 Medicald rate for swing-bed NF services after December 31 of the cost reporting period (line 5 x line 17) 19.00 Medicald rate for swing-bed NF services after December 31 of the cost reporting period (line 6 x line 18) 19.00 Medicald rate for swing-bed to | 9.00 | | the Program (excluding | swing-bed and | 3, 604 | 9.00 |
| through December 31 of the cost reporting period (see instructions) 12.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 0 pecember 31 of the cost reporting period (If calendar year, enter 0 on this line) 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 0 through December 31 of the cost reporting period (If calendar year, enter 0 on this line) 14.00 Medical in precessary private room days applicable to titles V or XIX only (including private room days) 0 13.00 after December 31 of the cost reporting period (If calendar year, enter 0 on this line) 15.00 Total nursery days (title V or XIX only) 0 15.00 Total nursery days (title V or XIX only) 0 15.00 SWINCE BO ADJUSTMENT 0 16.00 Nedsory days (title V or XIX only) 0 15.00 Nedicare rate for swing-bed SNF services applicable to services through December 31 of the cost 0.00 reporting period (Incare rate for swing-bed SNF services applicable to services after December 31 of the cost 0.00 reporting period (Incare rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 Plot (Incare rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 Plot (Incare rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 Plot (Incare rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 Plot (Incare in a period 0.00 Plot (Incare in a period 0.00 Plot (Incare in a period 0.00 Plot (Incare in a period 0.00 Plot (Incare in a period 0.00 Plot (Incare in a period 0.00 Plot (Incare in a period 0.00 Plot (Incare in a period 0.00 Plot (Incare in a period 0.00 Plot (Incare in a period 0.00 Plot (Incare in a period 0.00 Plot (Incare in a period 0.00 Plot (Incare in a period 0.00 Plot (Incare in a period 0.00 Plot (Incare in a period 0.00 Plot (Incare in a period 0.00 Plot (Incare in a period 0.00 Plot (Incare in a period 0.00 Plot (Incare in a period 0.0 | 10 00 | | oly (including private r | oom dave) | 0 | 10 00 |
| 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 15.00 IoTal nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Nursery days (title V or XIX only) 18.00 Nursery days (title V or XIX only) 19.00 Nursery days (title V or XIX only) 19.00 Nursery days (title V or XIX only) 19.00 Nursery days (title V or XIX only) 19.00 Nursery days (title V or XIX only) 19.00 Nursery days (title V or XIX only) 19.00 Nursery days (title V or XIX only) 19.00 Nursery days (title V or XIX only) 19.00 Nursery days (title V or XIX only) 19.00 Nursery days (title V or XIX only) 19.00 Nursery days (title V or XIX only) 19.00 Nursery days (title V or XIX only) 19.00 Nursery days (title V or XIX only) 19.00 Nursery days (title V or XIX only) 20.00 Nursery days (title V or XIX only) 20.00 Nursery days (title V or XIX only) 20.00 Nursery days (title V or XIX only) 20.00 Nursery days (title V or XIX only) 20.00 Nursery days (title V or XIX only) 20.00 Nursery days (title V or XIX only) 20.00 Nursery days (title V or XIX only) 20.00 Nursery days (title V or XIX only) 20.00 Nursery days (title V or XIX only) 20.00 Nursery days (title V or XIX only) 20.00 Nursery days (title V or XIX only) 20.00 Nursery days (title V or XIX only) 20.00 Nursery days (title V or XIX only) 20.00 Nursery days (title V or XIX only) 20.00 Nursery days (title V or XIX only) 20.00 Nursery days (title V or XIX only) 20.00 Nursery days (title V or XIX only) 20.00 Nursery days (title V or XIX only) 20.00 Nursery days (title V or XIX only) 20.00 Nursery days | 10.00 | | | oom days) | O | 10.00 |
| 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 16.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 17.00 Medicarly necessary private room days applicable to the Program (excluding swing-bed days) 18.00 Nursery days (title V or XIX only) 19.00 Nursery days (title V or XIX only) 19.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (line or rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (line or rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line or raporting period (line or x line 18) 20.00 Nursery days (lite V or XIX only) 21.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line or x line 18) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line or x line 19) 23.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line or x line 20) 24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line or x line 20) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line or x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 29.00 Private room charges (excluding swing-bed charges) | 11.00 | | | oom days) after | 0 | 11. 00 |
| through December 31 of the cost reporting period 13.00 Sing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 15.00 Total nursery days (title V or XIX only) 16.00 Total nursery days (title V or XIX only) 17.00 Medicare rate for swing-bed SNF services applicable to the Program (excluding swing-bed days) 18.00 Modicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (lace are rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (lace are rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (lace are rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (lace are rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (lace drate for swing-bed NF services applicable to services after December 31 of the cost reporting period (lace drate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 5 x line 17) 15.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 6 x line 18) 15.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18) 15.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 19) 15.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 20) 15.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 20) 15.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 15.00 Swing-bed cost applicable to NF type services after December 31 of the cos | | | | | | |
| 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (Including private room days) 0 12.00 | 12. 00 | | (only (including privat | e room days) | 0 | 12. 00 |
| after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15 | 12 00 | 1 31 | (only (including privat | a maam daysa) | 0 | 12 00 |
| 14. 00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 0 14. 00 15. 00 16. 00 16. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. | 13.00 | | | | U | 13.00 |
| 15.00 Total nursery days (title V or XIX only) 0 15.00 16.00 16.00 17.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 | 14.00 | | | | 0 | 14.00 |
| SWING BED ADJUSTNENT 17. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 0.00 18. 00 reporting period 19. 00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost 0.00 19. 00 reporting period 20. 00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20. 00 reporting period 21. 00 Total general inpatient routine service cost (see instructions) 22. 00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18) 25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19) 26. 00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19) 26. 00 Total swing-bed cost (see instructions) 27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 29. 00 Private room charges (excluding swing-bed charges) 29. 00 Private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 31. 00 General inpatient routine service cost for period (line 27 * line 28) 32. 00 Service room charges (excluding swing-bed charges) 33. 00 Average private room charges (fine 29 * line 3) 34. 00 Average private room charges (fine 29 * line 3) 35. 00 Average private room cost differential (line 3 x line 31) 36. 00 Average private room cost differential (line 3 x line 31) 37. 00 Average private room cos | | | | | 0 | |
| 17.00 Nedicare rate for swing-bed SNF services applicable to services through December 31 of the cost 0.00 17.00 | 16.00 | Nursery days (title V or XIX only) | | | 0 | 16. 00 |
| reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (1.00 Medical drate for swing-bed NF services applicable to services through December 31 of the cost (1.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost (1.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost (1.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost (1.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost (1.00 Medical drate for swing-bed NF services through December 31 of the cost reporting period (1.00 Ming-bed cost applicable to SNF type services through December 31 of the cost reporting period (1.00 Ming-bed cost applicable to SNF type services after December 31 of the cost reporting period (1.00 Ming-bed cost applicable to SNF type services after December 31 of the cost reporting period (1.00 Ming-bed cost applicable to NF type services after December 31 of the cost reporting period (1.00 Ming-bed cost applicable to NF type services after December 31 of the cost reporting period (1.00 Ming-bed Cost (1.00 Ming-bed Cost (1.00 Ming-bed Cost (1.00 Ming-bed Cost (1.00 Ming-bed Cost (1.00 Ming-bed Cost (1.00 Ming-bed Cost (1.00 Ming-bed Cost (1.00 Ming-bed Cost (1.00 Ming-bed Cost (1.00 Ming-bed Cost (1.00 Ming-bed Cost (1.00 Ming-bed Cost (1.00 Ming-bed Cost (1.00 Ming-bed Cost (1.00 Ming-bed Cost (1.00 Ming-bed Cost (1.00 Ming-bed Cost (1.00 Ming-bed Cost (1.00 Ming-bed Cost (1.00 Ming-bed Cost (1.00 Ming-bed Cost (1.00 Ming-bed Cost (1.00 Ming-bed Cost (1.00 Ming-bed Cost (1.00 Ming-bed Cost (1.00 Ming-bed Cost (1.00 Ming-bed Cost (1.00 Ming-bed Cost (1.00 Ming-bed Cost (1.00 Ming-bed Cost (1.00 Ming-bed Cost (1.00 Ming-bed Cost (1.00 Ming-bed Cost (1.00 Ming-bed Cost (1.00 Ming-bed Cost (1.00 Ming-bed Cost (1.00 Ming-bed Cost (1.00 Ming-bed Cost (1.00 Ming-bed Cost (1.00 Ming-bed Cost (1.00 Ming- | | | | | | |
| 18. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 0 | 17. 00 | 1 | es through December 31 o | f the cost | 0.00 | 17. 00 |
| reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 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) 26.00 Total swing-bed cost (see instructions) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 PRIVATE ROOM DIFFERENTIAL ADJUSTNENT 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room per diem charge (line 29 + line 3) 31.00 Average per livate room per diem charge (line 29 + line 3) 32.00 Average per private room per diem charge (line 30 + line 4) 33.00 Average per diem private room cost differential (line 3 x line 31) 33.00 Average per diem private room cost differential (line 3 x line 31) 34.00 General inpatient routine service cost per diem (see instructions) 35.00 Average per diem private room cost differential (line 3 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 31) 37.00 General inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x | 10 00 | | os after December 21 of | the cost | 0.00 | 10 00 |
| 19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 14,765,523 21.00 22.00 23.00 24.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 | 10.00 | | | | | 10.00 |
| 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18) 25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 26.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service cost net of swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 20.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room per diem charge (line 29 + line 3) 30.00 Semi-private room per diem charge (line 29 + line 3) 30.00 Average per diem private room charge differential (line 37 minus line 28) 30.00 Average per diem private room charge differential (line 30 minus line 33) (see instructions) 30.00 Semi-private room cost differential (line 30 minus line 33) (see instructions) 30.00 General inpatient routine service cost differential (line 32 minus line 33) (see instructions) 30.00 Private room cost differential adjustment (line 3 x line 35) 30.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 30.00 General inpatient routine service cost per diem (see instructions) 30.00 General inpatient routine service cost per diem (see instructions) 30.00 General inpatient routine service cost (line 9 x line 38) 30.00 Program general inpatient routine service cost (line 9 x line 38) 30.00 | 19. 00 | | s through December 31 of | the cost | 0.00 | 19. 00 |
| reporting period Total general inpatient routine service cost (see instructions) 22.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Total swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x iine 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) Total swing-bed cost (see instructions) 27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service cost net of swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 O Semi-private room per diem charge (line 29 + line 3) 30.00 Average per diem private room per diem charge (line 30 + line 4) 30.00 Average per diem private room cost differential (line 3x line 31) 30.00 Private room cost differential adjustment (line 3 x line 35) 31.00 Private room cost differential adjustment (line 3 x line 31) 32.00 Average per diem private room cost differential (line 3x line 31) 33.00 Private room cost differential adjustment (line 3 x line 31) 34.00 PROROMAN INFAILENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) | | | - | | | |
| 21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 6 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 19) 26.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32.00 Average private room per diem charge (line 29 + line 3) 33.00 Average semi-private room per diem charge (line 30 + line 4) 34.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 35.00 Private room cost differential (line 34 x line 31) 36.00 Private room cost differential (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 32 minus line 36) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) | 20. 00 | | s after December 31 of t | he cost | 0. 00 | 20. 00 |
| 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 Fivate room charges (excluding swing-bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average perivate room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room cost differential (line 34 x line 31) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 34 x line 31) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 14 x line 35) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) | 21 00 | ' " " | -) | | 1/ 7/5 500 | 21 00 |
| 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 v line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 v line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 v line 20) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 v line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service cost net of swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 * line 28) 32.00 Average private room per diem charge (line 29 * line 3) 33.00 Average semi-private room per diem charge (line 29 * line 3) 34.00 Average per diem private room per diem charge (line 30 * line 4) 34.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 32 minus line 33) 36.00 Private room cost differential adjustment (line 3 x line 31) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 14, 765, 523) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 14, 765, 523) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) | | | | ing period (line | | |
| x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25.00 x line 20) 26.00 Total swing-bed cost (see instructions) 0 26.00 Total swing-bed cost (see instructions) 0 26.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 14,765,523 27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 29.00 Private room charges (excluding swing-bed charges) 0 29.00 Semi-private room conduction service cost/charge ratio (line 27 ÷ line 28) 0.00 30.00 31.00 Semi-private room per diem charge (line 30 ÷ line 3) 0.00 32.00 33.00 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 3 x line 31) 0.00 35.00 Average per diem private room cost differential (line 3 x line 35) 0.00 Private room cost differential adjustment (line 3 x line 35) 0.00 Average per diem private room cost differential (line 3 x line 35) 0.00 Average per diem private room cost differential (line 3 x line 35) 0.00 Propram general inpatient routine service cost per diem (see instructions) 14,765,523 37.00 27 minus line 36) 27 minus line 36) 27 minus line 36) 28.00 Propram general inpa | 22.00 | | or or the cost report | ing period (inte | · · | 22.00 |
| 24. 00 24. 00 7 x line 19) 25. 00 8 wing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 7 x line 19) 26. 00 7 x line 20) 26. 00 7 total swing-bed cost (see instructions) 27. 00 28. 00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 29. 00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 29. 00 PRIVATE room charges (excluding swing-bed cost (line 21 minus line 26) PRIVATE room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 31. 00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32. 00 Average per diem private room per diem charge (line 29 + line 3) 33. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 34. 00 Average per diem private room cost differential (line 34 x line 31) Average per diem private room cost differential (line 34 x line 31) PRATT II - HOSPITAL AND SUBPROVI DERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Algiusted general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35) 40. 00 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 42. 00 25. 00 26. 00 27. 00 28. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29 | 23. 00 | · · · · · · · · · · · · · · · · · · · | 31 of the cost reporting | g period (line 6 | 0 | 23. 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) 26. 00 Total swing-bed cost (see instructions) 27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 28. 00 Private room charges (excluding swing-bed charges) 29. 00 Private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 31. 00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32. 00 Average private room per diem charge (line 29 + line 3) 33. 00 Average semi-private room per diem charge (line 29 + line 3) 34. 00 Average semi-private room cost differential (line 32 minus line 33)(see instructions) 35. 00 Average per diem private room cost differential (line 34 x line 31) 36. 00 Private room cost differential adjustment (line 3 x line 35) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 14, 765, 523) 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 38. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40. 00 Value (line 14 x line 35) 40. 00 Value (line 14 x line 35) 40. 00 Value (line 14 x line 35) 40. 00 Value (line 14 x line 35) 40. 00 Value (line 14 x line 35) 40. 00 Value (line 14 x line 35) | | 1 | | | | |
| 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT Ceneral inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges) Ceneral inpatient routine service cost/charge ratio (line 27 + line 28) Ceneral inpatient routine service cost/charge ratio (line 27 + line 28) Ceneral inpatient routine service cost/charge ratio (line 27 + line 28) Ceneral inpatient routine service cost/charge ratio (line 30 + line 4) Ceneral inpatient routine service cost/charge ratio (line 30 + line 4) Ceneral inpatient routine service cost/charge ratio (line 32 minus line 33) (see instructions) Ceneral inpatient routine service cost (line 30 + line 31) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 32 minus line 33) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 14, 765, 523) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 14, 765, 523) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost (line 9 x line 38) Ceneral inpatient routine service cost (line 9 x line 38) Ceneral inpatient routine service cost (line 9 x line 38) Ceneral inpatient routine service cost (line 9 x line 38) Ceneral inpatient routine service cost (line 9 x line 38) Ceneral inpatient routine service cost (line 9 x line 38) Ceneral inpatient routine service cost (line 9 x line 38) Ceneral inpatient routine service cost (line 9 x line 38) Ceneral inpatient routine service cost (line 9 x line 38) Ceneral inpatient routine serv | 24. 00 | | 31 of the cost reporti | ng period (line | 0 | 24. 00 |
| x line 20) 26. 00 Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 31. 00 General inpatient routine service cost/charge ratio (line 27 ± line 28) 32. 00 Average private room per diem charge (line 29 ± line 3) Average semi-private room per diem charge (line 30 ± line 4) 34. 00 Average per diem private room charge differential (line 34 x line 31) Average per diem private room cost differential (line 34 x line 31) Average per diem private room cost differential (line 3 x line 35) Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 14,765,523) 37. 00 Average per diem private room cost differential (see instructions) Average per diem private room cost differential (see instructions) Average per diem private room cost differential (see instructions) Average per diem private room cost differential (see instructions) Average per diem private room cost differential (see instructions) Average per diem private room cost differential (see instructions) Average per diem private room cost differential (see instructions) Average per diem private room cost differential (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) 5, 782, 330 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) | 25 00 | | 21 of the cost reporting | nariod (line 8 | 0 | 25 00 |
| 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 28.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 30.00 Average private room per diem charge (line 29 + line 3) 30.00 Average semi-private room per diem charge (line 30 + line 4) 30.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 14, 765, 523) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 14, 765, 523) 38.00 Ajusted general inpatient routine service cost per diem (see instructions) 38.00 Ajusted general inpatient routine service cost (line 9 x line 38) 38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00 | 23.00 |] 9 11 | or the cost reporting | perrod (Trile o | O | 23.00 |
| PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) 9. 00 Private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32. 00 Average private room per diem charge (line 29 ÷ line 3) 33. 00 Average semi-private room per diem charge (line 30 ÷ line 4) 34. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35. 00 Average per diem private room cost differential (line 34 x line 31) 36. 00 Private room cost differential adjustment (line 3 x line 35) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 14, 765, 523) 38. 00 Adjusted general inpatient routine service cost (line 9 x line 38) 9. 00 Program general inpatient routine service cost (line 9 x line 38) 1, 604. 42 38. 00 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 28. 00 28. 00 29. 00 29. 00 20. 00 20. 00 20. 00 20. 00 30. 00 31. 00 20. 00 32. 00 32. 00 32. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 39. 00 40. 00 39. 00 40. 00 | 26. 00 | | | | 0 | 26. 00 |
| 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 31.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 32.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 32.00 Average per diem private room cost differential (line 34 x line 31) 33.00 Average per diem private room cost differential (line 34 x line 31) 34.00 Private room cost differential adjustment (line 3 x line 35) 35.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 14, 765, 523) 36.00 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) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 28.00 29.00 29.00 29.00 30.00 0.00 30.00 0.0000000 31.00 0.0000000 31.00 32.00 32.00 33.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 0.00 33.00 36.00 37.00 40.00 | 27. 00 | General inpatient routine service cost net of swing-bed cost | (line 21 minus line 26) | | 14, 765, 523 | 27. 00 |
| 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 29 ÷ line 3) 4.00 Average per diem private room charge differential (line 30 ÷ line 4) 32.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 34.00 Average per diem private room cost differential (line 34 x line 31) 35.00 Average per diem private room cost differential (line 3 x line 35) 36.00 Private room cost differential adjustment (line 3 x line 35) 36.00 Private room cost differential adjustment (line 3 x line 35) 36.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 14, 765, 523) 37.00 PRATT II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 5, 782, 330 40.00 | | | | | | |
| 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 14, 765, 523) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 30.00 30.00 30.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 33.00 0.00 34.00 0.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 0 | | | d and observation bed ch | arges) | | |
| 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 36.00 Private room cost differential adjustment (line 3 x line 35) 36.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 14, 765, 523) 37.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 00 32.00 32.00 00 32.00 32.00 00 32.00 32.00 00 00 33.00 32.00 00 00 34.00 34.00 35.00 35.00 Private room cost differential (line 10 0.00 0.00 0.00 0.00 0.00 0.00 0.00 | | | | | | ł |
| 32.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 36.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 14, 765, 523) 37.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Program general inpatient routine service cost per diem (see instructions) 37.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 | | | line 28) | | | 1 |
| 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 14, 765, 523) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | , | - Trile 20) | | | ł |
| 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 14, 765, 523) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 34.00 36.00 37.00 14,765,523 37.00 14,765,523 37.00 15,762,330 38.00 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) | | | | | | 1 |
| 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 14, 765, 523) 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) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 36.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 37.00 14, 765, 523 3 | | Average per diem private room charge differential (line 32 mir | nus line 33)(see instruc | tions) | | 1 |
| 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 37.00 14, 765, 523 37.00 38.00 5, 782, 330 40.00 | | | | | | |
| 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,604.42 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 5,782,330 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00 | | , · · · · · · · · · · · · · · · · · · · | | | | |
| 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) 1,604.42 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 5,782,330 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00 | 37. 00 | | and private room cost di | fferential (line | 14, 765, 523 | 37. 00 |
| PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,604.42 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 5,782,330 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00 | | | | | | |
| Adjusted general inpatient routine service cost per diem (see instructions) 1,604.42 38.00 Program general inpatient routine service cost (line 9 x line 38) 5,782,330 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 1,604.42 38.00 5,782,330 40.00 | | | ISTMENTS | | | |
| 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 5,782,330 39.00 40.00 | 38. 00 | | | | 1. 604. 42 | 38, 00 |
| 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00 | | , , , , , , , , , , , , , , , , , , , , | | | | 1 |
| 41.00 Total Program general inpatient routine service cost (line 39 + line 40) 5,782,330 41.00 | | Medically necessary private room cost applicable to the Progra | am (line 14 x line 35) | | 0 | ł |
| | 41. 00 | Total Program general inpatient routine service cost (line 39 | + line 40) | | 5, 782, 330 | 41.00 |

| | Financial Systems | DEARBORN COUN | | ON 15 000/ | | eu of Form CMS- | |
|--------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|-------------------------|-------------------------|-----------------------------|-----------------------------|--------------------------------|------------------|
| COMPUT | ATION OF INPATIENT OPERATING COST | | Provider C | CN: 15-0086 | Peri od: From 01/01/2019 | | |
| | | | | | To 12/31/2019 | Date/Time Pre 6/3/2020 5:03 | |
| | Cook Cooks December 1 | Tabal | | XVIII | Hospi tal | PPS | |
| | Cost Center Description | Total Inpatient Cost | Total Inpatient Days | Average Per Diem (col. 1 | 3 | Program Cost (col. 3 x col. | |
| | | · | | col . 2) | | 4) | |
| 42.00 | NURSERY (title V & XIX only) | 1.00 | 2.00 | 3.00 | 4. 00 00 0 | 5. 00 | 42. 00 |
| | Intensive Care Type Inpatient Hospital Units | | | | | | |
| 43. 00 44. 00 | INTENSIVE CARE UNIT | 3, 017, 130 | 1, 807 | 1, 669. | 69 734 | 1, 225, 552 | 43. 00 44. 00 |
| 45. 00 | BURN INTENSIVE CARE UNIT | | | | | | 45. 00 |
| 46. 00 | | | | | | | 46. 00 |
| 47.00 | OTHER SPECIAL CARE (SPECIFY) Cost Center Description | | | | | | 47. 00 |
| | · | | | | | 1.00 | |
| 48.00 | Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines | | | nns) | | 7, 472, 831 14, 480, 713 | 1 |
| 47.00 | PASS THROUGH COST ADJUSTMENTS | 41 till ough 40) (| see mstructro |) is j | | 14, 400, 713 | 47.00 |
| 50. 00 | Pass through costs applicable to Program inp | atient routine | services (from | n Wkst. D, sur | m of Parts I and | 943, 933 | 50. 00 |
| 51. 00 | | atient ancillar | y services (fr | om Wkst. D, s | sum of Parts II | 525, 034 | 51. 00 |
| | and IV) | | | | | | |
| 52. 00 53. 00 | Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu- | | lated non-phy | vsician anestl | netist and | 1, 468, 967 13, 011, 746 | 1 |
| 00.00 | medical education costs (line 49 minus line | | | , si ci dii dilesti | | 10,011,710 |] 55: 55 |
| E4 00 | TARGET AMOUNT AND LIMIT COMPUTATION Program discharges | | | | | 0 | 54.00 |
| | Target amount per discharge | | | | | | 55. 00 |
| 56. 00 | Target amount (line 54 x line 55) | | | | 50) | | 56. 00 |
| 57. 00 58. 00 | Difference between adjusted inpatient operat Bonus payment (see instructions) | ing cost and ta | rget amount (I | ine 56 minus | line 53) | 0 | |
| 59. 00 | Lesser of lines 53/54 or 55 from the cost re | porting period | endi ng 1996, ເ | updated and co | ompounded by the | | 59. 00 |
| 60. 00 | market basket Lesser of lines 53/54 or 55 from prior year | cost report un | dated by the m | markat haskat | | 0.00 | 60.00 |
| 61. 00 | If line 53/54 is less than the lower of line | | | | the amount by | 0.00 | 1 |
| | which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target | | | | | | |
| 62. 00 | amount (line 56), otherwise enter zero (see Relief payment (see instructions) | instructions) | | | | 0 | 62. 00 |
| 63.00 Allowable Inpatient cost plus incentive payment (see instructions) | | | | | | | 63. 00 |
| 64. 00 | PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos | ts through Dece | mber 31 of the | e cost reporti | na period (See | 0 | 64. 00 |
| | instructions)(title XVIII only) | · · | | · | | | |
| 65. 00 | Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only) | ts after Decemb | er 31 of the d | cost reportin | g period (See | 0 | 65. 00 |
| 66. 00 | Total Medicare swing-bed SNF inpatient routi | ne costs (line | 64 plus line 6 | 55)(title XVI | II only). For | 0 | 66. 00 |
| 67. 00 | CAH (see instructions) Title V or XIX swing-bed NF inpatient routing | e costs through | December 31 c | of the cost re | enorting period | 0 | 67. 00 |
| | (line 12 x line 19) | 9 | | | | | |
| 68. 00 | Title V or XIX swing-bed NF inpatient routing (line 13 x line 20) | e costs after D | ecember 31 of | the cost repo | orting period | 0 | 68. 00 |
| 69. 00 | Total title V or XIX swing-bed NF inpatient | routine costs (| line 67 + line | e 68) | | 0 | 69. 00 |
| 70.00 | PART III - SKILLED NURSING FACILITY, OTHER NI | | | | <u> </u> | I | 70.00 |
| 70. 00 71. 00 | Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of | | | |) | | 70.00 |
| 72. 00 | Program routine service cost (line 9 x line | 71) | | | | | 72. 00 |
| 73. 00 74. 00 | Medically necessary private room cost application. Total Program general inpatient routine serv | | | | | | 73.00 |
| 75. 00 | Capital -related cost allocated to inpatient | • | | | Part II, column | | 75. 00 |
| 76. 00 | 26, line 45) Per diem capital-related costs (line 75 ÷ li | ne 2) | | | | | 76. 00 |
| 77. 00 | Program capital-related costs (line 9 x line | . * | | | | | 77. 00 |
| 78.00 | , | , | | 1-2 | | | 78. 00 |
| 79. 00 80. 00 | Aggregate charges to beneficiaries for exces Total Program routine service costs for comp. | | | • | nus line 79) | | 79. 00 80. 00 |
| 81. 00 | Inpatient routine service cost per diem limi | tati on | | • | , | | 81. 00 |
| 82. 00 83. 00 | Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (| | * . | | | | 82. 00 83. 00 |
| 84. 00 | Program inpatient ancillary services (see in | | <i>3)</i> | | | | 84. 00 |
| 85.00 | Utilization review - physician compensation | | | | | | 85. 00 |
| 86. 00 | Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS | | rougn 85) | | | | 86. 00 |
| 87. 00 | Total observation bed days (see instructions |) | | | | 2, 068 | 1 |
| 88. 00 89. 00 | Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se | | line 2) | | | 1, 604. 42 3, 317, 941 | |
| 57.00 | 10000. Validit bod cool (Title of A Title oo) (Se | 5 1115t1 GCt1 0115) | | | | J, J17, 741 | 1 57.00 |

| Health Financial Systems | DEARBORN COUN | TY HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|-----------------------------------------------|---------------|----------------|------------|----------------------------------|---------------------------------|---------|
| COMPUTATION OF INPATIENT OPERATING COST | | Provi der CC | | Peri od: | Worksheet D-1 | |
| | | | | From 01/01/2019 To 12/31/2019 | Date/Time Prep 6/3/2020 5:03 | |
| | | 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 | 2, 143, 957 | 14, 765, 523 | 0. 14520 | 0 3, 317, 941 | 481, 765 | 90.00 |
| 91.00 Nursing School cost | 0 | 14, 765, 523 | 0.00000 | 0 3, 317, 941 | 0 | 91.00 |
| 92.00 Allied health cost | 0 | 14, 765, 523 | 0.00000 | 0 3, 317, 941 | 0 | 92.00 |
| 93.00 All other Medical Education | 0 | 14, 765, 523 | 0. 00000 | 0 3, 317, 941 | 0 | 93. 00 |

| Health Financial Systems | DEARBORN COUNTY HOSPITAL | In Lie | u of Form CMS-2 | 2552-10 |
|-----------------------------------------|--------------------------|-----------------------------|-----------------------------|---------|
| COMPUTATION OF INPATIENT OPERATING COST | Provi der CCN: 15-0086 | Peri od: From 01/01/2019 | Worksheet D-1 | |
| | | To 12/31/2019 | Date/Time Pre 6/3/2020 5:03 | |
| | Title XIX | Hospi tal | Cost | |
| | | | | |

| | | T: +1 - VIV | 11: 4-1 | 6/3/2020 5: 03 | pm |
|------------------|---------------------------------------------------------------------------------------------------------------------------------|----------------------------|---------------------|----------------|--------|
| | Cost Center Description | Title XIX | Hospi tal | Cost | |
| | cost center bescription | | | 1. 00 | |
| | PART I - ALL PROVIDER COMPONENTS | | | | |
| | I NPATI ENT DAYS | | | | |
| 1.00 | Inpatient days (including private room days and swing-bed days | | | 9, 203 | 1.00 |
| 2.00 | Inpatient days (including private room days, excluding swing-b | <i>3 1</i> | | 9, 203 | 2.00 |
| 3. 00 | Private room days (excluding swing-bed and observation bed day do not complete this line. | ys). If you have only pr | ivate room days, | 0 | 3. 00 |
| 4.00 | Semi-private room days (excluding swing-bed and observation be | ed days) | | 7, 135 | 4.00 |
| 5. 00 | Total swing-bed SNF type inpatient days (including private room | | r 31 of the cost | 0 | 1 |
| | reporting period | | | | |
| 6.00 | Total swing-bed SNF type inpatient days (including private roo | om days) after December | 31 of the cost | 0 | 6. 00 |
| 7 00 | reporting period (if calendar year, enter 0 on this line) | | | | |
| 7. 00 | Total swing-bed NF type inpatient days (including private room reporting period | m days) through December | 31 of the cost | 0 | 7. 00 |
| 8. 00 | Total swing-bed NF type inpatient days (including private room | m days) after December 3 | 1 of the cost | 0 | 8.00 |
| 0.00 | reporting period (if calendar year, enter 0 on this line) | ii days) arter becomber o | TOT THE COST | | 0.00 |
| 9.00 | Total inpatient days including private room days applicable to | o the Program (excluding | swing-bed and | 169 | 9. 00 |
| | newborn days) | | | | |
| 10. 00 | Swing-bed SNF type inpatient days applicable to title XVIII or | | oom days) | 0 | 10.00 |
| 11. 00 | through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII or | | oom days) after | 0 | 11. 00 |
| 11.00 | December 31 of the cost reporting period (if calendar year, er | | oolii days) artei | ا | 11.00 |
| 12.00 | Swing-bed NF type inpatient days applicable to titles V or XI) | | e room days) | 0 | 12.00 |
| | through December 31 of the cost reporting period | | • | | |
| 13. 00 | Swing-bed NF type inpatient days applicable to titles V or XI) | | | 0 | 13. 00 |
| 14. 00 | after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra | | | 0 | 14. 00 |
| 15. 00 | Total nursery days (title V or XIX only) | all (excluding swing-bed | uays) | 587 | |
| 16. 00 | Nursery days (title V or XIX only) | | | 0 | |
| | SWI NG BED ADJUSTMENT | | | - | |
| 17. 00 | Medicare rate for swing-bed SNF services applicable to service | es through December 31 o | f the cost | 0.00 | 17. 00 |
| | reporting period | | | | |
| 18. 00 | Medicare rate for swing-bed SNF services applicable to service | es after December 31 of | the cost | 0. 00 | 18. 00 |
| 19. 00 | reporting period Medicaid rate for swing-bed NF services applicable to services | s through Docombor 21 of | the cost | 0.00 | 19. 00 |
| 17.00 | reporting period | s till ough becember 31 of | the cost | 0.00 | 19.00 |
| 20.00 | Medicaid rate for swing-bed NF services applicable to services | s after December 31 of t | he cost | 0.00 | 20.00 |
| | reporting period | | | | |
| 21. 00 | Total general inpatient routine service cost (see instructions | | | 14, 765, 523 | |
| 22. 00 | Swing-bed cost applicable to SNF type services through December 5×1 ine 17) | er 31 of the cost report | ing period (line | 0 | 22. 00 |
| 23. 00 | Swing-bed cost applicable to SNF type services after December | 31 of the cost reportin | a period (line 6 | 0 | 23. 00 |
| 20.00 | x line 18) | 0. 0. the dest repertion | g por rou (r r no o | ا | 20.00 |
| 24. 00 | Swing-bed cost applicable to NF type services through December | r 31 of the cost reporti | ng period (line | 0 | 24. 00 |
| | 7 x line 19) | | | | |
| 25. 00 | Swing-bed cost applicable to NF type services after December 3 | 31 of the cost reporting | period (line 8 | 0 | 25. 00 |
| 26. 00 | x line 20) 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) | | 14, 765, 523 | |
| | PRIVATE ROOM DIFFERENTIAL ADJUSTMENT | (| | | |
| 28. 00 | General inpatient routine service charges (excluding swing-bed | d and observation bed ch | arges) | 0 | 28. 00 |
| 29. 00 | Private room charges (excluding swing-bed charges) | | | 0 | |
| 30.00 | | 1: 20) | | 0 | |
| 31. 00 32. 00 | General inpatient routine service cost/charge ratio (line 27 - Average private room per diem charge (line 29 - line 3) | ÷ 11 ne 28) | | 0. 000000 | ı |
| 33. 00 | Average semi-private room per diem charge (line 30 ÷ line 4) | | | 0. 00 0. 00 | |
| 34. 00 | Average per diem private room charge differential (line 32 mir | nus line 33)(see instruc | tions) | 0.00 | 1 |
| 35. 00 | Average per diem private room cost differential (line 34 x lin | | • | 0.00 | |
| 36.00 | Private room cost differential adjustment (line 3 x line 35) | | | 0 | 36. 00 |
| 37. 00 | General inpatient routine service cost net of swing-bed cost a | and private room cost di | fferential (line | 14, 765, 523 | 37. 00 |
| | 27 minus line 36) | | | | ļ |
| | PART II - HOSPITAL AND SUBPROVIDERS ONLY | ISTMENITS | | | 1 |
| 38. 00 | PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see | | | 1, 604. 42 | 38. 00 |
| 39. 00 | Program general inpatient routine service cost per drem (see | • | | 271, 147 | 1 |
| 40. 00 | Medically necessary private room cost applicable to the Progra | - | | 271,117 | ı |
| 41. 00 | Total Program general inpatient routine service cost (line 39 | | | 271, 147 | 41.00 |
| | | · · | | | |

| Heal th | Financial Systems DEARBORN COUNTY HOSPITAL In Lie | eu of Form CMS-2 | 2552-10 |
|------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|------------------|
| COMPUT | ATION OF INPATIENT OPERATING COST Provider CCN: 15-0086 Period: From 01/01/2019 | Worksheet D-1 | |
| | To 12/31/2019 | Date/Time Prep 6/3/2020 5:03 | |
| | Title XIX Hospital Cost Center Description Total Total Average Per Program Days | Cost Program Cost | |
| | Inpatient Cost Inpatient Days Diem (col. 1 ÷ | (col. 3 x col. | |
| | 1.00 2.00 3.00 4.00 | 4) 5. 00 | |
| 42. 00 | NURSERY (title V & XIX only) 883,225 587 1,504.64 0 Intensive Care Type Inpatient Hospital Units | 0 | 42. 00 |
| 43. 00 | INTENSIVE CARE UNIT 3, 017, 130 1, 807 1, 669. 69 0 | 0 | 43. 00 |
| 44.00 | CORONARY CARE UNIT BURN INTENSIVE CARE UNIT | | 44. 00 45. 00 |
| 46. 00 | | | 46. 00 |
| 47. 00 | OTHER SPECIAL CARE (SPECIFY) Cost Center Description | | 47. 00 |
| 40.00 | · | 1.00 | 40.00 |
| 48. 00 49. 00 | Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) Total Program inpatient costs (sum of lines 41 through 48)(see instructions) | 156, 347 427, 494 | 48. 00 49. 00 |
| 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 |
| | III) | | |
| 51. 00 | Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV) | 0 | 51. 00 |
| 52.00 | Total Program excludable cost (sum of lines 50 and 51) | 0 | 52. 00 53. 00 |
| 53. 00 | Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52) | | 55.00 |
| 54 00 | TARGET AMOUNT AND LIMIT COMPUTATION Program discharges | 0 | 54. 00 |
| 55. 00 | Target amount per discharge | 0.00 | 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 | 56. 00 57. 00 |
| 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 market basket | | |
| 60. 00 61. 00 | | 0.00 | 60. 00 61. 00 |
| 01100 | which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target | | 011.00 |
| 62. 00 | | 0 | 62. 00 |
| 63. 00 | Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST | 0 | 63. 00 |
| 64. 00 | Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See | 0 | 64. 00 |
| 65. 00 | instructions)(title XVIII only) 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 |
| | CAH (see instructions) | | |
| 67. 00 | Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) | 0 | 67. 00 |
| 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) | 0 | 68. 00 |
| 69. 00 | Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) | 0 | 69. 00 |
| 70. 00 | PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 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) Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column | | 74. 00 75. 00 |
| | 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 79. 00 | Inpatient routine service cost (line 74 minus line 77) Aggregate charges to beneficiaries for excess costs (from provider records) | | 78. 00 79. 00 |
| 80. 00 | Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) | | 80. 00 |
| 81. 00 82. 00 | Inpatient routine service cost per diem limitation Inpatient routine service cost limitation (line 9 x line 81) | | 81. 00 82. 00 |
| 83. 00 | Reasonable inpatient routine service costs (see instructions) | | 83. 00 |
| 84. 00 85. 00 | Program inpatient ancillary services (see instructions) Utilization review - physician compensation (see instructions) | | 84. 00 85. 00 |
| 86. 00 | | | 86. 00 |
| 87. 00 | Total observation bed days (see instructions) | 2, 068 | 87. 00 |
| 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, 604. 42 3, 317, 941 | |
| | | | |

| Health Financial Systems | DEARBORN COUN | TY HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|-----------------------------------------------|---------------|----------------|------------|----------------------------------|---------------------------------|---------|
| COMPUTATION OF INPATIENT OPERATING COST | | Provi der CC | | Peri od: | Worksheet D-1 | |
| | | | | From 01/01/2019 To 12/31/2019 | Date/Time Prep 6/3/2020 5:03 | |
| | | 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 | 2, 143, 957 | 14, 765, 523 | 0. 14520 | 3, 317, 941 | 481, 765 | 90.00 |
| 91.00 Nursing School cost | 0 | 14, 765, 523 | 0.00000 | 3, 317, 941 | 0 | 91.00 |
| 92.00 Allied health cost | 0 | 14, 765, 523 | 0.00000 | 3, 317, 941 | 0 | 92.00 |
| 93.00 All other Medical Education | 0 | 14, 765, 523 | 0. 00000 | 3, 317, 941 | 0 | 93. 00 |

| Heal th Financial Systems | DEARBORN COUNTY HOSPITAL | ou 45 000/ | | u of Form CMS-2 | |
|---------------------------------------------------------------------------------|--------------------------|--------------|-----------------------------|-----------------|--------|
| INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provi der Co | | Peri od: From 01/01/2019 | Worksheet D-3 | |
| | | | To 12/31/2019 | Date/Time Pre | pared: |
| | | | | 6/3/2020 5:03 | |
| | Title | XVIII | Hospi tal | PPS | |
| Cost Center Description | | Ratio of Cos | | I npati ent | |
| | | To Charges | Program | Program Costs | |
| | | | Charges | (col. 1 x col. | |
| | | 4.00 | | 2) | |
| INDATIENT DOUTINE CEDVICE COCT CENTERS | | 1.00 | 2. 00 | 3. 00 | |
| I NPATI ENT ROUTI NE SERVI CE COST CENTERS | | 1 | 2 000 540 | | 20.00 |
| 30. 00 03000 ADULTS & PEDI ATRI CS | | | 3, 998, 549 | | 30.00 |
| 31. 00 03100 INTENSIVE CARE UNIT | | | 2, 512, 931 | | 31.00 |
| 43. 00 O4300 NURSERY ANCI LLARY SERVI CE COST CENTERS | | | | | 43. 00 |
| 50. 00 05000 OPERATING ROOM | | 0. 29771 | 9 5, 389, 067 | 1, 604, 428 | 50.00 |
| 51. 00 05100 RECOVERY ROOM | | 0. 29771 | | | |
| 52. 00 05200 DELI VERY ROOM & LABOR ROOM | | 0. 34042 | | | |
| 53. 00 05200 DELI VERT ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY | | 0. 04113 | | 30, 435 | |
| 54. 00 05400 RADI OLOGY - DI AGNOSTI C | | 0. 25827 | | 274, 615 | |
| 54. 01 05400 RADI OLOGI | | 0. 25827 | | 14, 147 | 54. 00 |
| 55. 00 05500 RADI OLOGY-THERAPEUTI C | | 0. 13373 | | 213, 076 | 55. 00 |
| 57. 00 05700 CT SCAN | | 0. 22003 | | | 57. 00 |
| 58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) | | 0. 24540 | | 30, 340 | |
| 59. 00 05900 CARDI AC CATHETERI ZATI ON | | 0. 00000 | | 0 | 59.00 |
| 60. 00 06000 LABORATORY | | 0. 23656 | | 906, 222 | 60.00 |
| 60. 01 06001 BLOOD LABORATORY | | 0. 00000 | | 0 | 60. 01 |
| 65. 00 06500 RESPIRATORY THERAPY | | 0. 28227 | | 848, 940 | |
| 65. 01 03950 SLEEP CLINI C | | 0. 30746 | | 8, 791 | 65. 01 |
| 66. 00 06600 PHYSI CAL THERAPY | | 0. 39976 | | | 66. 00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | | 0. 38891 | | 114, 662 | 67. 00 |
| 68.00 06800 SPEECH PATHOLOGY | | 0. 49347 | | 49, 459 | |
| 69. 00 06900 ELECTROCARDI OLOGY | | 0. 18840 | | | |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | S | 2. 22289 | | 358, 213 | |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | | 0. 07276 | | 117, 156 | |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | | 0. 46554 | | | |
| OUTDATIENT CEDVICE COCT CENTERS | | | | | Ì |

1. 233136

2, 116, 446

27, 249, 201

27, 249, 201

224, 585

91.00

411, 678

7, 472, 831 200. 00 201. 00 202. 00

OUTPATIENT SERVICE COST CENTERS
91. 00 09100 EMERGENCY

200.00

201. 00 202. 00

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)
Net charges (line 200 minus line 201)

| Hoal th | Financial Systems | DEARBORN COUNTY | UOSDI TAI | | In Lie | u of Form CMS-2 | 2552 10 |
|----------------------------|---------------------------------------------------------------------------------------------------------------------|-----------------|-----------|----------------------------------|---------------------------------------------|-------------------------------------------|----------------------------|
| | ENT ANCILLARY SERVICE COST APPORTIONMENT | DEARBORN COUNTY | | | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | pared: |
| | | | Ti t | le XIX | Hospi tal | Cost | Pili |
| | Cost Center Description | | | Ratio of Cos To Charges | t Inpatient Program Charges | Inpatient Program Costs (col. 1 x col. 2) | |
| | LADATI FAIT DOUTLAGE CEDIA OF COCT CENTEDO | | | 1.00 | 2. 00 | 3. 00 | |
| 31. 00 | INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04300 NURSERY | | | | 64, 393 326, 402 134 | | 30. 00 31. 00 43. 00 |
| 50. 00 51. 00 52. 00 | ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM | | | 0. 29771 0. 34042 0. 31436 | 2 187 | 19, 792 64 9, 941 | 50. 00 51. 00 52. 00 |
| 53. 00 54. 00 | 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C | | | 0. 04113 0. 25827 | 0 8 36, 702 | 0 9, 479 | 53. 00 54. 00 |
| | 05401 ULTRASOUND 05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN | | | 0. 15373 0. 22863 0. 06961 | 8 29, 832 3 40, 608 | 6, 821 2, 827 | 54. 01 55. 00 57. 00 |
| 58. 00 59. 00 60. 00 | 05800 MAGNETI C RESONANCE I MAGING (MRI) 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY | | | 0. 24540 0. 00000 0. 23160 | 0 0 | 871 0 36, 309 | 58. 00 59. 00 60. 00 |
| 60. 01 65. 00 65. 01 | 06001 BLOOD LABORATORY 06500 RESPI RATORY THERAPY 03950 SLEEP CLINIC | | | 0. 00000 0. 28160 0. 30746 | 7 116, 722 | 0 32, 870 0 | 60. 01 65. 00 65. 01 |
| 66. 00 67. 00 68. 00 | 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY | | | 0. 39976 0. 38891 | 6 1, 020 | 3, 260 397 | 66. 00 67. 00 68. 00 |
| 69. 00 71. 00 | 06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | | | 0. 49347 0. 18840 2. 22289 | 2 19, 619 4 39 | 0 3, 696 87 | 69. 00 71. 00 |
| 72. 00 73. 00 | O7200 IMPL. DEV. CHARGED TO PATIENT O7300 DRUGS CHARGED TO PATIENTS O7300 DRUGS CHARGED TO PATIENTS | | | 0. 07276 0. 46554 | | 0 | 72. 00 73. 00 |

1. 233136

152, 530

669, 494

29, 063

156, 347 200. 00 201. 00 202. 00

91.00

92.00 0

OUTPATIENT SERVICE COST CENTERS
91. 00 09100 EMERGENCY

200.00

201.00 202.00

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)
Net charges (line 200 minus line 201)

| Health Financial Systems | DEARBORN COUNTY HOSPITAL | In Lieu of Form CMS-2552-10 |
|-----------------------------------------|--------------------------|----------------------------------------------|
| CALCULATION OF REIMBURSEMENT SETTLEMENT | Provi der CCN: 15-0086 | Peri od: From 01/01/2019 To 12/31/2019 |

| | | | 10 12/31/2019 | 6/3/2020 5: 03 | | | |
|------------------|----------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------|--------------------|----------------|--|--|
| | | Title XVIII | Hospi tal | PPS | | | |
| | | | | 1. 00 | | | |
| | PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS | | | 1.00 | | | |
| 1. 00 1. 01 | DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurri | ng prior to October 1 (| see | 0 7, 046, 527 | 1. 00 1. 01 | | |
| 1. 02 | | | | | | | |
| 1. 03 | <pre>instructions) DRG for federal specific operating payment for Model 4 BPCI fo 1 (see instructions)</pre> | or discharges occurring | prior to October | 0 | 1. 03 | | |
| 1. 04 | DRG for federal specific operating payment for Model 4 BPCI for October 1 (see instructions) | or discharges occurring | on or after | 0 | 1. 04 | | |
| 2.00 | Outlier payments for discharges. (see instructions) | | | | 2.00 | | |
| 2. 01 2. 02 | Outlier reconciliation amount Outlier payment for discharges for Model 4 BPCI (see instructi | one) | | 0 | 2. 01 2. 02 | | |
| 2.02 | Outlier payments for discharges occurring prior to October 1 | | | 222, 470 | | | |
| 2. 04 | Outlier payments for discharges occurring on or after October | | | 147, 577 | 2. 04 | | |
| 3.00 | Managed Care Simulated Payments | , | | 0 | 3. 00 | | |
| 4.00 | Bed days available divided by number of days in the cost report | rting period (see instru | ctions) | 56. 33 | 4.00 | | |
| 5. 00 | Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the mosor before 12/31/1996. (see instructions) | t recent cost reporting | period ending on | 0. 00 | 5. 00 | | |
| 6.00 | FTE count for allopathic and osteopathic programs that meet the | ne criteria for an add-o | n to the cap for | 0. 00 | 6. 00 | | |
| 7. 00 | new programs in accordance with 42 CFR 413.79(e) MMA Section 422 reduction amount to the IME cap as specified u | under 42 CFR §412.105(f) | (1) (i v) (B) (1) | 0. 00 | 7. 00 | | |
| 7. 01 | ACA § 5503 reduction amount to the IME cap as specified under | | | 0. 00 | 7. 01 | | |
| 8.00 | cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for allopa | | | 0. 00 | 8. 00 | | |
| | affiliated programs in accordance with 42 CFR 413.75(b), 413.7998), and 67 FR 50069 (August 1, 2002). | 79(c)(2)(iv), 64 FR 2634 | 0 (May 12, | | | | |
| 8. 01 | The amount of increase if the hospital was awarded FTE cap sloreport straddles July 1, 2011, see instructions. | ots under § 5503 of the | ACA. If the cost | 0.00 | 8. 01 | | |
| 8. 02 | The amount of increase if the hospital was awarded FTE cap slounder § 5506 of ACA. (see instructions) | ots from a closed teachi | ng hospital | 0. 00 | 8. 02 | | |
| 9. 00 | Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line (instructions) | es (8, 8,01 and 8,02) (| see | 0. 00 | 9. 00 | | |
| 10.00 | FTE count for allopathic and osteopathic programs in the curre | ent year from your recor | ds | 0. 00 | | | |
| 11. 00 | FTE count for residents in dental and podiatric programs. | | | | 11.00 | | |
| 12.00 | Current year allowable FTE (see instructions) | | | 0.00 | | | |
| 13. 00 14. 00 | Total allowable FTE count for the prior year. Total allowable FTE count for the penultimate year if that year. | ar anded on ar after Son | tombor 20 1007 | 0. 00 0. 00 | | | |
| 14.00 | otherwise enter zero. | ar ended on or arter sep | telliber 30, 1997, | 0.00 | 14.00 | | |
| 15. 00 | Sum of lines 12 through 14 divided by 3. | | | 0.00 | | | |
| 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 19. 00 | Adjusted rolling average FTE count | | | 0. 00 0. 000000 | | | |
| 20. 00 | Current year resident to bed ratio (line 18 divided by line 4) Prior year resident to bed ratio (see instructions) | <i>)</i> . | | 0. 000000 | | | |
| 21. 00 | Enter the lesser of lines 19 or 20 (see instructions) | | | 0. 000000 | | | |
| 22. 00 | IME payment adjustment (see instructions) | | | 0 | 1 | | |
| 22. 01 | IME payment adjustment - Managed Care (see instructions) | | | 0 | 22. 01 | | |
| 23. 00 | Indirect Medical Education Adjustment for the Add-on for § 422 Number of additional allopathic and osteopathic IME FTE reside | | FR 412. 105 | 0.00 | 23. 00 | | |
| 24. 00 | (f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions) | | | 0. 00 | 24. 00 | | |
| 25. 00 | If the amount on line 24 is greater than -O-, then enter the | ower of line 23 or line | 24 (see | 0. 00 | | | |
| 26. 00 | instructions) Resident to bed ratio (divide line 25 by line 4) | | | 0. 000000 | 26. 00 | | |
| 27. 00 | IME payments adjustment factor. (see instructions) | | | 0.000000 | | | |
| 28. 00 | IME add-on adjustment amount (see instructions) | | | 0 | 28. 00 | | |
| 28. 01 | IME add-on adjustment amount - Managed Care (see instructions) |) | | 0 | | | |
| 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) | 3. 93 | 30.00 | | |
| 31. 00 | Percentage of Medicaid patient days (see instructions) | (333 1.131 40 | / | 19. 17 | | | |
| 32.00 | Sum of lines 30 and 31 | | | 23. 10 | | | |
| 33. 00 | Allowable disproportionate share percentage (see instructions) |) | | 8. 27 | | | |
| 34. 00 | Disproportionate share adjustment (see instructions) | | | 196, 942 | 34.00 | | |

| ALCUL | ATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0086 | Peri od: From 01/01/2019 To 12/31/2019 | | |
|----------------|-------------------------------------------------------------------------------------------------------------------------|-----------------------------|----------------------------------------------|-------------------------|------------|
| | | Title XVIII | Hospi tal | PPS | |
| | | | Prior to 10/1 | | |
| | | | 1. 00 | 2. 00 | |
| 5. 00 | Uncompensated Care Adjustment Total uncompensated care amount (see instructions) | | 0 272 072 447 | 8, 350, 599, 096 | 35. |
| 5. 00 | Factor 3 (see instructions) | | 0. 000104040 | | |
| | Hospital uncompensated care payment (If line 34 is zero, en | nter zero on this line) (se | | | |
| J. UZ | instructions) | (30 | 000,711 | 000, 027 | 00. |
| 5. 03 | Pro rata share of the hospital uncompensated care payment a | amount (see instructions) | 643, 764 | 214, 623 | 35. |
| 5. 00 | Total uncompensated care (sum of columns 1 and 2 on line 35 | | 858, 387 | | 36. |
| | Additional payment for high percentage of ESRD beneficiary | | | | |
| 0. 00 | Total Medicare discharges on Worksheet S-3, Part I excludir | ng discharges for MS-DRGs | 0 | | 40. |
| 1 00 | 652, 682, 683, 684 and 685 (see instructions) | 402 404 an 40E (coo | 0 | | 41. |
| 1. 00 | Total ESRD Medicare discharges excluding MS-DRGs 652, 682, instructions) | , 663, 664 all 665. (See | 0 | | 41. |
| 1. 01 | Total ESRD Medicare covered and paid discharges excluding N | MS-DRGs 652 682 683 684 | . 0 | | 41. |
| | an 685. (see instructions) | 5.1.05 502, 502, 503, 501 | | | ' ' ' |
| 2. 00 | Divide line 41 by line 40 (if less than 10%, you do not qua | alify for adjustment) | 0.00 | | 42. |
| 3. 00 | Total Medicare ESRD inpatient days excluding MS-DRGs 652, | 682, 683, 684 an 685. (see | 0 | | 43. |
| | instructions) | | | | |
| 4. 00 | Ratio of average length of stay to one week (line 43 divide | ed by line 41 divided by 7 | 0. 000000 | | 44. |
| - 00 | days) | ana) | 0.00 | | 45 |
| 5. 00 5. 00 | Average weekly cost for dialysis treatments (see instruction Total additional payment (line 45 times line 44 times line | | 0.00 | | 45. 46. |
| 7. 00 | Subtotal (see instructions) | 41.01) | 10, 950, 967 | | 47. |
| 3. 00 | Hospital specific payments (to be completed by SCH and MDH, | small rural hospitals | 10, 730, 707 | | 48. |
| 3. 00 | only. (see instructions) | , smarr rarar nespitars | | | 10. |
| | | | | Amount | |
| | | | | 1.00 | |
| 9. 00 | Total payment for inpatient operating costs (see instruction | | | 10, 950, 967 | 1 |
| 0.00 | Payment for inpatient program capital (from Wkst. L, Pt. I | | | 820, 009 | |
| 1. 00 | Exception payment for inpatient program capital (Wkst. L, F | | | 0 | |
| 2. 00 3. 00 | Direct graduate medical education payment (from Wkst. E-4, | Tine 49 see instructions). | | 0 | |
| 4. 00 | Nursing and Allied Health Managed Care payment Special add-on payments for new technologies | | | | |
| 4. 01 | Islet isolation add-on payment | | | | |
| 5. 00 | Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line | e 69) | | 0 | |
| 5. 00 | Cost of physicians' services in a teaching hospital (see in | • | | o o | |
| 7. 00 | Routine service other pass through costs (from Wkst. D, Pt. | | hrough 35). | o | |
| 3. 00 | Ancillary service other pass through costs from Wkst. D, P | | <i>3</i> , | 112, 605 | 58. |
| 9. 00 | Total (sum of amounts on lines 49 through 58) | | | 11, 883, 581 | 59. |
| 0. 00 | Primary payer payments | | | 2, 731 | 60. |
| 1. 00 | Total amount payable for program beneficiaries (line 59 min | nus line 60) | | 11, 880, 850 | |
| 2. 00 | Deductibles billed to program beneficiaries | | | 1, 240, 880 | |
| 3. 00 | Coinsurance billed to program beneficiaries | | | 21, 483 | |
| | Allowable bad debts (see instructions) | | | 94, 519 | |
| | Adjusted reimbursable bad debts (see instructions) | netrueti ene) | | 61, 437 | 1 |
| 6. 00 7. 00 | Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63) | HISTI UCTI OHS) | | 25, 574 10, 679, 924 | |
| 3. 00 | Credits received from manufacturers for replaced devices for | or applicable to MS_DRGs (s | ee instructions) | 10, 679, 924 | 1 . |
| 00 | Outlier payments reconciliation (sum of lines 93, 95 and 96 | | | 0 | 1 |
| 0.00 | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) | -, | / | l ő | 1 |
|). 50 | Rural Community Hospital Demonstration Project (§410A Demon | nstration) adjustment (see | instructions) | Ö | 1 |
| . 87 | Demonstration payment adjustment amount before sequestration | | , | o | 1 |
|). 88 | SCH or MDH volume decrease adjustment (contractor use only) | | | 0 | 70. |
|). 89 | Pioneer ACO demonstration payment adjustment amount (see in | | | | 70. |
|). 90 | HSP bonus payment HVBP adjustment amount (see instructions) |) | | 0 | |
|). 91 | HSP bonus payment HRR adjustment amount (see instructions) | | | 0 | 1 |
|). 92 | Bundled Model 1 discount amount (see instructions) | | | 0 | |
| | HVBP payment adjustment amount (see instructions) | | | 15, 844 | 70. |
| | HRR adjustment amount (see instructions) | | | -149, 748 | 1 - |

| Health Financial Systems | DEARBORN COUNTY | HOSPI TAL | | In Lie | u of Form CMS- | 2552-10 |
|---------------------------------------------------------------------------------------------------|-----------------|------------|--------------|----------------------------------------------|---------------------------------------------------------|---------|
| CALCULATION OF REIMBURSEMENT SETTLEMENT | | Provi der | CCN: 15-0086 | Peri od: From 01/01/2019 To 12/31/2019 | Worksheet E Part A Date/Time Pre 6/3/2020 5:03 | |
| | | Ti tl | e XVIII | Hospi tal | PPS | |
| | | | FFY | (уууу) | Amount | |
| | | | | 0 | 1. 00 | |
| 70.96 Low volume adjustment for federal fiscal year the corresponding federal year for the period | | n column 0 | | 0 | 0 | 70. 96 |

| | | | | 6/3/2020 5:03 | pm |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|---------------|------------------------------------|---------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | Titl∈ | e XVIII | Hospi tal | PPS | |
| | | FFY | (уууу) | Amount | |
| | | | 0 | 1. 00 | |
| 70.96 Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period prior to 10/1) | n column 0 | | 0 | 0 | 70. 96 |
| 70.97 Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period ending on or after the corresponding federal year for the period ending on or after the corresponding federal year for the period ending on or after the corresponding federal year for the period ending the federal year for the period year. | | : | 2020 | 167, 797 | 70. 97 |
| 70. 98 Low Volume Payment-3 | 10/1) | | | 0 | 70. 98 |
| 70. 99 HAC adjustment amount (see instructions) | | | | 118, 049 | |
| 71.00 Amount due provider (line 67 minus lines 68 plus/minus lines 6 | (۵ ه م | | | 10, 595, 768 | 1 |
| · · · · · · · · · · · · · · · · · · · | 39 & 70) | | | | |
| 71.01 Sequestration adjustment (see instructions) | | | | 211, 915 | |
| 71.02 Demonstration payment adjustment amount after sequestration | | | | 0 | 71. 02 |
| 72.00 Interim payments | | | | 10, 137, 601 | |
| 73.00 Tentative settlement (for contractor use only) | | | | 0 | 73. 00 |
| 74.00 Balance due provider/program (line 71 minus lines 71.01, 71.02 | 2, 72, and | | | 246, 252 | 74. 00 |
| [73] | | | | | |
| 75.00 Protested amounts (nonallowable cost report items) in accordar CMS Pub. 15-2, chapter 1, §115.2 | nce with | | | 170, 923 | 75. 00 |
| TO BE COMPLETED BY CONTRACTOR (lines 90 through 96) | | 1 | | | - |
| 90.00 Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of | of 2 02 | | | 0 | 90. 00 |
| plus 2.04 (see instructions) | 01 2.03 | | | U | 90.00 |
| li i | | | | 0 | 91.00 |
| | | | | - | |
| 92.00 Operating outlier reconciliation adjustment amount (see instru | , | | | 0 | 92.00 |
| 93.00 Capital outlier reconciliation adjustment amount (see instruct | | | | 0 | 93. 00 |
| 94.00 The rate used to calculate the time value of money (see instru | uctions) | | | 0. 00 | 1 |
| 95.00 Time value of money for operating expenses (see instructions) | | | | 0 | 95. 00 |
| 96.00 Time value of money for capital related expenses (see instruct | tions) | | | 0 | 96. 00 |
| | | | Prior to 10/1 | On/After 10/1 | |
| | | | 1. 00 | 2. 00 | |
| HSP Bonus Payment Amount | | | | | |
| 100 00 UCD harman ((((((((- | | | 0 | Ω | 100.00 |
| 100.00 HSP bonus amount (see instructions) | | | ų ų | U | 100.00 |
| HVBP Adjustment for HSP Bonus Payment | | | <u> </u> | 0 | 100.00 |
| HVBP Adjustment for HSP Bonus Payment | | | 0.0000000000 | 0. 0000000000 | |
| HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) | 5) | | -1 | 0. 0000000000 | |
| HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instructions) | 5) | | 0. 0000000000 | 0. 0000000000 | 101. 00 |
| HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instructions HRR Adjustment for HSP Bonus Payment | 5) | | 0.0000000000 | 0. 0000000000 | 101. 00 102. 00 |
| HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instructions HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) | | | 0. 0000000000 | 0. 000000000 0 0. 0000 | 101. 00 102. 00 103. 00 |
| HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instructions HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions) |) | istment | 0.0000000000 | 0. 000000000 0 0. 0000 | 101. 00 102. 00 |
| HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr |) ration) Adju | | 0.0000000000 | 0. 0000000000 0 0. 0000 0 | 101. 00 102. 00 103. 00 104. 00 |
| HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration per 100.00 Is this the first year of the current 5-year demonstration per |) ration) Adju | | 0.0000000000 | 0. 0000000000 0 0. 0000 0 | 101. 00 102. 00 103. 00 |
| HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Projec |) ration) Adju | | 0.0000000000 | 0. 0000000000 0 0. 0000 0 | 101. 00 102. 00 103. 00 104. 00 |
| HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment factor (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration |) ration) Adju riod under t | | 0.0000000000 | 0. 000000000 0 0. 0000 0 | 101. 00 102. 00 103. 00 104. 00 200. 00 |
| HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment factor (see instructions) 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr 200.00 Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line |) ration) Adju riod under t | | 0.0000000000 | 0. 000000000 0 0. 0000 0 | 101. 00 102. 00 103. 00 104. 00 200. 00 |
| HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Projec |) ration) Adju riod under t | | 0.0000000000 | 0. 0000000000 0 0. 0000 0 | 101. 00 102. 00 103. 00 104. 00 200. 00 |
| HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr 200.00 Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 202.00 Medicare discharges (see instructions) 203.00 Case-mix adjustment factor (see instructions) | ration) Adjuriod under t | the 21st | 0. 0000000000 0 0. 0000 0 | 0. 000000000 0 0. 0000 0 | 101. 00 102. 00 103. 00 104. 00 200. 00 |
| HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr 200.00 Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 202.00 Medicare discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in | ration) Adjuriod under t | the 21st | 0. 0000000000 0 0. 0000 0 | 0. 000000000 0 0. 0000 0 | 101. 00 102. 00 103. 00 104. 00 200. 00 |
| HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment factor (see instructions) 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr 200.00 Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 202.00 Medicare discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) | ration) Adjuriod under t | the 21st | 0. 0000000000 0 0. 0000 0 | 0.000000000 0 0.0000 0 | 101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 |
| HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment factor (see instructions) 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr 200.00 Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 202.00 Medicare discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) 204.00 Medicare target amount | ration) Adjuriod under t | the 21st | 0. 0000000000 0 0. 0000 0 | 0.0000000000 0.0000 0.0000 0 | 101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 |
| HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr 200.00 Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 202.00 Medicare discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) 204.00 Medicare target amount 205.00 Case-mix adjusted target amount (line 203 times line 204) | ration) Adjuriod under t | the 21st | 0. 0000000000 0 0. 0000 0 | 0. 0000000000 0 0. 0000 0 o | 101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 |
| HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Projec | ration) Adjuriod under t | the 21st | 0. 0000000000 0 0. 0000 0 | 0. 0000000000 0 0. 0000 0 o | 101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 |
| HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instructions HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project | ration) Adju riod under t e 49) first year | the 21st | 0. 0000000000 0 0. 0000 0 | 0.0000000000 0 0.0000 0 | 101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 |
| HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instructions HRR Adjustment factor (see instructions) 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration (N/A In Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A | ration) Adjuriod under te 49) first year | the 21st | 0. 0000000000 0 0. 0000 0 | 0.000000000 0 0.0000 0 | 101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 |
| HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr 200.00 Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 202.00 Medicare discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) 204.00 Medicare target amount 205.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) 204.00 Medicare inpatient routine cost cap (line 202 times line 204) 206.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 207.00 Program reimbursement under the §410A Demonstration (see instructions) On Medicare Part A inpatient service costs (from Wkst. E, Pt. A, | ration) Adjuriod under te 49) first year | the 21st | 0. 0000000000 0 0. 0000 0 | 0.000000000 0 0.0000 0 | 101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 |
| HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instructions HRR Adjustment factor (see instructions) 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration (N/A In Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A Demonstration (§41A | ration) Adjuriod under te 49) first year | the 21st | 0. 0000000000 0 0. 0000 0 | 0.000000000 0 0.0000 0 | 101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 |
| HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr 200.00 Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 202.00 Medicare discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) 204.00 Medicare target amount 205.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) 204.00 Medicare inpatient routine cost cap (line 202 times line 204) 206.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 207.00 Program reimbursement under the §410A Demonstration (see instructions) On Medicare Part A inpatient service costs (from Wkst. E, Pt. A, | ration) Adjuriod under te 49) first year | the 21st | 0. 0000000000 0 0. 0000 0 | 0.000000000 0 0.0000 0 | 101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 |
| HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration (N/A In Demonstration Project (§410A Demonstration (N/A In Demonstration Project (§410A Demonstration Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project | ration) Adjuriod under te 49) first year | the 21st | 0. 0000000000 0 0. 0000 0 | 0.000000000 0 0.0000 0 | 101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 |
| HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration (N/A in Demonstration Project (§410A Demonstration (N/A in Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demon | ration) Adjuriod under te 49) first year | the 21st | 0. 0000000000 0 0. 0000 0 | 0.000000000 0 0.0000 0 | 101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 |
| HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instructions) 103.00 HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration (N/A in period) 201.00 Medicare target amount 202.00 Medicare inpatient routine cost cap (line 202 times line 204) 203.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 204.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, 209.00 Adjustment to Medicare IPPS payments (see instructions) 205.00 Reserved for future use 207.00 Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement | first year ructions) | the 21st | 0. 0000000000 0 0. 0000 0 | 0.0000000000 0 0.0000 0 | 101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00 |
| HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instructions HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration (N/A In Deroid) 201.00 Medicare discharges (see instructions) 203.00 Case-mix adjustment factor (see instructions) 204.00 Medicare target amount 205.00 Case-mix adjusted target amount (line 203 times line 204) 206.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 207.00 Program reimbursement under the §410A Demonstration (see instructions) 208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, 209.00 Adjustment to Medicare IPPS payments (see instructions) 210.00 Reserved for future use 211.00 Total adjustment to Medicare IPPS payments (see instructions) | first year ructions) | the 21st | 0. 0000000000 0 0. 0000 0 | 0.000000000 0 0.0000 0 | 101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00 |
| HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instructions HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration (N/A In Demonstration Project (§410A Demonstration (N/A In Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration (§410A Demonstration (§410A Demonstration (§410A Demonstration (§410A Demonstration (§410A Demonstration (§410A Demonstration (§410A Demonstration (§410A Demonstration (§410A Demonstration (§410A Demonstration (§410A Demonstration (§410A Demonstration (§410A Demonstration (§410A Demonstration (§410A Demonstration (§410A Demonstration (§410A Demonstration (§410A Demonstration (§410A Demonstration (§410A Demonstration (§410A Demonstration (§410A Demonstration (§410A Demonstration (§410A Demonstration (§410A Demonstration (§410A Demonstration (§410A Demonstration (§410A Demonstration (§410A Demonstration (§410A Demonstration (§410A Demonstration (§410A Demonstration (§410A Demonstration (§410A Demonstration (§410A Demonstration (§410A Demonstration (§410A Demonstration (§410A Demonstration (§410A Demonstration (§410A Demonstration (§410A Demonstration (§410A Demonstration (§410A Demonstration (§410A Demonstration (§410A Demonstration (§410 | first year ructions) line 59) | of the currer | 0. 0000000000 0 0. 0000 0 | 0.000000000 0 0.0000 0 | 101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00 211. 00 212. 00 213. 00 |
| HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instructions HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment for HSP Bonus Payment (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration (N/A In Demonstration Project (§410A Demonstration (N/A In Demonstration Project (§410A Demonstration Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Project Pro | first year ructions) line 59) | of the currer | 0. 0000000000 0 0. 0000 0 | 0.000000000 0 0.0000 0 | 101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00 |

Provider CCN: 15-0086

Peri od: Worksheet E From 01/01/2019 Part A Exhi bit 4 To 12/31/2019 Date/Time Prepared: 6/3/2020 5: 03 pm

| | | | | Title | XVIII | Hospi tal | 6/3/2020 5: 03 PPS | _pm |
|------------------|----------------------------------------------------------------|------------------|--------------------------|---------------------|------------------|----------------|-----------------------|--------|
| | | | Amounts (from | Pre/Post | Period Prior | Peri od | Total (Col 2 | |
| | | line 0 | E, Part A) 1.00 | Entitlement 2.00 | to 10/01 3.00 | On/After 10/01 | through 4) | |
| 1. 00 | DRG amounts other than outlier | | 1.00 | 2.00 | 3.00 | 4. 00 | 5. 00 | 1. (|
| | payments | | | | _ | | | |
| 1. 01 | DRG amounts other than outlier | 1. 01 | 7, 046, 527 | 0 | 7, 046, 527 | | 7, 046, 527 | 1. 0 |
| | payments for discharges occurring prior to October 1 | | | | | | | |
| 1. 02 | DRG amounts other than outlier | 1. 02 | 2, 479, 064 | 0 | | 2, 479, 064 | 2, 479, 064 | 1. 0 |
| | payments for discharges | | _,, | | | _,, | _,, | |
| | occurring on or after October | | | | | | | |
| 1 00 | 1 DDC for Fodorel and file | 1 00 | | 0 | 0 | | | 1, |
| 1. 03 | DRG for Federal specific operating payment for Model 4 | 1. 03 | 0 | U | U | | 0 | 1.0 |
| | BPCI occurring prior to | | | | | | | |
| | October 1 | | | | | | | |
| 1.04 | DRG for Federal specific | 1. 04 | 0 | 0 | | 0 | 0 | 1. (|
| | operating payment for Model 4 BPCI occurring on or after | | | | | | | |
| | October 1 | | | | | | | |
| 2. 00 | Outlier payments for | 2. 00 | | | | | | 2.0 |
| | discharges (see instructions) | | | | | | | |
| 2. 01 | Outlier payments for | 2. 02 | 0 | 0 | 0 | 0 | 0 | 2. 0 |
| 2 02 | discharges for Model 4 BPCI | 2 02 | 222 470 | 0 | 222, 470 | | 222 470 | 2 (|
| 2. 02 | Outlier payments for discharges occurring prior to | 2. 03 | 222, 470 | U | 222, 470 | | 222, 470 | 2.0 |
| | October 1 (see instructions) | | | | | | | |
| 2.03 | Outlier payments for | 2. 04 | 147, 577 | 0 | | 147, 577 | 147, 577 | 2.0 |
| | discharges occurring on or | | | | | | | |
| | after October 1 (see instructions) | | | | | | | |
| 3. 00 | Operating outlier | 2. 01 | 0 | 0 | 0 | 0 | 0 | 3. (|
| 3.00 | reconciliation | 2.01 | Ĭ | J | O | J | J |] 3. (|
| 4.00 | Managed care simulated | 3. 00 | o | 0 | 0 | 0 | 0 | 4. (|
| | payments | | | | | | | |
| F 00 | Indirect Medical Education Adju | | 0.000000 | 0.000000 | 0.000000 | 0.000000 | | - , |
| 5. 00 | Amount from Worksheet E, Part A, line 21 (see instructions) | 21.00 | 0. 000000 | 0. 000000 | 0. 000000 | 0. 000000 | | 5.0 |
| 6. 00 | IME payment adjustment (see | 22. 00 | О | 0 | 0 | 0 | 0 | 6.0 |
| | instructions) | | | | | | | |
| 6. 01 | IME payment adjustment for | 22. 01 | 0 | 0 | 0 | 0 | 0 | 6.0 |
| | managed care (see | | | | | | | |
| | instructions) Indirect Medical Education Adju | ıstment for the | Add-on for Se | ction 422 of t | he MMA | | | |
| 7. 00 | IME payment adjustment factor | 27. 00 | 0. 000000 | 0. 000000 | 0. 000000 | 0.000000 | | 7. (|
| | (see instructions) | | | | | | | |
| 8.00 | IME adjustment (see | 28. 00 | 0 | 0 | 0 | 0 | 0 | 8. 0 |
| 8. 01 | instructions) IME payment adjustment add on | 28. 01 | 0 | 0 | 0 | 0 | 0 | 8. 0 |
| 0.01 | for managed care (see | 20.01 | Ĭ | J | O | J | Ŭ | 0.0 |
| | instructions) | | | | | | | |
| 9. 00 | Total IME payment (sum of | 29. 00 | 0 | 0 | 0 | 0 | 0 | 9. 0 |
| 9. 01 | lines 6 and 8) Total IME payment for managed | 29. 01 | 0 | 0 | 0 | 0 | 0 | 9. 0 |
| 9.01 | care (sum of lines 6.01 and | 29.01 | ٥ | U | U | U | U | 9.0 |
| | 8. 01) | | | | | | | |
| | Di sproporti onate Share Adjustmo | | | | | | | |
| 10. 00 | Allowable disproportionate | 33. 00 | 0. 0827 | 0. 0827 | 0. 0827 | 0. 0827 | | 10.0 |
| | share percentage (see instructions) | | | | | | | |
| 11. 00 | Di sproporti onate share | 34.00 | 196, 942 | 0 | 145, 687 | 51, 255 | 196, 942 | 11 (|
| 11.00 | adjustment (see instructions) | 01.00 | 170,712 | Ŭ | 110,007 | 01, 200 | 170, 712 | ' ' ' |
| 11. 01 | Uncompensated care payments | 36.00 | 858, 387 | 0 | 643, 764 | 214, 623 | 858, 387 | 11.0 |
| 40.5- | Additional payment for high per | | D beneficiary | | | | | |
| 12. 00 | Total ESRD additional payment (see instructions) | 46. 00 | 0 | 0 | 0 | 0 | 0 | 12. (|
| 13. 00 | Subtotal (see instructions) | 47. 00 | 10, 950, 967 | 0 | 8, 058, 448 | 2, 892, 519 | 10, 950, 967 | 13. (|
| 14. 00 | Hospital specific payments | 48. 00 | 0 | o | 0 | 0 | 0 | 1 |
| | (completed by SCH and MDH, | | | | | | | 1 |
| | small rural hospitals only.) | | | | | | | 1 |
| | | I . | | | 0.050.410 | 0.000 540 | 10.050.07 | 1 . |
| 15 00 | (see instructions) | 40.00 | 10 050 0/- | | | 2, 892, 519 | 10, 950, 967 | 15. (|
| 15. 00 | Total payment for inpatient | 49. 00 | 10, 950, 967 | 0 | 8, 058, 448 | 2,072,017 | 10,700,707 | l . |
| 15. 00 | Total payment for inpatient operating costs (see | 49. 00 | 10, 950, 967 | 0 | 6, 036, 446 | 2,072,017 | 10,700,707 | |
| 15. 00 16. 00 | Total payment for inpatient | 49. 00 50. 00 | 10, 950, 967 820, 009 | 0 | 599, 407 | | 820, 009 | 16. 0 |
| | Total payment for inpatient operating costs (see instructions) | | | | | | | 16. 0 |

| | | | | | | rom 01/01/2019 o 12/31/2019 | Part A Exhibit Date/Time Pre 6/3/2020 5:03 | pared: |
|--------|--------------------------------|---------------|---------------|-------------|--------------|--------------------------------|--------------------------------------------|---------|
| - | | | | Title | XVIII | Hospi tal | PPS | рш |
| | | W/S E. Part A | Amounts (from | Pre/Post | Period Prior | Peri od | Total (Col 2 | |
| | | line | E, Part A) | Entitlement | to 10/01 | On/After 10/01 | through 4) | |
| | | 0 | 1.00 | 2.00 | 3.00 | 4. 00 | 5. 00 | |
| 17. 00 | Special add-on payments for | 54.00 | 0 | 0 | C | 0 | 0 | 17. 00 |
| | new technologies | | | | | | | |
| 17. 01 | Net organ aquisition cost | | | | | | | 17. 01 |
| 17. 02 | Credits received from | 68. 00 | 0 | 0 | (| ol | 0 | 17. 02 |
| | manufacturers for replaced | | | | | | | |
| | devices for applicable MS-DRGs | | | | | | | |
| 18. 00 | Capital outlier reconciliation | 93. 00 | 0 | 0 | l | ol | 0 | 18. 00 |
| | adjustment amount (see | | | | | | | |
| | instructions) | | | | | | | |
| 19.00 | SUBTOTAL | | | 0 | 8, 657, 855 | 3, 113, 121 | 11, 770, 976 | 19. 00 |
| | | W/S L, line | (Amounts from | | | | | |
| | | | L) | | | | | |
| | | 0 | 1.00 | 2.00 | 3.00 | 4. 00 | 5. 00 | |
| 20.00 | Capital DRG other than outlier | 1. 00 | 766, 243 | 0 | 569, 805 | 196, 438 | 766, 243 | 20.00 |
| 20. 01 | Model 4 BPCI Capital DRG other | 1. 01 | 0 | 0 | C | 0 | 0 | 20. 01 |
| | than outlier | | | | | | | |
| 21.00 | Capital DRG outlier payments | 2. 00 | 53, 766 | 0 | 29, 602 | 24, 164 | 53, 766 | 21.00 |
| 21. 01 | Model 4 BPCI Capital DRG | 2. 01 | 0 | 0 | C | o | 0 | 21. 01 |
| | outlier payments | | | | | | | |
| 22.00 | Indirect medical education | 5. 00 | 0. 0000 | 0.0000 | 0.0000 | 0.0000 | | 22. 00 |
| | percentage (see instructions) | | | | | | | |
| 23.00 | Indirect medical education | 6. 00 | 0 | 0 | C | 0 | 0 | 23. 00 |
| | adjustment (see instructions) | | | | | | | |
| 24.00 | Allowable disproportionate | 10.00 | 0. 0000 | 0.0000 | 0.0000 | 0.0000 | | 24.00 |
| | share percentage (see | | | | | | | |
| | instructions) | | | | | | | |
| 25.00 | Disproportionate share | 11. 00 | 0 | 0 | C | 0 | 0 | 25. 00 |
| | adjustment (see instructions) | | | | | | | |
| 26.00 | Total prospective capital | 12. 00 | 820, 009 | 0 | 599, 407 | 220, 602 | 820, 009 | 26. 00 |
| | payments (see instructions) | | | | | | | |
| | | W/S E, Part A | | | | | | |
| | | line | Part A) | | | | | |
| | | 0 | 1.00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | |
| 27. 00 | Low volume adjustment factor | | | | 0. 000000 | 0. 053900 | | 27. 00 |
| 28. 00 | Low volume adjustment | 70. 96 | | | C | | 0 | 28. 00 |
| | (transfer amount to Wkst. E, | | | | | | | |
| | Pt. A, line) | | | | | | | |
| 29. 00 | Low volume adjustment | 70. 97 | | | | 167, 797 | 167, 797 | 29. 00 |
| | (transfer amount to Wkst. E, | | | | | | | |
| 400.00 | Pt. A, line) | | | | | | | 400.00 |
| 100.00 | Transfer low volume | | Y | | | | | 100. 00 |
| | adjustments to Wkst. E, Pt. A. | | | | | 1 | | |

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 Provider CCN: 15-0086 Peri od: Worksheet E From 01/01/2019 Part A Exhibit 5 Date/Time Prepared: 6/3/2020 5:03 pm 12/31/2019 Hospi tal Title XVIII Period to Total (cols. 2 Wkst. E, Pt. Amt. from Peri od on 10/01 A. line Wkst. E, Pt. after 10/01 and 3) A) 2.00 3. 00 0 4.00 1.00 1.00 DRG amounts other than outlier payments 1. 00 1. 00 DRG amounts other than outlier payments for 1.01 1.01 7, 046, 527 7, 046, 527 7, 046, 527 1.01 discharges occurring prior to October 1 1.02 DRG amounts other than outlier payments for 1.02 2.479.064 2, 479, 064 2.479.064 1.02 discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment 1.03 1.03 C 0 for Model 4 BPCI occurring prior to October DRG for Federal specific operating payment 1.04 1.04 0 1.04 for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 2.00 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 2.01 **BPCI** 2 02 Outlier payments for discharges occurring 2 03 222, 470 222 470 222 470 2 02 prior to October 1 (see instructions) Outlier payments for discharges occurring on 2.03 2.04 147, 577 147, 577 147, 577 2.03 or after October 1 (see instructions) 3.00 Operating outlier reconciliation 2.01 0 3.00 Managed care simulated payments 4.00 3.00 0 4.00 Indirect Medical Education Adjustment 5.00 Amount from Worksheet E, Part A, line 21 21.00 0.000000 0.000000 0.000000 5.00 (see instructions) IME payment adjustment (see instructions) 6.00 22.00 0 0 0 6.00 IME payment adjustment for managed care (see 0 6.01 22.01 0 0 6.01 instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 IME payment adjustment factor (see 27. 00 0.000000 0.000000 0.000000 7.00 instructions) 8 00 IME adjustment (see instructions) 28 00 8 00 0 0 0 0 8.01 IME payment adjustment add on for managed 28.01 0 0 8.01 care (see instructions) Total IME payment (sum of lines 6 and 8) 29.00 9.00 C 0 9.00 Total IME payment for managed care (sum of 9.01 29.01 C 0 9.01 lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 Allowable disproportionate share percentage 33.00 0.0827 0.0827 0.0827 10.00 (see instructions) 11.00 Disproportionate share adjustment (see 34.00 196, 942 145, 687 51, 255 196, 942 11.00 instructions) 11.01 Uncompensated care payments 36, 00 858, 387 643, 764 214, 623 858, 387 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment (see 46. 00 12.00 instructions) 47.00 13 00 10, 950, 967 8, 058, 448 2, 892, 519 10, 950, 967 Subtotal (see instructions) 13 00 14.00 Hospital specific payments (completed by SCH 48.00 14.00 and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs 49.00 10, 950, 967 8, 058, 448 2, 892, 519 10, 950, 967 15.00 15.00 (see instructions) 16.00 Payment for inpatient program capital (from 50 00 820, 009 599, 407 220, 602 820, 009 16.00 Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 54.00 17.00 0 17.01 Net organ acquisition cost 17.01 Credits received from manufacturers for 68.00 0 17.02 17.02 0 replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment 93.00 18.00 0 amount (see instructions)

8, 657, 855

3, 113, 121

11, 770, 976 19. 00

SUBTOTAL

19.00

| Heal th | Financial Systems | DEARBORN COUN | TY HOSPITAL | | In Lie | eu of Form CMS-2 | 2552-10 |
|---------|------------------------------------------------------------------|-------------------------|----------------------------------|----------|---------------------------------------------|-----------------------------|---------|
| HOSPI T | AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA | TION EXHIBIT 5 | Provider CO | | Period: From 01/01/2019 To 12/31/2019 | | pared: |
| | | | Title | : XVIII | Hospi tal | PPS | |
| | | Wkst. L, line | (Amt. from Wkst. L) | | | | |
| | | 0 | 1.00 | 2.00 | 3. 00 | 4. 00 | |
| 20.00 | Capital DRG other than outlier | 1.00 | 766, 243 | 569, 80 | 196, 438 | 766, 243 | 20.00 |
| 20. 01 | Model 4 BPCI Capital DRG other than outlier | 1. 01 | 0 | | 0 0 | 0 | 20. 01 |
| 21.00 | Capital DRG outlier payments | 2.00 | 53, 766 | 29, 60 | 24, 164 | 53, 766 | 21.00 |
| 21. 01 | Model 4 BPCI Capital DRG outlier payments | 2. 01 | 0 | | 0 0 | 0 | 21. 01 |
| 22. 00 | Indirect medical education percentage (see instructions) | 5. 00 | 0.0000 | 0.000 | 0.0000 | | 22. 00 |
| 23. 00 | Indirect medical education adjustment (see instructions) | 6. 00 | 0 | | 0 0 | 0 | 23. 00 |
| 24. 00 | Allowable disproportionate share percentage (see instructions) | 10.00 | 0.0000 | 0.000 | 0. 0000 | | 24. 00 |
| 25. 00 | Disproportionate share adjustment (see instructions) | 11.00 | 0 | | 0 0 | 0 | 25. 00 |
| 26. 00 | Total prospective capital payments (see instructions) | 12. 00 | 820, 009 | 599, 40 | 220, 602 | 820, 009 | 26. 00 |
| | , | Wkst. E, Pt. A, line | (Amt. from Wkst. E, Pt. A) | | | | |
| | | 0 | 1.00 | 2.00 | 3. 00 | 4. 00 | |
| 27. 00 | | | | | | | 27. 00 |
| 28.00 | Low volume adjustment prior to October 1 | 70. 96 | 0 | | 0 | 0 | 28.00 |
| 29.00 | Low volume adjustment on or after October 1 | 70. 97 | 167, 797 | | 167, 797 | 167, 797 | 29.00 |
| 30.00 | HVBP payment adjustment (see instructions) | 70. 93 | 15, 844 | 17, 90 | -2, 062 | 15, 844 | 30.00 |
| 30. 01 | HVBP payment adjustment for HSP bonus payment (see instructions) | 70. 90 | 0 | | 0 0 | 0 | 30. 01 |
| 31.00 | HRR adjustment (see instructions) | 70. 94 | -149, 748 | -107, 10 | -42, 640 | -149, 748 | 31.00 |
| | HRR adjustment for HSP bonus payment (see instructions) | 70. 91 | 0 | , | 0 0 | 0 | 31. 01 |
| | | | | | | (Amt. to Wkst. E, Pt. A) | |
| | | 0 | 1.00 | 2.00 | 3. 00 | 4. 00 | |
| 32. 00 | HAC Reduction Program adjustment (see instructions) | 70. 99 | | 85, 68 | 32, 362 | 118, 049 | 32. 00 |
| 100.00 | Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A. | | Y | | | | 100. 00 |

| Health Financial Systems | DEARBORN COUNTY HOSPITAL | In Lie | u of Form CMS-2552-10 |
|-----------------------------------------|--------------------------|----------------------------------------------|---------------------------------------------------------|
| CALCULATION OF REIMBURSEMENT SETTLEMENT | Provi der CCN: 15-0086 | Peri od: From 01/01/2019 To 12/31/2019 | Worksheet E Part B Date/Time Prepared: 6/3/2020 5:03 pm |

| . 00 Me . 00 Me . 00 OP . 00 Ou . 01 Ou . 00 En . 00 Li . 00 Su . 00 Tr . 00 An 0. 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 | ART B - MEDICAL AND OTHER HEALTH SERVICES edical and other services (see instructions) edical and other services reimbursed under OPPS (see instruct PPS payments utlier payment (see instructions) utlier reconciliation amount (see instructions) nter the hospital specific payment to cost ratio (see instructione 2 times line 5 um of lines 3, 4, and 4.01, divided by line 6 ransitional corridor payment (see instructions) | · | Hospi tal | 1. 00 4, 754 8, 361, 712 6, 078, 395 48, 262 | 1.00 |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|---------------|----------------------------------------------------------|---------|
| . 00 Me . 00 Me . 00 OP . 00 Ou . 01 Ou . 00 En . 00 Li . 00 Su . 00 Tr . 00 An 0. 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 | edical and other services (see instructions) edical and other services reimbursed under OPPS (see instruct PPS payments utlier payment (see instructions) utlier reconciliation amount (see instructions) nter the hospital specific payment to cost ratio (see instructions) ince 2 times line 5 um of lines 3, 4, and 4.01, divided by line 6 | · | | 4, 754 8, 361, 712 6, 078, 395 | 2. 00 |
| . 00 Me . 00 Me . 00 OP . 00 Ou . 01 Ou . 00 En . 00 Li . 00 Su . 00 Tr . 00 An 0. 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 | edical and other services (see instructions) edical and other services reimbursed under OPPS (see instruct PPS payments utlier payment (see instructions) utlier reconciliation amount (see instructions) nter the hospital specific payment to cost ratio (see instructions) ince 2 times line 5 um of lines 3, 4, and 4.01, divided by line 6 | · | | 4, 754 8, 361, 712 6, 078, 395 | 2. 00 |
| . 00 Me . 00 Me . 00 OP . 00 Ou . 01 Ou . 00 En . 00 Li . 00 Su . 00 Tr . 00 An 0. 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 Or . 00 | edical and other services (see instructions) edical and other services reimbursed under OPPS (see instruct PPS payments utlier payment (see instructions) utlier reconciliation amount (see instructions) nter the hospital specific payment to cost ratio (see instructions) ince 2 times line 5 um of lines 3, 4, and 4.01, divided by line 6 | · | | 8, 361, 712 6, 078, 395 | 2. 00 |
| .00 Me .00 OP .00 Ou .01 Ou .00 En .00 Li .00 Su .00 Tr .00 An .00 O To .00 To | edical and other services reimbursed under OPPS (see instruct PPS payments utlier payment (see instructions) utlier reconciliation amount (see instructions) nter the hospital specific payment to cost ratio (see instruc- ine 2 times line 5 um of lines 3, 4, and 4.01, divided by line 6 | · | | 8, 361, 712 6, 078, 395 | 2. 00 |
| .00 OP .00 Ou .01 Ou .00 En .00 Li .00 Su .00 Tr .00 An 0.00 Or 1.00 To | PPS payments utlier payment (see instructions) utlier reconciliation amount (see instructions) nter the hospital specific payment to cost ratio (see instructions) ine 2 times line 5 um of lines 3, 4, and 4.01, divided by line 6 | · | | 6, 078, 395 | |
| .00 Ou .01 Ou .00 En .00 Li .00 Su .00 Tr .00 An .00 Or .00 It .00 Col .00 Res | utlier payment (see instructions) utlier reconciliation amount (see instructions) nter the hospital specific payment to cost ratio (see instructions) ine 2 times line 5 um of lines 3, 4, and 4.01, divided by line 6 | ctions) | | | 3.00 |
| . 01 | utlier reconciliation amount (see instructions) nter the hospital specific payment to cost ratio (see instruc- ine 2 times line 5 um of lines 3, 4, and 4.01, divided by line 6 | ctions) | | .0,202 | 1 |
| .00 En .00 Li .00 Su .00 Tr .00 An 0.00 Or 1.00 CO Rea | nter the hospital specific payment to cost ratio (see instruc ine 2 times line 5 um of lines 3, 4, and 4.01, divided by line 6 | ctions) | | 0 | 1 |
| . 00 Su . 00 Tr . 00 An 0. 00 Or 1. 00 To COI | um of lines 3, 4, and 4.01, divided by line 6 | | | 0. 000 | 5. 00 |
| . 00 Tr . 00 An 0. 00 Or 1. 00 To COI Rea | | | | 0 | 6. 00 |
| . 00 An 0. 00 Or 1. 00 To COI Rea | ransitional corridor payment (see instructions) | | | 0. 00 | |
| 0. 00 Or 1. 00 <u>To</u> COI Rea | | | | 0 | |
| 1.00 To COI Rea | ncillary service other pass through costs from Wkst. D, Pt. I | IV, col. 13, line 200 | | 52, 740 | 1 |
| COI Rea | rgan acquisitions | | | 0 4, 754 | |
| Rea | otal cost (sum of lines 1 and 10) (see instructions) MPUTATION OF LESSER OF COST OR CHARGES | | | 4, 734 |] 11.00 |
| | easonable charges | | | | i |
| 2. 00 An | ncillary service charges | | | 19, 283 | 12. 00 |
| | rgan acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii | ne 69) | | 0 | 13.00 |
| | otal reasonable charges (sum of lines 12 and 13) | | | 19, 283 | 14. 00 |
| | istomary charges | | | | 4 |
| | ggregate amount actually collected from patients liable for particular to the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the con | | | 0 | |
| | nounts that would have been realized from patients liable for ad such payment been made in accordance with 42 CFR §413.13(e | | a chargebasis | 0 | 16. 00 |
| | atio of line 15 to line 16 (not to exceed 1.000000) | =) | | 0. 000000 | 17. 00 |
| | otal customary charges (see instructions) | | | 19, 283 | |
| 1 | xcess of customary charges over reasonable cost (complete onl | y if line 18 exceeds line | 11) (see | 14, 529 | |
| in | nstructions) | | | | |
| | xcess of reasonable cost over customary charges (complete onl | y if line 11 exceeds line | 18) (see | 0 | 20.00 |
| | nstructions) | | | 4 754 | 21 00 |
| 1 | esser of cost or charges (see instructions) nterns and residents (see instructions) | | | 4, 754 | 21.00 |
| | ost of physicians' services in a teaching hospital (see instr | ructions) | | 0 | |
| 1 | otal prospective payment (sum of lines 3, 4, 4.01, 8 and 9) | 4611 6113) | | 6, 179, 397 | |
| _ | DMPUTATION OF REIMBURSEMENT SETTLEMENT | | | | |
| 5.00 De | eductibles and coinsurance amounts (for CAH, see instructions | s) | | 3, 610 | 25.00 |
| | eductibles and Coinsurance amounts relating to amount on line | | | 1, 246, 041 | |
| | ubtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p | olus the sum of lines 22 a | nd 23] (see | 4, 934, 500 | 27. 00 |
| 1 | nstructions) Frect graduate medical education payments (from Wkst. E-4, li | no 50) | | 0 | 28. 00 |
| | SRD direct medical education costs (from Wkst. E-4, line 36) | THE 30) | | 0 | |
| - 1 | ubtotal (sum of lines 27 through 29) | | | 4, 934, 500 | |
| 1 | rimary payer payments | | | 793 | 1 |
| | ubtotal (line 30 minus line 31) | | | 4, 933, 707 | 32.00 |
| | LOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE | CES) | | | 4 |
| | omposite rate ESRD (from Wkst. I-5, line 11) | | | 104.05(| |
| | llowable bad debts (see instructions) djusted reimbursable bad debts (see instructions) | | | 184, 956 120, 221 | |
| | ajusted reminduisable bad debts (see firstructions) Howable bad debts for dual eligible beneficiaries (see instr | ructions) | | 147, 136 | |
| | ubtotal (see instructions) | 401.05) | | 5, 053, 928 | |
| | SP-LCC reconciliation amount from PS&R | | | -17 | |
| 9. 00 OT | THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) | | | 0 | 39.00 |
| | oneer ACO demonstration payment adjustment (see instructions | s) | | | 39. 50 |
| 1 | emonstration payment adjustment amount before sequestration | | _ | 0 | |
| | artial or full credits received from manufacturers for replace | ced devices (see instructi | ons) | 0 | |
| 1 | ECOVERY OF ACCELERATED DEPRECIATION | | | 0 5 045 | |
| 1 | ubtotal (see instructions) | | | 5, 053, 945 101, 079 | |
| | Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration | | | | 40. 02 |
| | Interim payments | | | | |
| 1 | entative settlement (for contractors use only) | | | 4, 935, 110 0 | 1 |
| 1 | alance due provider/program (see instructions) | | | 17, 756 | |
| | rotested amounts (nonallowable cost report items) in accordan | nce with CMS Pub. 15-2, ch | apter 1, | 0 | 44.00 |
| | 115. 2 | | | | |
| |) BE COMPLETED BY CONTRACTOR | | | 0 | 1 00 00 |
| 1 | riginal outlier amount (see instructions) utlier reconciliation adjustment amount (see instructions) | | | 0 | 1 |
| 1 | he rate used to calculate the Time Value of Money | | | | 91.00 |
| | ime Value of Money (see instructions) | | | 0.00 | |
| | otal (sum of lines 91 and 93) | | | 0 | |

In Lieu of Form CMS-2552-10

| Period: | Worksheet E-1 |
| From 01/01/2019 | Part |
| To 12/31/2019 | Date/Time Prepared: 6/3/2020 5:03 pm Health Financial Systems DEA ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-0086

| | | | | | 6/3/2020 5: 03 | pm |
|-------|----------------------------------------------------------------|------------|--------------|----------------|---------------------|-------|
| | | Title | XVIII | Hospi tal | PPS | |
| | | I npati en | t Part A | Par | rt B | |
| | | mm/dd/yyyy | Amount | mm/dd/yyyy | Amount | |
| | | 1.00 | 2.00 | 3. 00 | 4.00 | |
| 1.00 | Total interim payments paid to provider | | 10, 038, 333 | 3 | 4, 787, 451 | 1. 00 |
| 2.00 | Interim payments payable on individual bills, either | | (| | 0 | 2.00 |
| | submitted or to be submitted to the contractor for | | | | | |
| | services rendered in the cost reporting period. If none, | | | | | |
| | write "NONE" or enter a zero | | | | | |
| 3.00 | List separately each retroactive lump sum adjustment | | | | | 3.00 |
| | amount based on subsequent revision of the interim rate | | | | | |
| | for the cost reporting period. Also show date of each | | | | | |
| | payment. If none, write "NONE" or enter a zero. (1) | | | | | |
| | Program to Provider | I | | | | |
| 3. 01 | ADJUSTMENTS TO PROVIDER | 12/31/2019 | 99, 268 | | 147, 659 | 3. 01 |
| 3. 02 | | | (| | 0 | 3. 02 |
| 3. 03 | | | C | | 0 | 3. 03 |
| 3. 04 | | | C | | 0 | 3. 04 |
| 3. 05 | | | (|) | 0 | 3. 05 |
| | Provi der to Program | ı | | | | |
| 3.50 | ADJUSTMENTS TO PROGRAM | | (| | 0 | 3. 50 |
| 3.51 | | | (| | 0 | 3. 51 |
| 3.52 | | | (| | 0 | 3. 52 |
| 3.53 | | | (| | 0 | 3. 53 |
| 3.54 | | | 00.046 | | 0 | 3. 54 |
| 3. 99 | Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) | | 99, 268 | 3 | 147, 659 | 3. 99 |
| 4. 00 | Total interim payments (sum of lines 1, 2, and 3.99) | | 10, 137, 601 | | 4, 935, 110 | 4. 00 |
| 4.00 | (transfer to Wkst. E or Wkst. E-3, line and column as | | 10, 137, 001 | | 4, 733, 110 | 4.00 |
| | appropriate) | | | | | |
| | TO BE COMPLETED BY CONTRACTOR | L | l . | | | |
| 5.00 | List separately each tentative settlement payment after | | | | | 5. 00 |
| 0.00 | desk review. Also show date of each payment. If none, | | | | | 0.00 |
| | write "NONE" or enter a zero. (1) | | | | | |
| | Program to Provider | • | • | 1 | • | |
| 5. 01 | TENTATI VE TO PROVI DER | | C |) | 0 | 5. 01 |
| 5.02 | | | (| | 0 | 5. 02 |
| 5.03 | | | (| | 0 | 5.03 |
| | Provider to Program | | | | | |
| 5.50 | TENTATI VE TO PROGRAM | | C | | 0 | 5. 50 |
| 5. 51 | | | (| | 0 | 5. 51 |
| 5. 52 | | | (| | 0 | 5. 52 |
| 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) | | | | | |
| 6. 01 | SETTLEMENT TO PROVI DER | | 246, 252 | | 17, 756 | 6. 01 |
| 6. 02 | SETTLEMENT TO PROGRAM | | (| | 0 | 6. 02 |
| 7. 00 | Total Medicare program liability (see instructions) | | 10, 383, 853 | | 4, 952, 866 | 7. 00 |
| | | | | Contractor | NPR Date | |
| | | - |) | Number 1.00 | (Mo/Day/Yr) 2.00 | |
| 8. 00 | Name of Contractor | | | 1.00 | 2.00 | 8. 00 |
| 0.00 | Intalic of contractor | I | | I | 1 | 0.00 |

| Heal th | Health Financial Systems DEARBORN COUNTY HOSPITAL In Lieu | | | | | |
|---------|----------------------------------------------------------------------------------------------------------------------|-------------------------|------------------|-------|--------|--|
| CALCUL | CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0086 From 01/01/2019 To 12/31/2019 Part Bate 6/3/: | | | | | |
| | | Title XVIII | Hospi tal | PPS | | |
| | | | | | | |
| | | | | 1. 00 | | |
| | TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS | | | | 1 | |
| | HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION | | | | 1.00 | |
| 1.00 | 0 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14 | | | | | |
| 2.00 | 00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12 | | | | | |
| 3.00 | Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 | | | | 3. 00 | |
| 4.00 | Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8 | 1-12 | | | 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 l | ine 20 | | | 6. 00 | |
| 7. 00 | CAH only - The reasonable cost incurred for the purchase of cline 168 | ertified HIT technology | Wkst. S-2, Pt. I | | 7. 00 | |
| 8.00 | Calculation of the HIT incentive payment (see instructions) | | | | 8. 00 | |
| 9.00 | Sequestration adjustment amount (see instructions) | | | | 9. 00 | |
| 10.00 | Calculation of the HIT incentive payment after sequestration | (see instructions) | | | 10.00 | |
| | INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH | - | | | 1 | |
| 30.00 | Initial/interim HIT payment adjustment (see instructions) | | | | 30. 00 | |
| | Other Adjustment (specify) | | | | 31.00 | |
| 22 00 | 20 Delance due provider (Line 0 (an line 10) minus line 20 and line 21) (acc instructions) | | | | | |

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

30. 00 31. 00 32. 00

| Health Financial Systems | DEARBORN COUNTY HOSPITAL | In Lieu of Form CMS-2552-10 |
|-----------------------------------------|--------------------------|-----------------------------------------------------------------------------------------|
| CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0086 | Peri od: Worksheet E-3 From 01/01/2019 Part VII To 12/31/2019 Date/Time Prepared: |

| | | | lo 12/31/2019 | Date/lime Pre 6/3/2020 5:03 | |
|--------|-------------------------------------------------------------------------------------------|----------------------------|---------------|--------------------------------|--------|
| | | Title XIX | Hospi tal | Cost | P |
| | | 2 12 | Inpatient | Outpati ent | |
| | | | 1. 00 | 2. 00 | |
| | PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER | VICES FOR TITLES V OR XI) | SERVI CES | | |
| | COMPUTATION OF NET COST OF COVERED SERVICES | | | | 1 |
| 1.00 | Inpatient hospital/SNF/NF services | | 427, 494 | | 1.00 |
| 2.00 | Medical and other services | | | 0 | 2.00 |
| 3.00 | Organ acquisition (certified transplant centers only) | | o | | 3.00 |
| 4.00 | Subtotal (sum of lines 1, 2 and 3) | | 427, 494 | 0 | 4.00 |
| 5.00 | Inpatient primary payer payments | | 0 | | 5. 00 |
| 6.00 | Outpatient primary payer payments | | | 0 | 6.00 |
| 7.00 | Subtotal (line 4 less sum of lines 5 and 6) | | 427, 494 | 0 | 7. 00 |
| | COMPUTATION OF LESSER OF COST OR CHARGES | | | | |
| | Reasonabl e Charges | | | | |
| 8.00 | Routi ne servi ce charges | | 390, 928 | | 8.00 |
| 9.00 | Ancillary service charges | | 669, 494 | 0 | 9. 00 |
| 10.00 | Organ acquisition charges, net of revenue | | 0 | | 10. 00 |
| 11.00 | Incentive from target amount computation | | 0 | | 11. 00 |
| 12.00 | Total reasonable charges (sum of lines 8 through 11) | | 1, 060, 422 | 0 | 12. 00 |
| | CUSTOMARY CHARGES | | | | |
| 13.00 | Amount actually collected from patients liable for payment for | services on a charge | 0 | 0 | 13. 00 |
| | basi s | | | | |
| 14. 00 | Amounts that would have been realized from patients liable for | | 0 | 0 | 14. 00 |
| 45.00 | a charge basis had such payment been made in accordance with 4 | 2 CFR §413.13(e) | | | 45.00 |
| 15.00 | Ratio of line 13 to line 14 (not to exceed 1.000000) | | 0.000000 | 0. 000000 | 1 |
| 16.00 | Total customary charges (see instructions) | :61: 4/ | 1, 060, 422 | 0 | 16.00 |
| 17. 00 | Excess of customary charges over reasonable cost (complete onl | y IT line 16 exceeds | 632, 928 | 0 | 17. 00 |
| 18. 00 | line 4) (see instructions) Excess of reasonable cost over customary charges (complete onl | vifling 4 avecade line | 0 | 0 | 18. 00 |
| 18.00 | 16) (see instructions) | y II IIIle 4 exceeds IIIle | 0 | Ü | 18.00 |
| 19. 00 | Interns and Residents (see instructions) | | 0 | 0 | 19.00 |
| 20. 00 | Cost of physicians' services in a teaching hospital (see instr | suctions) | 0 | 0 | 20.00 |
| 21. 00 | Cost of covered services (enter the lesser of line 4 or line 1 | | 427, 494 | 0 | |
| 21.00 | PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be | | | 0 | 21.00 |
| 22. 00 | Other than outlier payments | compreted for 113 provide | 0 | 0 | 22.00 |
| | Outlier payments | | 0 | 0 | |
| 24. 00 | Program capital payments | | 0 | Ü | 24.00 |
| 25. 00 | Capital exception payments (see instructions) | | 0 | | 25. 00 |
| 26. 00 | Routine and Ancillary service other pass through costs | | 0 | 0 | |
| 27. 00 | Subtotal (sum of lines 22 through 26) | | 0 | 0 | 1 |
| 28. 00 | Customary charges (title V or XIX PPS covered services only) | | 0 | 0 | 1 |
| 29. 00 | Titles V or XIX (sum of lines 21 and 27) | | 427, 494 | 0 | |
| | COMPUTATION OF REIMBURSEMENT SETTLEMENT | | | | |
| 30.00 | Excess of reasonable cost (from line 18) | | 0 | 0 | 30.00 |
| 31.00 | Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) | | 427, 494 | 0 | 31.00 |
| 32.00 | Deducti bl es | | 0 | 0 | 32. 00 |
| 33.00 | Coinsurance | | 0 | 0 | 33. 00 |
| 34.00 | Allowable bad debts (see instructions) | | 0 | 0 | 34.00 |
| 35.00 | Utilization review | | 0 | | 35. 00 |
| 36.00 | Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) | | 427, 494 | 0 | 36. 00 |
| 37.00 | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) | | 0 | 0 | 37. 00 |
| | Subtotal (line 36 ± line 37) | | 427, 494 | 0 | 38. 00 |
| | Direct graduate medical education payments (from Wkst. E-4) | | 0 | | 39. 00 |
| | Total amount payable to the provider (sum of lines 38 and 39) | | 427, 494 | 0 | 40. 00 |
| 41. 00 | Interim payments | | 676, 718 | 0 | |
| 42.00 | Balance due provider/program (line 40 minus line 41) | | -249, 224 | 0 | |
| 43.00 | Protested amounts (nonallowable cost report items) in accordan | nce with CMS Pub 15-2, | 0 | 0 | 43. 00 |
| | chapter 1, §115.2 | | | | |
| | | | | | |

Health Financial Systems

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

Provider CCN: 15-0086

Peri od: Worksheet G From 01/01/2019 To 12/31/2019 Date/Ti me Prepared: 6/3/2020 5:03 pm

| | | General Fund | Speci fi c | Endowment Fund | Plant Fund | pili |
|------------------|-------------------------------------------------------------------------------|-----------------------------------------|--------------|----------------|------------|------------------|
| | | | Purpose Fund | | | |
| | CURRENT ACCETC | 1.00 | 2.00 | 3. 00 | 4. 00 | |
| 1. 00 | CURRENT ASSETS Cash on hand in banks | 7, 483, 647 | 0 | ol | 0 | 1.00 |
| 2. 00 | Temporary investments | 0 | 0 | | 0 | 2.00 |
| 3.00 | Notes recei vabl e | 0 | Ö | | 0 | 3. 00 |
| 4.00 | Accounts recei vable | 50, 063, 983 | 0 | o | 0 | 4. 00 |
| 5. 00 | Other recei vabl e | 0 | 0 | 0 | 0 | 5. 00 |
| 6.00 | Allowances for uncollectible notes and accounts receivable | -39, 362, 764 | 0 | 0 | 0 | 6. 00 |
| 7.00 | Inventory | 1, 365, 432 | 0 | 0 | 0 | 7. 00 |
| 8. 00 9. 00 | Prepaid expenses Other current assets | 1, 107, 268 6, 910, 001 | 0 | 0 | 0 | 8. 00 9. 00 |
| 10. 00 | Due from other funds | 0,910,001 | | 0 | 0 | 10.00 |
| 11. 00 | Total current assets (sum of lines 1-10) | 27, 567, 567 | 0 | _ | 0 | 11.00 |
| | FIXED ASSETS | , , , , , , , , , , , , , , , , , , , , | | · | | |
| 12.00 | Land | 75, 208 | 0 | 0 | 0 | 12.00 |
| 13.00 | Land improvements | 1, 548, 970 | | _ | 0 | 13. 00 |
| 14.00 | Accumulated depreciation | -1, 350, 258 | 0 | 0 | 0 | 14.00 |
| 15. 00 | Buildings | 56, 127, 457 | 0 | 0 | 0 | 15.00 |
| 16. 00 17. 00 | Accumulated depreciation Leasehold improvements | -38, 379, 878 11, 660, 366 | | - | 0 | 16. 00 17. 00 |
| 18. 00 | Accumulated depreciation | -9, 367, 304 | 0 | - | 0 | 18.00 |
| 19. 00 | Fi xed equipment | 18, 608, 225 | Ö | o o | 0 | 19.00 |
| 20. 00 | Accumulated depreciation | -14, 576, 029 | Ō | Ö | 0 | 20.00 |
| 21. 00 | Automobiles and trucks | 277, 439 | | o | 0 | 21. 00 |
| 22. 00 | Accumulated depreciation | -248, 256 | 0 | 0 | 0 | 22. 00 |
| 23.00 | Major movable equipment | 43, 492, 832 | 0 | 0 | 0 | 23. 00 |
| 24. 00 | Accumulated depreciation | -31, 750, 932 | 0 | 0 | 0 | 24. 00 |
| 25. 00 | Mi nor equi pment depreci abl e | 4, 775 | 0 | 0 | 0 | 25. 00 |
| 26. 00 | Accumulated depreciation | -4, 775 | 0 | 0 | 0 | 26.00 |
| 27. 00 28. 00 | HIT designated Assets Accumulated depreciation | 0 | 0 | 0 | 0 | 27. 00 28. 00 |
| 29. 00 | Mi nor equi pment-nondepreci abl e | 0 | | 0 | 0 | 29.00 |
| 30. 00 | Total fixed assets (sum of lines 12-29) | 36, 117, 840 | | | 0 | 30.00 |
| 00.00 | OTHER ASSETS | 1 00/11/7010 | | 5 | | 00.00 |
| 31.00 | Investments | 0 | 0 | 0 | 0 | 31. 00 |
| 32. 00 | Deposits on Leases | 0 | 0 | 0 | 0 | 32. 00 |
| 33. 00 | Due from owners/officers | 0 | 0 | _ | 0 | 33. 00 |
| 34.00 | Other assets | 83, 314, 072 | | - | 0 | 34.00 |
| 35. 00 | Total other assets (sum of lines 31-34) | 83, 314, 072 | | | 0 | 35.00 |
| 36. 00 | Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES | 146, 999, 479 | 0 | l o | 0 | 36. 00 |
| 37. 00 | Accounts payable | 55, 668, 231 | 0 | ol | 0 | 37. 00 |
| 38. 00 | Salaries, wages, and fees payable | 4, 505, 110 | | Ö | 0 | 38. 00 |
| 39. 00 | Payrol I taxes payable | 943, 168 | | o | 0 | 39. 00 |
| 40.00 | Notes and Loans payable (short term) | 800, 000 | 0 | 0 | 0 | 40. 00 |
| 41. 00 | Deferred income | 0 | 0 | 0 | 0 | 41.00 |
| 42. 00 | Accel erated payments | 0 | _ | _ | _ | 42.00 |
| 43.00 | Due to other funds | 1 072 240 | 0 | 0 | 0 | 43.00 |
| 44. 00 45. 00 | Other current liabilities Total current liabilities (sum of lines 37 thru 44) | 1, 073, 249 62, 989, 758 | | 0 | 0 | 44. 00 45. 00 |
| 43.00 | LONG TERM LIABILITIES | 02, 707, 730 | | <u> </u> | | 45.00 |
| 46. 00 | Mortgage payable | 0 | 0 | O | 0 | 46. 00 |
| 47. 00 | Notes payable | 26, 397, 681 | Ō | Ö | 0 | 47. 00 |
| 48. 00 | Unsecured Loans | 0 | 0 | o | 0 | 48. 00 |
| 49. 00 | Other long term liabilities | 6, 896, 989 | 0 | 0 | 0 | 49. 00 |
| 50.00 | Total long term liabilities (sum of lines 46 thru 49) | 33, 294, 670 | | | 0 | 50.00 |
| 51. 00 | Total liabilities (sum of lines 45 and 50) | 96, 284, 428 | 0 | 0 | 0 | 51.00 |
| E2 00 | CAPITAL ACCOUNTS | FO 71E 0E1 | | | | E2 00 |
| 52. 00 53. 00 | General fund balance Specific purpose fund | 50, 715, 051 | 0 | | | 52. 00 53. 00 |
| 54. 00 | Donor created - endowment fund balance - restricted | | | 0 | | 54.00 |
| 55. 00 | Donor created - endowment fund balance - unrestricted | | | Ö | | 55. 00 |
| 56. 00 | Governing body created - endowment fund balance | | | o | | 56. 00 |
| 57. 00 | Plant fund balance - invested in plant | | | | 0 | 57. 00 |
| 58. 00 | Plant fund balance - reserve for plant improvement, | | | | 0 | 58. 00 |
| | repl acement, and expansi on | | | | | |
| 59. 00 | Total fund balances (sum of lines 52 thru 58) | 50, 715, 051 | 0 | | 0 | 59.00 |
| 60. 00 | Total liabilities and fund balances (sum of lines 51 and 59) | 146, 999, 479 | 0 | 0 | 0 | 60.00 |
| | 10// | I | I | ı l | | ı |

Provider CCN: 15-0086

| | | | | | То | 12/31/2019 | Date/Time Pre 6/3/2020 5:03 | |
|----------------|---------------------------------------------------------------------------------|----------------|---------------|----------|-----|------------|----------------------------------------------------------------------------------------------------------------|------------------|
| | | General | Fund | Speci al | Pur | pose Fund | Endowment Fund | |
| | | | | · | | | | |
| | | | | | | | | |
| 1.00 | Te did di di di di di di di di di di di di | 1.00 | 2.00 | 3.00 | | 4. 00 | 5. 00 | 1 00 |
| 1.00 | Fund balances at beginning of period | | 61, 661, 740 | | | 0 | | 1.00 |
| 2.00 | Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) | | -10, 946, 689 | | | 0 | | 2.00 |
| 3. 00 4. 00 | Additions (credit adjustments) (specify) | 0 | 50, 715, 051 | | 0 | U | 0 | 3. 00 4. 00 |
| 5.00 | Additions (credit adjustments) (specify) | | | | 0 | | 0 | |
| 6. 00 | | | | | 0 | | 0 | |
| 7. 00 | | | | | 0 | | 0 | |
| 8.00 | | | | | 0 | | 0 | |
| 9. 00 | | 0 | | | 0 | | 0 | |
| 10.00 | Total additions (sum of line 4-9) | | 0 | | | 0 | , and the second second second second second second second second second second second second second second se | 10.00 |
| 11. 00 | Subtotal (line 3 plus line 10) | | 50, 715, 051 | | | 0 | | 11. 00 |
| 12. 00 | Deductions (debit adjustments) (specify) | 0 | 00,7.0,00. | | 0 | J | 0 | |
| 13. 00 | , (, (, (, /, /, /, /, /, / | o | | | 0 | | 0 | |
| 14. 00 | | O | | | 0 | | 0 | |
| 15.00 | | O | | | 0 | | 0 | 15. 00 |
| 16.00 | | o | | | 0 | | 0 | 16. 00 |
| 17.00 | | 0 | | | 0 | | 0 | 17. 00 |
| 18.00 | Total deductions (sum of lines 12-17) | | 0 | | | 0 | | 18. 00 |
| 19. 00 | Fund balance at end of period per balance | | 50, 715, 051 | | | 0 | | 19. 00 |
| | sheet (line 11 minus line 18) | | | | | | | |
| | | Endowment Fund | PI ant | Fund | | | | |
| | | 6.00 | 7. 00 | 8. 00 | | | | |
| 1.00 | Fund balances at beginning of period | 0.00 | 7.00 | 0.00 | 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) | 0 | | | 0 | | | 3. 00 |
| 4. 00 | Additions (credit adjustments) (specify) | | 0 | | | | | 4. 00 |
| 5. 00 | (====================================== | | 0 | | | | | 5. 00 |
| 6.00 | | | 0 | | | | | 6. 00 |
| 7.00 | | | 0 | | | | | 7. 00 |
| 8.00 | | | 0 | | | | | 8. 00 |
| 9.00 | | | 0 | | | | | 9. 00 |
| 10.00 | Total additions (sum of line 4-9) | 0 | | | 0 | | | 10.00 |
| 11. 00 | Subtotal (line 3 plus line 10) | 0 | | | 0 | | | 11. 00 |
| 12.00 | Deductions (debit adjustments) (specify) | | 0 | | | | | 12. 00 |
| 13. 00 | | | 0 | | | | | 13. 00 |
| 14. 00 | | | 0 | | | | | 14. 00 |
| 15. 00 | | | 0 | | | | | 15. 00 |
| 16.00 | | | 0 | | | | | 16. 00 |
| 17. 00 | T | | 0 | | | | | 17. 00 |
| 18.00 | Total deductions (sum of lines 12-17) | 0 | | | 0 | | | 18. 00 19. 00 |
| 19. 00 | Fund balance at end of period per balance | () | | | | | | 1 (9 (11) |
| | sheet (line 11 minus line 18) | l Y | | | U | | | 17.00 |

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0086

| | | ' | 0 12/31/2019 | 6/3/2020 5: 03 | |
|--------|----------------------------------------------------------------------------|--------------|---------------|----------------|--------|
| | Cost Center Description | Inpatient | Outpati ent | Total | |
| | | 1.00 | 2. 00 | 3. 00 | |
| | PART I - PATIENT REVENUES | | | | |
| | General Inpatient Routine Services | | | | |
| 1.00 | Hospi tal | 12, 353, 057 | ' | 12, 353, 057 | 1.00 |
| 2.00 | SUBPROVI DER - I PF | | | | 2. 00 |
| 3.00 | SUBPROVI DER - I RF | | | | 3. 00 |
| 4.00 | SUBPROVI DER | | | | 4. 00 |
| 5.00 | Swing bed - SNF | | | 0 | 5. 00 |
| 6.00 | Swing bed - NF | | | 0 | 6. 00 |
| 7.00 | SKILLED NURSING FACILITY | |) | 0 | 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) | 12, 353, 057 | | 12, 353, 057 | 10. 00 |
| | Intensive Care Type Inpatient Hospital Services | | | | |
| 11. 00 | INTENSIVE CARE UNIT | 5, 491, 473 | 8 | 5, 491, 473 | 11. 00 |
| 12.00 | CORONARY CARE UNIT | | | | 12.00 |
| 13.00 | BURN INTENSIVE CARE UNIT | | | | 13.00 |
| 14.00 | SURGI CAL INTENSIVE CARE UNIT | | | | 14.00 |
| 15.00 | OTHER SPECIAL CARE (SPECIFY) | F 401 473 | | F 401 470 | 15.00 |
| 16. 00 | Total intensive care type inpatient hospital services (sum of lines | 5, 491, 473 | | 5, 491, 473 | 16. 00 |
| 17. 00 | 11-15) Total inpatient routine care services (sum of lines 10 and 16) | 17, 844, 530 | | 17, 844, 530 | 17. 00 |
| 18. 00 | Ancillary services | 51, 608, 229 | | 166, 733, 048 | 18.00 |
| 19. 00 | Outpatient services | 3, 885, 040 | | 25, 167, 842 | 19. 00 |
| 20. 00 | RURAL HEALTH CLINIC | 3, 003, 040 | | 23, 107, 042 | 20. 00 |
| 21. 00 | FEDERALLY QUALIFIED HEALTH CENTER | | 1 1 | 0 | 21. 00 |
| 22. 00 | HOME HEALTH AGENCY | | 1, 254, 042 | 1, 254, 042 | 22. 00 |
| 23. 00 | AMBULANCE SERVI CES | | 1, 254, 042 | 1, 254, 042 | 23. 00 |
| 24. 00 | CMHC | | | | 24. 00 |
| 25. 00 | AMBULATORY SURGICAL CENTER (D. P.) | | | | 25. 00 |
| 26. 00 | HOSPI CE | | 1, 062, 666 | 1, 062, 666 | |
| 27. 00 | OCCUPATI ONAL HEALTH | | | 87, 581 | 27. 00 |
| 27. 01 | PROFESSI ONAL FEES | | 1, 565, 412 | 1, 565, 412 | 27. 01 |
| 28. 00 | Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. | 73, 337, 799 | 140, 377, 322 | 213, 715, 121 | 28. 00 |
| | G-3, line 1) | | | | |
| | PART II - OPERATING EXPENSES | | | | |
| 29. 00 | Operating expenses (per Wkst. A, column 3, line 200) | | 84, 345, 637 | | 29. 00 |
| 30.00 | ADD (SPECIFY) | (| | | 30. 00 |
| 31.00 | | (| 1 | | 31. 00 |
| 32.00 | | | 1 | | 32.00 |
| 33. 00 | | | 1 | | 33. 00 |
| 34.00 | | | | | 34. 00 |
| 35. 00 | | | | | 35. 00 |
| 36. 00 | Total additions (sum of lines 30-35) | | 0 | | 36. 00 |
| 37. 00 | DEDUCT (SPECIFY) | (| 1 | | 37. 00 |
| 38. 00 | | | | | 38. 00 |
| 39. 00 | | | 1 | | 39. 00 |
| 40.00 | | | | | 40.00 |
| 41. 00 | T + 1 + 1 + 1 | (| | | 41.00 |
| 42. 00 | Total deductions (sum of lines 37-41) | | 04 045 (07 | | 42.00 |
| 43. 00 | Total operating expenses (sum of lines 29 and 36 minus line 42)(transf | er | 84, 345, 637 | | 43. 00 |
| | to Wkst. G-3, line 4) | I | 1 | | |

| Heal th | Financial Systems DEAF | RBORN COUNTY | HOSPI TAL | | u of Form CMS-2 | 2552-10 |
|---------|----------------------------------------------------|--------------|-----------------------|-----------------|-----------------------------|---------|
| STATEM | IENT OF REVENUES AND EXPENSES | | Provider CCN: 15-0086 | Peri od: | Worksheet G-3 | |
| | | | | From 01/01/2019 | | |
| | | | | To 12/31/2019 | Date/Time Pre 6/3/2020 5:03 | |
| | | | 1 | | 0/3/2020 3.03 | pili |
| | | | | | 1. 00 | |
| 1. 00 | Total patient revenues (from Wkst. G-2, Part I, co | olumn 3 lin | e 28) | | 213, 715, 121 | 1. 00 |
| 2.00 | Less contractual allowances and discounts on patie | | | | 150, 534, 167 | 2. 00 |
| 3.00 | Net patient revenues (line 1 minus line 2) | | | | 63, 180, 954 | 3. 00 |
| 4. 00 | Less total operating expenses (from Wkst. G-2, Par | rt II. line | 43) | | 84, 345, 637 | |
| 5. 00 | Net income from service to patients (line 3 minus | | , | | -21, 164, 683 | |
| | OTHER I NCOME | | | | | |
| 6.00 | Contributions, donations, bequests, etc | | | | 0 | 6. 00 |
| 7. 00 | Income from investments | | | | 0 | 7. 00 |
| 8.00 | | | | | | 8. 00 |
| 9.00 | · · | | | | | 9. 00 |
| 10. 00 | Purchase di scounts | | | | 0 | 10.00 |
| 11. 00 | Rebates and refunds of expenses | | | | 0 | 11. 00 |
| | Parking Lot receipts | | | | 0 | 12.00 |
| 13.00 | Revenue from Laundry and Linen service | | | | 0 | 13.00 |
| | Revenue from meals sold to employees and guests | | | | 0 | 14.00 |
| 15. 00 | Revenue from rental of living quarters | | | | 0 | 15. 00 |
| | Revenue from sale of medical and surgical supplies | s to other t | han 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 | S | | | 0 | 18. 00 |
| 19. 00 | Tuition (fees, sale of textbooks, uniforms, etc.) | | | | 0 | 19. 00 |
| 20.00 | Revenue from gifts, flowers, coffee shops, and can | nteen | | | 0 | 20.00 |
| 21.00 | Rental of vending machines | | | | 0 | 21. 00 |
| | Rental of hospital space | | | | 0 | 22. 00 |
| 23.00 | Governmental appropriations | | | | 0 | 23. 00 |
| | OPERATI NG REVENUE | | | | 2, 243, 540 | 24. 00 |
| 24. 01 | INVESTMENT INCOME | | | | 7, 820, 940 | 24. 01 |
| 24. 02 | OTHER NON-OPERATING EXPENSES | | | | 153, 514 | 24. 02 |
| 25 00 | 20 Total other income (our of Lines (24) | | | | | 25 00 |

10, 217, 994

-10, 946, 689

-10, 946, 689 29. 00

25.00

89 26.00 0 27.00 0 28.00

24.02 OTHER NON-OPERATING EXPENSES
25.00 Total other income (sum of lines 6-24)
26.00 Total (line 5 plus line 25)
27.00 OTHER EXPENSES (SPECIFY)
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)

-6. 104

1, 170, 439

1, 170, 439

24.00

24.00 Total (sum of lines 1-23)

| | Financial Systems | | DEARBORN COUNT | | | | ieu of Form CMS- | |
|------------------|----------------------------------------------------------|----------------------------------|-------------------|-------------|-------------|--------------------------|-----------------------------------|------------------|
| COST A | LLOCATION - HHA GENERAL SERVICE | E COST | | Provi der C | | Period: From 01/01/20 | Worksheet H-1 Part | |
| | | | | HHA CCN: | 15-7055 | To 12/31/20° | 19 Date/Time Pre 6/3/2020 5:03 | |
| | | | | | | Home Health | PPS | • |
| | | | Capital Rela | ated Costs | | Agency I | | |
| | | Net Expenses | BI dgs & | Movabl e | PI ant | Transportatio | on Subtotal | - |
| | | for Cost | Fixtures | Equi pment | Operation | | (col s. 0-4) | |
| | | Allocation (from Wkst. H, | | | Mai ntenanc | е | | |
| | | col . 10) | | | | | | |
| | GENERAL SERVICE COST CENTERS | 0 | 1.00 | 2. 00 | 3.00 | 4. 00 | 4A. 00 | |
| 1.00 | Capital Related - Bldg. & | 0 | 0 | | | | С | 1.00 |
| 2. 00 | Fixtures Capital Related - Movable | 0 | | 0 | | | | 2.00 |
| | Equi pment | | | Ö | | | | 1 |
| 3. 00 4. 00 | Plant Operation & Maintenance Transportation | 0 | 0 | 0 | | 0 | 0 | 3.00 |
| 5. 00 | Administrative and General | 436, 732 | 0 | 0 | 1 | o | 0 436, 732 | |
| 4 00 | HHA REIMBURSABLE SERVICES Skilled Nursing Care | 490, 615 | O | 0 | ı | 0 | 0 490, 615 | 6.00 |
| 6. 00 7. 00 | Physical Therapy | 166, 284 | 0 | 0 | 1 | 0 | 0 490, 615 0 166, 284 | 1 |
| 8.00 | Occupational Therapy | 50, 465 | 0 | 0 | 1 | 0 | 0 50, 465 | |
| 9. 00 10. 00 | Speech Pathology Medical Social Services | 5, 538 0 | 0 | 0 | 1 | 0 | 0 5, 538 | |
| 11. 00 | Home Health Aide | 20, 805 | O | O | 1 | 0 | 0 20, 805 | 11. 00 |
| 12. 00 13. 00 | Supplies (see instructions) Drugs | 0 | 0 | 0 | | 0 | | |
| 14. 00 | DME | 0 | 0 | 0 | 1 | Ö | 0 0 | |
| 15 00 | HHA NONREI MBURSABLE SERVI CES | 0 | 0 | | | O | ol c | 15.00 |
| 15. 00 16. 00 | Home Dialysis Aide Services Respiratory Therapy | 0 | 0 | 0 | 1 | 0 | | |
| 17. 00 | Private Duty Nursing | 0 | 0 | 0 | 1 | 0 | 0 0 | |
| 18. 00 19. 00 | Clinic Health Promotion Activities | 0 | 0 | 0 | | 0 | | |
| 20. 00 | Day Care Program | 0 | ő | 0 | 1 | Ö | 0 | 1 |
| 21. 00 | Home Delivered Meals Program | 0 | 0 | 0 | 1 | 0 | | |
| 22. 00 23. 00 | Homemaker Service All Others (specify) | 0 | 0 | 0 | 1 | 0 | | |
| 23. 50 | Tel emedi ci ne | 0 | 0 | 0 | 1 | 0 | 0 0 | |
| 24.00 | Total (sum of lines 1-23) | 1, 170, 439 Admi ni strati ve | Total (cols. | 0 | | 0 | 0 1, 170, 439 | 24.00 |
| | | & General | 4A + 5) | | | | | |
| | GENERAL SERVICE COST CENTERS | 5. 00 | 6. 00 | | | | | |
| 1.00 | Capital Related - Bldg. & | | | | | | | 1. 00 |
| 2. 00 | Fixtures Capital Related - Movable | | | | | | | 2. 00 |
| | Equi pment | | | | | | | |
| 3. 00 4. 00 | Plant Operation & Maintenance Transportation | | | | | | | 3. 00 4. 00 |
| 5.00 | Administrative and General | 436, 732 | | | | | | 5. 00 |
| 6. 00 | HHA REIMBURSABLE SERVICES Skilled Nursing Care | 292, 034 | 782, 649 | | | | | 6.00 |
| 7.00 | Physi cal Therapy | 98, 979 | 265, 263 | | | | | 7. 00 |
| 8. 00 9. 00 | Occupational Therapy Speech Pathology | 30, 039 3, 296 | 80, 504 8, 834 | | | | | 8. 00 9. 00 |
| 10. 00 | Medical Social Services | 3, 240 | 0, 834 | | | | | 10.00 |
| 11.00 | Home Heal th Ai de | 12, 384 | 33, 189 | | | | | 11.00 |
| 12. 00 13. 00 | Supplies (see instructions) Drugs | 0 | 0 | | | | | 12. 00 |
| 14. 00 | DME | 0 | 0 | | | | | 14. 00 |
| 15. 00 | HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services | 0 | 0 | | | | | 15. 00 |
| 16. 00 | Respiratory Therapy | 0 | 0 | | | | | 16. 00 |
| 17. 00 18. 00 | Private Duty Nursing | 0 | 0 | | | | | 17. 00 18. 00 |
| 19. 00 | Health Promotion Activities | | 0 | | | | | 19. 00 |
| 20.00 | Day Care Program | 0 | 0 | | | | | 20.00 |
| 21. 00 22. 00 | Home Delivered Meals Program Homemaker Service | | 0 | | | | | 22.00 |
| 23. 00 | All Others (specify) | 0 | 0 | | | | | 23. 00 |
| | Telemedicine Total (sum of lines 1-23) | | 1, 170, 439 | | | | | 23. 50 24. 00 |
| | • | | | | | | | |

| Heal th | Financial Systems | | DEARBORN COUN | TY HOSPITAL | | In Lie | eu of Form CMS-2 | 2552-10 |
|----------------|--------------------------------------------------------------|---------------------------------------|-----------------------------------------|------------------------------------------------------|----------------------------|----------------------------------|----------------------------------------------|----------------|
| | LLOCATION - HHA STATISTICAL BAS | SIS | | Provi der Co | CN: 15-0086 | Peri od: | Worksheet H-1 | |
| | | | | HHA CCN: | 15-7055 | From 01/01/2019 To 12/31/2019 | Part II Date/Time Pre 6/3/2020 5:03 | pared: |
| | | | | | | Home Health Agency I | PPS | |
| | | Capital Rel | ated Costs | | | I igeney : | | |
| | | BI dgs & Fixtures (SQUARE FEET) | Movable Equi pment (DOLLAR VALUE) | Plant Operation & Maintenance (SQUARE FEET) | Transportati (MI LEAGE) | onReconciliation | Administrative & General (ACCUM. COST) | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | 5A. 00 | 5. 00 | |
| | GENERAL SERVICE COST CENTERS | | | | | | | |
| 1. 00 2. 00 | Capital Related - Bldg. & Fixtures Capital Related - Movable | 0 | 0 | | | 0 | | 1. 00 2. 00 |
| 3. 00 | Equipment Plant Operation & Maintenance | 0 | 0 | | | | | 3.00 |
| 4. 00 | Transportation (see | 0 | 0 | 0 | | o | | 4. 00 |
| 5. 00 | instructions) Administrative and General | 0 | 0 | 0 | | 0 -436, 732 | 733, 707 | 5. 00 |
| | HHA REIMBURSABLE SERVICES | 1 | _ | _ | 1 | _ | | |
| 6.00 | Skilled Nursing Care | 0 | _ | 1 | 1 | 0 0 | , | 1 |
| 7.00 | Physical Therapy | 0 | 0 | 0 | | 0 0 | 166, 284 | |
| 8. 00 9. 00 | Occupational Therapy Speech Pathology | 0 | 0 | 0 | | 0 | 50, 465 | |
| 10. 00 | Medical Social Services | 0 | 0 | 0 | | 0 | 5, 538 0 | 1 |
| 11. 00 | Home Health Aide | 0 | 0 | 0 | | 0 | 20, 805 | |
| 12. 00 | Supplies (see instructions) | 0 | 0 | 0 | | 0 | 20, 805 | 12.00 |
| 13. 00 | Drugs | | 0 | 0 | | 0 | 0 | 1 |
| 14. 00 | DME | | 0 | | | 0 0 | l ~ | 14. 00 |
| 14.00 | HHA NONREI MBURSABLE SERVI CES | 0 | 0 | | 1 | 0 0 | 0 | 14.00 |
| 15. 00 | Home Dialysis Aide Services | 0 | 0 | 0 | ı | 0 0 | 0 | 15. 00 |
| 16. 00 | Respiratory Therapy | 0 | 0 | 0 | 1 | 0 0 | l e | 16. 00 |
| 17. 00 | Private Duty Nursing | 0 | 0 | 0 | | 0 0 | l ő | 17. 00 |
| 18. 00 | Clinic | 0 | 0 | 0 | | 0 0 | l ő | 18. 00 |
| 19. 00 | Health Promotion Activities | 0 | 0 | 0 | | 0 0 | l ő | 19. 00 |
| 20. 00 | Day Care Program | 0 | 0 | 0 | | 0 0 | l ő | 20.00 |
| 21. 00 | Home Delivered Meals Program | 0 | 0 | 0 | | 0 0 | l ő | 21. 00 |
| 22. 00 | Homemaker Service | 0 | 0 | 0 | | 0 0 | l ő | 22. 00 |
| 23. 00 | All Others (specify) | 1 0 | l 0 | ĺ | | o o | l ő | 23. 00 |
| 23. 50 | Tel emedi ci ne | 1 0 | 0 | ا | , | 0 0 | ا م | 23. 50 |
| 24. 00 | Total (sum of lines 1-23) | 0 | l o | 0 | , | 0 -436, 732 | 733, 707 | |
| 25. 00 | Cost To Be Allocated (per Worksheet H-1, Part I) | 0 | Ö | 0 | | 0 | 436, 732 | |
| 26. 00 | Unit Cost Multiplier | 0. 000000 | 0. 000000 | 0. 000000 | 0.0000 | 00 | 0. 595240 | 26. 00 |

Worksheet H-2 Part I Date/Time Prepared: 6/3/2020 5:03 pm From 01/01/2019 To 12/31/2019 HHA CCN: 15-7055 Home Health

| | | | | | | Agency I | PPS | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|--------------------|------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|----------------------------------------------------------------|---------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | | | CAPITAL REI | LATED COSTS | , | | | |
| | Cost Center Description | HHA Trial Balance (1) | NEW BLDG & FIXT | NEW MVBLE EQUI P | EMPLOYEE BENEFITS DEPARTMENT | COMMUNI CATI ONS | DATA PROCESSI NG | |
| | | 0 | 1. 00 | 2.00 | 4. 00 | 5. 01 | 5. 02 | |
| 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50 20. 00 21. 00 | Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum | 0 782, 649 265, 263 80, 504 8, 834 0 33, 189 0 0 0 0 0 0 0 0 0 | 37, 677 | 18, 317 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 227, 341 0 0 0 0 0 0 0 0 0 | 1, 359 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 148, 877 0 0 0 0 0 0 0 0 0 0 0 0 0 | 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50 20. 00 21. 00 |
| | of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places. Cost Center Description | PURCHASI NG RECEI VI NG AND STORES | ADMI TTI NG | CASHI ERI NG/ACC OUNTS RECEI VABLE | Subtotal | OTHER ADMI NI STRATI VE AND GENERAL | OPERATION OF PLANT | |
| | | 5. 03 | 5. 04 | 5. 05 | 5A. 05 | 5. 06 | 7. 00 | |
| 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 21. 00 | Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 1, rounded to 6 decimal places. | 2, 145 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | 0 0 0 0 0 0 0 0 0 0 0 0 | 782, 649 265, 263 80, 504 8, 834 0 33, 189 0 0 0 0 0 | 66, 198 22, 436 6, 809 747 0 2, 807 0 0 0 0 0 0 0 0 0 136, 934 | 90, 019 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 16. 00 17. 00 18. 00 19. 00 19. 50 |

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

| | | | LI BRARY | | | | & Post | |
|--------|-----------------------------------------|--------|----------------|----------------|--------|-------------|-------------|--------|
| | | | | | | | Stepdown | |
| | | 15.00 | 1/ 00 | 17.00 | 22.00 | 24.00 | Adjustments | |
| 4 00 | | 15. 00 | 16. 00 | 17. 00 | 23. 00 | 24. 00 | 25. 00 | 4 00 |
| 1.00 | Administrative and General | 0 | 9, 122 | 302 | 0 | 612, 487 | 0 | 1.00 |
| 2.00 | Skilled Nursing Care | 0 | 0 | 0 | 0 | 848, 847 | 0 | 2.00 |
| 3.00 | Physi cal Therapy | 0 | O ₁ | O ₁ | 0 | 287, 699 | 0 | 3.00 |
| 4.00 | Occupational Therapy | 0 | 0 | 0 | 0 | 87, 313 | 0 | 4. 00 |
| 5.00 | Speech Pathology | 0 | 0 | 0 | 0 | 9, 581 | 0 | 5. 00 |
| 6.00 | Medical Social Services | 0 | O | O | 0 | 0 | 0 | 6. 00 |
| 7. 00 | Home Heal th Aide | 0 | 0 | 0 | 0 | 35, 996 | 0 | 7. 00 |
| 8.00 | Supplies (see instructions) | 0 | 0 | 0 | 0 | 0 | 0 | 8. 00 |
| 9.00 | Drugs | 0 | 0 | 0 | 0 | 0 | 0 | 9. 00 |
| 10. 00 | DME | 0 | 0 | 0 | 0 | 0 | 0 | 10. 00 |
| 11. 00 | , , , , , , , , , , , , , , , , , , , , | 0 | 0 | 0 | 0 | 0 | 0 | 11. 00 |
| 12. 00 | Respiratory Therapy | 0 | 0 | 0 | 0 | 0 | 0 | 12. 00 |
| 13.00 | Private Duty Nursing | 0 | 0 | 0 | 0 | 0 | 0 | 13.00 |
| 14.00 | Clinic | 0 | 0 | 0 | 0 | 0 | 0 | 14.00 |
| 15. 00 | Health Promotion Activities | 0 | 0 | 0 | 0 | 0 | 0 | 15. 00 |
| 16.00 | Day Care Program | 0 | 0 | 0 | 0 | 0 | 0 | 16. 00 |
| 17.00 | Home Delivered Meals Program | 0 | 0 | 0 | 0 | 0 | 0 | 17. 00 |
| 18.00 | Homemaker Service | 0 | 0 | 0 | 0 | 0 | 0 | 18. 00 |
| 19.00 | All Others (specify) | o | o | o | 0 | 0 | 0 | 19. 00 |
| 19. 50 | Tel emedi ci ne | o | o | o | 0 | 0 | 0 | 19. 50 |
| 20.00 | Total (sum of lines 1-19) (2) | o | 9, 122 | 302 | 0 | 1, 881, 923 | 0 | 20. 00 |
| 21.00 | Unit Cost Multiplier: column | | | | | | | 21. 00 |
| | 26, line 1 divided by the sum | | | | | | | |
| | of column 26, line 20 minus | | | | | | | |
| | column 26, line 1, rounded to | | | | | | | |
| | 6 decimal places. | | | | | | | |

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

HHA CCN: 15-7055

| | | | | | | 0/3/2020 5:03 | piii |
|--------|-------------------------------|-------------|---------------|-------------|-------------------------|---------------|--------|
| | | | | | Home Health Agency I | PPS | |
| | Cost Center Description | Subtotal | Allocated HHA | Total HHA | · · · · · · · | | |
| | | | A&G (see Part | Costs | | | |
| | | | 11) | | | | |
| | | 26. 00 | 27. 00 | 28. 00 | | | |
| 1.00 | Administrative and General | 612, 487 | | | | | 1. 00 |
| 2.00 | Skilled Nursing Care | 848, 847 | 409, 558 | 1, 258, 405 | | | 2. 00 |
| 3.00 | Physical Therapy | 287, 699 | 138, 811 | 426, 510 | | | 3. 00 |
| 4.00 | Occupational Therapy | 87, 313 | 42, 127 | 129, 440 | | | 4. 00 |
| 5.00 | Speech Pathology | 9, 581 | 4, 623 | 14, 204 | | | 5. 00 |
| 6.00 | Medical Social Services | 0 | O | 0 | | | 6. 00 |
| 7.00 | Home Health Aide | 35, 996 | 17, 368 | 53, 364 | | | 7. 00 |
| 8.00 | Supplies (see instructions) | 0 | o | 0 | | | 8. 00 |
| 9.00 | Drugs | 0 | o | 0 | | | 9. 00 |
| 10.00 | DME | 0 | o | 0 | | | 10.00 |
| 11.00 | Home Dialysis Aide Services | 0 | O | 0 | | | 11. 00 |
| 12.00 | Respiratory Therapy | 0 | O | 0 | | | 12. 00 |
| 13.00 | Private Duty Nursing | 0 | O | 0 | | | 13. 00 |
| 14.00 | Clinic | 0 | O | 0 | | | 14. 00 |
| 15.00 | Health Promotion Activities | 0 | O | 0 | | | 15. 00 |
| 16.00 | Day Care Program | 0 | 0 | 0 | | | 16. 00 |
| 17.00 | Home Delivered Meals Program | 0 | 0 | 0 | | | 17. 00 |
| 18.00 | Homemaker Service | 0 | 0 | 0 | | | 18. 00 |
| 19.00 | All Others (specify) | 0 | 0 | 0 | | | 19. 00 |
| 19. 50 | Tel emedi ci ne | 0 | 0 | 0 | | | 19. 50 |
| 20.00 | Total (sum of lines 1-19) (2) | 1, 881, 923 | 612, 487 | 1, 881, 923 | | | 20. 00 |
| 21.00 | Unit Cost Multiplier: column | | 0. 482487 | | | | 21. 00 |
| | 26, line 1 divided by the sum | | | | | | |
| | of column 26, line 20 minus | | | | | | |
| | column 26, line 1, rounded to | | | | | | |
| | 6 decimal places. | | | | | | |

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

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

Peri od:
Worksheet H-2
Part II
Date/Time Prepared:
6/3/2020 5:03 pm
PPS BASIS HHA CCN: 15-7055

| | | | | | Home Health Agency I | PPS | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | CAPITAL REL | ATED COSTS | | | Agency | | |
| Cost Center Description | NEW BLDG & FIXT (SQUARE FEET) | NEW MVBLE EQUIP (SQUARE FEET) | EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES) | COMMUNI CATI ONS (PHONES) | DATA PROCESSING (DP EQUIPMENT) | PURCHASI NG RECEI VI NG AND STORES (SUPPLY EXPENSE) | |
| | 1.00 | 2.00 | 4. 00 | 5. 01 | 5. 02 | 5. 03 | |
| 1.00 Administrative and General 2.00 Skilled Nursing Care 3.00 Physical Therapy 4.00 Occupational Therapy 5.00 Speech Pathology 6.00 Medical Social Services 7.00 Home Health Aide 8.00 Supplies (see instructions) 9.00 Drugs 10.00 DME 11.00 Home Dialysis Aide Services 12.00 Respiratory Therapy 13.00 Private Duty Nursing 14.00 Clinic 15.00 Health Promotion Activities 16.00 Day Care Program 17.00 Home Delivered Meals Program 18.00 Homemaker Service 19.00 All Others (specify) 19.50 Telemedicine 20.00 Total (sum of lines 1-19) 21.00 Total cost to be allocated 22.00 Unit cost multiplier Cost Center Description | 3, 085 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 3, 085 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 996, 163 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 0 0 0 0 0 0 0 0 0 0 0 41 148, 877 3, 631. 146341 | 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 21.00 |
| | 5. 04 | 5. 05 | 5A. 06 | 5. 06 | 7. 00 | 8. 00 | |
| 1.00 Administrative and General 2.00 Skilled Nursing Care 3.00 Physical Therapy 4.00 Occupational Therapy 5.00 Speech Pathology 6.00 Medical Social Services 7.00 Home Health Aide 8.00 Supplies (see instructions) 9.00 Drugs 10.00 DME 11.00 Home Dialysis Aide Services 12.00 Respiratory Therapy 13.00 Private Duty Nursing 14.00 Clinic 15.00 Health Promotion Activities 16.00 Day Care Program 17.00 Home Delivered Meals Program 18.00 Homemaker Service 19.00 All Others (specify) 19.50 Telemedicine 20.00 Total (sum of lines 1-19) 21.00 Total cost to be allocated 22.00 Unit cost multiplier | 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 1, 254, 042 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 448, 529 782, 649 265, 263 80, 504 8, 834 0 33, 189 | 3, 085 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 0 0 0 0 0 0 0 0 0 0 0 0 0 | 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 00 20. 00 21. 00 22. 00 |

Heal th Financial Systems DEARBORN COUNTY HOSPITAL ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL Provider CCN: 15-0086 Worksheet H-2 Part II Date/Time Prepared: 6/3/2020 5:03 pm Peri od: From 01/01/2019 To 12/31/2019 BASIS HHA CCN: 15-7055 Home Health PPS

| | | | | | | Agency I | | |
|------------------|------------------------------------------------|---------------|----------------|-------------|------------------------|------------------|-----------|------------------|
| | Cost Center Description | HOUSEKEEPI NG | DI ETARY | CAFETERI A | NURSI NG | CENTRAL | PHARMACY | |
| | | (SQUARE | (MEALS | (MAN HOURS) | ADMI NI STRATI ON | SERVICE & | (100%) | |
| | | FEET) | SERVED) | | (CDOCC HOUDC) | SUPPLY | | |
| | | 9. 00 | 10.00 | 11. 00 | (GROSS HOURS) 13.00 | (100%) 14. 00 | 15. 00 | |
| 1. 00 | Administrative and General | 3, 085 | 10.00 | 11.00 | | 14.00 | 15.00 | 1. 00 |
| 2. 00 | Skilled Nursing Care | 0 | 0 | Č | | ol | 0 | 2. 00 |
| 3. 00 | Physical Therapy | 0 | 0 | Ċ | | ol | 0 | 3. 00 |
| 4.00 | Occupational Therapy | 0 | 0 | C | o | o | 0 | 4. 00 |
| 5.00 | Speech Pathology | 0 | 0 | C | o | o | 0 | 5. 00 |
| 6.00 | Medical Social Services | 0 | 0 | C | o | o | 0 | 6. 00 |
| 7.00 | Home Health Aide | 0 | 0 | C | 0 | o | 0 | 7. 00 |
| 8.00 | Supplies (see instructions) | 0 | 0 | C | 0 | 0 | 0 | 8. 00 |
| 9.00 | Drugs | 0 | 0 | C | 0 | 0 | 0 | 9. 00 |
| 10.00 | DME | 0 | 0 | C | 1 | 0 | 0 | 10.00 |
| 11. 00 | Home Dialysis Aide Services | 0 | 0 | C | 1 | 0 | 0 | 11. 00 |
| 12. 00 | Respiratory Therapy | 0 | 0 | C | 1 | 0 | 0 | 12. 00 |
| 13.00 | Private Duty Nursing | 0 | 0 | C | 1 | 0 | 0 | 13.00 |
| 14.00 | Clinic | 0 | 0 | C | 1 | 0 | 0 | 14.00 |
| 15. 00 | Health Promotion Activities | 0 | 0 | C | 1 | 0 | 0 | 15. 00 |
| 16. 00 17. 00 | Day Care Program | 0 | 0 | | 0 | 0 | 0 | 16. 00 17. 00 |
| 17.00 | Home Delivered Meals Program Homemaker Service | | 0 | | | 0 | 0 | 17.00 |
| 19. 00 | All Others (specify) | 0 | 0 | | | ol | 0 | 19. 00 |
| 19. 50 | Tel emedi ci ne | 0 | 0 | | | 0 | 0 | 19. 50 |
| 20. 00 | Total (sum of lines 1-19) | 3, 085 | 0 | | | Ö | 0 | 20. 00 |
| 21. 00 | Total cost to be allocated | 26, 578 | 0 | Č | | Ö | 0 | 21. 00 |
| 22. 00 | Unit cost multiplier | 8. 615235 | 0. 000000 | 0. 000000 | 0.000000 | 0. 000000 | 0. 000000 | 22. 00 |
| | Cost Center Description | MEDI CAL | SOCIAL SERVICE | PHARMACY | | | | |
| | | RECORDS & | | RESI DENCY | | | | |
| | | LI BRARY | (TIME | (ASSI GNED | | | | |
| | | (ADJUSTED | SPENT) | TIME) | | | | |
| | | 16. 00 | 17. 00 | 23. 00 | - | - | | |
| 1. 00 | Administrative and General | 1, 254, 042 | 17.00 | 23.00 | | | | 1. 00 |
| 2. 00 | Skilled Nursing Care | 1, 234, 042 | 0 | | 1 | | | 2. 00 |
| 3. 00 | Physical Therapy | | 0 | | 1 | | | 3. 00 |
| 4. 00 | Occupational Therapy | 0 | 0 | Č | 1 | | | 4. 00 |
| 5. 00 | Speech Pathology | 0 | 0 | Ċ | 1 | | | 5. 00 |
| 6.00 | Medical Social Services | 0 | 0 | C | | | | 6. 00 |
| 7.00 | Home Health Aide | 0 | 0 | C | | | | 7. 00 |
| 8.00 | Supplies (see instructions) | 0 | 0 | C | | | | 8. 00 |
| 9.00 | Drugs | 0 | 0 | C | 1 | | | 9. 00 |
| 10. 00 | DME | 0 | 0 | C | 1 | | | 10.00 |
| 11. 00 | Home Dialysis Aide Services | 0 | 0 | C | 1 | | | 11. 00 |
| 12. 00 | Respiratory Therapy | 0 | 0 | C | 1 | | | 12. 00 |
| 13.00 | Private Duty Nursing | 0 | 0 | C | 1 | | | 13. 00 |
| 14.00 | Clinic | 0 | 0 | C | 1 | | | 14. 00 |
| 15. 00 16. 00 | Health Promotion Activities | 0 | 0 | 0 | | | | 15. 00 |
| 17. 00 | Day Care Program Home Delivered Meals Program | | 0 | | | | | 16. 00 17. 00 |
| 18. 00 | Homemaker Service | 0 | 0 | | 1 | | | 18. 00 |
| 19. 00 | All Others (specify) | 0 | 0 | | 1 | | | 19. 00 |
| 19. 50 | Tel emedi ci ne | | 0 | | | | | 19. 50 |
| 20. 00 | Total (sum of lines 1-19) | 1, 254, 042 | 3 | | | | | 20. 00 |
| 21. 00 | Total cost to be allocated | 9, 122 | 302 | Č | | | | 21. 00 |
| | Unit cost multiplier | 0. 007274 | | 0. 000000 | 1 | | | 22. 00 |
| | • | • | , , | | • | | ' | |

| Hoal th | Financial Systems | | DEARBORN COUN | TV HOSDITAI | | In lie | eu of Form CMS-2 | 2552_10 |
|---------|---------------------------------------------------------------|----------------|-----------------|----------------|-------------------------------|--------------------------|-----------------------------|---------|
| | TONMENT OF PATIENT SERVICE COST | -S | DEARBORN COON | | CN: 15-0086 | Peri od: | Worksheet H-3 | |
| | | | | | | From 01/01/2019 | Part I | |
| | | | | HHA CCN: | 15-7055 | To 12/31/2019 | Date/Time Pre 6/3/2020 5:03 | pared: |
| | | | | Ti tl e | e XVIII | Home Health | PPS | рііі |
| | Cost Center Description | From, Wkst. | Facility Costs | Shared | Total HHA | Agency I Total Visits | Average Cost | |
| | cost center beserver on | H-2, Part I, | (from Wkst. | Ancillary | Costs (col s. | | Per Vi si t | |
| | | col. 28, line | | Costs (from | + 2) | | (col. 3 ÷ col. | |
| | | | , | Part II) | , | | 4) | |
| | | 0 | 1.00 | 2.00 | 3. 00 | 4. 00 | 5. 00 | |
| | PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION | OF AGGREGATE F | PROGRAM COST, A | GGREGATE OF TH | HE PROGRAM LIN | MITATION COST, OF | R | |
| | Cost Per Visit Computation | | | | | | | 1 |
| 1.00 | Skilled Nursing Care | 2. 00 | 1, 258, 405 | | 1, 258, 40 | 05 4, 186 | 300. 62 | 1.00 |
| 2.00 | Physi cal Therapy | 3.00 | 426, 510 | (| 426, 5 | 10 2, 455 | 173. 73 | 2. 00 |
| 3.00 | Occupational Therapy | 4. 00 | 129, 440 | (| 129, 4 | 40 623 | 207. 77 | 3. 00 |
| 4.00 | Speech Pathology | 5. 00 | 14, 204 | (| 14, 20 | 75 | 189. 39 | 4. 00 |
| 5.00 | Medical Social Services | 6. 00 | | | | 0 | | |
| 6.00 | Home Health Aide | 7. 00 | · · | | 53, 30 | | l . | 1 |
| 7. 00 | Total (sum of lines 1-6) | | 1, 881, 923 | (| 1, 881, 9 | | | 7. 00 |
| | | | ı | | Program Visi | | | |
| | | | 0004 11 (4) | | | art B | | |
| | Cost Center Description | Cost Limits | CBSA No. (1) | Part A | Not Subject | | | |
| | | | | | Deducti bl es Coi nsurance | | | |
| | | 0 | 1.00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | |
| | Limitation Cost Computation | , | 1.00 | 2.00 | 0.00 | 1. 00 | 0.00 | |
| 8.00 | Skilled Nursing Care | | 17140 | (| 1, 6 | 65 | | 8. 00 |
| 8. 01 | Skilled Nursing Care | | 99915 | (| 48 | 31 | | 8. 01 |
| 9.00 | Physi cal Therapy | | 17140 | (| 1, 19 | 93 | | 9. 00 |
| 9. 01 | Physi cal Therapy | | 99915 | (|) 19 | 93 | | 9. 01 |
| 10.00 | Occupational Therapy | | 17140 | (| • | 73 | | 10. 00 |
| 10. 01 | Occupational Therapy | | 99915 | (| | 67 | | 10. 01 |
| 11. 00 | Speech Pathology | | 17140 | (| | 9 | | 11. 00 |
| 11. 01 | Speech Pathology | | 99915 | (| | 6 | | 11. 01 |
| 12.00 | Medical Social Services | | 17140 | (| | 0 | | 12.00 |
| 12. 01 | Medical Social Services | | 99915 | | 1. | 0 | | 12. 01 |
| 13.00 | 4 | | 17140 | | | 76 | | 13.00 |
| 13. 01 | Home Heal th Ai de | | 99915 | | 1 | 31 | | 13. 01 |
| 14.00 | Total (sum of lines 8-13) Cost Center Description | From Wkst U 2 | Facility Costs | Shared | Total HHA | | Ratio (col. 3 | 14. 00 |
| | cost center bescription | Part I, col. | (from Wkst. | Ancillary | Costs (col s. | | ÷ col . 4) | |
| | | 28. line | H-2, Part I) | Costs (from | + 2) | Records) | | |
| | | | , , | Part II) | '-/ | , | | |
| | | 0 | 1. 00 | 2.00 | 3.00 | 4. 00 | 5. 00 | |
| | Supplies and Drugs Cost Computa | | | | 1 | | 1 | |
| 15.00 | • • • • • • • • • • • • • • • • • • • • | 8.00 | | (| | 0 0 | | |
| 16. 00 | Cost of Drugs | 9. 00 | Program Visits | (| Cost of | 0 0 | 0. 000000 | 16.00 |
| | | | Program visits | | Servi ces | | | |
| | | | Par | † R | _ Services | Part B | | |
| | Cost Center Description | Part A | Not Subject to | | Part A | Not Subject to | Subject to | |
| | 2001 2011101 20001 1 211011 | | Deductibles & | | | Deductibles & | | |
| | | | Coi nsurance | Coi nsurance | | Coi nsurance | Coi nsurance | |
| | | 6. 00 | 7. 00 | 8. 00 | 9.00 | 10.00 | 11.00 | |
| | PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION | OF AGGREGATE F | PROGRAM COST, A | GGREGATE OF TH | HE PROGRAM LIN | MITATION COST, OF | R | |
| | Cost Per Visit Computation | | | | | | | |
| 1.00 | Skilled Nursing Care | 0 | 2, 146 | | | 0 645, 131 | | 1.00 |
| 2.00 | Physical Therapy | 0 | | | | 0 240, 790 | | 2. 00 |
| 3.00 | Occupational Therapy | 0 | 340 | | | 0 70, 642 | | 3. 00 |
| 4.00 | Speech Pathology | 0 | 15 | | | 0 2, 841 | | 4. 00 |
| 5.00 | Medical Social Services | 0 | 0 | | | 0 0 | | 5. 00 |
| 6.00 | Home Health Aide | 0 | 207 | | | 0 18, 442 | | 6. 00 |
| 7. 00 | Total (sum of lines 1-6) | 0 | 4, 094 | | 1 | 0 977, 846 | 1 | 7. 00 |
| | | | | | | | | |

| n Financial Systems TIONMENT OF PATIENT SERVICE COST | S | | | | | | 2552-10 |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| | | | Provi der C | CN: 15-0086 | Peri od: | Worksheet H-3 | |
| | | | HHA CCN: | 15-7055 | From 01/01/2019 To 12/31/2019 | Part I Date/Time Pre 6/3/2020 5:03 | |
| | | | Title | e XVIII | Home Health Agency I | PPS | piii |
| Cost Center Description | | 7.00 | | | | | |
| limitation Cost Computation | 6.00 | 7.00 | 8.00 | 9.00 | 10.00 | 11.00 | |
| Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Medical Social Services Home Health Aide Home Health Aide | | | | | | | 8. 00 8. 01 9. 00 9. 01 10. 00 11. 01 12. 00 12. 01 13. 00 13. 01 |
| Total (sum of lines 8-13) | Drog | ram Covered Cha | race | Cost of | | | 14. 00 |
| | Progr | | | Servi ces | Part B | | |
| Cost Center Description | Part A | Not Subject to | Subj ect to | Part A | Not Subject to Deductibles & Coinsurance | Subject to Deductibles & Coinsurance | |
| | 6. 00 | 7. 00 | 8. 00 | 9. 00 | 10.00 | 11. 00 | |
| | | 22 200 | 0 | | | | 15. 00 |
| | | 32, 289 | | | | | |
| Cost Center Description | Total Program Cost (sum of cols. 9-10) 12.00 | | | | | | |
| BENEFICIARY COST LIMITATION | OF AGGREGATE F | PROGRAM COST, A | GGREGATE OF TH | IE PROGRAM LI | MITATION COST, OR | ! | |
| Skilled Nursing Care | | | | | | | 1.00 |
| | | | | | | | 2.00 |
| | | | | | | | 3. 00 4. 00 |
| Medical Social Services | | | | | | | 5. 00 |
| Home Health Aide | | | | | | | 6. 00 |
| | 977, 846 | | | | | | 7. 00 |
| cost center bescription | 12 00 | | | | | | - |
| Limitation Cost Computation | 12.00 | | | | I | | |
| Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Medical Social Services Home Health Aide | | | | | | | 8. 00 8. 01 9. 00 9. 01 10. 00 11. 01 12. 00 12. 01 13. 00 13. 01 |
| | Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Medical Social Services Home Health Aide Home Health Aide Total (sum of lines 8-13) Cost Center Description Supplies and Drugs Cost Computation Cost of Medical Supplies Cost of Drugs Cost Center Description PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Medical Social Services Medical Social Services Medical Social Services | Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Medical Social Services Home Health Aide Home Health Aide Total (sum of lines 8-13) Prog Cost Center Description Cost Center Description Part A 6.00 Supplies and Drugs Cost Computations Cost of Medical Supplies Cost Center Description Cost Center Description Total Program Cost (sum of cols. 9-10) 12.00 PART I - COMPUTATION OF LESSER OF AGGREGATE F BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care | Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Desc | Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Medical Social Services Home Health Aide Home Health Aide Home Health Description Part A Not Subject to Subject to Deductibles & Colnsurance Cost of Medical Supplies October Consumers October Cost of Medical Supplies October Cost of Medical Supplies October Cost of Medical Supplies October Cost of Medical Supplies October Cost of Medical Supplies October Cost of Medical Supplies October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost October Cost O | Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupation | Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathol ogy Medical Social Services Home Health Aide Total (sum of lines 8-13) Program Covered Charges Cost Center Description Cost Center Description Supplies and Drugs Cost Computations Cost of Medical Supplies Cost Of Medical Supplies Cost Genter Description Supplies and Drugs Cost Computations Cost of Medical Supplies Cost Genter Description Cost Genter Description Part A Not Subject to Deductibles & Deductibles & Deductibles & Deductibles & Coinsurance Coinsurance Coinsurance Coinsurance Coinsurance Cost of Medical Supplies Cost of Medical Supplies Cost Genter Description Cost Genter Description Cost Genter Description Cost Genter Description Cost Genter Description Cost Genter Description Cost Genter Description Cost Genter Description Cost Genter Description Cost Genter Description Cost Genter Description Cost Genter Description Cost Genter Description Cost Genter Description Cost Genter Description Cost Genter Description Cost Genter Description Cost Genter Description Limitation Cost Computation Skilled Nursing Care Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathol ogy Medical Social Services Home Health Aide Home Health Aide Home Health Aide Home Health Aide Home Health Aide Home Health Aide Home Health Aide Home Health Aide Home Health Aide Home Health Aide Home Health Aide Home Health Aide Home Health Aide Home Health Aide Home Health Aide Home Health Aide Home Health Aide Home Health Aide Home Health Aide Home Health Aide Home Health Aide Home Health Aide Home Health Aide Home Health Aide Home Health Aide Home Health Aide Home Health Aide Home Health Aide | Limitation Cost Computation |

| Health Financial Sys | ems | | DEARBORN COUN | TY HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|-----------------------|------------------|----------------|------------------|----------------|------------------------|----------------------------------|-----------------|---------|
| APPORTI ONMENT OF PAT | ENT SERVICE COS | TS | | Provi der C | Provi der CCN: 15-0086 | | Worksheet H-3 | |
| | | | | HHA CCN: | 15-7055 | From 01/01/2019 To 12/31/2019 | | narod: |
| | | | | | 13-7033 | 10 12/31/2017 | 6/3/2020 5: 03 | |
| | | | | | XVIII | Home Health | PPS | |
| | | | | | | Agency I | | |
| Cost Cer | ter Description | From Wkst. C, | Cost to Charge | Total HHA | HHA Shared | Transfer to | | |
| | | Part I, col. | Ratio | Charge (from | Ancillary | Part I as | | |
| | | 9, line | | provi der | Costs (col. | 1 Indicated | | |
| | | | | records) | x col. 2) | | | |
| | | 0 | 1.00 | 2. 00 | 3. 00 | 4. 00 | | |
| PART II - APPO | RTIONMENT OF COS | T OF HHA SERVI | CES FURNI SHED B | Y SHARED HOSPI | TAL DEPARTMEN | TS | | |
| 1.00 Physical Ther | ру | 66. 00 | 0. 399764 | C | | 0 col. 2, line 2 | . 00 | 1.00 |
| 2.00 Occupational | herapy | 67.00 | 0. 388916 | C | | Ocol. 2, line 3 | . 00 | 2. 00 |
| 3.00 Speech Pathol | gy | 68. 00 | 0. 493471 | C | | Ocol. 2, line 4 | . 00 | 3. 00 |
| 4.00 Cost of Medic | l Supplies | 71. 00 | 2. 222894 | C | | 0 col. 2, line 1 | 5. 00 | 4. 00 |
| 5.00 Cost of Drugs | | 73. 00 | 0. 465545 | C | | 0 col. 2, line 1 | 6. 00 | 5. 00 |

| | Financial Systems DEARBORN COUNTY | | CN: 1E 000/ | | u of Form CMS-2 | |
|-----------|------------------------------------------------------------------------------------------------------------------------------|----------------|-------------|---------------------------------------------|---------------------------------------------|------|
| ALCULA | TION OF HHA REIMBURSEMENT SETTLEMENT | Provider CC | 15-7055 | Period: From 01/01/2019 To 12/31/2019 | Worksheet H-4 Part I-II Date/Time Pre | pare |
| | | Title | XVIII | Home Health | 6/3/2020 5: 03 PPS | pm |
| | | | | Agency I Par | t B | |
| | | | Part A | Not Subject to Deductibles & | Subject to Deductibles & | |
| | | | 1 00 | Coi nsurance | Coi nsurance | |
| P | PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUS | TOMARY CHARGE: | 1. 00 S | 2. 00 | 3. 00 | |
| | Reasonable Cost of Part A & Part B Services | | | | | |
| - 1 | Reasonable cost of services (see instructions) | | | 0 0 | 0 | |
| | Total charges Customary Charges | | | 0 0 | 0 | 2 |
| | Amount actually collected from patients liable for payment fo | or services | | 0 0 | 0 | 3 |
| | on a charge basis (from your records) | | | | · · | |
| f | Amount that would have been realized from patients liable fo for services on a charge basis had such payment been made in | | | 0 0 | 0 | 4 |
| | with 42 CFR §413.13(b) Ratio of line 3 to line 4 (not to exceed 1.000000) | | 0. 0000 | 0. 00000 | 0. 000000 | 5 |
| | Total customary charges (see instructions) | | 0.0000 | 0.00000 | 0.000000 | 1 |
| | Excess of total customary charges over total reasonable cost | (complete | | 0 0 | 0 | 7 |
| 1 | only if line 6 exceeds line 1) | | | | | |
| | Excess of reasonable cost over customary charges (complete o 1 exceeds line 6) | nlyifline | | 0 0 | 0 | 8 |
| | Primary payer amounts | | | 0 0 | 0 | 9 |
| | | | | Part A | Part B | |
| | | | | Servi ces 1.00 | Servi ces 2. 00 | |
| P | PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT | | | 1.00 | 2.00 | |
| - 1 | Total reasonable cost (see instructions) | | | 0 | 0 | |
| | Total PPS Reimbursement - Full Episodes without Outliers | | | 0 | 710, 366 | |
| | Total PPS Reimbursement – Full Episodes with Outliers Total PPS Reimbursement – LUPA Episodes | | | 0 | 23, 630 19, 395 | |
| - 1 | Total PPS Reimbursement - PEP Episodes | | | 0 | 6, 273 | |
| 1 | Total PPS Outlier Reimbursement - Full Episodes with Outlier | S | | 0 | 5, 837 | |
| | Total PPS Outlier Reimbursement - PEP Episodes | | | 0 | 769 | |
| | Total Other Payments DME Payments | | | 0 | 0 | 13 |
| | Oxygen Payments | | | 0 | 0 | 10 |
| 4 | Prosthetic and Orthotic Payments | | | 0 | 0 | 20 |
| 1 | Part B deductibles billed to Medicare patients (exclude coin | surance) | | | 0 | |
| | Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) | | | 0 | 766, 270 0 | 2: |
| - 1 | Subtotal (line 22 minus line 23) | | | 0 | 766, 270 | |
| | Coinsurance billed to program patients (from your records) | | | | 0 | 2! |
| | Net cost (line 24 minus line 25) | | | 0 | 766, 270 | |
| | Reimbursable bad debts (from your records) | instructions) | | | | 27 |
| | Reimbursable bad debts for dual eligible beneficiaries (see Total costs – current cost reporting period (line 26 plus li | | | 0 | 766, 270 | |
| - 1 | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) | 27) | | 0 | 0 | 1 |
| - 1 | Pioneer ACO demonstration payment adjustment (see instruction | | | 0 | 0 | |
| | Demonstration payment adjustment amount before sequestration | | | 0 | 7// 270 | |
| | Subtotal (see instructions) Sequestration adjustment (see instructions) | | | 0 | 766, 270 15, 326 | |
| | Demonstration payment adjustment amount after sequestration | | | 0 | 15, 320 | |
| . 00 I | Interim payments (see instructions) | | | 0 | 750, 945 | 32 |
| | Tentative settlement (for contractor use only) | | | 0 | 0 | |
| I. 00 E | Balance due provider/program (line 31 minus lines 31.01, 32, | | | 0 | -1 | 1 |
| 1 | Protested amounts (nonallowable cost report items) in accord | | | 0 | 0 | 35 |

In Lieu of Form CMS-2552-10

Heal th Financial Systems

DEARBORN COUNTY HOSPITAL

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED

TO PROGRAM BENEFICIARIES

DEARBORN COUNTY HOSPITAL

Provider

LINA CON-Provider CCN: 15-0086 Peri od: From 01/01/2019 To 12/31/2019 Worksheet H-5 Date/Time Prepared: 6/3/2020 5:03 pm HHA CCN: 15-7055

| | | | | Home Health PPS Agency I | | |
|----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|----------|--------------------------|----------------------|----------------|
| | | Inpatien | t Part A | | t B | |
| | | mm/dd/yyyy | Amount | mm/dd/yyyy | Amount | |
| | | 1. 00 | 2. 00 | 3. 00 | 4. 00 | |
| 1. 00 2. 00 | Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero | | | 0 | 750, 945 0 | 1. 00 2. 00 |
| 3. 00 | List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider | | | | | 3. 00 |
| 3. 01 | | | | O | 0 | 3. 01 |
| 3. 02 | | | | 0 | 0 | 3. 02 |
| 3. 03 3. 04 | | | | 0 | 0 | 3. 03 3. 04 |
| 3. 05 | | | | 0 | 0 | 3. 05 |
| 0.00 | Provider to Program | | | <u> </u> | | 0.00 |
| 3.50 | | | (| O | 0 | 3. 50 |
| 3. 51 | | | | 0 | 0 | 3. 51 |
| 3. 52 | | | | O | 0 | 3. 52 |
| 3.53 | | | | 0 | 0 | 3. 53 |
| 3. 54 3. 99 | Subtotal (sum of lines 3.01-3.49 minus sum of lines | | | 0 | 0 | 3. 54 3. 99 |
| 3. 77 | 3. 50-3. 98) | | ' | 3 | ا | 3. 77 |
| 4.00 | Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32) | | (| 0 | 750, 945 | 4. 00 |
| | TO BE COMPLETED BY CONTRACTOR | | | | | |
| 5. 00 | List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) | | | | | 5. 00 |
| | Program to Provider | | | | | |
| 5. 01 | | | | O | 0 | 5. 01 |
| 5. 02 5. 03 | | | | 0 | 0 | 5. 02 5. 03 |
| 3.03 | Provider to Program | | <u> </u> | <u> </u> | 0 | 5. 05 |
| 5.50 | The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s | | (| O | 0 | 5. 50 |
| 5. 51 | | | | C | 0 | 5. 51 |
| 5. 52 | | | | O | 0 | 5. 52 |
| 5. 99 | Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) | | (| 0 | 0 | 5. 99 |
| 6. 00 | Determined net settlement amount (balance due) based on the cost report. (1) | | | | | 6. 00 |
| 6. 01 | SETTLEMENT TO PROVI DER | | | O | 0 | 6. 01 |
| 6. 02 | SETTLEMENT TO PROGRAM | | | 0 | 750.044 | 6. 02 |
| 7. 00 | Total Medicare program liability (see instructions) | | | Contractor | 750, 944 NPR Date | 7. 00 |
| | | (| 1 | Number 1.00 | (Mo/Day/Yr) 2.00 | |
| 8. 00 | Name of Contractor | | J | 1.00 | 2.00 | 8. 00 |
| 0.00 | Induite of Sofit actor | | | 1 | | 0.00 |

Provider CCN: 15-0086 Peri od: From 01/01/2019 To 12/31/2019 Worksheet 0 Date/Time Prepared: 6/3/2020 5:03 pm Hospi ce CCN: 15-1531

| SALARIES | | | | | | Hospi ce I | 0,0,2020 0.00 | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|------------------------------------|-----------|---------|----------------|------------|---------------|--------|
| SENERAL_SERVICE COST_CENTERS | | | SALARI ES | OTHER | SUBTOTAL (col. | | SUBTOTAL | |
| GENERAL SERVICE COST CENTERS | | | | | 1 plus col. 2) | | | |
| 1.00 CAP REL COSTS-BLOG & FIXT" | | | 1.00 | 2.00 | 3.00 | 4. 00 | 5. 00 | |
| 2.00 CAP REL COSTS-AWDRLE FOULP" 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | GENERAL SERVICE COST CENTERS | | | | | | |
| Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Deficition Def | 1.00 | | | C | 0 | 0 | 0 | 1.00 |
| A.000 ADMIN STRATIVE & GENERAL 140,971 38,274 179,245 0 179,245 0 0 0 0 5.00 0 0 0 0 0 0 0 0 0 | 2.00 | CAP REL COSTS-MVBLE EQUIP* | | C | 0 | 0 | 0 | 2.00 |
| 5.00 PLANT OPERATION & MAINTENANCE* 0 0 0 0 0 0 0 0 0 | 3.00 | EMPLOYEE BENEFITS DEPARTMENT* | 0 | C | 0 | 0 | 0 | 3. 00 |
| AUNDRY & LINEN SERVICE* | 4.00 | ADMINISTRATIVE & GENERAL* | 140, 971 | 38, 274 | 179, 245 | 0 | 179, 245 | 4. 00 |
| 7. 0.0 HOUSEKEEPING* 0 0 0 0 0 0 0 0 0 | 5.00 | PLANT OPERATION & MAINTENANCE* | 0 | C | 0 | 0 | 0 | 5. 00 |
| 8.00 O IFTARY* | 6.00 | LAUNDRY & LINEN SERVICE* | 0 | C | 0 | 0 | 0 | 6. 00 |
| 9.00 NURSING ADMINISTRATION* 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 7.00 | HOUSEKEEPI NG* | 0 | C | o | 0 | 0 | 7. 00 |
| 10.00 ROUTI NE NEDICAL SUPPLIES* 0 0 0 0 0 0 0 0 0 | 8.00 | DI ETARY* | 0 | C | o | 0 | 0 | 8. 00 |
| 11.00 MEDI CAL RECORDS* 22,881 0 22,881 0 0 22,881 0 12.00 12.00 12.00 13.00 0 0 0 0 0 0 0 0 0 | 9.00 | NURSING ADMINISTRATION* | 0 | C | o o | 0 | 0 | 9. 00 |
| 12. 00 STAFF TRANSPORTATION* 0 0 0 0 0 0 13. 00 14. 00 PHARMACY* 0 0 0 0 0 0 14. 00 14. 00 PHARMACY* 0 0 0 0 0 0 0 14. 00 16. 00 PHARMACY* 0 0 0 0 0 0 0 0 16. 00 OTHER GENERAL SERVICES* 0 269, 230 269, 230 0 269, 230 17. 00 OTHER GENERAL SERVICES* 0 269, 230 269, 230 0 269, 230 17. 00 OTHER GENERAL SERVICES* 0 269, 230 269, 230 0 269, 230 17. 00 OTHER GENERAL SERVICES* 0 269, 230 269, 230 0 269, 230 18. 00 RECT PATIENT ALCARE SERVICES 0 0 0 0 0 0 19. 00 0 0 0 0 0 0 0 0 19. 00 0 0 0 0 0 0 0 0 19. 00 0 0 0 0 0 0 0 0 19. 00 0 0 0 0 0 0 0 19. 00 0 0 0 0 0 0 0 19. 00 0 0 0 0 0 0 19. 00 0 0 0 0 0 0 19. 00 0 0 0 0 0 0 0 19. 00 0 0 0 0 0 0 19. 00 0 0 0 0 0 0 19. 00 0 0 0 0 0 19. 00 0 0 0 0 0 19. 00 0 0 0 0 0 19. 00 0 0 0 0 0 19. 00 0 0 0 0 0 19. 00 0 0 0 0 19. 00 0 0 0 0 19. 00 0 0 0 0 19. 00 0 0 0 0 19. 00 0 0 0 0 19. 00 0 0 0 0 19. 00 0 0 0 0 19. 00 0 0 0 0 19. 00 0 0 0 0 19. 00 0 0 0 0 19. 00 0 0 0 0 19. 00 0 0 0 0 19. 00 0 0 0 0 19. 00 0 0 0 0 19. 00 0 0 0 0 19. 00 0 0 0 0 19. 00 0 0 0 0 19. 00 0 0 0 0 19. 00 0 0 0 0 19. 00 0 0 0 0 19. 00 0 0 0 0 19. 00 0 0 0 0 19. 00 0 0 0 0 19. 00 0 0 0 0 19. 00 0 0 0 0 19. 00 0 0 0 0 19. 00 0 0 0 0 19. 00 0 0 0 0 19. 00 0 0 0 0 19. 00 0 0 0 0 19. 00 0 0 0 0 19. 00 0 0 0 0 19. 00 0 0 0 0 | 10.00 | ROUTINE MEDICAL SUPPLIES* | 0 | C | o | 0 | 0 | 10.00 |
| 12.00 STAFF TRANSPORTATION* 0 0 0 0 0 0 12.001 | 11.00 | MEDI CAL RECORDS* | 22, 881 | C | 22, 881 | o | 22, 881 | 11. 00 |
| 14. 00 PHARMACY* 0 0 0 0 0 0 14. 00 15. 00 PHYSI CIAN AND NI STRATIVE SERVICES* 0 12. 001 12. 001 12. 001 0 17. 00 PATIENT CARE SERVICE* 0 269, 230 269, 230 0 269, 230 16. 00 17. 00 PATIENT CARE SERVICE COST CENTERS 0 0 0 0 0 0 25. 00 NURSE PRACTITIONER** 0 0 0 0 0 0 0 0 26. 00 0 0 0 0 0 0 0 0 0 | 12.00 | STAFF TRANSPORTATION* | 0 | C | o | o | | 12.00 |
| 15. 00 PHYSI CIAN ADMINISTRATIVE SERVICES* 0 12, 001 12, 001 12, 001 15. 00 16. 00 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 001 17. 0 | 13.00 | VOLUNTEER SERVICE COORDINATION* | O | C | o | o | 0 | 13. 00 |
| 16. 00 | 14.00 | PHARMACY* | O | C | ol ol | o | 0 | 14.00 |
| 16. 00 OTHER GENERAL SERVICE* 0 269, 230 269, 230 0 269, 230 16. 00 | 15. 00 | PHYSICIAN ADMINISTRATIVE SERVICES* | o | 12, 001 | 12, 001 | o | 12, 001 | 15. 00 |
| 17. 00 | 16.00 | | o | | | o | | 16. 00 |
| DIRECT PATIENT CARE SERVICE COST CENTERS | 17. 00 | | | | | | · | 17. 00 |
| 25. 00 INPATIENT CARE-CONTRACTED** 0 0 0 0 25. 00 | | | l | | ' | <u>'</u> | | |
| 26. 00 PHYSICIAN SERVICES** 0 0 0 0 0 0 26. 00 27. 00 NURSE PRACTITIONER** 0 0 0 0 0 0 27. 00 28. 00 REGISTERED NURSE** 111.595 0 111.595 0 111.595 20 29. 00 LPN/LVN** 0 0 0 0 0 0 0 0 29. 00 30. 00 PHYSICIAL THERAPY** 0 0 0 0 0 0 0 0 30. 00 31. 00 OCCUPATIONAL THERAPY** 0 0 0 0 0 0 0 0 31. 00 32. 00 SPECH/LANGUAGE PATHOLOGY** 0 0 0 0 0 0 0 32. 00 33. 00 MEDI CAL SCOL AL SERVICES** 1,167 0 1,167 0 1,167 0 1,167 33. 00 34. 00 SPIRI TUAL COUNSELI NG** 8,125 0 8,125 0 8,125 34. 00 35. 00 DI TEARY COUNSELING** 0 0 0 0 0 0 0 0 0 35. 00 36. 00 COUNSELING - 0THER** 0 0 0 0 0 0 0 0 0 35. 00 36. 00 COUNSELING - 0THER** 0 0 0 0 0 0 0 0 35. 00 37. 00 HOSPICE AIDE & HOMEMAKER SERVICES** 9,498 0 9,498 0 9,498 30 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN** 0 0 0 0 0 0 0 38. 00 39. 00 PATIENT TRANSPORTATION** 0 0 0 0 0 0 0 39. 00 41. 00 LABS & DIAGNOSTICS** 0 0 34,531 34,531 -32,284 2,247 41. 00 42. 00 MEDI CAL SUPLES-NON-ROUTI NE** 0 0 0 0 0 0 0 0 0 42. 00 42. 00 MEDI CAL SUPLES-NON-ROUTI NE** 0 0 0 0 0 0 0 0 0 0 42. 00 44. 00 PALLI ATIVE CHEMOTHARY** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 25. 00 | | | C | 0 | 0 | 0 | 25. 00 |
| 27. 00 NURSE PRACTITIONER** | | PHYSI CI AN SERVI CES** | o | | | o | | |
| 28. 00 REGI STERED NURSE** 111, 595 0 LPN/LVN** 0 0 0 0 0 0 0 0 0 29.00 LPN/LVN** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | | 0 | C | | 0 | 0 | |
| 29. 00 PHYLINN** | | | 111. 595 | Ċ | 111. 595 | 0 | | |
| 30.00 PHYSI CAL THERAPY** | | LPN/LVN** | 0 | C | | 0 | | |
| 31.00 OCCUPATI ONAL THERAPY** 0 0 0 0 0 0 31.00 | | 1 | o | Ċ | ol ol | 0 | | |
| 32.00 SPECH/LANGUAGE PATHOLOGY** 0 0 0 0 0 32.00 33.00 MEDI CAL SOCI AL SERVI CES** 1,167 0 1,167 0 1,167 33.00 34.00 SPIR ITUAL COUNSELI NG** 8,125 0 8,125 0 8,125 34.00 35.00 DI ETARY COUNSELI NG** 0 0 0 0 0 0 35.00 36.00 COUNSELI NG* - OTHER** 0 0 0 0 0 0 36.00 37.00 HOSPI CE AI DE & HOMEMAKER SERVI CES** 9,498 0 9,498 0 9,498 0 9,498 77.00 38.00 DURABLE MEDI CAL EQUI PMENT/OXYGEN** 0 0 0 0 0 0 38.00 39.00 PATILENT TRANSPORTATI ON** 0 0 0 0 0 0 0 0 41.00 LABS & DI AGNOSTI CS** 0 0 0 0 0 0 0 42.50 MEDI CAL SUPPLI ES-NON-ROUTI NE** 0 0 0 0 0 0 0 42.50 VALUAR ANGED TO PATILENTS** 0 0 0 0 0 0 0 44.00 PALLI ATI VE CHEMOTHERAPY** 0 0 0 0 0 0 0 46.00 OTHER PATIENT CARE SERVI CES (SPECI FY)** 0 0 0 0 0 0 60.00 ERERAVEMENT PROGRAM * 0 0 0 0 0 0 0 60.00 FUNDRAI SI NG* 0 0 0 0 0 0 60.00 OTHER PHYSI CIAN SERVI CES* 0 0 0 0 0 60.00 OTHER PROGRAM * 0 0 0 0 0 0 60.00 OTHER PHYSI CIAN SERVI CES* 0 0 0 0 0 60.00 OTHER PHYSI CIAN SERVI CES* 0 0 0 0 0 60.00 OTHER PHYSI CIAN SERVI CES* 0 0 0 0 0 60.00 OTHER PHYSI CIAN SERVI CES* 0 0 0 0 0 60.00 OTHER PHYSI CIAN SERVI CES* 0 0 0 0 0 60.00 OTHER PHYSI CIAN SERVI CES* 0 0 0 0 0 60.00 OTHER PHYSI CIAN SERVI CES* 0 0 0 0 0 60.00 OTHER PHYSI CIAN SERVI CES* 0 0 0 0 0 60.00 OTHER PHYSI CIAN SERVI CES* 0 0 0 0 60.00 OTHER PHYSI CIAN SERVI CES* 0 0 0 0 0 60.00 OTHER PHYSI CIAN SERVI CES* 0 0 0 0 0 60.00 OTHER PHYSI CIAN SERVI CES* 0 0 0 0 0 60.00 OTHER PHYSI CIAN SERVI CES* 0 0 0 0 0 60.00 OTHER PHYSI CIAN SERVI CES* 0 0 0 0 0 60.00 OTHER PHYS | | | o | C | ol ol | o | 0 | |
| 33.00 MEDICAL SOCIAL SERVICES** 1, 167 0 1, 167 0 0 1, 167 33.00 34.00 SPIRI TUAL COUNSELING** 8, 125 0 8, 125 34.00 35.00 DIETARY COUNSELING** 0 0 0 0 0 0 35.00 36.00 COUNSELING - OTHER** 0 0 0 0 0 0 0 37.00 HOSPICE AIDE & HOMEMAKER SERVICES** 9, 498 0 9, 498 0 9, 498 0 9, 498 37.00 38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN** 0 0 0 0 0 0 0 39.00 PATIENT TRANSPORTATION** 0 0 0 0 0 0 0 41.00 LABS & DIAGNOSTICS** 0 34,531 34,531 -32,284 2,247 41.00 42.00 MEDICAL SUPPLIES-NON-ROUTINE** 0 0 0 0 0 0 42.00 MEDICAL SUPPLIES-NON-ROUTINE** 0 0 0 0 0 0 42.50 DRUGS CHARGED TO PATIENTS** 0 0 0 0 0 0 43.00 UTPATIENT SERVICES** 0 0 0 0 0 0 44.00 PALLIATIVE RABIATION THERAPY** 0 0 0 0 0 0 45.00 PALLIATIVE CHEMOTHERAPY** 0 0 0 0 0 0 46.00 THER PATIENT CARE SERVICES (SPECIFY)** 0 0 0 0 0 0 60.00 61.00 O D 0 0 0 0 61.00 O DALLIATIVE CARE PROGRAM * 0 0 0 0 0 61.00 O DALLIATIVE CARE PROGRAM * 0 0 0 0 0 65.00 O O O O 0 0 66.00 RESIDENTIAL CARE* 0 0 0 0 0 66.00 RESIDENTIAL CARE* 0 0 0 0 66.00 RESIDENTIAL CARE* 0 0 0 0 66.00 RESIDENTIAL CARE* 0 0 0 0 66.00 RESIDENTIAL CARE* 0 0 0 0 66.00 RESIDENTIAL CARE* 0 0 0 0 66.00 RESIDENTIAL CARE* 0 0 0 0 66.00 RESIDENTIAL CARE* 0 0 0 0 66.00 RESIDENTIAL CARE* 0 0 0 0 67.00 0 0 0 0 0 67.00 0 0 0 0 0 67.00 0 0 0 0 0 67.00 0 0 0 0 0 67.00 0 0 0 0 0 67.00 0 0 0 0 67.00 0 0 0 0 0 67.00 0 0 0 0 0 67.00 0 0 0 0 0 67.00 0 0 0 0 0 67.00 0 0 0 0 0 67.00 0 0 0 0 0 67.00 0 | | | o | C | ol ol | o | 0 | |
| 34.00 SPIRITUAL COUNSELING** S, 125 O S, 125 O O O O O O O O O | | | 1. 167 | Ċ | 1. 167 | 0 | 1. 167 | |
| 35.00 DIETARY COUNSELING** 0 0 0 0 0 0 0 0 0 35.00 | | | l ' l | C | | 0 | | |
| 36. 00 COUNSELING - OTHER** | | | 1 | Ċ | | 0 | | |
| 37. 00 HOSPICE AIDE & HOMEMAKER SERVICES** 9, 498 0 9, 498 0 0 9, 498 37. 00 38. 00 DURABLE MEDICAL EQUI PMENT/OXYGEN** 0 0 0 0 0 0 0 38. 00 39. 00 PATIENT TRANSPORTATION** 0 0 0 0 0 0 0 39. 00 40. 00 IMAGI NG SERVICES** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | | o | Ċ | ol ol | 0 | | |
| 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN** 0 0 0 0 0 0 0 38. 00 39. 00 PATI ENT TRANSPORTATI ON** 0 0 0 0 0 0 39. 00 40. 00 IMAGI NG SERVI CES** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | | 9, 498 | C | 9, 498 | 0 | 9. 498 | 37.00 |
| 39.00 PATIENT TRANSPORTATION** 0 0 0 0 0 0 0 0 0 39.00 40.00 IMAGING SERVICES** 0 0 0 0 0 0 0 0 0 0 40.00 41.00 LABS & DIAGNOSTICS** 0 34,531 34,531 -32,284 2,247 41.00 42.00 MEDICAL SUPPLIES-NON-ROUTINE** 0 0 0 0 0 0 0 0 42.50 DRUGS CHARGED TO PATIENTS** 0 0 0 0 0 0 0 0 42.50 43.00 OUTPATIENT SERVICES** 0 0 0 0 0 0 0 0 0 43.00 44.00 PALLIATIVE RADIATION THERAPY** 0 0 0 0 0 0 0 0 0 0 44.00 45.00 PALLIATIVE CHEMOTHERAPY** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | | 0 | Ċ | | 0 | • | |
| 40.00 IMAGI NG SERVI CES** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | | 0 | Ċ | ol ol | 0 | | |
| 41. 00 LABS & DI AGNOSTI CS** 0 34, 531 34, 531 -32, 284 2, 247 41. 00 42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE** 0 0 0 0 0 0 0 42. 00 42. 50 DRUGS CHARGED TO PATI ENTS** 0 0 0 0 0 0 0 0 42. 50 43. 00 OUTPATI ENT SERVI CES** 0 0 0 0 0 0 0 0 0 43. 00 44. 00 PALLI ATI VE RADI ATI ON THERAPY** 0 0 0 0 0 0 0 0 44. 00 45. 00 PALLI ATI VE CHEMOTHERAPY** 0 0 0 0 0 0 0 0 44. 00 46. 00 OTHER PATI ENT CARE SERVI CES (SPECI FY)** 0 0 0 0 0 0 0 0 0 46. 00 NONREI MBURSABLE COST CENTERS 60. 00 BEREAVEMENT PROGRAM * 0 0 0 0 0 0 0 0 0 61. 00 61. 00 VOLUNTEER PROGRAM * 0 0 0 0 0 0 0 0 62. 00 63. 00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS* 0 0 0 0 0 0 0 0 0 0 65. 00 64. 00 PALLI ATI VE CARE PROGRAM* 0 0 0 0 0 0 0 0 65. 00 65. 00 OTHER PHYSI CI AN SERVI CES* 0 0 0 0 0 0 0 0 65. 00 66. 00 RESI DENTI AL CARE* | | | 0 | Ċ | ol ol | 0 | | |
| 42. 00 MEDICAL SUPPLIES-NON-ROUTINE** 0 0 0 0 0 0 42. 00 42. 50 DRUGS CHARGED TO PATIENTS** 0 0 0 0 0 0 0 42. 50 43. 00 OUTPATIENT SERVICES** 0 0 0 0 0 0 0 0 43. 00 44. 00 PALLIATIVE RADIATION THERAPY** 0 0 0 0 0 0 0 44. 00 45. 00 PALLIATIVE CHEMOTHERAPY** 0 0 0 0 0 0 0 45. 00 46. 00 OTHER PATIENT CARE SERVICES (SPECIFY)** 0 0 0 0 0 0 0 0 45. 00 NONREIMBURSABLE COST CENTERS 60. 00 BEREAVEMENT PROGRAM * 0 0 0 0 0 0 0 0 60. 00 61. 00 VOLUNTEER PROGRAM * 0 0 0 0 0 0 0 61. 00 62. 00 FUNDRAI SI NG* 0 0 0 0 0 0 62. 00 63. 00 HOSPI CE/PALLIATIVE MEDICINE FELLOWS* 0 0 0 0 0 0 65. 00 64. 00 PALLIATIVE CARE PROGRAM* 0 0 0 0 0 0 65. 00 65. 00 OTHER PHYSICIAN SERVICES* 0 0 0 0 0 0 66. 00 66. 00 RESI DENTIAL CARE* | | | 0 | 34 531 | 34 531 | -32 284 | 2 247 | |
| 42.50 DRUGS CHARGED TO PATIENTS** 0 0 0 0 0 0 42.50 43.00 OUTPATIENT SERVICES** 0 0 0 0 0 0 0 43.00 44.00 PALLIATIVE RADIATION THERAPY** 0 0 0 0 0 0 0 44.00 45.00 PALLIATIVE CHEMOTHERAPY** 0 0 0 0 0 0 0 0 45.00 46.00 OTHER PATIENT CARE SERVICES (SPECIFY)** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | | o | | | 02,201 | | |
| 43.00 OUTPATIENT SERVICES** O O O O O O O O O O O O O O O O O O | | | o | Č | | 0 | | |
| 44.00 PALLIATIVE RADIATION THERAPY** 0 0 0 0 0 44.00 45.00 PALLIATIVE CHEMOTHERAPY** 0 0 0 0 0 45.00 46.00 OTHER PATIENT CARE SERVICES (SPECIFY)** 0 0 0 0 0 46.00 NONREI MBURSABLE COST CENTERS 60.00 BEREAVEMENT PROGRAM * 0 0 0 0 0 0 60.00 61.00 VOLUNTEER PROGRAM * 0 0 0 0 0 61.00 62.00 FUNDRAI SI NG* 0 0 0 0 0 61.00 63.00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS* 0 0 0 0 0 63.00 64.00 PALLI ATI VE CARE PROGRAM* 0 0 0 0 0 64.00 65.00 OTHER PHYSI CI AN SERVI CES* 0 0 0 0 0 65.00 66.00 RESI DENTI AL CARE* 0 0 0 0 0 66.00 | | | o | Č | | 0 | | |
| 45. 00 PALLIATIVE CHEMOTHERAPY** 0 0 0 0 0 0 45. 00 46. 00 OTHER PATIENT CARE SERVICES (SPECIFY)** 0 0 0 0 0 0 46. 00 NONREIMBURSABLE COST CENTERS 60. 00 BEREAVEMENT PROGRAM * 0 0 0 0 0 0 61. 00 61. 00 VOLUNTEER PROGRAM * 0 0 0 0 0 0 61. 00 62. 00 FUNDRAI SI NG* 0 0 0 0 0 0 63. 00 63. 00 HOSPI CE/PALLIATIVE MEDICINE FELLOWS* 0 0 0 0 0 0 63. 00 64. 00 PALLIATIVE CARE PROGRAM* 0 0 0 0 0 0 64. 00 65. 00 OTHER PHYSI CI AN SERVICES* 0 0 0 0 0 0 65. 00 66. 00 RESI DENTIAL CARE* | | | o | Č | | 0 | - | |
| 46.00 OTHER PATIENT CARE SERVICES (SPECIFY)** 0 0 0 0 0 0 0 46.00 NONREIMBURSABLE COST CENTERS 60.00 BEREAVEMENT PROGRAM * 0 0 0 0 0 0 0 60.00 61.00 62.00 62.00 FUNDRAI SI NG* 0 0 0 0 0 0 62.00 63.00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS* 0 0 0 0 0 0 63.00 64.00 PALLI ATI VE CARE PROGRAM* 0 0 0 0 0 0 65.00 65.00 OTHER PHYSI CI AN SERVI CES* 0 0 0 0 0 0 65.00 66.00 RESI DENTI AL CARE* | | | o | Ċ | ol ol | 0 | | |
| NONREI MBURSABLE COST CENTERS | | | o | Č | | 0 | | |
| 60. 00 BEREAVEMENT PROGRAM * 0 0 0 0 0 0 60. 00 61. 00 61. 00 0 0 0 0 0 61. 00 62. 00 62. 00 FUNDRAI SI NG* 0 0 0 0 0 0 62. 00 63. 00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS* 0 0 0 0 0 0 63. 00 64. 00 PALLI ATI VE CARE PROGRAM* 0 0 0 0 0 0 64. 00 65. 00 0 0 0 0 65. 00 0 0 0 0 65. 00 66. 00 RESI DENTI AL CARE* 0 0 0 0 0 0 0 66. 00 | 10.00 | ` / | <u> </u> | | ,1 | <u> </u> | | 10.00 |
| 61. 00 VOLUNTEER PROGRAM * 0 0 0 0 0 61. 00 62. 00 63. 00 64. 00 0 0 0 0 62. 00 63. 00 64. 00 9 0 0 0 0 0 63. 00 64. 00 9 0 0 0 0 0 0 64. 00 65. 00 0 0 0 0 0 0 0 65. 00 66. 00 RESI DENTI AL CARE* | 60. 00 | | 0 | C | 0 | 0 | 0 | 60.00 |
| 62. 00 FUNDRAI SI NG* 0 0 0 0 0 0 62. 00 63. 00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS* 0 0 0 0 0 0 63. 00 64. 00 PALLI ATI VE CARE PROGRAM* 0 0 0 0 0 0 64. 00 65. 00 OTHER PHYSI CI AN SERVI CES* 0 0 0 0 0 0 65. 00 66. 00 RESI DENTI AL CARE* 0 0 0 0 0 0 66. 00 | | 1 | o | | | - 1 | | |
| 63. 00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS* 0 0 0 0 63. 00 64. 00 9 ALLI ATI VE CARE PROGRAM* 0 0 0 0 0 64. 00 65. 00 0 0 0 0 65. 00 66. 00 RESI DENTI AL CARE* 0 0 0 0 0 0 66. 00 | | 1 | o | Č | | 0 | | |
| 64. 00 PALLIATIVE CARE PROGRAM* 0 0 0 0 0 64. 00 65. 00 0 THER PHYSICIAN SERVICES* 0 0 0 0 0 65. 00 66. 00 RESIDENTIAL CARE* 0 0 0 0 0 66. 00 | | 1 | o o | Č | ól ől | 0 | | |
| 65. 00 OTHER PHYSICIAN SERVICES* 0 0 0 0 65. 00 66. 00 RESIDENTIAL CARE* 0 0 0 0 66. 00 | | | o o | Č | ól ől | 0 | | |
| 66. 00 RESI DENTI AL CARE* 0 0 0 0 0 66. 00 | | | o o | Č | 1 1 | 0 | | |
| | | | | (| | 0 | | • |
| 67 OO JADVERTISING* OI OI OI OI OI OI OI OI OI OI OI OI OI | 67. 00 | ADVERTI SI NG* | | (| | 0 | 0 | 67. 00 |
| 68. 00 TELEHEALTH/TELEMONI TORI NG* | | | | (| | o o | - | |
| 69. 00 THRIFT STORE* 0 0 0 0 0 69. 00 | | | | (| | 0 | | |
| 70. 00 NURSING FACILITY ROOM & BOARD* 0 0 0 70. 00 | | | | (| | 0 | - | |
| 71. 00 OTHER NONREI MBURSABLE (SPECI FY)* 0 4, 187 4, 187 0 4, 187 71. 00 | | | | ∆ 197 | 4 197 | o O | | |
| 100. 00 TOTAL 294, 237 358, 223 652, 460 -32, 284 620, 176 100. 00 | | | 294 237 | | | -32 284 | | |
| * Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate. | | | - | | | 5=, =0 1 | , ., 0 | |

^{*} Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate. ** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

| | | | · | | 6/3/2020 5: 0: | 3 pm |
|--------|------------------------------------------|-------------|---------------|------------|----------------|---------|
| | | | | Hospi ce I | | |
| | | ADJUSTMENTS | TOTAL (col. 5 | | | |
| | | / 00 | ± col. 6) | | | |
| | GENERAL SERVICE COST CENTERS | 6. 00 | 7.00 | | | |
| 1.00 | CAP REL COSTS-BLDG & FLXT* | 1 0 | ol ol | | | 1.00 |
| 2. 00 | CAP REL COSTS-MVBLE EQUIP* | | 1 | | | 2. 00 |
| 3.00 | EMPLOYEE BENEFITS DEPARTMENT* | | 1 | | | 3. 00 |
| 4.00 | ADMINISTRATIVE & GENERAL* | | 1 | | | 4. 00 |
| 5. 00 | PLANT OPERATION & MAINTENANCE* | | 0 | | | 5. 00 |
| 6. 00 | LAUNDRY & LINEN SERVICE* | | | | | 6. 00 |
| 7. 00 | HOUSEKEEPI NG* | | | | | 7. 00 |
| 8. 00 | DI ETARY* | | | | | 8. 00 |
| 9. 00 | NURSING ADMINISTRATION* | 0 | ol ol | | | 9. 00 |
| 10.00 | ROUTI NE MEDI CAL SUPPLI ES* | | ا ا | | | 10.00 |
| 11. 00 | MEDI CAL RECORDS* | | 1 | | | 11. 00 |
| 12. 00 | STAFF TRANSPORTATION* | 0 | | | | 12. 00 |
| 13. 00 | VOLUNTEER SERVICE COORDINATION* | 0 | ol ol | | | 13. 00 |
| 14. 00 | PHARMACY* | 0 | ol ol | | | 14. 00 |
| 15. 00 | PHYSICIAN ADMINISTRATIVE SERVICES* | 0 | 12, 001 | | | 15. 00 |
| 16. 00 | OTHER GENERAL SERVICE* | 0 | 1 | | | 16. 00 |
| 17. 00 | PATIENT/RESIDENTIAL CARE SERVICES | | | | | 17. 00 |
| | DIRECT PATIENT CARE SERVICE COST CENTERS | | <u>'</u> | | | |
| 25.00 | INPATIENT CARE-CONTRACTED** | 0 | 0 | | | 25. 00 |
| 26.00 | PHYSI CI AN SERVI CES** | 0 | 1 1 | | | 26. 00 |
| 27.00 | NURSE PRACTITIONER** | 0 | ol ol | | | 27. 00 |
| 28.00 | REGI STERED NURSE** | 0 | 111, 595 | | | 28. 00 |
| 29.00 | LPN/LVN** | 0 | ol ol | | | 29. 00 |
| 30.00 | PHYSI CAL THERAPY** | 0 | ol ol | | | 30.00 |
| 31.00 | OCCUPATIONAL THERAPY** | 0 | 0 | | | 31.00 |
| 32.00 | SPEECH/LANGUAGE PATHOLOGY** | 0 | 0 | | | 32.00 |
| 33.00 | MEDICAL SOCIAL SERVICES** | 0 | 1, 167 | | | 33. 00 |
| 34.00 | SPIRITUAL COUNSELING** | 0 | 8, 125 | | | 34.00 |
| 35. 00 | DI ETARY COUNSELI NG** | 0 | 0 | | | 35. 00 |
| 36.00 | COUNSELING - OTHER** | 0 | 0 | | | 36. 00 |
| 37.00 | HOSPICE AIDE & HOMEMAKER SERVICES** | 0 | 9, 498 | | | 37. 00 |
| 38. 00 | DURABLE MEDICAL EQUIPMENT/OXYGEN** | 0 | 0 | | | 38. 00 |
| 39. 00 | PATIENT TRANSPORTATION** | 0 | 0 | | | 39. 00 |
| 40.00 | I MAGING SERVI CES** | 0 | 0 | | | 40.00 |
| 41.00 | LABS & DIAGNOSTICS** | 0 | 2, 247 | | | 41. 00 |
| 42.00 | MEDICAL SUPPLIES-NON-ROUTINE** | 0 | 0 | | | 42. 00 |
| 42. 50 | DRUGS CHARGED TO PATIENTS** | 0 | 0 | | | 42. 50 |
| 43.00 | OUTPATI ENT SERVI CES** | 0 | 0 | | | 43. 00 |
| 44. 00 | PALLIATIVE RADIATION THERAPY** | 0 | 이 | | | 44. 00 |
| 45. 00 | PALLIATIVE CHEMOTHERAPY** | 0 | 1 | | | 45. 00 |
| 46. 00 | OTHER PATIENT CARE SERVICES (SPECIFY)** | 0 | 0 | | | 46. 00 |
| | NONREI MBURSABLE COST CENTERS | | | | | |
| 60. 00 | BEREAVEMENT PROGRAM * | 0 | 1 | | | 60.00 |
| 61. 00 | VOLUNTEER PROGRAM * | 0 | 1 | | | 61.00 |
| 62. 00 | FUNDRAI SI NG* | 0 | 1 | | | 62. 00 |
| 63.00 | HOSPICE/PALLIATIVE MEDICINE FELLOWS* | 0 | 1 | | | 63.00 |
| 64.00 | 1 | 0 | 1 | | | 64. 00 |
| 65. 00 | 1 | 0 | 1 | | | 65. 00 |
| 66.00 | RESI DENTI AL CARE* | 0 | 0 | | | 66. 00 |
| 67. 00 | | 0 | 0 | | | 67. 00 |
| 68.00 | | 0 | 1 | | | 68. 00 |
| 69. 00 | | 0 | 1 | | | 69. 00 |
| 70.00 | | 0 | 1 | | | 70.00 |
| 71.00 | ` ′ | -4, 187 | | | | 71. 00 |
| 100.00 | TOTAL | -4, 187 | 615, 989 | | | 100. 00 |

^{*} Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate. ** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

Peri od: From 01/01/2019 To 12/31/2019 Date/Ti me Prepared: 6/3/2020 5:03 pm HOME CARE Hospi ce CCN: 15-1531

| | | | | | Hospi ce I | | |
|--------|---------------------------------------------|---------------|-------|----------------|---------------|----------|--------|
| | | SALARI ES | OTHER | SUBTOTAL (col. | RECLASSI FI - | SUBTOTAL | |
| | | | | 1 + col. 2) | CATI ONS | | |
| | | 1.00 | 2.00 | 3.00 | 4. 00 | 5. 00 | |
| | DIRECT PATIENT CARE SERVICE COST CENTERS | | | | | | |
| 25. 00 | I NPATIENT CARE-CONTRACTED | | | | | | 25. 00 |
| 26. 00 | PHYSI CI AN SERVI CES | 0 | 0 | 0 | 0 | 0 | 26. 00 |
| 27. 00 | NURSE PRACTITIONER | 0 | 0 | 0 | 0 | 0 | 27. 00 |
| 28. 00 | REGI STERED NURSE | 0 | 0 | 0 | 0 | 0 | 28. 00 |
| 29. 00 | LPN/LVN | 0 | 0 | 0 | 0 | 0 | 29. 00 |
| 30.00 | PHYSI CAL THERAPY | 0 | 0 | 0 | 0 | 0 | 30.00 |
| 31.00 | OCCUPATI ONAL THERAPY | 0 | 0 | 0 | 0 | 0 | 31. 00 |
| 32.00 | SPEECH/LANGUAGE PATHOLOGY | 0 | 0 | 0 | 0 | 0 | 32. 00 |
| 33.00 | MEDICAL SOCIAL SERVICES | 0 | 0 | 0 | 0 | 0 | 33. 00 |
| 34.00 | SPIRITUAL COUNSELING | 0 | 0 | 0 | 0 | 0 | 34. 00 |
| 35.00 | DI ETARY COUNSELI NG | 0 | 0 | 0 | 0 | 0 | 35. 00 |
| 36.00 | COUNSELING - OTHER | 0 | 0 | 0 | 0 | 0 | 36. 00 |
| 37.00 | HOSPICE AIDE & HOMEMAKER SERVICES | 0 | 0 | 0 | 0 | 0 | 37. 00 |
| 38. 00 | DURABLE MEDICAL EQUIPMENT/OXYGEN | 0 | 0 | 0 | 0 | 0 | 38. 00 |
| 39. 00 | PATI ENT TRANSPORTATION | 0 | 0 | 0 | 0 | 0 | 39. 00 |
| 40.00 | I MAGI NG SERVI CES | 0 | 0 | 0 | 0 | 0 | 40. 00 |
| 41.00 | LABS & DIAGNOSTICS | 0 | 0 | 0 | 0 | 0 | 41. 00 |
| 42.00 | MEDICAL SUPPLIES-NON-ROUTINE | 0 | 0 | 0 | 0 | 0 | 42. 00 |
| 42. 50 | DRUGS CHARGED TO PATIENTS | 0 | 0 | 0 | 0 | 0 | 42. 50 |
| 43.00 | OUTPATI ENT SERVI CES | 0 | 0 | 0 | 0 | 0 | 43. 00 |
| 44.00 | PALLIATIVE RADIATION THERAPY | 0 | 0 | 0 | 0 | 0 | 44. 00 |
| 45.00 | PALLIATIVE CHEMOTHERAPY | 0 | 0 | 0 | 0 | 0 | 45. 00 |
| 46.00 | OTHER PATIENT CARE SERVICES (SPECIFY) | 0 | 0 | 0 | 0 | 0 | 46. 00 |
| 100.00 | TOTAL * | 0 | 0 | 0 | 0 | 0 | 100.00 |
| * Tran | sfer the amount in column 7 to Wkst 0-5 col | umn 1 line 50 | | | | | |

Transfer the amount in column 7 to Wkst. 0-5, column 1, line 50.

| | | ADJUSTMENTS | TOTAL (col E | |
|--------|------------------------------------------|---------------|----------------------------|--------|
| | | ADJUSTIVIENTS | TOTAL (col. 5 ± col. 6) | |
| | | 6. 00 | 7.00 | |
| | DIRECT PATIENT CARE SERVICE COST CENTERS | 0.00 | 7.00 | |
| 25.00 | I NPATI ENT CARE-CONTRACTED | | | 25. 00 |
| 26.00 | PHYSI CI AN SERVI CES | 0 | 0 | 26. 00 |
| 27.00 | NURSE PRACTITIONER | 0 | 0 | 27. 00 |
| 28.00 | REGI STERED NURSE | 0 | 0 | 28. 00 |
| 29.00 | LPN/LVN | 0 | 0 | 29. 00 |
| 30.00 | PHYSI CAL THERAPY | 0 | 0 | 30.00 |
| 31.00 | OCCUPATIONAL THERAPY | 0 | 0 | 31.00 |
| 32.00 | SPEECH/LANGUAGE PATHOLOGY | 0 | 0 | 32. 00 |
| 33.00 | MEDICAL SOCIAL SERVICES | 0 | 0 | 33.00 |
| 34.00 | SPI RI TUAL COUNSELI NG | 0 | 0 | 34.00 |
| 35.00 | DI ETARY COUNSELING | 0 | 0 | 35.00 |
| 36.00 | COUNSELING - OTHER | 0 | 0 | 36.00 |
| 37.00 | HOSPICE AIDE & HOMEMAKER SERVICES | 0 | 0 | 37. 00 |
| 38. 00 | DURABLE MEDICAL EQUIPMENT/OXYGEN | 0 | 0 | 38. 00 |
| 39. 00 | PATI ENT TRANSPORTATION | 0 | 0 | 39. 00 |
| 40.00 | I MAGI NG SERVI CES | 0 | 0 | 40. 00 |
| 41.00 | LABS & DIAGNOSTICS | 0 | 0 | 41. 00 |
| 42.00 | MEDICAL SUPPLIES-NON-ROUTINE | 0 | 0 | 42. 00 |
| 42. 50 | DRUGS CHARGED TO PATIENTS | 0 | 0 | 42. 50 |
| 43.00 | OUTPATIENT SERVICES | 0 | 0 | 43.00 |
| 44.00 | PALLIATIVE RADIATION THERAPY | 0 | 0 | 44. 00 |
| 45.00 | PALLI ATI VE CHEMOTHERAPY | 0 | 0 | 45. 00 |
| | OTHER PATIENT CARE SERVICES (SPECIFY) | 0 | 0 | 46. 00 |
| 100.00 | TOTAL * | 0 | 0 | 100.00 |

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 50.

Hospi ce CCN: 15-1531

Peri od: Worksheet 0-2 From 01/01/2019 To 12/31/2019

Date/Time Prepared: 6/3/2020 5:03 pm

| | | | | | 6/3/2020 5:03 | pm |
|---------------------------------------------|-----------|---------|----------------|--------------|---------------|---------|
| | | | | Hospi ce I | | |
| | SALARI ES | OTHER | SUBTOTAL (col. | RECLASSIFI - | SUBTOTAL | |
| | | | 1 + col. 2) | CATI ONS | | |
| | 1. 00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | |
| DIRECT PATIENT CARE SERVICE COST CENTERS | | | | | | |
| 25. 00 I NPATI ENT CARE-CONTRACTED | | | | | | 25. 00 |
| 26. 00 PHYSI CI AN SERVI CES | 0 | 0 | 0 | 0 | 0 | 26. 00 |
| 27. 00 NURSE PRACTITIONER | 0 | 0 | 0 | 0 | 0 | 27. 00 |
| 28. 00 REGI STERED NURSE | 86, 180 | 0 | 86, 180 | 0 | 86, 180 | 28. 00 |
| 29. 00 LPN/LVN | 0 | 0 | 0 | 0 | 0 | 29. 00 |
| 30. 00 PHYSI CAL THERAPY | 0 | 0 | 0 | 0 | 0 | 30.00 |
| 31. 00 OCCUPATI ONAL THERAPY | 0 | 0 | 0 | 0 | 0 | 31. 00 |
| 32.00 SPEECH/LANGUAGE PATHOLOGY | 0 | 0 | 0 | 0 | 0 | 32. 00 |
| 33.00 MEDICAL SOCIAL SERVICES | 901 | 0 | 901 | 0 | 901 | 33. 00 |
| 34. 00 SPIRITUAL COUNSELING | 6, 275 | 0 | 6, 275 | 0 | 6, 275 | 34.00 |
| 35. 00 DI ETARY COUNSELI NG | 0 | 0 | 0 | 0 | 0 | 35. 00 |
| 36. 00 COUNSELING - OTHER | 0 | 0 | 0 | 0 | 0 | 36. 00 |
| 37.00 HOSPICE AIDE & HOMEMAKER SERVICES | 7, 335 | 0 | 7, 335 | 0 | 7, 335 | 37. 00 |
| 38. 00 DURABLE MEDICAL EQUIPMENT/OXYGEN | 0 | 0 | 0 | 0 | 0 | 38. 00 |
| 39. 00 PATI ENT TRANSPORTATION | 0 | 0 | 0 | 0 | 0 | 39. 00 |
| 40. 00 I MAGI NG SERVI CES | 0 | 0 | 0 | 0 | 0 | 40. 00 |
| 41.00 LABS & DIAGNOSTICS | 0 | 34, 531 | 34, 531 | -32, 284 | 2, 247 | 41. 00 |
| 42. 00 MEDICAL SUPPLIES-NON-ROUTINE | 0 | 0 | 0 | 0 | 0 | 42. 00 |
| 42.50 DRUGS CHARGED TO PATIENTS | 0 | 0 | 0 | 0 | 0 | 42. 50 |
| 43. 00 OUTPATIENT SERVICES | 0 | 0 | 0 | 0 | 0 | 43.00 |
| 44.00 PALLIATIVE RADIATION THERAPY | 0 | 0 | 0 | 0 | 0 | 44. 00 |
| 45. 00 PALLIATIVE CHEMOTHERAPY | 0 | 0 | 0 | 0 | 0 | 45. 00 |
| 46.00 OTHER PATIENT CARE SERVICES (SPECIFY) | 0 | 0 | 0 | 0 | 0 | 46. 00 |
| 100. 00 TOTAL * | 100, 691 | 34, 531 | 135, 222 | -32, 284 | 102, 938 | 100. 00 |
| * T | l 1 | | | | | |

 $^{^{\}star}$ Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

| | | AD ILICTMENTS | TOTAL (L E | |
|--------|------------------------------------------|---------------|---------------|--------|
| | | ADJUSTMENTS | TOTAL (col. 5 | |
| | | 6. 00 | ± col. 6) | |
| | DIRECT PATIENT CARE SERVICE COST CENTERS | 6.00 | 7.00 | |
| 25. 00 | | I | T | 25. 00 |
| | I NPATI ENT CARE-CONTRACTED | | | |
| 26. 00 | PHYSI CI AN SERVI CES | 0 | 0 | 26. 00 |
| 27. 00 | NURSE PRACTITIONER | 0 | 0 100 | 27. 00 |
| 28. 00 | REGI STERED NURSE | 0 | 86, 180 | 28. 00 |
| 29. 00 | LPN/LVN | 0 | 0 | 29. 00 |
| 30. 00 | PHYSI CAL THERAPY | 0 | 0 | 30.00 |
| 31. 00 | OCCUPATI ONAL THERAPY | 0 | 0 | 31.00 |
| 32. 00 | SPEECH/LANGUAGE PATHOLOGY | 0 | 0 | 32. 00 |
| 33.00 | MEDICAL SOCIAL SERVICES | 0 | 901 | 33. 00 |
| 34.00 | SPI RI TUAL COUNSELI NG | 0 | 6, 275 | 34.00 |
| 35.00 | DI ETARY COUNSELING | 0 | 0 | 35. 00 |
| 36.00 | COUNSELI NG - OTHER | 0 | 0 | 36. 00 |
| 37.00 | HOSPICE AIDE & HOMEMAKER SERVICES | 0 | 7, 335 | 37. 00 |
| 38.00 | DURABLE MEDICAL EQUIPMENT/OXYGEN | 0 | 0 | 38. 00 |
| 39.00 | PATIENT TRANSPORTATION | 0 | 0 | 39. 00 |
| 40.00 | I MAGING SERVICES | 0 | 0 | 40.00 |
| 41.00 | LABS & DIAGNOSTICS | 0 | 2, 247 | 41.00 |
| 42.00 | MEDICAL SUPPLIES-NON-ROUTINE | 0 | o | 42. 00 |
| 42.50 | DRUGS CHARGED TO PATIENTS | 0 | o | 42. 50 |
| 43.00 | OUTPATIENT SERVICES | 0 | o | 43.00 |
| 44.00 | PALLIATIVE RADIATION THERAPY | 0 | ol | 44. 00 |
| 45. 00 | PALLIATIVE CHEMOTHERAPY | 0 | o | 45. 00 |
| 46. 00 | OTHER PATIENT CARE SERVICES (SPECIFY) | 0 | o | 46. 00 |
| 100.00 | TOTAL * | 0 | 102, 938 | 100.00 |

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

INPATIENT CARE

Peri od: Worksheet 0-4 Hospi ce CCN: 15-1531 To 12/31/2019 Date/Time Prepared:

| | | · | | | 6/3/2020 5:03 | pm |
|--------------------------------------------------|----------------|-------|----------------|--------------|---------------|--------|
| | | | | Hospi ce I | | |
| | SALARI ES | OTHER | SUBTOTAL (col. | RECLASSIFI - | SUBTOTAL | |
| | | | 1 + col . 2) | CATI ONS | | |
| | 1.00 | 2.00 | 3.00 | 4. 00 | 5. 00 | |
| DIRECT PATIENT CARE SERVICE COST CENTERS | | | | | | |
| 25. 00 INPATIENT CARE-CONTRACTED | | (| 0 0 | 0 | 0 | 25. 00 |
| 26. 00 PHYSI CI AN SERVI CES | 0 | (| 0 0 | 0 | 0 | 26. 00 |
| 27. 00 NURSE PRACTITIONER | 0 | (| 0 0 | 0 | 0 | 27. 00 |
| 28. 00 REGI STERED NURSE | 25, 415 | (| 25, 415 | 0 | 25, 415 | 28. 00 |
| 29. 00 LPN/LVN | 0 | (| 0 (c | 0 | 0 | 29. 00 |
| 30. 00 PHYSI CAL THERAPY | 0 | (| 0 (c | 0 | 0 | 30.00 |
| 31. 00 OCCUPATI ONAL THERAPY | 0 | (| 0 (c | 0 | 0 | 31.00 |
| 32.00 SPEECH/LANGUAGE PATHOLOGY | 0 | (| 0 0 | 0 | 0 | 32. 00 |
| 33.00 MEDICAL SOCIAL SERVICES | 266 | (| 266 | 0 | 266 | 33. 00 |
| 34.00 SPIRITUAL COUNSELING | 1, 850 | (| 1, 850 | 0 | 1, 850 | 34.00 |
| 35. 00 DI ETARY COUNSELI NG | 0 | (| 0 0 | 0 | 0 | 35. 00 |
| 36. 00 COUNSELING - OTHER | 0 | (| 0 0 | 0 | 0 | 36.00 |
| 37.00 HOSPICE AIDE & HOMEMAKER SERVICES | 2, 163 | (| 2, 163 | 0 | 2, 163 | 37. 00 |
| 38. 00 DURABLE MEDICAL EQUIPMENT/OXYGEN | 0 | (| 0 (c | 0 | 0 | 38. 00 |
| 39.00 PATIENT TRANSPORTATION | 0 | (| 0 (c | 0 | 0 | 39. 00 |
| 40.00 I MAGI NG SERVI CES | 0 | (| 0 (c | 0 | 0 | 40.00 |
| 41.00 LABS & DIAGNOSTICS | 0 | (| 0 (c | 0 | 0 | 41. 00 |
| 42.00 MEDICAL SUPPLIES-NON-ROUTINE | 0 | (| 0 (c | 0 | 0 | 42.00 |
| 42.50 DRUGS CHARGED TO PATIENTS | 0 | (| 0 (c | 0 | 0 | 42. 50 |
| 43. 00 OUTPATIENT SERVICES | 0 | (| 0 (c | 0 | 0 | 43.00 |
| 44.00 PALLIATIVE RADIATION THERAPY | 0 | (| 0 (c | 0 | 0 | 44. 00 |
| 45.00 PALLIATIVE CHEMOTHERAPY | 0 | (| 0 (c | 0 | 0 | 45. 00 |
| 46.00 OTHER PATIENT CARE SERVICES (SPECIFY) | 0 | (| 0 (c | 0 | 0 | |
| 100. 00 TOTAL * | 29, 694 | (| 29, 694 | 0 | 29, 694 | 100.00 |
| * Transfer the amount in column 7 to Wkst 0-5 co | lumn 1 line 53 | | | | | |

Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

| | | ADJUSTMENTS | TOTAL (col. 5 | |
|--------|------------------------------------------|-------------|---------------|--------|
| | | | ± col. 6) | |
| | | 6. 00 | 7. 00 | |
| | DIRECT PATIENT CARE SERVICE COST CENTERS | | | |
| 25.00 | I NPATIENT CARE-CONTRACTED | 0 | 0 | 25.00 |
| 26.00 | PHYSI CI AN SERVI CES | 0 | 0 | 26.00 |
| 27. 00 | NURSE PRACTITIONER | 0 | 0 | 27.00 |
| 28.00 | REGI STERED NURSE | 0 | 25, 415 | 28.00 |
| 29.00 | LPN/LVN | 0 | 0 | 29.00 |
| 30.00 | PHYSI CAL THERAPY | 0 | 0 | 30.00 |
| 31.00 | OCCUPATI ONAL THERAPY | 0 | 0 | 31.00 |
| 32.00 | SPEECH/LANGUAGE PATHOLOGY | 0 | 0 | 32.00 |
| 33.00 | MEDICAL SOCIAL SERVICES | 0 | 266 | 33.00 |
| 34.00 | SPIRITUAL COUNSELING | 0 | 1, 850 | 34.00 |
| 35.00 | DI ETARY COUNSELI NG | 0 | 0 | 35.00 |
| 36.00 | COUNSELING - OTHER | 0 | 0 | 36.00 |
| 37.00 | HOSPICE AIDE & HOMEMAKER SERVICES | 0 | 2, 163 | 37.00 |
| 38.00 | DURABLE MEDICAL EQUIPMENT/OXYGEN | 0 | 0 | 38.00 |
| 39.00 | PATIENT TRANSPORTATION | 0 | 0 | 39.00 |
| 40.00 | I MAGI NG SERVI CES | 0 | 0 | 40.00 |
| 41.00 | LABS & DIAGNOSTICS | 0 | 0 | 41.00 |
| 42.00 | MEDICAL SUPPLIES-NON-ROUTINE | 0 | 0 | 42.00 |
| 42.50 | DRUGS CHARGED TO PATIENTS | 0 | 0 | 42.50 |
| 43.00 | OUTPATIENT SERVICES | 0 | 0 | 43.00 |
| 44.00 | PALLIATIVE RADIATION THERAPY | 0 | 0 | 44.00 |
| 45.00 | PALLI ATI VE CHEMOTHERAPY | 0 | 0 | 45.00 |
| 46.00 | OTHER PATIENT CARE SERVICES (SPECIFY) | 0 | 0 | 46.00 |
| 100.00 | TOTAL * | 0 | 29, 694 | 100.00 |

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

| Heal th | Financial Systems DEARBORN COUNT | Y HOSPITAL | | In Lie | eu of Form CMS-2 | 2552-10 |
|---------|---------------------------------------------------------|-------------|-------------------------------------------|----------------------------------|-------------------------------------|---------|
| | LLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET | Provi der C | | Peri od: | Worksheet 0-5 | |
| EXPENS | ES FOR ALLOCATION | Hospi ce CC | | From 01/01/2019 Fo 12/31/2019 | Date/Time Pre 6/3/2020 5:03 | |
| | | | | Hospi ce I | | |
| | Descriptions | | HOSPICE DIRECTEXPENSES (see instructions) | SERVI CE | TOTAL EXPENSES (sum of cols. 1 + 2) | |
| | | | Thistractions) | WKST B PART I | 1 + 2) | |
| | | | | (see instructions) | | |
| | | | 1.00 | 2. 00 | 3.00 | |
| | GENERAL SERVICE COST CENTERS | | | | | |
| 1.00 | CAP REL COSTS-BLDG & FLXT | | | 3, 847 | 3, 847 | 1. 00 |
| 2.00 | CAP REL COSTS-MVBLE EQUIP | | | 1, 870 | | |
| 3.00 | EMPLOYEE BENEFITS DEPARTMENT | | | 67, 150 | | |
| 4.00 | ADMINISTRATIVE & GENERAL | | 179, 24! | | | 4. 00 |
| 5. 00 | PLANT OPERATION & MAINTENANCE | | | 9, 192 | 9, 192 | 5. 00 |
| 6.00 | LAUNDRY & LINEN SERVICE | | | 0 | 0 | 6. 00 |
| 7.00 | HOUSEKEEPI NG | | | 2, 714 | 2, 714 | 7. 00 |
| 8.00 | DI ETARY | | | 0 | 0 | 8. 00 |
| 9. 00 | NURSI NG ADMINI STRATI ON | | | 0 | 0 | 9. 00 |
| 10.00 | ROUTINE MEDICAL SUPPLIES | | | 0 | 0 | 10. 00 |
| 11. 00 | MEDI CAL RECORDS | | 22, 88 | 7, 730 | 30, 611 | 11. 00 |
| 12.00 | STAFF TRANSPORTATION | | | | 0 | 1 |
| 13. 00 | VOLUNTEER SERVICE COORDINATION | | | | 0 | 13. 00 |
| 14. 00 | PHARMACY | | | 0 | 0 | |
| 15. 00 | PHYSICIAN ADMINISTRATIVE SERVICES | | 12, 00 | 1 | 12, 001 | 15. 00 |

Heal th FinancialSystemsDEARBORN COCOST ALLOCATION- HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

| | | | | | | 6/3/2020 5: 03 | pm |
|--------|-------------------------------------|-------------------|---------------|---------------|------------|----------------|---------|
| | | | | | Hospi ce I | | |
| | Descriptions | TOTAL EXPENSES CA | AP REL BLDG & | CAP REL MVBLE | EMPLOYEE | SUBTOTAL | |
| | | | FIX | EQUI P | BENEFI TS | | |
| | | | | | DEPARTMENT | | |
| | | 0 | 1. 00 | 2.00 | 3.00 | 3A | |
| | GENERAL SERVICE COST CENTERS | | | | | | |
| 1.00 | CAP REL COSTS-BLDG & FLXT | 3, 847 | 3, 847 | | | | 1. 00 |
| 2.00 | CAP REL COSTS-MVBLE EQUIP | 1, 870 | | 1, 87 | | | 2. 00 |
| 3.00 | EMPLOYEE BENEFITS DEPARTMENT | 67, 150 | 0 | | 67, 150 | | 3. 00 |
| 4.00 | ADMINISTRATIVE & GENERAL | 252, 063 | 0 | | ol | 252, 063 | 4. 00 |
| 5.00 | PLANT OPERATION & MAINTENANCE | 9, 192 | 0 | | ol ol | 9, 192 | 5. 00 |
| 6.00 | LAUNDRY & LINEN SERVICE | . 0 | 0 | | ol ol | . 0 | 6. 00 |
| 7.00 | HOUSEKEEPI NG | 2,714 | 0 | | | 2, 714 | 7. 00 |
| 8.00 | DIETARY | 0 | 0 | | | . 0 | 8. 00 |
| 9.00 | NURSING ADMINISTRATION | 0 | 0 | | | 0 | 9. 00 |
| 10. 00 | ROUTINE MEDICAL SUPPLIES | 0 | 0 | | | 0 | 10.00 |
| 11. 00 | MEDI CAL RECORDS | 30, 611 | 0 | | | 30, 611 | 11. 00 |
| 12. 00 | STAFF TRANSPORTATION | 0,011 | 0 | | | 00,011 | 12. 00 |
| 13. 00 | VOLUNTEER SERVICE COORDINATION | | 0 | | | 0 | 13. 00 |
| 14. 00 | PHARMACY | o o | 0 | | | 0 | 14. 00 |
| 15. 00 | PHYSICIAN ADMINISTRATIVE SERVICES | 12,001 | 0 | | | 12, 001 | 15. 00 |
| 16. 00 | OTHER GENERAL SERVICE | 269, 230 | 0 | | | 269, 230 | 16. 00 |
| 17. 00 | PATIENT/RESIDENTIAL CARE SERVICES | 207, 230 | 0 | | | 9, 573 | 17. 00 |
| 17.00 | LEVEL OF CARE | <u> </u> | | | ا ا | 7, 373 | 17.00 |
| 50. 00 | HOSPICE CONTINUOUS HOME CARE | 0 | | | O | 0 | 50.00 |
| 51. 00 | HOSPICE ROUTINE HOME CARE | 102, 938 | | | 51, 857 | 154, 795 | 51. 00 |
| 52. 00 | HOSPICE INPATIENT RESPITE CARE | 102, 700 | 0 | | 01,007 | 0 | 52. 00 |
| 53. 00 | HOSPICE GENERAL INPATIENT CARE | 29, 694 | 3, 847 | 1, 87 | 15, 293 | 50, 704 | 53. 00 |
| 55.00 | NONREI MBURSABLE COST CENTERS | 27,074 | 3, 047 | 1,07 | 5 15, 275 | 30, 704 | 33.00 |
| 60. 00 | BEREAVEMENT PROGRAM | 0 | 0 | | ol ol | 0 | 60.00 |
| 61. 00 | VOLUNTEER PROGRAM | | 0 | | | 0 | 61. 00 |
| 62. 00 | FUNDRAI SI NG | 0 | 0 | | | 0 | 62. 00 |
| 63. 00 | HOSPICE/PALLIATIVE MEDICINE FELLOWS | 0 | 0 | | | 0 | 63. 00 |
| 64. 00 | PALLIATIVE CARE PROGRAM | | 0 | | | 0 | 64. 00 |
| 65. 00 | OTHER PHYSI CI AN SERVI CES | | 0 | | | 0 | 65. 00 |
| 66. 00 | RESI DENTI AL CARE | | 0 | | | 0 | 66. 00 |
| 67. 00 | ADVERTI SI NG | | 0 | | | 0 | 67. 00 |
| 68. 00 | TELEHEALTH/TELEMONI TORI NG | | 0 | | | 0 | 68. 00 |
| 69. 00 | THRIFT STORE | | 0 | | | 0 | 69. 00 |
| 70. 00 | NURSING FACILITY ROOM & BOARD | | 0 | | 7 | 0 | 70.00 |
| 70.00 | OTHER NONREIMBURSABLE (SPECIFY) | | 0 | | | 0 | 70.00 |
| 99.00 | NEGATIVE COST CENTER | | 0 | | | U | 99.00 |
| | TOTAL | 790, 883 | 3, 847 | l . | | 790, 883 | |
| 100.00 | אן זעזאב | 170,003 | 3, 047 | 1,07 | o, 150 | 170,003 | 1100.00 |

Heal th FinancialSystemsDEARBORN CCOST ALLOCATION- HOSPITAL-BASED HOSPICE GENERALSERVICE COSTS Peri od: Worksheet 0-6
From 01/01/2019
To 12/31/2019 Date/Time Prepared: 6/3/2020 5: 03 pm Provider CCN: 15-0086 Hospi ce CCN: 15-1531

| | | | | | | 0/3/2020 3.03 | pili |
|--------|-------------------------------------|-------------------|--------------|---------------|---------------|---------------|---------|
| | | | | | Hospi ce I | | |
| | Descriptions | ADMI NI STRATI VE | | LAUNDRY & | HOUSEKEEPI NG | DI ETARY | |
| | | & GENERAL | OPERATION & | LINEN SERVICE | | | |
| | | | MAI NTENANCE | | | | |
| | | 4.00 | 5. 00 | 6. 00 | 7. 00 | 8. 00 | |
| | GENERAL SERVICE COST CENTERS | | | | | | |
| 1.00 | CAP REL COSTS-BLDG & FLXT | | | | | | 1. 00 |
| 2.00 | CAP REL COSTS-MVBLE EQUIP | | | | | | 2. 00 |
| 3.00 | EMPLOYEE BENEFITS DEPARTMENT | | | | | | 3. 00 |
| 4.00 | ADMINISTRATIVE & GENERAL | 252, 063 | | | | | 4. 00 |
| 5.00 | PLANT OPERATION & MAINTENANCE | 4, 300 | 13, 492 | | | | 5. 00 |
| 6.00 | LAUNDRY & LINEN SERVICE | 0 | 0 | 0 | | | 6. 00 |
| 7.00 | HOUSEKEEPI NG | 1, 270 | Ö |) | 3, 984 | | 7. 00 |
| 8.00 | DI ETARY | 0 | Ö |) | o | 0 | 8. 00 |
| 9.00 | NURSING ADMINISTRATION | 0 | Ö |) | o | | 9. 00 |
| 10.00 | ROUTINE MEDICAL SUPPLIES | o | O | | o | | 10.00 |
| 11. 00 | MEDI CAL RECORDS | 14, 320 | O | | o | | 11.00 |
| 12.00 | STAFF TRANSPORTATION | 0 | 0 | | l ol | | 12. 00 |
| 13.00 | VOLUNTEER SERVICE COORDINATION | o | 0 | | l ol | | 13.00 |
| 14.00 | PHARMACY | o | O | | o | | 14.00 |
| 15.00 | PHYSICIAN ADMINISTRATIVE SERVICES | 5, 614 | O | | o | | 15. 00 |
| 16.00 | OTHER GENERAL SERVICE | 125, 947 | O | | o | | 16. 00 |
| 17.00 | PATIENT/RESIDENTIAL CARE SERVICES | 4, 478 | Ö |) | o | | 17. 00 |
| | LEVEL OF CARE | | | | | | 1 |
| 50.00 | HOSPICE CONTINUOUS HOME CARE | 0 | | | | | 50.00 |
| 51.00 | HOSPICE ROUTINE HOME CARE | 72, 414 | | | | | 51.00 |
| 52.00 | HOSPICE INPATIENT RESPITE CARE | 0 | 0 | 0 | 0 | 0 | 52.00 |
| 53.00 | HOSPICE GENERAL INPATIENT CARE | 23, 720 | 13, 492 | 2 0 | 3, 984 | 0 | 53. 00 |
| | NONREI MBURSABLE COST CENTERS | | | | | | |
| 60.00 | BEREAVEMENT PROGRAM | 0 | 0 |) | 0 | | 60.00 |
| 61. 00 | VOLUNTEER PROGRAM | 0 | 0 |) | 0 | | 61.00 |
| 62.00 | FUNDRAI SI NG | 0 | 0 |) | 0 | | 62. 00 |
| 63.00 | HOSPICE/PALLIATIVE MEDICINE FELLOWS | 0 | 0 |) | 0 | | 63. 00 |
| 64.00 | PALLIATIVE CARE PROGRAM | 0 | 0 |) | 0 | | 64.00 |
| 65.00 | OTHER PHYSICIAN SERVICES | 0 | 0 |) | 0 | | 65.00 |
| 66.00 | RESI DENTI AL CARE | 0 | 0 | 0 | 0 | 0 | |
| 67.00 | ADVERTI SI NG | 0 | 0 |) | 0 | | 67. 00 |
| 68.00 | TELEHEALTH/TELEMONI TORI NG | 0 | 0 |) | 0 | | 68. 00 |
| 69. 00 | THRI FT STORE | 0 | 0 |) | 0 | | 69. 00 |
| 70.00 | NURSING FACILITY ROOM & BOARD | | | | | | 70. 00 |
| 71. 00 | OTHER NONREIMBURSABLE (SPECIFY) | 0 | 0 |) 0 | 0 | 0 | |
| 99. 00 | NEGATI VE COST CENTER | 0 | 0 | 0 | 0 | 0 | |
| 100.00 | TOTAL | 252, 063 | 13, 492 | 2 0 | 3, 984 | 0 | 100. 00 |
| | | | | | | | |

| Heal th | Financial Systems | DEARBORN COUNTY | HOSPI TAL | | In Lie | u of Form CMS- | 2552-10 |
|------------------|---------------------------------------------------------|-------------------|--------------|-------------|-----------------|-----------------------------|------------------|
| | ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL | SERVICE COSTS | Provi der CC | CN: 15-0086 | Peri od: | Worksheet 0-6 | |
| | | | | 1 15 1501 | From 01/01/2019 | Part I | |
| | | | Hospi ce CCN | l: 15-1531 | To 12/31/2019 | Date/Time Pre 6/3/2020 5:03 | parea: nm |
| | | | | | Hospi ce I | 0,0,2020 0.00 | Pili |
| | Descriptions | NURSI NG | ROUTI NE | MEDI CAL | STAFF | VOLUNTEER | |
| | · | ADMI NI STRATI ON | MEDI CAL | RECORDS | TRANSPORTATI ON | SERVI CE | |
| | | | SUPPLI ES | | | COORDI NATI ON | |
| | | 9. 00 | 10. 00 | 11. 00 | 12.00 | 13. 00 | |
| | GENERAL SERVICE COST CENTERS | | | | | | |
| 1.00 | CAP REL COSTS-BLDG & FLXT | | | | | | 1. 00 |
| 2.00 | CAP REL COSTS-MVBLE EQUIP | | | | | | 2. 00 |
| 3.00 | EMPLOYEE BENEFITS DEPARTMENT | | | | | | 3. 00 |
| 4.00 | ADMINISTRATIVE & GENERAL | | | | | | 4. 00 |
| 5.00 | PLANT OPERATION & MAINTENANCE | | | | | | 5. 00 |
| 6. 00 | LAUNDRY & LINEN SERVICE | | | | | | 6. 00 |
| 7. 00 | HOUSEKEEPI NG | | | | | | 7. 00 |
| 8.00 | DI ETARY | | | | | | 8. 00 |
| 9.00 | NURSI NG ADMI NI STRATI ON | 0 | | | | | 9.00 |
| 10.00 | ROUTINE MEDICAL SUPPLIES | 0 | 0 | 44.0 | | | 10.00 |
| 11.00 | MEDICAL RECORDS | 0 | | 44, 93 | 31 | | 11.00 |
| 12.00 | STAFF TRANSPORTATION | 0 | | | 0 | | 12.00 |
| 13.00 | VOLUNTEER SERVICE COORDINATION | O O | | | 0 | 0 | 13.00 |
| 14.00 | PHARMACY | 0 | | | 0 | 0 | 14.00 |
| 15.00 | PHYSICIAN ADMINISTRATIVE SERVICES | 0 | | | 0 | 0 | 15.00 |
| 16. 00 17. 00 | OTHER GENERAL SERVICE PATIENT/RESIDENTIAL CARE SERVICES | | | | U | U | 16. 00 17. 00 |
| 17.00 | LEVEL OF CARE | | | | | | 17.00 |
| 50. 00 | HOSPICE CONTINUOUS HOME CARE | 0 | ol | | ol ol | 0 | 50.00 |
| 51. 00 | HOSPICE CONTINUOUS HOME CARE | 0 | 0 | 41, 9! | | 0 | 51.00 |
| 52. 00 | HOSPICE INPATIENT RESPITE CARE | 0 | 0 | 41, 7 | 0 0 | 0 | 52.00 |
| 53. 00 | HOSPICE GENERAL INPATIENT CARE | 0 | 0 | 2, 9 | | 0 | |
| 33.00 | NONREI MBURSABLE COST CENTERS | <u> </u> | <u> </u> | Ζ, 7. | 73 0 | | 33.00 |
| 60.00 | BEREAVEMENT PROGRAM | 0 | | | O | 0 | 60.00 |
| 61. 00 | VOLUNTEER PROGRAM | 0 | | | 0 | 0 | 61.00 |
| 62. 00 | FUNDRAI SI NG | 0 | | | o | 0 | 62. 00 |
| 63.00 | HOSPICE/PALLIATIVE MEDICINE FELLOWS | l | | | o | 0 | 63.00 |
| 64. 00 | PALLIATIVE CARE PROGRAM | 0 | | | o | 0 | 64. 00 |
| 65. 00 | OTHER PHYSICIAN SERVICES | l ol | | | o | 0 | 65. 00 |
| 66.00 | RESI DENTI AL CARE | 0 | | | o | 0 | 66.00 |
| 67.00 | ADVERTI SI NG | l ol | | | o | 0 | 67.00 |
| 68. 00 | TELEHEALTH/TELEMONI TORI NG | o | | | o | 0 | 68. 00 |
| 69.00 | THRI FT STORE | ol | | | o | 0 | 69. 00 |
| 70.00 | NURSING FACILITY ROOM & BOARD | | ļ | | | | 70. 00 |
| 71.00 | OTHER NONREIMBURSABLE (SPECIFY) | 0 | l | | o | 0 | 71. 00 |
| 99. 00 | NEGATIVE COST CENTER | 0 | o | | 0 0 | 0 | 99. 00 |
| 100.00 | TOTAL | 0 | O | 44, 93 | 31 0 | 0 | 100. 00 |
| | | | | | | | |

 Heal th Financial
 Systems
 DEARBORN COUNTY
 HOSPITAL

 COST ALLOCATION
 - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
 Provider
 Provider CCN: 15-0086 Hospi ce CCN: 15-1531

| | | | | | | 07 07 2020 0.00 | РШ |
|--------|-------------------------------------|----------|-------------------|---------------|---------------|-----------------|--------|
| | · - · · · · | | | | Hospi ce I | | |
| | Descriptions | PHARMACY | PHYSI CI AN | OTHER GENERAL | | TOTAL | |
| | | | ADMI NI STRATI VE | SERVI CE | RESI DENTI AL | | |
| | | | SERVI CES | | CARE SERVICES | | |
| | | 14. 00 | 15. 00 | 16. 00 | 17. 00 | 18. 00 | |
| | GENERAL SERVICE COST CENTERS | | | | | | |
| 1.00 | CAP REL COSTS-BLDG & FLXT | | | | | | 1. 00 |
| 2.00 | CAP REL COSTS-MVBLE EQUIP | | | | | | 2. 00 |
| 3.00 | EMPLOYEE BENEFITS DEPARTMENT | | | | | | 3. 00 |
| 4.00 | ADMINISTRATIVE & GENERAL | | | | | | 4. 00 |
| 5.00 | PLANT OPERATION & MAINTENANCE | | | | | | 5. 00 |
| 6.00 | LAUNDRY & LINEN SERVICE | | | | | | 6. 00 |
| 7.00 | HOUSEKEEPI NG | | | | | | 7. 00 |
| 8.00 | DI ETARY | | | | | | 8. 00 |
| 9.00 | NURSING ADMINISTRATION | | | | | | 9. 00 |
| 10.00 | ROUTINE MEDICAL SUPPLIES | | | | | | 10. 00 |
| 11. 00 | MEDI CAL RECORDS | | | | | | 11. 00 |
| 12.00 | STAFF TRANSPORTATION | | | | | | 12.00 |
| 13.00 | VOLUNTEER SERVICE COORDINATION | | | | | | 13.00 |
| 14.00 | PHARMACY | (| | | | | 14.00 |
| 15.00 | PHYSICIAN ADMINISTRATIVE SERVICES | (| 17, 615 | | | | 15. 00 |
| 16.00 | OTHER GENERAL SERVICE | (| | 395, 177 | 1 | | 16. 00 |
| 17.00 | PATIENT/RESIDENTIAL CARE SERVICES | | | | 14, 051 | | 17. 00 |
| | LEVEL OF CARE | | | | | | |
| 50.00 | HOSPICE CONTINUOUS HOME CARE | (| 0 | 1 | | 0 | 50. 00 |
| 51.00 | HOSPICE ROUTINE HOME CARE | (| 16, 449 | 305, 176 | , | 590, 792 | 51.00 |
| 52.00 | HOSPICE INPATIENT RESPITE CARE | (| 0 | 0 | 0 | 0 | 52.00 |
| 53.00 | HOSPICE GENERAL INPATIENT CARE | (| 1, 166 | 90, 001 | 14, 051 | 200, 091 | 53. 00 |
| | NONREI MBURSABLE COST CENTERS | | | | | | |
| 60.00 | BEREAVEMENT PROGRAM | (|) | 0 | | 0 | 60.00 |
| 61.00 | VOLUNTEER PROGRAM | (| | 0 | | 0 | 61.00 |
| 62.00 | FUNDRAI SI NG | (| | 0 | | 0 | 62.00 |
| 63.00 | HOSPICE/PALLIATIVE MEDICINE FELLOWS | (| | 0 | | 0 | 63.00 |
| 64.00 | PALLIATIVE CARE PROGRAM | | | 0 |) | 0 | 64. 00 |
| 65.00 | OTHER PHYSICIAN SERVICES | | | 0 |) | 0 | 65. 00 |
| 66.00 | RESI DENTI AL CARE | | ol o | 0 | o | 0 | 66. 00 |
| 67.00 | ADVERTI SI NG | | | 0 |) | 0 | 67. 00 |
| 68.00 | TELEHEALTH/TELEMONI TORI NG | | | 0 |) | 0 | 68. 00 |
| 69.00 | THRI FT STORE | | | 0 |) | 0 | 69. 00 |
| 70.00 | NURSING FACILITY ROOM & BOARD | | | | | 0 | 70.00 |
| 71. 00 | OTHER NONREIMBURSABLE (SPECIFY) | | ol o | 0 | o | 0 | 1 |
| 99. 00 | NEGATIVE COST CENTER | | ol o | O | ol | 0 | 1 |
| 100.00 | | | 17, 615 | 395, 177 | 14, 051 | 790, 883 | 100.00 |
| | 1 | • | | • | | • | |

| Health Financial Systems | DEARBORN COUNTY HOSPITAL | In Lie | u of Form CMS-2552-10 |
|--------------------------------------------------------------|------------------------------------------------------|--------------------------------------------------|-------------------------------------------|
| COST ALLOCATION - HOSPITAL-BASED HOSPIC STATISTICAL BASIS | CE GENERAL SERVICE COSTS Provider CCN: Hospice CCN: | Peri od: From 01/01/2019 To 12/31/2019 | Worksheet 0-6 Part II Date/Time Prepared: |

| CAP REL BLDG & CAP REL MVBLE EMPLOYEE BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS BENEFI TS |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| FIX |
| COUARE FEET COULAR VALUE DEPARTMENT (GROSS SALARI ES) COSTS COSTS |
| COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COSTS COST |
| SALARIES 1.00 2.00 3.00 4A 4.00 |
| 1.00 2.00 3.00 4A 4.00 |
| CAP REL COSTS-BLDG & FIXT 315 1.00 2.00 2.00 3.00 2.00 3.00 2.00 3.00 2.00 3.00 3.00 2.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3 |
| 1. 00 CAP REL COSTS-BLDG & FIXT 315 2. 00 2. 00 CAP REL COSTS-MVBLE EQUIP 315 315 2. 00 3. 00 EMPLOYEE BENEFITS DEPARTMENT 0 0 294, 238 3. 00 4. 00 ADMINISTRATIVE & GENERAL 0 0 0 0 -252, 063 538, 820 4. 00 5. 00 PLANT OPERATION & MAINTENANCE 0 0 0 0 0, 9, 192 5. 00 6. 00 LAUNDRY & LINEN SERVICE 0 0 0 0 0 0 0 0. 0 6. 00 7. 00 HOUSEKEEPING 0 0 0 0 0 2, 714 7. 00 |
| 2. 00 CAP REL COSTS-MVBLE EQUI P 315 2. 00 3. 00 EMPLOYEE BENEFITS DEPARTMENT 0 0 294, 238 3. 00 4. 00 ADMI NI STRATI VE & GENERAL 0 0 0 -252, 063 538, 820 4. 00 5. 00 PLANT OPERATI ON & MAI NTENANCE 0 0 0 0 9, 192 5. 00 6. 00 LAUNDRY & LI NEN SERVI CE 0 0 0 0 0 0 0 0 0 7. 00 HOUSEKEEPI NG 0 0 0 0 0 2, 714 7. 00 |
| 3. 00 EMPLOYEE BENEFITS DEPARTMENT 0 0 294, 238 3. 00 4. 00 ADMI NI STRATI VE & GENERAL 0 0 0 -252, 063 538, 820 4. 00 5. 00 PLANT OPERATI ON & MAI NTENANCE 0 0 0 0 0 9, 192 5. 00 6. 00 LAUNDRY & LI NEN SERVI CE 0 0 0 0 0 0 0 0 0 0 2, 714 7. 00 |
| 3. 00 EMPLOYEE BENEFITS DEPARTMENT 0 0 294, 238 3. 00 4. 00 ADMI NI STRATI VE & GENERAL 0 0 0 -252, 063 538, 820 4. 00 5. 00 PLANT OPERATI ON & MAI NTENANCE 0 0 0 0 0 9, 192 5. 00 6. 00 LAUNDRY & LI NEN SERVI CE 0 0 0 0 0 0 0 0 0 0 2, 714 7. 00 |
| 4. 00 ADMI NI STRATI VE & GENERAL 0 0 -252, 063 538, 820 4. 00 5. 00 PLANT OPERATI ON & MAI NTENANCE 0 0 0 0 9, 192 5. 00 6. 00 LAUNDRY & LI NEN SERVI CE 0 0 0 0 0 0 0 0 6. 00 7. 00 HOUSEKEEPI NG 0 0 0 0 0 2, 714 7. 00 |
| 5. 00 PLANT OPERATION & MAINTENANCE 0 0 0 9, 192 5. 00 6. 00 LAUNDRY & LI NEN SERVI CE 0 0 0 0 0 0 6. 00 7. 00 HOUSEKEEPI NG 0 0 0 0 0 2, 714 7. 00 |
| 6. 00 LAUNDRY & LI NEN SERVI CE 0 0 0 0 6. 00 7. 00 HOUSEKEEPI NG 0 0 0 0 2, 714 7. 00 |
| 7. 00 HOUSEKEEPING 0 0 0 2, 714 7. 00 |
| |
| 8. 00 DI FTARY |
| 9. 00 NURSI NG ADMI NI STRATI ON 0 0 0 0 9. 00 |
| 10. 00 ROUTI NE MEDI CAL SUPPLI ES 0 0 0 0 10. 00 |
| 11. 00 MEDI CAL RECORDS 0 0 0 30, 611 11.00 |
| 12. 00 STAFF TRANSPORTATION |
| 13. 00 VOLUNTEER SERVI CE COORDINATION |
| 14. 00 PHARMACY 0 0 0 0 0 14. 00 |
| |
| |
| 16. 00 OTHER GENERAL SERVICE 0 0 0 269, 230 16. 00 |
| 17. 00 PATI ENT/RESI DENTI AL CARE SERVI CES 0 0 0 9, 573 17. 00 |
| LEVEL OF CARE |
| 50. 00 HOSPI CE CONTI NUOUS HOME CARE 0 0 0 50. 00 |
| 51. 00 HOSPI CE ROUTI NE HOME CARE 227, 226 0 154, 795 51. 00 |
| 52. 00 HOSPICE INPATIENT RESPITE CARE 0 0 0 0 52. 00 |
| 53. 00 HOSPICE GENERAL INPATIENT CARE 315 315 67, 012 0 50, 704 53. 00 |
| NONREI MBURSABLE COST CENTERS |
| 60. 00 BEREAVEMENT PROGRAM 0 0 0 0 60. 00 |
| 61.00 VOLUNTEER PROGRAM 0 0 0 0 0 0 61.00 |
| 62. 00 FUNDRAI SI NG 0 0 0 0 0 0 62. 00 |
| 63.00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS 0 0 0 0 63.00 |
| 64. 00 PALLI ATI VE CARE PROGRAM 0 0 0 0 0 0 64. 00 |
| 65. 00 OTHER PHYSICIAN SERVICES 0 0 0 0 0 65. 00 |
| 66. 00 RESI DENTI AL CARE 0 0 0 0 0 0 66. 00 |
| 67. 00 ADVERTI SI NG 0 0 0 0 67. 00 |
| 68. 00 TELEHEALTH/TELEMONI TORI NG 0 0 0 0 68. 00 |
| 69. 00 THRI FT STORE 0 0 0 0 0 0 69. 00 |
| 70.00 NURSING FACILITY ROOM & BOARD 0 70.00 |
| 71. 00 OTHER NONREI MBURSABLE (SPECI FY) 0 0 0 0 71. 00 |
| 99.00 NEGATIVE COST CENTER 99.00 |
| 100.00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 3,847 1,870 67,150 252,063 100.00 |
| 101. 00 UNIT COST MULTIPLIER 12. 212698 5. 936508 0. 228217 0. 467806 101. 00 |

| Health Financial Systems | DEARBORN COUNTY H | OSPI TAL | In Lie | u of Form CMS-2552-10 |
|-----------------------------------------------------------|-------------------|----------------------|------------------|-----------------------|
| COST ALLOCATION - HOSPITAL-BASED HOS STATISTICAL BASIS | | Provider CCN: 15-008 | From 01/01/2019 | |
| | | Hospice CCN: 15-15 | 31 To 12/31/2019 | Date/Time_Prepared: |

| STATISTICAL BASIS | | | | | o 12/31/2019 | | pared: |
|-------------------|------------------------------------------------------|---------------|---------------|---------------|--------------|-------------------|------------------|
| | | | | | Hospi ce I | 0.0,000 | |
| | Cost Center Descriptions | PLANT | LAUNDRY & | HOUSEKEEPI NG | DI ETARY | NURSI NG | |
| | | OPERATION & | LINEN SERVICE | (SQUARE FEET) | , | ADMI NI STRATI ON | |
| | | MAI NTENANCE | (IN-FACILITY | | DAYS) | (======= | |
| | | (SQUARE FEET) | DAYS) | | | (DI RECT NURS. | |
| | | F 00 | 4 00 | 7.00 | 0.00 | HRS.) | |
| | GENERAL SERVICE COST CENTERS | 5. 00 | 6. 00 | 7. 00 | 8. 00 | 9. 00 | |
| 1.00 | CAP REL COSTS-BLDG & FLXT | | | | | | 1.00 |
| 2.00 | CAP REL COSTS-BEDG & TTXT | | | | | | 2.00 |
| 3.00 | EMPLOYEE BENEFITS DEPARTMENT | | | | | | 3. 00 |
| 4.00 | ADMI NI STRATI VE & GENERAL | | | | | | 4.00 |
| 5. 00 | PLANT OPERATION & MAINTENANCE | 315 | | | | | 5.00 |
| 6.00 | LAUNDRY & LINEN SERVICE | 0.0 | | | | | 6. 00 |
| 7. 00 | HOUSEKEEPI NG | 0 | Ĭ | 315 | | | 7. 00 |
| 8. 00 | DI ETARY | 0 | | | | | 8. 00 |
| 9. 00 | NURSING ADMINISTRATION | 0 | | | | 0 | 1 |
| 10.00 | ROUTI NE MEDI CAL SUPPLI ES | 0 | | | | 0 | 10.00 |
| 11. 00 | MEDI CAL RECORDS | 0 | | | | 0 | 11. 00 |
| 12. 00 | STAFF TRANSPORTATION | 0 | | |) | 0 | 12. 00 |
| 13. 00 | VOLUNTEER SERVICE COORDINATION | 0 | | |) | 0 | 13. 00 |
| 14. 00 | PHARMACY | 0 | | |) | 0 | 14. 00 |
| 15. 00 | PHYSICIAN ADMINISTRATIVE SERVICES | 0 | | |) | 0 | 15. 00 |
| 16. 00 | OTHER GENERAL SERVICE | 0 | | |) | 0 | 16. 00 |
| 17.00 | PATIENT/RESIDENTIAL CARE SERVICES | 0 | | |) | | 17. 00 |
| | LEVEL OF CARE | <u>'</u> | <u> </u> | | | <u> </u> | |
| 50.00 | HOSPICE CONTINUOUS HOME CARE | | | | | 0 | 50.00 |
| 51.00 | HOSPICE ROUTINE HOME CARE | | | | | 0 | 51.00 |
| 52.00 | HOSPICE INPATIENT RESPITE CARE | 0 | 0 |) C | 0 | 0 | 52. 00 |
| 53.00 | HOSPICE GENERAL INPATIENT CARE | 315 | C | 315 | 0 | 0 | 53. 00 |
| | NONREI MBURSABLE COST CENTERS | | | | | | |
| 60. 00 | BEREAVEMENT PROGRAM | 0 | | C | | 0 | 60. 00 |
| 61. 00 | VOLUNTEER PROGRAM | 0 | ł | C |) | 0 | 61. 00 |
| 62. 00 | FUNDRAI SI NG | 0 | | |) | 0 | 62. 00 |
| 63. 00 | HOSPICE/PALLIATIVE MEDICINE FELLOWS | 0 | | | | 0 | 63.00 |
| 64. 00 | PALLIATIVE CARE PROGRAM | 0 | | | | 0 | 64.00 |
| 65. 00 | OTHER PHYSICIAN SERVICES | 0 | | | | 0 | 65. 00 |
| 66. 00 | RESI DENTI AL CARE | 0 | 0 | | 0 | | 66.00 |
| 67. 00 | ADVERTI SI NG | 0 | | | | 0 | 67.00 |
| 68. 00 | TELEHEALTH/TELEMONI TORI NG | 0 | | | | 0 | 68. 00 |
| 69. 00 | THRIFT STORE | 0 | | | | 0 | 69.00 |
| 70.00 | NURSING FACILITY ROOM & BOARD | | | | | | 70.00 |
| 71. 00 | OTHER NONREIMBURSABLE (SPECIFY) NEGATIVE COST CENTER | 0 | 0 | C | 0 | 0 | 71. 00 99. 00 |
| | COST TO BE ALLOCATED (per Wkst. 0-6, Part I) | 13, 492 | | 3, 984 | _ | _ | 100.00 |
| | UNIT COST MULTIPLIER | 42. 831746 | | 1 | | | |
| 101.00 | ONIT COST MULTIFLIER | 42.031740 | 0.00000 | η 12.04/019 | 0.00000 | 0.00000 | 1101.00 |

| Heal th Financial | Systems | | DEAR | BORN COUNTY | HOSPI TAL | | In Lie | u of Form CMS-2552-10 |
|-------------------|-------------------|------------------|----------|-------------|-------------|--------------|-----------------|-----------------------|
| COST ALLOCATION - | - HOSPI TAL-BASED | HOSPI CE GENERAL | SERVI CE | COSTS | Provi der (| CCN: 15-0086 | | Worksheet 0-6 |
| STATISTICAL BASIS | 3 | | | | | | From 01/01/2019 | Part II |

| SIAIIS | ITCAL DASIS | Hospi ce CCI | N: 15-1531 | To 12/31/2019 | Date/Time Pre 6/3/2020 5:03 | | |
|----------------|-------------------------------------------------------------------|-----------------------------------|----------------------------------------------------------|------------------------|-------------------------------------|-----------------------|----------------|
| | | | | | Hospi ce I | | |
| | Cost Center Descriptions | ROUTI NE MEDI CAL SUPPLI ES | MEDICAL RECORDS (PATIENT DAYS) | STAFF TRANSPORTATIO | VOLUNTEER N SERVI CE COORDI NATI ON | PHARMACY (CHARGES) | |
| | | (PATIENT DAYS) | (····· - ··· - ··· - ··· - / | (MI LEAGE) | (HOURS OF SERVICE) | | |
| | | 10.00 | 11. 00 | 12. 00 | 13. 00 | 14.00 | |
| | GENERAL SERVICE COST CENTERS | | | T | | | |
| 1.00 | CAP REL COSTS-BLDG & FLXT | | | | | | 1.00 |
| 2.00 | CAP REL COSTS-MVBLE EQUIP | | | | | | 2.00 |
| 3. 00 4. 00 | EMPLOYEE BENEFITS DEPARTMENT | | | | | | 3. 00 4. 00 |
| 4. 00 5. 00 | ADMINISTRATIVE & GENERAL PLANT OPERATION & MAINTENANCE | | | | | | 5. 00 |
| 6. 00 | LAUNDRY & LINEN SERVICE | | | | | | 6. 00 |
| 7. 00 | HOUSEKEEPI NG | | | | | | 7. 00 |
| 8. 00 | DI ETARY | | | | | | 8.00 |
| 9. 00 | NURSI NG ADMINI STRATI ON | | | | | | 9. 00 |
| 10.00 | ROUTINE MEDICAL SUPPLIES | o | | | | | 10.00 |
| 11.00 | MEDICAL RECORDS | | 2, 962 | | | | 11.00 |
| 12.00 | STAFF TRANSPORTATION | | | | o | | 12. 00 |
| 13.00 | VOLUNTEER SERVICE COORDINATION | | | | o o | | 13. 00 |
| 14.00 | PHARMACY | | | | 0 0 | 0 | 14. 00 |
| 15. 00 | PHYSICIAN ADMINISTRATIVE SERVICES | | | | 0 0 | 0 | 15. 00 |
| 16. 00 | OTHER GENERAL SERVICE | | | | 0 0 | 0 | |
| 17. 00 | PATIENT/RESIDENTIAL CARE SERVICES | | | | | | 17. 00 |
| | LEVEL OF CARE | | | 1 | | _ | |
| | HOSPI CE CONTI NUOUS HOME CARE | 0 | 0 | 1 | 0 0 | 0 | |
| | HOSPICE ROUTINE HOME CARE | 0 | 2, 766 | | 0 0 | 0 | |
| | HOSPICE INPATIENT RESPITE CARE | 0 | 0 196 | | 0 0 | 0 | |
| 53.00 | HOSPICE GENERAL INPATIENT CARE NONREIMBURSABLE COST CENTERS | l o | 190 |)[| 0 0 | 0 | 33.00 |
| 60. 00 | BEREAVEMENT PROGRAM | | | Ι | ol ol | 0 | 60.00 |
| 61. 00 | VOLUNTEER PROGRAM | | | | o o | 0 | |
| | FUNDRAI SI NG | | | | o o | 0 | |
| 63. 00 | HOSPICE/PALLIATIVE MEDICINE FELLOWS | | | | o o | 0 | 1 |
| 64.00 | PALLIATIVE CARE PROGRAM | | | | o o | 0 | 64.00 |
| 65.00 | OTHER PHYSICIAN SERVICES | | | | o o | 0 | 65. 00 |
| 66.00 | RESI DENTI AL CARE | | | | 0 0 | 0 | 66. 00 |
| 67.00 | ADVERTI SI NG | | | | 0 0 | 0 | 67. 00 |
| 68.00 | TELEHEALTH/TELEMONI TORI NG | | | | 0 0 | 0 | 00.00 |
| | THRI FT STORE | | | | 0 | 0 | |
| | NURSING FACILITY ROOM & BOARD | | | | | i | 70. 00 |
| | OTHER NONREIMBURSABLE (SPECIFY) | | | | 이 | 0 | 7 00 |
| | NEGATIVE COST CENTER | | 44 004 | | | | 99. 00 |
| | COST TO BE ALLOCATED (per Wkst. 0-6, Part I) UNIT COST MULTIPLIER | 0. 000000 | 44, 931 15. 169142 | | 0.000000 | | 100.00 |
| 101.00 | UNII COSI MULIIPLIER | 0.000000 | 13. 109142 | .1 0.00000 | u. 000000 | 0. 000000 | 1101.00 |

| Health Financial Systems | DEARBORN COUNTY | HOSPI TAL | | In Lieu | u of Form CMS-2552-10 |
|--------------------------------------------------------------|-----------------|-------------------------------|--------------------|-----------------|-------------------------------------------|
| COST ALLOCATION - HOSPITAL-BASED HOSPIC STATISTICAL BASIS | | Provider CCN: Hospice CCN: | 15-0086 15-1531 | From 01/01/2019 | Worksheet 0-6 Part II Date/Time Prepared: |

| | | | | | | 6/3/2020 5:03 pm |
|--------|----------------------------------------------|-------------------|---------------|---------------|------------|------------------|
| | | | | | Hospi ce I | |
| | Cost Center Descriptions | PHYSI CI AN | OTHER GENERAL | PATI ENT/ | | |
| | | ADMI NI STRATI VE | | RESI DENTI AL | | |
| | | SERVI CES | (SPECI FY | CARE SERVICES | | |
| | | (PATIENT DAYS) | BASIS) | (IN-FACILITY | | |
| | | | | DAYS) | | |
| | | 15. 00 | 16. 00 | 17. 00 | | |
| | GENERAL SERVICE COST CENTERS | | | | | |
| 1.00 | CAP REL COSTS-BLDG & FLXT | | | | | 1. |
| 2.00 | CAP REL COSTS-MVBLE EQUIP | | | | | 2. |
| 3.00 | EMPLOYEE BENEFITS DEPARTMENT | | | | | 3. |
| 4.00 | ADMINISTRATIVE & GENERAL | | | | | 4. |
| 5.00 | PLANT OPERATION & MAINTENANCE | | | | | 5. |
| 6.00 | LAUNDRY & LINEN SERVICE | | | | | 6. |
| 7.00 | HOUSEKEEPI NG | | | | | 7. |
| 8.00 | DI ETARY | | | | | 8. |
| 9.00 | NURSING ADMINISTRATION | | | | | 9. |
| 10.00 | ROUTINE MEDICAL SUPPLIES | | | | | 10. |
| 11.00 | MEDI CAL RECORDS | | | | | 11. |
| 12.00 | STAFF TRANSPORTATION | | | | | 12. |
| 13.00 | VOLUNTEER SERVICE COORDINATION | | | | | 13. |
| 14.00 | PHARMACY | | | | | 14. |
| 15.00 | PHYSICIAN ADMINISTRATIVE SERVICES | 2, 962 | | | | 15. |
| 16.00 | OTHER GENERAL SERVICE | | 396, 619 | | | 16. |
| 17.00 | PATIENT/RESIDENTIAL CARE SERVICES | | | 19 | 6 | 17. |
| | LEVEL OF CARE | | | | | |
| 50.00 | HOSPICE CONTINUOUS HOME CARE | 0 | 0 |) | | 50. |
| 51.00 | HOSPICE ROUTINE HOME CARE | 2, 766 | 306, 290 | | | 51. |
| 52.00 | HOSPICE INPATIENT RESPITE CARE | 0 | 0 | | 0 | 52. |
| 53.00 | HOSPICE GENERAL INPATIENT CARE | 196 | 90, 329 | 19 | 6 | 53. |
| | NONREI MBURSABLE COST CENTERS | | | | | |
| 60.00 | BEREAVEMENT PROGRAM | | 0 |) | | 60. |
| 61.00 | VOLUNTEER PROGRAM | | 0 | | | 61. |
| 62.00 | FUNDRAI SI NG | | 0 | | | 62. |
| 63.00 | HOSPICE/PALLIATIVE MEDICINE FELLOWS | | 0 | | | 63. |
| 64. 00 | PALLIATIVE CARE PROGRAM | | 0 | | | 64. |
| 65. 00 | OTHER PHYSICIAN SERVICES | | 0 | | | 65. |
| 66.00 | RESI DENTI AL CARE | 0 | 0 | | 0 | 66. |
| 67. 00 | ADVERTI SI NG | | | | | 67. |
| 68. 00 | TELEHEALTH/TELEMONI TORI NG | | | | | 68. |
| 69. 00 | THRI FT STORE | | | | | 69. |
| 70. 00 | NURSING FACILITY ROOM & BOARD | | | | | 70. |
| 71. 00 | OTHER NONREIMBURSABLE (SPECIFY) | 0 | | | o | 71. |
| | NEGATIVE COST CENTER | | | | | 99. |
| | COST TO BE ALLOCATED (per Wkst. 0-6, Part I) | 17, 615 | 395, 177 | 14, 05 | 1 | 100. |
| 100.00 | | | | | | |

| | APPORT | Financial Systems IONMENT OF HOSPITAL-BASED HOSPICE SHARED SERV OF CARE | DEARBORN COUN TICE COSTS BY | Provi der Co | CN: 15-0086 N: 15-1531 | In Lie Period: From 01/01/2019 To 12/31/2019 | Date/Time Pre | pared: |
|---|--------|-------------------------------------------------------------------------------|----------------------------------|---------------------------|---------------------------|-------------------------------------------------------|------------------------|--------|
| _ | | | | · · | | | 6/3/2020 5:03 | pm |
| | | | | | | Hospi ce I | | |
| | | | | | Charges by | /LOC (from Provi | der Records) | |
| | | Cost Center Descriptions | From Wkst. C, | Cost to Charge | HCHC | HRHC | HI RC | |
| | | | Part I, Col. 9 line | | | | | |
| | | | 0 | 1.00 | 2.00 | 3. 00 | 4. 00 | |
| | | ANCILLARY SERVICE COST CENTERS | | | | | | |
| | 1.00 | PHYSI CAL THERAPY | 66. 00 | 0. 399764 | | 0 | 0 | 1. 00 |
| | 2.00 | OCCUPATI ONAL THERAPY | 67. 00 | | | 0 | 0 | |
| | 3.00 | SPEECH PATHOLOGY | 68. 00 | 0. 493471 | | 0 | 0 | 3. 00 |
| | 4.00 | DRUGS CHARGED TO PATIENTS | 73. 00 | 0. 465545 | | 0 0 | 0 | 4.00 |
| | 5.00 | DURABLE MEDICAL EQUIP-RENTED | 96. 00 | | | | | 5. 00 |
| | 6.00 | LABORATORY | 60.00 | 0. 231606 | | 0 | 0 | 6. 00 |
| | 6. 01 | BLOOD LABORATORY | 60. 01 | 0. 000000 | | 0 0 | 0 | 6. 01 |
| | 7.00 | MEDICAL SUPPLIES CHARGED TO PATIENTS | 71. 00 | 2. 222894 | | 0 0 | 0 | 7. 00 |
| | 8. 00 | OTHER OUTPATIENT SERVICE COST CENTER | 93.00 | | | | | 8. 00 |
| | 9.00 | RADI OLOGY-THERAPEUTI C | 55. 00 | 0. 228638 | | 0 0 | 0 | 9. 00 |
| | 10.00 | OTHER ANCILLARY SERVICE COST CENTERS | 76. 00 | | | | | 10.00 |
| | 11. 00 | Totals (sum of lines 1-11) | | | | | | 11. 00 |
| | | | Charges by LOC (from Provider | | Shared Servi | ce Costs by LOC | | |
| | | | Records) | | | | | |
| | | Cost Center Descriptions | HGI P | HCHC (col. 1 x col. 2) | HRHC (col. 1 col. 3) | xHIRC (col. 1 x col. 4) | HGIP (col. 1 x col. 5) | |
| | | | 5. 00 | 6. 00 | 7.00 | 8. 00 | 9. 00 | |
| | | ANCILLARY SERVICE COST CENTERS | | | | | | |
| | | PHYSI CAL THERAPY | 0 | 0 | | 0 0 | 0 | 1.00 |
| | 2.00 | OCCUPATI ONAL THERAPY | o | 0 | | 0 0 | 0 | 2. 00 |
| | 3.00 | SPEECH PATHOLOGY | o | 0 | | 0 0 | 0 | 3. 00 |
| | 4.00 | DRUGS CHARGED TO PATIENTS | 0 | 0 | | 0 0 | 0 | 4. 00 |
| | | | 1 | | 1 | | | 1 |

5.00

6.00

6.01

7.00

8.00

9. 00

10.00

0 11.00

0

0

0 0 0

0

5.00

6.00

6.01

7.00

8.00

9.00

DURABLE MEDICAL EQUIP-RENTED

10.00 OTHER ANCILLARY SERVICE COST CENTERS

MEDICAL SUPPLIES CHARGED TO PATIENTS

OTHER OUTPATIENT SERVICE COST CENTER

LABORATORY

BLOOD LABORATORY

RADI OLOGY-THERAPEUTI C

11.00 Totals (sum of lines 1-11)

| Health Financial Systems | DEARBORN | COUNTY HOSPITAL | | In Lieu | u of Form CMS-2552-10 |
|-------------------------------------------|-----------|-----------------|---------|-----------------|-----------------------|
| CALCULATION OF HOSPITAL-BASED HOSPICE PER | DIEM COST | Provi der CCN: | 15-0086 | | Worksheet 0-8 |
| | | | | From 01/01/2019 | |
| | | CCN | | | D-+- /T! D |

| | | Hospi ce CCN | N: 15-1531 T | o 12/31/2019 | Date/Time Pre 6/3/2020 5:03 | |
|--------|----------------------------------------------------------------|--------------|--------------|--------------|-----------------------------|--------|
| | | | | Hospi ce I | | |
| | | | TITLE XVIII | TITLE XIX | TOTAL | |
| | | | MEDI CARE | MEDI CAI D | | |
| | | | 1. 00 | 2. 00 | 3. 00 | |
| | HOSPICE CONTINUOUS HOME CARE | | | | | |
| 1.00 | Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7 | 7, col. 6, | | | 0 | 1. 00 |
| | line 11) | | | | | |
| 2.00 | Total unduplicated days (Wkst. S-9, col. 4, line 10) | | | | 0 | 2. 00 |
| 3.00 | Total average cost per diem (line 1 divided by line 2) | | | | 0.00 | 3. 00 |
| 4.00 | Unduplicated program days (Wkst. S-9 col. as appropriate, line | 10) | 0 | 0 | | 4. 00 |
| 5.00 | Program cost (line 3 times line 4) | | 0 | 0 | | 5. 00 |
| | HOSPICE ROUTINE HOME CARE | | | | | |
| 6.00 | Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7 | 7, col. 7, | | | 590, 792 | 6. 00 |
| | line 11) | | | | | |
| 7. 00 | Total unduplicated days (Wkst. S-9, col. 4, line 11) | | | | 2, 766 | 7. 00 |
| 8. 00 | Total average cost per diem (line 6 divided by line 7) | | | | 213. 59 | |
| 9.00 | Unduplicated program days (Wkst. S-9, col. as appropriate, lir | ne 11) | 2, 277 | | | 9. 00 |
| 10. 00 | Program cost (line 8 times line 9) | | 486, 344 | 13, 670 | | 10.00 |
| | HOSPICE INPATIENT RESPITE CARE | | | | | |
| 11. 00 | Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7 | 7, col. 8, | | | 0 | 11. 00 |
| | line 11) | | | | | |
| 12. 00 | Total unduplicated days (Wkst. S-9, col. 4, line 12) | | | | 0 | 1 |
| | Total average cost per diem (line 11 divided by line 12) | | | | 0.00 | |
| 14. 00 | Unduplicated program days (Wkst. S-9, col. as appropriate, lir | ne 12) | 0 | - | | 14. 00 |
| 15. 00 | Program cost (line 13 times line 14) | | 0 | 0 | | 15. 00 |
| | HOSPICE GENERAL INPATIENT CARE | | | | | |
| 16. 00 | | 7, col. 9, | | | 200, 091 | 16. 00 |
| | line 11) | | | | | |
| | Total unduplicated days (Wkst. S-9, col. 4, line 13) | | | | 196 | |
| | Total average cost per diem (line 16 divided by line 17) | | | | 1, 020. 87 | 1 |
| 19. 00 | Unduplicated program days (Wkst. S-9, col. as appropriate, lir | ne 13) | 133 | | | 19. 00 |
| 20. 00 | Program cost (line 18 times line 19) | | 135, 776 | 7, 146 | | 20. 00 |
| | TOTAL HOSPICE CARE | | | | | |
| | Total cost (sum of line 1 + line 6 + line 11 + line 16) | | | | 790, 883 | |
| | Total unduplicated days (Wkst. S-9, col. 4, line 14) | | | | | 22. 00 |
| 23. 00 | Average cost per diem (line 21 divided by line 22) | | | | 267. 01 | 23. 00 |

| Heal th | Financial Systems DEARBORN COUNT | Y HOSPITAL | In Lie | u of Form CMS-2 | 2552-10 |
|----------------|------------------------------------------------------------------------------------------------------------------------------|---------------------------|----------------------------------------------|--------------------------------------------------------------|----------------|
| | ATION OF CAPITAL PAYMENT | Provi der CCN: 15-0086 | Peri od: From 01/01/2019 To 12/31/2019 | Worksheet L Parts I-III Date/Time Pre 6/3/2020 5:03 | pared: |
| | | Title XVIII | Hospi tal | PPS | |
| | | | | | |
| | DART I FILLY PROCRECTIVE METHOD | | | 1. 00 | |
| | PART I - FULLY PROSPECTIVE METHOD | | | | |
| 1. 00 | CAPITAL FEDERAL AMOUNT Capital DRG other than outlier | | | 766, 243 | 1.00 |
| 1. 01 | Model 4 BPCI Capital DRG other than outlier | | | 700, 243 | 1.00 |
| 2. 00 | Capital DRG outlier payments | | | 53, 766 | 2.00 |
| 2. 01 | Model 4 BPCI Capital DRG outlier payments | | | 0 | 2. 01 |
| 3.00 | Total inpatient days divided by number of days in the cost r | eporting period (see inst | ructions) | 24. 62 | 3. 00 |
| 4.00 | Number of interns & residents (see instructions) | | | 0.00 | 4. 00 |
| 5.00 | Indirect medical education percentage (see instructions) | | | 0.00 | 5. 00 |
| 6. 00 | Indirect medical education adjustment (multiply line 5 by th 1.01)(see instructions) | e sum of lines 1 and 1.0° | , columns 1 and | 0 | 6. 00 |
| 7. 00 | Percentage of SSI recipient patient days to Medicare Part A 30) (see instructions) | patient days (Worksheet E | E, part A line | 0. 00 | 7. 00 |
| 8.00 | Percentage of Medicaid patient days to total days (see instr | uctions) | | 0.00 | 8. 00 |
| 9.00 | Sum of lines 7 and 8 | | | 0. 00 | 9. 00 |
| 10.00 | Allowable disproportionate share percentage (see instruction | s) | | 0. 00 | |
| 11.00 | Disproporti onate share adjustment (see instructions) | | | 0 | 11.00 |
| 12.00 | Total prospective capital payments (see instructions) | | | 820, 009 | 12. 00 |
| | | | | 1. 00 | |
| | PART II - PAYMENT UNDER REASONABLE COST | | | 00 | |
| 1.00 | Program inpatient routine capital cost (see instructions) | | | 0 | 1.00 |
| 2.00 | Program inpatient ancillary capital cost (see instructions) | | | 0 | 2. 00 |
| 3.00 | Total inpatient program capital cost (line 1 plus line 2) | | | 0 | 3. 00 |
| 4.00 | Capital cost payment factor (see instructions) | | | 0 | 4. 00 |
| 5. 00 | Total inpatient program capital cost (line 3 x line 4) | | | 0 | 5. 00 |
| | | | | 1. 00 | |
| 1 00 | PART III - COMPUTATION OF EXCEPTION PAYMENTS | | | 0 | 1 00 |
| 1. 00 2. 00 | Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstan | cos (soo instructions) | | 0 | 1. 00 2. 00 |
| 3. 00 | Net program inpatient capital costs for extraordinary circumstant left program inpatient capital costs (line 1 minus line 2) | ces (see mistructions) | | 0 | 3.00 |
| 4. 00 | Applicable exception percentage (see instructions) | | | 0.00 | 4. 00 |
| 5. 00 | Capital cost for comparison to payments (line 3 x line 4) | | | 0 | 5. 00 |
| 6.00 | Percentage adjustment for extraordinary circumstances (see i | nstructions) | | 0.00 | 6. 00 |
| 7.00 | Adjustment to capital minimum payment level for extraordinar | y circumstances (line 2 > | (line 6) | 0 | 7. 00 |
| 8.00 | Capital minimum payment level (line 5 plus line 7) | | | 0 | 8. 00 |
| 9. 00 | Current year capital payments (from Part I, line 12, as appl | | | 0 | 9. 00 |
| 10.00 | Current year comparison of capital minimum payment level to | | | 0 | 10.00 |
| 11. 00 | Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) | capital payment (from pri | or year | 0 | 11. 00 |
| 12. 00 | Net comparison of capital minimum payment level to capital p | avments (line 10 nlus lin | ne 11) | 0 | 12. 00 |
| 13. 00 | Current year exception payment (if line 12 is positive, ente | | | 0 | 13. 00 |
| 14. 00 | Carryover of accumulated capital minimum payment level over | | | 0 | 14. 00 |
| | (if line 12 is negative, enter the amount on this line) | | 9 1 | | |
| 15. 00 | | structions) | | 0 | 15. 00 |
| | Current year operating and capital costs (see instructions) | | | 0 | 16.00 |
| 17.00 | Current year exception offset amount (see instructions) | | l | 0 | 17. 00 |