DEARBORN COUNTY HOSPITAL

In Lieu of Form CMS-2552-10

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 01/01/2020 Parts I-III AND SETTLEMENT SUMMARY 10/31/2020 Date/Time Prepared: То 3/31/2021 12:34 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 3/31/2021 Time: 12:34 pm Manually prepared cost report use only 2. []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. 3 0 Ē 4 [6. Date Received: 7. Contractor No. 10. NPR Date: Contractor 5.]Cost Report Status Γ

 (1) As Submitted
 7. Contractor No.
 11. Contractor's Vendor Code:
 4

 (2) Settled without Audit 8. [N] Initial Report for this Provider CCN
 11. Contractor's Code:
 4

 (3) Settled with Audit
 9. [N] Final Report for this Provider CCN
 11. Contractor's Vendor Code:
 4

 11. Contractor's Vendor Code: use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened (5) Amended PART II - CERTIFICATION MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT. CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S) I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by DEARBORN COUNTY HOSPITAL (15-0086) for the cost reporting period beginning 01/01/2020 and ending 10/31/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations. [X] 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. BILL RITZMANN (Si gned) Officer or Administrator of Provider(s) CHIEF OF TRANSITION COMMITTEE Title (Dated when report is electronically signed.) Date Title XVIII

	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
	·	1.00	2.00	3.00	4.00	5.00	
-	PART III - SETTLEMENT SUMMARY			-			
1.00	Hospi tal	0	127, 990	-50, 551	0	-114, 031	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	127, 990	-50, 551	0	-114,031	200.00
Tho ab	ave amounts represent "due to" or "due from"	the applicable	program for t	ho alomont of	the above compl	ov indicatod	

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-MEDI CARE.

	AL AND HOSPITAL HEALTH CARE COMPLEX		Provio	der CCN: 1		Period: From 01/01/ To 10/31/	2020	Workshe Part I Date/Ti 3/31/20	me Pre	epared:
	1.00	2.00		3.00		4	4.00			
00	Hospital and Hospital Health Care Co									1 00
. 00	Street: 600 WILSON CREEK ROAD City: LAWRENCEBURG	PO Box: State: IN	Zin Cod	e: 47025-	Count					1.00
. 00	CITY. LAWRENCEBURG	Component Name	CCN	CBSA	Provi der	ty: DEARBORN Date	Payme	nt Syst	em (P	2.00
		component mame	Number	Number	Type	Certi fi ed		0, or		
							V V	XVIII		1
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	1
	Hospital and Hospital-Based Componer			1						
00	Hospi tal	DEARBORN COUNTY	150086	17140	1	07/01/1966	N	P	0	3.00
00		HOSPI TAL								1.0
00	Subprovi der – IPF Subprovi der – IRF									4.0
00	Subprovider - (Other)									6.0
. 00	Swing Beds - SNF									7.0
. 00	Swing Beds - NF									8.00
00	Hospital-Based SNF									9.0
0. 00	Hospital-Based NF									10.0
1.00	Hospital-Based OLTC									11.0
2.00	Hospital-Based HHA	HEALTH SERVICES CORP.	157055	17140		10/01/1978	N	P	N	12.00
		OF SE IN								10.0
	Separately Certified ASC		151501	17140		12/22/1994				13.00
4.00	Hospi tal -Based Hospi ce	HOSPICE OF SOUTHEASTERN	151531	17140		12/22/1994				14.00
5 00	Hospital-Based Health Clinic - RHC	INDIANA								15.0
	Hospital -Based Health Clinic - FQHC									16.0
	Hospital-Based (CMHC) I									17.0
8.00	Renal Dialysis									18.0
9.00	Other									19.00
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						1.00		2.0	00	
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1.00 2.00 2.01 2.02 2.02	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju \$412.106? In column 1, enter "Y" fof facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fof Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting period Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost ref Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in co for the portion of the cost reportir in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no.	istment, in accordance wi or yes or "N" for no. Is (412.106(c)(2)(Pickle amo or yes or "N" for no. icompensated care payment mn 1, "Y" for yes or "N" eriod occurring prior to "for no for the portion er October 1. (see instr requires final uncomper port settlement? (see in "for no, for the portion er 1. Enter in column 2, ie cost reporting period accord to delineating stati tolumn 1, "Y" for yes or ig period prior to Octobe no for the portion of the er October 1. (see instr tolumn 1, "Y" for yes or ig period prior to Octobe no for the portion of the 2.105)? Enter in column	th 42 CF this endment s for th for no October n of the ructions) nsated ca structio on of the "Y" for on or af m urban t stical a "N" for er 1. Ent te cost 09 beds (3, "Y" f	R is for 1. cost re ns) yes ter o reas no er as or	Y Y N	9 2.00 N Y N N		3. (00	21.0 22.0 22.0 22.0 22.0
1.00 2.00 2.01 2.02 2.02	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fof facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" for Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting period Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost re Enter in column 1, "Y" for yes or "N cost reporting period prior to October or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in co for the portion of the cost reportir in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41	istment, in accordance wi or yes or "N" for no. Is (412.106(c)(2)(Pickle amo or yes or "N" for no. icompensated care payment mn 1, "Y" for yes or "N' eriod occurring prior to "for no for the portion er October 1. (see instra- requires final uncomper port settlement? (see in "for no, for the portion er 1. Enter in column 2, be cost reporting period and reclassification from ds for delineating stati- column 1, "Y" for yes or g period prior to Octobe no for the portion of the er October 1. (see instra- toolumn 1, "Y" for yes or g period prior to Octobe no for the portion of the er October 1. (see instra- 100 but not more than 49 2.105)? Enter in column edicaid days on lines 24	th 42 CF this endment ts for th for no October n of the uctions) nsated ca structio on of the "Y" for on or af m urban t stical a "N" for er 1. Ent ne cost uctions) 09 beds (3, "Y" f	R is for 1. cost re ns) yes ter o reas no er as or 5	Y Y N	9 2.00 N Y N N		3. (00	21.0 22.0 22.0 22.0
1.00 2.00 2.01 2.02 2.02	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fc facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fc Did this hospital receive interim ur cost reporting period? Enter in colu the portion of the cost reporting pe Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost re- Enter in column 1, "Y" for yes or "N cost reporting period prior to Octodo or "N" for no, for the portion of th October 1. Did this hospital receive a geograph- rural as a result of the OMB standar adopted by CMS in FY2015? Enter in co for the portion of the cost reportir in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no.	istment, in accordance wi in yes or "N" for no. Is (412.106(c)(2)(Pickle amo or yes or "N" for no. icompensated care payment imn 1, "Y" for yes or "N' eriod occurring prior to "for no for the portion er October 1. (see instr requires final uncomper port settlement? (see in "for no, for the portion er 1. Enter in column 2, the cost reporting period and reclassification from rds for delineating stati solumn 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 49 2.105)? Enter in column edicaid days on lines 24 of admission, 2 if censu	th 42 CF this endment is for the of the uctions) hasted ca histruction on of the "Y" for on or af h urban t stical a "N" for er 1. Ent he cost uctions) 09 beds (3, "Y" f and/or 2 us days,	R is for 1. cost re ns) yes ter o reas no er as for 5 or 3	Y Y N	9 2.00 N Y N N		3. (00	21.0 22.0 22.0 22.0 22.0
1.00 2.00 2.01 2.02	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fc facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fc Did this hospital receive interim ur cost reporting period? Enter in colu the portion of the cost reporting pe Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost re- Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in col for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Which method is used to determine Me below? In column 1, enter 1 if date	istment, in accordance wi in yes or "N" for no. Is (412.106(c)(2)(Pickle and or yes or "N" for no. iccompensated care payment mun 1, "Y" for yes or "N" eriod occurring prior to "for no for the portion er October 1. (see instr requires final uncomper port settlement? (see in "for no, for the portion er 1. Enter in column 2, ie cost reporting period dic reclassification from ds for delineating stati- column 1, "Y" for yes or ig period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 42 2.105)? Enter in column edicaid days on lines 24 of admission, 2 if censu- of identifying the days method used in the prior	th 42 CF this endment s for th for no October n of the ructions) sated ca astructio on of the "Y" for on or af n urban t stical a "N" for er 1. Ent he cost "Y" f and/or 2 us days, in this cost	R is for 1. cost re ns) yes ter o reas no er as for 5 or 3	Y Y N	9 2.00 N Y N N		3. (00	21. 0 22. 0 22. 0 22. 0

PITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA I	Provider CC	CN: 15-0086	Peri od:			neet S-2	2
					1/2020	3/31/2	ime Pre 2021 12:	eparec 34 pm
	In-State Medicaid paid days	ln-State Medicaid eligible	Out-of State Medi cai d	Out-of State Medicaid	Medica HMO da	iys Me	Other di cai d days	
		unpai d days	paid days	el i gi bl e unpai d				_
20 If this provider is an LDDS bespital enter the	1.00	2.00	3.00	4.00	5.00		6.00	2 24
 D0 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 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. D0 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 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 	0	941		0		420 0	C	24.1
Medicaid eligible unpaid days in column 4, Medicaid								
HMO paid and eligible but unpaid days in column 5.							6.0	
				Urban/F			f Geogr 00	-
00 Enter your standard geographic classification (not wa		at the be	ginning of		1		00	26.
cost reporting period. Enter "1" for urban or "2" for D0 Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi	age) status r "2" for r	ural. If a		st	1			27.
00 If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	e number of	periods S	CH status i		0	E 1		35.
				Begi n 1.			i ng: 00	-
20 Enter applicable beginning and ending dates of SCH st of periods in excess of one and enter subsequent date		cript line	36 for num	ber				36.
00 If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.		r of perio	ds MDH stat	us	0			37.
1 Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo instructions)								37.
D0 If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.				Y/		V	/N	38
				1.			00	-
Do Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet 1 accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions)), (íi), or the mileage	(iii)? En requireme	ter in colu nts in	ume Y mn			Y	39
00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	ber 1. Ente	r "Y" for			/	_	N	40
					V 1.00	XVIII 2.00		-
Prospective Payment System (PPS)-Capital						. 2.00	3.00	
D0 Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions)		·				N	N	45
D0 Is this facility eligible for additional payment excerpursuant to 42 CFR §412.348(f)? If yes, complete Wks1 Pt. III.	eption for t. L, Pt. I	extraordin II and Wks	ary circums t. L-1, Pt.	tances I through	N	N	N	46
00 Is this a new hospital under 42 CFR §412.300(b) PPS of 1s the facility electing full federal capital payment Teaching Hospitals					N N	N N	N N	47 48
00 Is this a hospital involved in training residents in "N" for no in column 1. If column 1 is "Y", are you i	impacted by	CR 11642						56
GME payment reduction? Enter "Y" for yes or "N" for DO If line 56 is yes, is this the first cost reporting p	period duri	ng which r " for no i	n column 1.	lf column				57
GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "'	th of this Y", complet	e Workshee						
is "Y" did residents start training in the first mont	th of this Y", complet I, if appli pursement f	e Workshee cable. or physici	t E-4. lf c	olumn 2 is				58

ealth Financial Systems DEARBOF OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA	Provider CO	1	Period: From 01/01/2020 To 10/31/2020	u of Form CMS-2 Worksheet S-2 Part I Date/Time Pre 3/31/2021 12:	pared:
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
			1.00	2.00	3.00	
0.00 Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413 instructions) Enter "Y" for yes or "N" for no in co is "Y", are you impacted by CR 11642 (or subsequent adjustement? Enter "Y" for yes or "N" for no in col If line 60 is yes, complete columns 2 and 3 for each	.85? (s Lumn 1. CR) NAHE umn 2.	see If column 1 E MA payment	Y	Y 23.00	1	60. 0 60. 0
instructions)	Y/N	IME	Direct GME	I ME	Direct GME	
	1 00	2.00	2.00	4.00	E 00	
1.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in	1.00 N	2.00	3.00	4.00	5.00	61.0
column 1. (see instructions) 1.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61. 0 [.]
1.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.0
1.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.0
 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 						61.0
1.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line						61.0
 61.04 minus line 61.03). (see instructions) 1.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) 						61.0
	Pro	gram Name	Program Code	e Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
T		1.00	2.00	3.00	4.00	
1.10 Of the FTEs in line 61.05, specify each new program special ty, 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.				0.00	0. 00	61.1
1.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4,				0.00	0. 00	61.2
the direct GME FTE unweighted count.	I		I	1		
ACA Provisions Affecting the Health Resources and Se	rvices	Administration	(HRSA)		1.00	
2.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instru	trainec ctions)	l in this cost	reporting pe		0.00	62.0
2.01 Enter the number of FTE residents that rotated from during in this cost reporting period of HRSA THC pro	a Teachi gram. (s	see instructio		o your hospital	0.00	62.0
Teaching Hospitals that Claim Residents in Nonprovid 3.00 Has your facility trained residents in nonprovider so "Y" for yes or "N" for no in column 1. If yes, completion	ettings	during this c			N	63.0

	nancial Systems AND HOSPITAL HEALTH CARE COMP		RN COUNTY HOSPITAL ATA Provider C	CN: 15-0086 Pe	eriod:	u of Form CMS-2 Worksheet S-2	
oor rine					rom 01/01/2020	Part I	pared:
				Unweighted	Unweighted	Ratio (col.	
				FTEs Nonprovider Site	FTEs in Hospital	1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	-
Se	ection 5504 of the ACA Base Yea	r FTE Residents in N	lonprovider Settings-				
	eriod that begins on or after J			,			
i n re se re	nter in column 1, if line 63 is a the base year period, the num ssident FTEs attributable to ro ettings. Enter in column 2 the ssident FTEs that trained in yo f (column 1 divided by (column	ber of unweighted no tations occurring in number of unweighte ur hospital. Enter i	n-primary care all nonprovider d non-primary care n column 3 the ratio		0.00	0. 000000	64.00
	(cordinin i divided by (cordinin	Program Name	Program Code	Unweighted	Unweighted	Ratio (col.	
				FTËs Nonprovi der	FTEs in Hospital	3/ (col . 3 + col . 4))	
	-	1 00	2.00	Si te	1.00	E 00	-
5.00 En	iter in column 1, if line 63	1.00	2.00	3.00	4.00	5.00 0.000000	65 00
is tr ye as FT re th co un re no co un re yo, di	s yes, or your facility rained residents in the base ar period, the program name sociated with primary care "Es for each primary care ogram in which you trained esidents. Enter in column 2, he program code. Enter in olumn 3, the number of weighted primary care FTE esidents attributable to otations occurring in all on-provider settings. Enter in olumn 4, the number of weighted primary care esident FTEs that trained in our hospital. Enter in column the ratio of (column 3 vided by (column 3 + column). (see instructions)			Unweighted	Unwei ghted	Ratio (col.	
				FTEs Nonprovi der Si te	FTEs in Hospital	1/ (col. 1 + col. 2))	_
5.	ection 5504 of the ACA Current	Voar ETE Docidonto :	n Nonnrovidor Sottin	1.00	2.00	3.00	
	ginning on or after July 1, 20		n Nonprovider Settin	gsErrective r	or cost report	ing periods	
6.00 En FT En	iter in column 1 the number of Es attributable to rotations o iter in column 2 the number of Es that trained in your hospit	unweighted non-prima ccurring in all nonp unweighted non-prima	rovider settings. ry care resident	0.00	0.00	0. 000000	66.00
	column 1 divided by (column 1 +						
		Program Name	Program Code	Unweighted	Unweighted	Ratio (col.	
				FTEs Nonprovider	FTEs in Hospital	3/ (col . 3 + col . 4))	
				Site	nospi tai	(01. 4))	
		1.00	2.00	3.00	4.00	5.00	1
na	ter in column 1, the program me associated with each of	1.00	2.00	0.00			67.00
wh En co nu ca to no co un re yo 5, di	pur primary care programs in nich you trained residents. hter in column 2, the program de. Enter in column 3, the umber of unweighted primary ure FTE residents attributable portations occurring in all pon-provider settings. Enter in olumn 4, the number of weighted primary care esident FTEs that trained in pur hospital. Enter in column the ratio of (column 3 vided by (column 3 + column). (see instructions)						

Heal th	Financial Systems DEARBORN COUNTY HOSPITAL		In	Li eu	of Form	n CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider		eriod: rom 01/01/ o 10/31/	2020	Workshe Part I Date/Ti 3/31/202	me Pre	pared:
		I					34 pili
	Inpatient Psychiatric Facility PPS				2.00	3.00	70.00
	Is this facility an Inpatient Psychiatric Facility (IPF), or does it cor Enter "Y" for yes or "N" for no.			N			70.00
	If line 70 is yes: Column 1: Did the facility have an approved GME teach recent cost report filed on or before November 15, 2004? Enter "Y" for 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train resident program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for Column 3: If column 2 is Y, indicate which program year began during thi (see instructions)	yes or "N" for ts in a new teac yes or "N" for	no. (see hi ng no.			0	71.00
75 00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it	contain an LRE		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 teach		the most			0	76.00
	recent cost reporting period ending on or before November 15, 2004? Enter no. Column 2: Did this facility train residents in a new teaching progra CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: I indicate which program year began during this cost reporting period. (see	er "Y" for yes c am in accordance f column 2 is Y	r "N" for with 42			0	/0.00
				-	1.0	0	
	Long Term Care Hospi tal PPS						
	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for Is this a LTCH co-located within another hospital for part or all of the "Y" for yes and "N" for no.		period? E	nter	N N		80.00 81.00
85.00	TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Ent	ter "Y" for yes	or "N" for	no.	N		85.00
	Did this facility establish a new Other subprovider (excluded unit) unde \$413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified		n		N		86.00 87.00
07.00	1886(d) (1) (B) (vi)? Enter "Y" for yes or "N" for no.		V			,	07.00
			1.00		XI X 2. 0		
90.00	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services?	Enter "Y" for	N		Y		90.00
91.00	yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost repo	ort either in	N		Y		91.00
	full or in part? Enter "Y" for yes or "N" for no in the applicable colum Are title XIX NF patients occupying title XVIII SNF beds (dual certifica instructions) Enter "Y" for yes or "N" for no in the applicable column.				Ν		92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V a	and XIX? Enter	N		Ν		93.00
94.00	"Y" for yes or "N" for no in the applicable column. Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for	no in the	N		Ν		94.00
	applicable column. If line 94 is "Y", enter the reduction percentage in the applicable colu Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for		0. 00 N		0. 0 N	0	95.00 96.00
97.00	applicable column. If line 96 is "Y", enter the reduction percentage in the applicable colu	umn.	0.00		0.0	0	97.00
	Does title V or XIX follow Medicare (title XVIII) for the interns and restepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "M	esidents post	Y		Y		98.00
98. 01	column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the reporting of c C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and i	5	Y		Y		98.01
98. 02	title XIX. Does title V or XIX follow Medicare (title XVIII) for the calculation of bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no		Y		Y		98.02
98.03	for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a critical access reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for		N		Ν		98.03
98. 04	for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 1 outpatient services cost? Enter "Y" for yes or "N" for no in column 1 fo		N		Ν		98.04
98.05	in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) and add back the RCE c Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for		Y		Y		98.05
	column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) when cost reimbursed f Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title column 2 for title XIX.		Y		Y		98.06
405 -	column 2 for title XIX. Rural Providers						105
	Does this hospital qualify as a CAH? If this facility qualifies as a CAH, has it elected the all-inclusive me	ethod of payment	N N				105.00 106.00
107.00	for outpatient services? (see instructions) Column 1: If line 105 is Y, is this facility eligible for cost reimburse	ement for I&R	N				107.00
	training programs? Enter "Y" for yes or "N" for no in column 1. (see in Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train 18 approved medical education program in the CAH's excluded IPF and/or IRF	nstructions) &Rs in an					
	Enter "Y" for yes or "N" for no in column 2. (see instructions)	an (3):					

Health Financial Systems DEARBORN COUNT	Y HOSPI TAL		In Lieu	of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C		eriod: com 01/01/2020 o 10/31/2020	Worksheet S- Part I Date/Time Pr 3/31/2021 12	epared:
			V	XI X	_
108.00 Is this a rural hospital qualifying for an exception to the	CRNA fee sche	edul e? See 42	1.00 N	2.00	108.00
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Physi cal	Occupati onal	Speech	Respi ratory	
	1.00	2. 00	Speech 3.00	4.00	_
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
110.00 Did this hospital participate in the Rural Community Hospita Demonstration)for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.	Y" for yes or	"N" for no. I	f yes,	1.00 N	110.00
			1.00	2.00	_
111.00 If this facility qualifies as a CAH, did it participate in t Health Integration Project (FCHIP) demonstration for this co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ad for tele-health services.	ost reporting Dumn 1 is Y, ticipating ir	period? Enter enter the column 2.	N		111.00
		1.00	2.00	3.00	-
112.00 Did this hospital participate in the Pennsylvania Rural Heal demonstration for any portion of the current cost reporting Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital cea participation in the demonstration, if applicable.	period? "Y", enter Ne	N			112.00
Miscellaneous Cost Reporting Information 115.00[Is this an all-inclusive rate provider? Enter "Y" for yes or	"N" for no	N			0115.00
in column 1. If column 1 is yes, enter the method used (A, B in column 2. If column 2 is "E", enter in column 3 either "9 for short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals provider the definition in CMS Pub. 15-1, chapter 22, §2208.1.	8, or E only) 23" percent includes rs) based on				11/ 00
116.00 Is this facility classified as a referral center? Enter "Y" "N" for no.	for yes or	N			116.00
117.00 Is this facility legally-required to carry malpractice insur "Y" for yes or "N" for no.	ance? Enter	Y			117.00
118.00 Is the malpractice insurance a claims-made or occurrence pol lif the policy is claim-made. Enter 2 if the policy is occurr		1			118.00
		Premi ums	Losses	Insurance	
118.01 List amounts of malpractice premiums and paid losses:		1.00	2.00	3.00	0118.01
					_
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein.			1.00 N	2.00	118.02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendment	column 1, "۱ اalifies for t	(" for yes or the Outpatient	Ν	Ν	119.00 120.00
Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no.	intable device	es charged to	Y		121.00
122.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.			Ν		122.00
Transplant Center Information 125.00Does this facility operate a transplant center? Enter "Y" fo	or yes and "N"	for no. If	N		125.00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, en	iter the certi	fication date			126.00
in column 1 and termination date, if applicable, in column 2 127.00 If this is a Medicare certified heart transplant center, ent	2.				127.00
in column 1 and termination date, if applicable, in column 2 128.00 If this is a Medicare certified liver transplant center, ent	2.				127.00
129.00 129.00					128.00

ilth Financial Systems SPITAL AND HOSPITAL HEALTH CARE COMPLE		COUNTY HOSPITAL A Provider CC	N: 15-0086	Per		eu of Form CMS Worksheet S Part I	
				To	10/31/2020	Date/Time P 3/31/2021 1	repare 2:34 pi
				_	1.00	2.00	_
0.00 If this is a Medicare certified pa			ti fi cati or	۱			130.
date in column 1 and termination (1.00 f this is a Medicare certified in			erti fi cati	on			131.
date in column 1 and termination of	date, if applicable, i	in column 2.					131.
2.00 f this is a Medicare certified is in column 1 and termination date,		-	cation da	ate			132.
3. 00 Removed and reserved	Ti appricable, Ti co	rumr z.					133.
4.00 If this is an organ procurement of and termination date, if applicable All Providers		ter the OPO number i	in column	1			134.
0. 00 Are there any related organization	n or home office cost	s as defined in CMS	Pub. 15-1	I,	N		140.
chapter 10? Enter "Y" for yes or				osts			
are claimed, enter in column 2 the 1.00	e nome office chain n	2.00	tions)		3.00		
If this facility is part of a cha		er on lines 141 thro	ugh 143 tl	he name		s of the home	
office and enter the home office	<u>Contractor name and c</u>		Contra	actor's	Number:		141.
2.00 Street:	PO Box:						142.
8. 00 Ci ty:	State:		Zip Co	ode:			143.
						1.00	-
.00 Are provider based physicians' co	sts included in Works	heet A?				Y	144.
				-	1.00	2.00	_
.00 If costs for renal services are c	laimed on Wkst. A, li	ne 74, are the costs	s for		1.00	2.00	145.
inpatient services only? Enter "Y							
no, does the dialysis facility in period? Enter "Y" for yes or "N"		ation for this cost	reporting	3			
0.00 Has the cost allocation methodolog	gy changed from the p				Ν		146.
Enter "Y" for yes or "N" for no in		Pub. 15-2, chapter 4	40, §4020)	lf			
yes, enter the approval date (mm/o	dd/yyyy) in column 2.						_
						1.00	
7.00 Was there a change in the statisti	ical basis? Enter "Y"					N	
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.00 Was there a change in the statisti .00 Was there a change in the order o .00 Was there a change to the simplifi Does this facility contain a prov or charges? Enter "Y" for yes or .00 Hospital .00 Subprovider - IPF .00 Subprovider - IRF .00 SUBPROVIDER .00 SNF .00 HOME HEALTH AGENCY .00 CMHC Multicampus .00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no. .00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)	ical basis? Enter "Y" f allocation? Enter "Y ied cost finding meth ider that qualifies f "N" for no for each c ampus hospital that ha <u>Name</u> 0	Y" for yes or "N" for od? Enter "Y" for yes Part A 1.00 for an exemption fro component for Part A N N N N N N N N N N N N N N N N N N N	or no. es or "N" Part I 2.00 m the appl and Part N N N N N N N N State 2.00	B licatic B. (Se fferen Zip Cc 3.00	Title V 3.00 on of the Io ee 42 CFR §4 N N N N N N N N N t CBSAs? ode CBSA 0 4.00	N N N Title XIX 4.00 wer of costs 13.13) N N N N N N N N N N N N N N N N N N N	148. 149. 155. 156. 157. 158. 159. 160. 161. 165.
.00 Was there a change in the statisti .00 Was there a change in the order of .00 Was there a change to the simplified Does this facility contain a provor or charges? Enter "Y" for yes or .00 Hospital .00 Subprovider - IPF .00 Subprovider - IRF .00 SUBPROVIDER .00 SUBPROVIDER .00 Multicampus .00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no. .00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)	ical basis? Enter "Y" f allocation? Enter "Y ied cost finding meth ider that qualifies f "N" for no for each c ampus hospital that ha Name 0 T) incentive in the A	Y" for yes or "N" for od? Enter "Y" for yes Part A 1.00 for an exemption fro component for Part A N N N N N N N N N N N N N N N N N N N	or no. es or "N" Part I 2.00 m the appl and Part N N N N N N N N N N N N N	B licatic B. (Se fferen Zip Cc 3. 00	Title V 3.00 on of the Io ee 42 CFR §4 N N N N N N N N N t CBSAs? ode CBSA 0 4.00	N N N Title XIX 4.00 wer of costs 13.13) N N N N N N N N N N N N N N N N N N N	148. 149. 155. 156. 157. 158. 159. 160. 161. 165. 00 166.
OO Was there a change in the statisti OO Was there a change in the order of OO Was there a change to the simplifi Does this facility contain a prov or charges? Enter "Y" for yes or OO Hospital OO Subprovider - IPF OO Subprovider - IRF OO SUBPROVIDER OO SUBPROVIDER OO SUBPROVIDER OO CMHC Multicampus OO 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) Heal th Information Technology (HI OO If this provider a meaningful use	ical basis? Enter "Y" f allocation? Enter "Y ied cost finding methi ider that qualifies f "N" for no for each c "N" for no for each c	Y" for yes or "N" for od? Enter "Y" for yes Part A 1.00 for an exemption fro component for Part A N N N N N N N N N N N N N N N N N N N	and Part Part I 2.00 m the appl and Part N N N N N N N N N N N N N	B licatic B. (Se fferen Zip CC 3.00 tment A	Title V 3.00 on of the lo 22 CFR §4 N N N N N N N N N N N N N	N N N Title XIX 4.00 wer of costs 13.13) N N N N N N N N N N N N N N N N N N N	148. 149. 155. 156. 157. 158. 159. 160. 161. 165. 00 166.
7. 00 Was there a change in the statisti 8. 00 Was there a change in the order of 9. 00 Was there a change to the simplific Does this facility contain a provious or charges? Enter "Y" for yes or 5. 00 Hospital 5. 00 Subprovider - IPF 7. 00 Subprovider - IRF 8. 00 SUBPROVIDER 9. 00 SNF 9. 00 SNF 9. 00 HOME HEALTH AGENCY 1. 00 CMHC Multicampus 5. 00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 0, county in column 1, state in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 7. 00 If his provider a meaningful user 8. 00 If this provider is a CAH (line 10) reasonable cost incurred for the line 10) and the second for the line 10) and t	ical basis? Enter "Y" f allocation? Enter "Y ied cost finding mething ider that qualifies f "N" for no for each c "N" for no for each c	Y" for yes or "N" fo od? Enter "Y" for yes Part A 1.00 for an exemption fro component for Part A N N N N N N N N N N N N N	or no. es or "N" Part I 2.00 m the appl and Part N N N N N N N N N N N N N	B licatic B. (Se B. (Se fferen Zip Cc 3. 0C tment A D. 'Y"), e	Title V 3.00 on of the lo e 42 CFR §4 N N N N N N N N N N CBSAS? Ode CBSA O 4.00 Act Act The lo	N N N Title XIX 4.00 wer of costs 13.13) N N N N N N N N N N N N N N N N N N N	155. 156. 157. 158. 159. 160. 161. 165. 00 166. 00 166.
OO Was there a change in the statisti OO Was there a change in the order of OO Was there a change to the simplifi Does this facility contain a prov or charges? Enter "Y" for yes or OO Hospital OO Subprovider - IPF OO Subprovider - IRF OO SUBPROVIDER OO SUBPROVIDER OO SUBPROVIDER OO CMHC Multicampus OO 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) Heal th Information Technology (HI OO If this provider a meaningful use	ical basis? Enter "Y" f allocation? Enter "Y ied cost finding methi ider that qualifies f "N" for no for each c "N" for no for each c	Y" for yes or "N" fo od? Enter "Y" for ye Part A 1.00 or an exemption fro component for Part A N N N N N N N N N N N N N	or no. es or "N" Part I 2.00 m the appl and Part N N N N N N N N N N N N N	B ii cati c B. (Se E. (Se fferen Zip Cc 3.00 tment A). 'Y"), e for a pns)	Title V 3.00 on of the Io ee 42 CFR §4 N N N N N N N N N N N N N	N N N Title XIX 4.00 wer of costs 13.13) N N N N N N N N N N N N N N N N N N N	148. 149. 155. 156. 157. 158. 159. 160. 161. 165. 00 166.

Health Financial Systems	DEARBORN COUNTY	HOSPI TAL	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDE	NTIFICATION DATA	Provider CCN: 15-0086	Period:	Worksheet S-	2
			From 01/01/2020		
			To 10/31/2020	Date/Time Pr 3/31/2021 12	
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginn period respectively (mm/dd/yyyy)			170.00		
			1.00	2.00	
171.00 If line 167 is "Y", does this provider	have any days for indiv	viduals enrolled in	N		0171.00
section 1876 Medicare cost plans report					
"Y" for yes and "N" for no in column 1.	lf column 1 is yes, en	nter the number of secti	on		
1876 Medicare days in column 2. (see in	structions)				

	Financial Systems DEARBORN COUN AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	ITY HOSPITAL Provider C	CN- 15 0096	Peri od:	u of Form CMS Worksheet S-	
5711	AL AND HOSFITAL HEALTH GARE REIMBORSEMENT QUESTIONNALKE	FIOVIDEI C	CN. 15-0080	From 01/01/2020 To 10/31/2020	Part II	epared
				Y/N	Date	<u>. 34 p</u>
				1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter M mm/dd/yyyy format.	N for all NO r	esponses. En	ter all dates in	the	
	COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation					
00	Has the provider changed ownership immediately prior to the			N		1.
	reporting period? If yes, enter the date of the change in	corumn 2. (see	Y/N	Date	V/I	
			1.00	2.00	3.00	
00	Has the provider terminated participation in the Medicare I yes, enter in column 2 the date of termination and in colu voluntary or "I" for involuntary.		N			2.
00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug der or its of the board	N			3.
			Y/N	Туре	Date	
			1.00	2.00	3.00	
00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cerr Accountant? Column 2: If yes, enter "A" for Audited, "C" or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	for Compiled, ailable in	Y	A		4.
00	Are the cost report total expenses and total revenues differences on the filed financial statements? If yes, submit re-		N	Y/N	Legal Oper.	5.
				1.00	2.00	+
	Approved Educational Activities					
00	Column 1: Are costs claimed for nursing school? Column 2:	lfyes, is t	he provider	is N		6.
00	the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see in	nstructions		Y		7.
00	Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.		d during the			8.
00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		cal education	n N		9
. 00	Was an approved Intern and Resident GME program initiated of cost reporting period? If yes, see instructions.		the current	N		10
. 00	Are GME cost directly assigned to cost centers other than Teaching Program on Worksheet A? If yes, see instructions.	I & R in an Ap	proved	N		11
					Y/N 1.00	+
	Bad Debts	<u>.</u>			1.00	
. 00	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.			cost reporting	Y N	12. 13.
. 00	If line 12 is yes, were patient deductibles and/or co-paym	ents waived? I	fyes, see i	nstructions.	Ν	14
~ ~	Bed Complement					
. 00	Did total beds available change from the prior cost report		<u>yes, see in</u> t A	structions. Par	Y + B	15
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
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	Y	12/16/2020) Y	12/16/2020	16
00	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)	Ν		N		17
. 00	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 scores?	Ν		N		18
. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	N		Ν		19

Heal th	Fi nanci al	Systems	

DEARBORN COUNTY HOSPITAL

In Lieu of Form CMS-2552-10

HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C		Period:	Worksheet S-2	2
				From 01/01/2020 To 10/31/2020		epared: 34 pm
		Descri	ption	Y/N	Y/N	
		()	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	
01.00		1.00	2.00	3.00	4.00	01.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS H	HOSPI TALS)			_
22.00	Capital Related Cost				N	
	Have assets been relifed for Medicare purposes? If yes, see Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	ng the cost	N N	22.00 23.00		
24.00	Were new leases and/or amendments to existing leases enter If yes, see instructions	orting period?	Y	24.00		
25.00	Have there been new capitalized leases entered into during instructions.	g the cost repor	rting period?	lfyes, see	Ν	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during t instructions.	he cost reporti	ng period? If	yes, see	Ν	26.00
27.00	Has the provider's capitalization policy changed during th copy.	ne cost reportin	ng period?lf	yes, submit	N	27.00
	Interest Expense					_
	Were new loans, mortgage agreements or letters of credit e period? If yes, see instructions.		-		Y	28.00
	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see inst	ructions			N	29.00
	Has existing debt been replaced prior to its scheduled mat instructions.	5	5		N	30.00
31.00	Has debt been recalled before scheduled maturity without i instructions.	ssuance of new	debt? If yes,	see	N	31.00
22 00	Purchased Services Have changes or new agreements occurred in patient care se	rul coc furni ch	ad through con	tractual	N	32.00
	arrangements with suppliers of services? If yes, see instr If line 32 is yes, were the requirements of Sec. 2135.2 ap	ructions.	0			33.00
	no, see instructions.					_
24 00	Provider-Based Physicians Are services furnished at the provider facility under an a	rrangement with	n providor bas	od physicians?	Y	34.00
34.00	If yes, see instructions.	irrangement with	i provider-bas	eu physicians?	ř	34.00
35.00	If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see i	isting agreemer	nts with the p	rovi der-based	Ν	35.00
	physicians during the cost reporting period, in yes, see i			Y/N	Date	
				1.00	2.00	
	Home Office Costs			T		
	Were home office costs claimed on the cost report?			N		36.00
37.00	If line 36 is yes, has a home office cost statement been p	prepared by the	home office?			37.00
38.00	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year en					38.00
39.00	If line 36 is yes, did the provider render services to oth see instructions.					39.00
40.00	If line 36 is yes, did the provider render services to the instructions.	e home office?	lf yes, see			40.00
		00				
	Cost Report Preparer Contact Information	00				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	JODI		SANDERS		41.00
42.00	respectively. Enter the employer/company name of the cost report	BLUE & CO., LL	с			42.00
	preparer.					
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7956		JSANDERS@BLUEA	NDCO. COM	43.00

Heal th	Financial Systems DEARBOR	N COUM	NTY HOSPI TAL	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAI	RE	Provider CCN: 15-0086	Period:	Worksheet S-2	
				From 01/01/2020 To 10/31/2020	Date/Time Pre 3/31/2021 12:	pared: 34 pm
			3.00			
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position	on	MANAGER			41.00
	held by the cost report preparer in columns 1, 2, and	d 3,				
	respectively.					
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 o	cost				43.00
	report preparer in columns 1 and 2, respectively.					

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	DEARBORN COUNT	Provider C	CN: 15-0086	Peri od:	u of Form CMS-2 Worksheet S-3	
					From 01/01/2020	Part I	
					To 10/31/2020	Date/Time Pre	
						3/31/2021 12: I/P Days /	34 pm
						0/P Visits /	
						Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
	componente	Line Number		Avai I abl e	of all flood of o		
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	54	16, 47	70 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						3.0
1.00	HMO IRF Subprovider						4.0
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.0
b. 00	Hospital Adults & Peds. Swing Bed NF					0	6.0
. 00	Total Adults and Peds. (exclude observation		54	16, 47	70 0.00	0	7.0
	beds) (see instructions)						
. 00	INTENSIVE CARE UNIT	31.00	8	2, 44	40 0.00	0	8.0
. 00	CORONARY CARE UNIT						9.0
0.00	BURN INTENSIVE CARE UNIT						10.0
1.00	SURGI CAL I NTENSI VE CARE UNI T						11.0
2.00	OTHER SPECIAL CARE (SPECIFY)	10.00				0	12.0
3.00	NURSERY	43.00	(0)	10.0		0	
4.00	Total (see instructions)		62	18, 91	0.00	0	14.0
5.00	CAH visits					0	
6.00 7.00	SUBPROVI DER – I PF SUBPROVI DER – I RF						16.0
7.00 8.00	SUBPROVIDER - TRF						17.0
8.00 9.00	SUBPROVIDER SKILLED NURSING FACILITY	44.00	0		0	0	
0.00	NURSING FACILITY	44.00	0		0	0	20.0
1.00	OTHER LONG TERM CARE						20.0
2.00	HOME HEALTH AGENCY	101.00				0	
3.00	AMBULATORY SURGICAL CENTER (D. P.)	101.00				0	23.0
4.00	HOSPI CE	116.00	0		0		24.0
4.10	HOSPICE (non-distinct part)	30,00	0		0		24.1
5.00	CMHC - CMHC	00.00					25.0
6. 00	RURAL HEALTH CLINIC						26.0
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	
7.00	Total (sum of lines 14-26)		62			-	27.0
8.00	Observation Bed Days		-			0	
9.00	Ambul ance Trips						29.0
0.00	Employee discount days (see instruction)						30.0
1.00	Employee discount days - IRF						31.0
2.00	Labor & delivery days (see instructions)		0		0		32.0
2.01	Total ancillary labor & delivery room						32.0
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33.0
33.01	LTCH site neutral days and discharges						33.0

Component 1.00 Hospi tal Adults & Peds. (cc 8 exclude Swing Bed, Observ. Hospi ce days) (see instructi for the portion of LDP room 2.00 HM0 and other (see instruct 3.00 HM0 IPF Subprovi der 5.00 Hospi tal Adults & Peds. Swi 6.00 Hospi tal Adults & Peds. Swi 7.00 Total Adults and Peds. (exc beds) (see instructions) 8.00 INTENSI VE CARE UNIT 9.00 CORONARY CARE UNIT 10.00 BURN INTENSI VE CARE UNIT 11.00 SURGI CAL INTENSI VE CARE UNIT 12.00 OTHER SPECI AL CARE (SPECI FY 13.00 NURSERY 14.00 Total (see instructions) 15.00 CAH visits 16.00 SUBPROVI DER - I PF 17.00 SUBPROVI DER - I RF 18.00 SUBPROVI DER 19.00 SKI LLED NURSI NG FACI LI TY 20.00 NURSI NG FACI LI TY 21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY		DEARBORN COUNT		NI: 15 0004		u of Form CMS-	
 Hospi tal Adults & Peds. (cc 8 exclude Swing Bed, Observ. Hospice days) (see instructi for the portion of LDP room 00 HMO and other (see instruct 00 HMO IPF Subprovider 00 HMO IPF Subprovider 00 Hospi tal Adults & Peds. Swi 00 Hospi tal Adults & Peds. Swi 00 Total Adults and Peds. (exc beds) (see instructions) 00 INTENSIVE CARE UNIT 00 CORONARY CARE UNIT 00 SURGICAL INTENSIVE CARE UNIT 00 OTHAR SPECIAL CARE (SPECIFY 13.00 NURSERY 01 Otal (see instructions) 02 CAH visits 03 SUBPROVIDER - IPF 04 SUBPROVIDER - IPF 05 SUBPROVIDER - IRF 06 SUBPROVIDER - IRF 07 OTHER LONG TERM CARE 08 OHME HEALTH AGENCY 09 OME (and the complexity of the complexity of	CARE COMPLEX STATISTIC	AL DATA	Provider CC		Period: From 01/01/2020	Worksheet S-3 Part I	5
 Hospital Adults & Peds. (cc 8 exclude Swing Bed, Observ. Hospice days) (see instructi for the portion of LDP room 00 HMO and other (see instruct 00 HMO IPF Subprovider 00 HMO IPF Subprovider 00 HMO IRF Subprovider 00 Hospital Adults & Peds. Swi 00 Total Adults and Peds. (exc beds) (see instructions) 00 INTENSIVE CARE UNIT 00 CORONARY CARE UNIT 00 SURGICAL INTENSIVE CARE UNIT 00 OTHAL SPECIAL CARE (SPECIFY 00 OTHER SPECIAL CARE (SPECIFY 01 OTAI (see instructions) 02 CAH visits 03 SUBPROVIDER - IPF 04 SUBPROVIDER - IPF 05 SUBPROVIDER - IRF 00 OTHER LONG TERM CARE 01 HOSPICE (non-distinct part) 05 OC CMHC - CMHC 06 RURAL HEALTH CLINIC 07 FEDERALLY QUALIFIED HEALTH 07 Total (sum of lines 14-26) 08 OD BWU and Inice Trips 00 OE Employee discount days (see 00 Employee discount days - IF 					To 10/31/2020	Date/Time Pre	
 Hospital Adults & Peds. (cc 8 exclude Swing Bed, Observ. Hospice days) (see instructi for the portion of LDP room 00 HMO and other (see instruct 00 HMO IPF Subprovider 00 HMO IPF Subprovider 00 HMO IRF Subprovider 00 Hospital Adults & Peds. Swi 00 Total Adults and Peds. (exc beds) (see instructions) 00 INTENSIVE CARE UNIT 00 CORONARY CARE UNIT 00 SURGICAL INTENSIVE CARE UNIT 00 OTHAL SPECIAL CARE (SPECIFY 13.00 NURSERY 01 Otal (see instructions) 02 CAH visits 03 SUBPROVIDER - IPF 04 SUBPROVIDER - IPF 05 SUBPROVIDER - IRF 06 SUBPROVIDER - IRF 07 OTHER LONG TERM CARE 08 ONURSING FACILITY 00 OTHER LONG TERM CARE 01 HOSPICE (non-distinct part) 05 OCMHC - CMHC 06 RURAL HEALTH CLINIC 07 FEDERALLY QUALIFIED HEALTH 07 OTAI (sum of lines 14-26) 08 OD BWU and Trips 						3/31/2021 12:	34 pm
 Hospital Adults & Peds. (cc 8 exclude Swing Bed, Observ. Hospice days) (see instructi for the portion of LDP room 00 HMO and other (see instruct 00 HMO IPF Subprovider 00 HMO IPF Subprovider 00 HMO IRF Subprovider 00 Hospital Adults & Peds. Swi 00 Total Adults and Peds. (exc beds) (see instructions) 00 INTENSIVE CARE UNIT 00 CORONARY CARE UNIT 00 SURGICAL INTENSIVE CARE UNIT 00 OTHAL SPECIAL CARE (SPECIFY 13.00 NURSERY 01 Otal (see instructions) 02 CAR visits 03 OSUBPROVIDER - IPF 04 OSUBPROVIDER - IPF 05 OSUBPROVIDER - IRF 00 SUBPROVIDER - IRF 00 SUBPROVIDER - IRF 00 OTHER LONG TERM CARE 01 ONER LED NURSING FACILITY 02 OME HEALTH AGENCY 03 OMBULATORY SURGICAL CENTER 04 HOSPICE 05 OKHC - CMHC 06 RURAL HEALTH CLINIC 26 FEDERALLY QUALIFIED HEALTH 27.00 Total (sum of lines 14-26) 28 OO OBservation Bed Days 29 OO Ambulance Trips 04 Deve discount days (see 04 Employee discount days - IF 		T/P Days	/ O/P Visits	/ Trips	Full lime	Equi val ents	
 Hospital Adults & Peds. (cc 8 exclude Swing Bed, Observ. Hospice days) (see instructi for the portion of LDP room 00 HMO and other (see instruct 00 HMO IPF Subprovider 00 HMO IPF Subprovider 00 HMO IRF Subprovider 00 Hospital Adults & Peds. Swi 00 Total Adults and Peds. (exc beds) (see instructions) 00 INTENSIVE CARE UNIT 00 CORONARY CARE UNIT 00 SURGICAL INTENSIVE CARE UNIT 00 OTHAL SPECIAL CARE (SPECIFY 13.00 NURSERY 01 Otal (see instructions) 02 CAR visits 03 OSUBPROVIDER - IPF 04 OSUBPROVIDER - IPF 05 OSUBPROVIDER - IRF 00 SUBPROVIDER - IRF 00 SUBPROVIDER - IRF 00 OTHER LONG TERM CARE 01 ONER LED NURSING FACILITY 02 OME HEALTH AGENCY 03 OMBULATORY SURGICAL CENTER 04 HOSPICE 05 OKHC - CMHC 06 RURAL HEALTH CLINIC 26 FEDERALLY QUALIFIED HEALTH 27.00 Total (sum of lines 14-26) 28 OO OBservation Bed Days 29 OO Ambulance Trips 04 Deve discount days (see 04 Employee discount days - IF 							
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29.00 Ambul ance Trips 30.00 Employee discount days (see 31.00 Employee discount days - IF	-26)			1 05	0.00	483.20	
30.00Employee di scount days (see31.00Employee di scount days - LE			16	1, 05	/		28.00
31.00 Employee discount days - IF		0					29.00
					0		30.00
32.00 ILADOR & DELIVERV DAVS (SEE					0		31.00
5 5 5 4		0	23	3			32.00
32.01 Total ancillary labor & del					0		32.01
outpatient days (see instru 33.00 LTCH non-covered days	ISTI UCTI ONS)	0					33.00
33.00 LTCH non-covered days 33.01 LTCH site neutral days and	and discharges	0					33.00

HOSPI 1	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CO	CN: 15-0086	Period: From 01/01/2020	Worksheet S-3 Part I	
					To 10/31/2020	Date/Time Pre 3/31/2021 12:	
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Patients	
		11.00	12.00	13.00	14.00	15.00	1.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	1, 04	41 78	2, 379	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	24 425		2.00
3.00	HMO I PF Subprovi der				0		3.00
4.00	HMO I RF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF				-		5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation						7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNI T						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGI CAL INTENSI VE CARE UNI T						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	1, 04	41 78	2, 379	
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00 18.00	SUBPROVI DER – I RF SUBPROVI DER						17.00 18.00
19.00	SUBPROVIDER SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY	0.00					20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambul ance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room						32.01
33.00	outpatient days (see instructions) LTCH non-covered days				0		33.00
JJ. 00	LIGH HUH-COVELED DAYS				V		1 33.00

	Financial Systems AL WAGE INDEX INFORMATION		DEARBORN COUN	Provi der CC		eriod: rom 01/01/2020	u of Form CMS-2 Worksheet S-3 Part II	
					T			epar
		Wkst. A Line Number	Amount Reported	Recl assi fi cat ion of Sal ari es (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	34
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA SALARIES							1
00	Total salaries (see instructions)	200.00	24, 035, 545	0	24, 035, 545	837, 558. 00	28. 70	
00	Non-physician anesthetist Part		0	0	0	0.00	0.00	
0	A Non-physician anesthetist Part		0	0	0	0.00	0.00	
0	B Physician-Part A -		0	0	0	0.00	0.00	
)1	Administrative Physicians - Part A - Teaching		0	0	0	0.00	0.00	
0	Physician and Non Physician-Part B		0	0	0	0.00	0.00) [
00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0. 00	0.00	
0	Interns & residents (in an	21.00	0	0	0	0.00	0.00	
)1	approved program) Contracted interns and residents (in an approved		0	0	0	0.00	0.00	
00	programs) Home office and/or related		0	0	0	0.00	0.00	8
00	organization personnel SNF	44.00	0	0	0	0.00	0.00	
00	Excluded area salaries (see instructions) OTHER WAGES & RELATED COSTS		1, 135, 277	112, 603	1, 247, 880	38, 747. 00	32. 21	10
00	Contract Labor: Direct Patient Care		373, 127	0	373, 127	4, 359. 96	85.58	1
00	Contract labor: Top level management and other management and administrative		0	0	0	0.00	0.00	1:
00	services Contract Labor: Physician-Part		332, 500	0	332, 500	1, 405. 00	236.65	1:
00	A - Administrative Home office and/or related organization salaries and		0	0	0	0.00	0.00	14
01	wage-related costs Home office salaries		0	0	0	0.00	0.00	
02 00	Related organization salaries Home office: Physician Part A		0	0	0	0.00 0.00	0. 00 0. 00	
00	- Administrative Home office and Contract		0	0	0	0.00	0.00	
	Physicians Part A - Teaching		0	0				
01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	
02	Home office contract <u>Physicians Part A - Teaching</u> WAGE-RELATED COSTS		0	0	0	0.00	0.00	10
00	Wage-related costs (core) (see		6, 430, 042	0	6, 430, 042			1
00	instructions) Wage-related costs (other)							18
00 00	(see instructions) Excluded areas Non-physician anesthetist Part		311, 895 0	0	311, 895 0			10 20
00	A Non-physician anesthetist Part		0	0	0			2
00	B Physician Part A - Administrative		0	0	о			2
01	Physician Part A - Teaching		0	0	0			22
00 00	Physician Part B Wage-related costs (RHC/FQHC)		0 0	0	0			23
00	Interns & residents (in an approved program)		0	0	0			2
50	Home office wage-related (core)		0	0	0			2
51	Related organization wage-related (core)		0	0	0			2
52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			2!

Heal th	Financial Systems		DEARBORN COUN	ITY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	AL WAGE INDEX INFORMATION					Period: From 01/01/2020 To 10/31/2020		pared:
		Wkst. A Line Number	Amount Reported	Reclassificat ion of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6, 00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core) OVERHEAD COSTS - DIRECT SALARI		0			0		25. 53
26.00	Employee Benefits Department	4.00	244, 817	0	244, 81	7 7, 956, 00	30. 77	26.00
	Administrative & General	5.00	3, 743, 289		3, 743, 28			
	Administrative & General under		574, 929		574, 92			
20.00	contract (see inst.)		574, 727		574, 72	4, 374.00	130. 04	20.00
29.00	Maintenance & Repairs	6.00	0	0		0.00	0.00	29.00
30.00	Operation of Plant	7.00	670, 382	0	623, 68			
31.00	Laundry & Linen Service	8.00	69,901	0	69,90			31.00
32.00	Housekeeping	9.00	663, 160	0	663, 16			
33.00	Housekeeping under contract (see instructions)		0	0		0 0.00		33.00
34.00	Dietary	10.00	596, 705	-378, 490	218, 21	5 13, 259. 00	16.46	34.00
35.00	Dietary under contract (see instructions)		0	0		0 0.00	0.00	35.00
36.00	Cafeteria	11.00	0	378, 490	378, 49	0 22, 997. 00	16.46	36.00
37.00	Maintenance of Personnel	12.00	0	0		0 0.00	0.00	37.00
38.00	Nursing Administration	13.00	969, 807	0	969, 80	7 26, 443. 00	36.68	38.00
39.00	Central Services and Supply	14.00	219, 567	0	219, 56	7 11, 734. 00	18. 71	39.00
40.00	Pharmacy	15.00	1, 060, 908	-65, 901	995, 00	7 23, 265. 00	42.77	40.00
41.00	Medi cal Records & Medi cal Records Li brary	16.00	471, 302	0	471, 30	2 20, 542. 00	22.94	41.00
42.00	Social Service	17.00	184, 698	0	184, 69	6, 062. 00	30. 47	42.00
43.00	Other General Service	18.00	0	0		0 0.00	0.00	43.00

Heal th	Financial Systems		DEARBORN COUN	ITY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPI 1	AL WAGE INDEX INFORMATION			Provider C		Period: From 01/01/2020 To 10/31/2020		pared:
		Worksheet A	Amount	Recl assi fi cat	Adj usted	Paid Hours	Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet				
				A-6)				
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY			_			
1.00	Net salaries (see		24, 610, 474	0	24, 610, 47	4 841, 952. 00	29.23	1.00
	instructions)							
2.00	Excluded area salaries (see		1, 135, 277	112, 603	1, 247, 88	0 38, 747. 00	32.21	2.00
	instructions)							
3.00	Subtotal salaries (line 1		23, 475, 197	-112, 603	23, 362, 59	4 803, 205. 00	29.09	3.00
	minus line 2)							
4.00	Subtotal other wages & related		705, 627	0	705, 62	7 5, 764. 96	122.40	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		6, 430, 042	0	6, 430, 04	2 0.00	27.52	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		30, 610, 866	-112, 603	30, 498, 26	3 808, 969. 96	37.70	6.00
7.00	Total overhead cost (see		9, 469, 465	-112, 603	9, 356, 86	2 338, 373. 00	27.65	7.00
	instructions)							
								-

Heal th	Financial Systems	DEARBORN COUNTY	HOSPI TAL				In Lie	u of Form CMS-2	2552-10
	TAL WAGE RELATED COSTS		Provi der	CCN:	15-0086	Period: From 01/ To 10/		Worksheet S-3 Part IV	pared:
								Amount Reported	
								1.00	
	PART IV - WAGE RELATED COSTS						ı		
	Part A - Core List								
	RETIREMENT COST								
1.00	401K Employer Contributions							396, 915	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Cont							0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (s							0	3.00
4.00	Qualified Defined Benefit Plan Cost (see							0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to Extern	nal Organization)							
5.00	401K/TSA Plan Administration fees							0	
6.00	Legal /Accounting/Management Fees-Pension							0	6.00
7.00	Employee Managed Care Program Administrat HEALTH AND INSURANCE COST	tion Fees						0	7.00
8.00	Health Insurance (Purchased or Self Funde	24)						0	8.00
8.00 8.01	Health Insurance (Self Funded without a T		ator)					0	
8.01	Heal th Insurance (Self Funded without a Thir							3, 618, 388	
8.02	Heal th Insurance (Purchased)	u Failty Administrato	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					3,010,300	
9.00	Prescription Drug Plan							0	
10.00	Dental, Hearing and Vision Plan							106, 659	
11.00	Life Insurance (If employee is owner or b	eneficiary)						38, 782	
12.00	Accident Insurance (If employee is owner							0,702	
13.00	Disability Insurance (If employee is owned							73, 042	
14.00	Long-Term Care Insurance (If employee is		()					0,0,0,0	
15.00	'Workers' Compensation Insurance		,					265, 277	
16.00	Retirement Health Care Cost (Only current	t vear, not the extra	ordi narv 🗧	accru	al requir	ed by FASE	3 106.	0	
	Non cumulative portion)	5	5		•	5			
	TAXES								
17.00	FICA-Employers Portion Only							1, 433, 072	17.00
18.00	Medicare Taxes - Employers Portion Only							341, 421	18.00
19.00	Unemployment Insurance							305, 154	19.00
20.00	0.00 State or Federal Unemployment Taxes							0	20.00
	OTHER								
21.00	Executive Deferred Compensation (Other Th instructions))	nan Retirement Cost R	eported o	n lin	es 1 thro	ough 4 abov	/e. (see	0	21.00
22.00	Day Care Cost and Allowances							0	22.00
23.00	Tuition Reimbursement							163, 228	
24.00	Total Wage Related cost (Sum of lines 1 -	-23)						6, 741, 938	24.00
	Part B - Other than Core Related Cost								
25.00	OTHER WAGE RELATED COSTS (SPECIFY)						I		25.00

Heal th	Financial Systems	DEARBORN COUNTY H	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
H0SPI T	AL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0086	Peri od:	Worksheet S-3	
				From 01/01/2020 To 10/31/2020		nared
				10 10/31/2020	3/31/2021 12:	
	Cost Center Description			Contract	Benefit Cost	
				Labor		
				1.00	2.00	
	PART V - Contract Labor and Benefit Cost	<u> </u>				
1 00	Hospital and Hospital-Based Component Identi			070.407	(744 000	1 00
1.00	Total facility's contract labor and benefit	COST		373, 127		
2.00	Hospi tal			373, 127	6, 741, 938	2.00
3.00	Subprovider - IPF					3.00
4.00	Subprovider - IRF				0	4.00
5.00	Subprovider - (Other)			0	0	5.00
6.00 7.00	Swing Beds - SNF			0	0	6.00 7.00
8.00	Swing Beds - NF Hospital-Based SNF			0	0	8.00
9.00	Hospital-Based NF			0	0	9.00
	Hospital-Based OLTC					10.00
	Hospi tal -Based HHA			0	0	11.00
	Separately Certified ASC			0	0	12.00
	Hospi tal -Based Hospi ce			0	0	
	Hospital - Based Health Clinic RHC			Ŭ	0	14.00
	Hospital - Based Health Clinic FQHC					15.00
	Hospi tal -Based-CMHC					16.00
	Renal Dialysis					17.00
18.00	Other			0	0	18.00

Heal th	n Financial Systems	DEARBORN COUN	TY HOSPI TAL		In Lie	u of Form CMS-:	2552-10
HOME	HEALTH AGENCY STATI STI CAL DATA				Period: From 01/01/2020 To 10/31/2020		pared:
					Home Health	3/31/2021 12: PPS	<u>34 pm</u>
	-				Agency I		
0.00	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	865	5	8 388	1, 311	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	218.00		0 0.00 oloyees (Full Ti	218.00	
					_		
		Enter the number your normal		Staff	Contract	Total	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES	C)	1.00	2.00	3.00	
3.00	Administrator and Assistant Administrator(s)		40.00			0.00	•
4.00 5.00	Director(s) and Assistant Director(s) Other Administrative Personnel			0.6		0.64 2.02	•
6.00	Direct Nursing Service			4.6	6 0.00	4.66	6.00
7.00 8.00	Nursing Supervisor Physical Therapy Service			0.0		0.00 2.19	•
9.00	Physical Therapy Supervisor			0.0		0.00	
10.00				0.2		0.26	
11.00 12.00	1 13 1			0.0		0.00 0.02	
13.00	Speech Pathology Supervisor			0.0		0.02	13.00
14.00				0.0		0.00	•
15.00 16.00				0.0		0.00 0.63	•
17.00				0.0	0.00	0.00	17.00
18.00	Other (specify) HOME HEALTH AGENCY CBSA CODES			0.0	0 0.00	0.00	18.00
19.00	Enter in column 1 the number of CBSAs where				2		19.00
	you provided services during the cost reporting period.						
20.00	List those CBSA code(s) in column 1 serviced			17140			20.00
	during this cost reporting period (line 20 contains the first code).						
20.01		Full Ep	vi sodos	99915			20.01
		Wi thout	With Outliers	LUPA Epi sodes			
		0utliers 1.00	2.00	3.00	Epi sodes 4.00	<u> </u>	
21 02	PPS ACTIVITY DATA			1			21.00
21.00 22.00	5	1, 180 236, 865	121 24, 285			1, 376 276, 203	
23.00	Physical Therapy Visits	875	38	1	1 17	941	23.00
24.00 25.00	3	192, 603 180	8, 370 27		3 3, 744 0 6	207, 140 213	1
26.00	Occupational Therapy Visit Charges	39, 645	5, 947		0 1, 322	46, 914	26.00
27.00	1 05	2	14 3 084		0 0	16 3, 525	•
28.00 29.00		441 0	3, 084 0		0 0	3, 525 0	
30.00	Medical Social Service Visit Charges	0	C		0 0	0	30.00
31.00 32.00		104 23, 383	9 1, 752		0 14 0 3,270	127 28, 405	
33.00	Total visits (sum of lines 21, 23, 25, 27,	2, 341	209		8 65	2, 673	•
34.00	29, and 31) Other Charges	0	0			0	34.00
34.00 35.00	Total Charges (sum of lines 22, 24, 26, 28,	492, 937	43, 438		6 13, 956	562, 187	
36.00	30, 32, and 34) Total Number of Episodes (standard/non	253		3	4 7	294	36.00
37.00	outlier)		Ģ		0	9	
	Total Non-Routine Medical Supply Charges	10, 139	3, 943	31			38.00

	Financial Systems		DEARBORN COUN			In Lie	u of Form CMS-2	2552-10
HOSPI 1	FAL-BASED HOSPICE IDENTIFICATION	I DATA		Provider CO Hospice CCI	CN: 15-0086 N: 15-1531		Worksheet S-9 PARTS I THROU Date/Time Pre 3/31/2021 12:	GH IV pared:
						Hospi ce I		
		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII Skilled	Title XIX Nursing	All Other	Total (sum of cols. 1, 2 &	
				Nursing Facility	Facility		5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART I - ENROLLMENT DAYS FOR CO		PERIODS BEGINN					
1.00 2.00 3.00	Hospice Continuous Home Care Hospice Routine Home Care Hospice Inpatient Respite Care							1.00 2.00 3.00
4.00 5.00	Hospice General Inpatient Care Total Hospice Days							4.00
5.00	Part II - CENSUS DATA FOR COST	REPORTING PER	ODS BEGINNING	BEFORE OCTOBE	2 1 2015			5.00
6. 00	Number of patients receiving hospice care				(1, 2010			6.00
7.00	Total number of unduplicated Continuous Care hours billable to Medicare							7.00
B. 00	Average Length of Stay (line 5 / line 6)							8.00
9.00	Unduplicated census count							9.00
NOTE:	Parts I and II, columns 1 and 2	also include	the days repor	ted in columns	3 and 4.			
				Title XVIII	Title XIX	Other	Total (sum of	
							cols. 1 through 3)	
	1			1.00	2.00	3.00	4.00	
	PART III - ENROLLMENT DAYS FOR	COST REPORTING	G PERIODS BEGI	NNING ON OR AF	ER OCTOBER 1			
10.00	Hospice Continuous Home Care			0		0 0	0	
11.00	Hospice Routine Home Care Hospice Inpatient Respite Care			41		0 0	41	11.00
13.00	Hospice General Inpatient Care			0		0 0	0	12.00
14.00				48		0 0	48	14.00
00	PART IV - CONTRACTED STATISTIC	AL DATA FOR COS	ST REPORTING P	ERIODS BEGINNIN	G ON OR AFTE	0		11.00
1 - 00	Hospi ce Inpati ent Respi te Care			0		0 0	-	15.00
15.00								

Heal th	Financial Systems DEARBORN COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider C	CN: 15-0086	Period:	Worksheet S-1	
				From 01/01/2020 To 10/31/2020		pared: 34 pm
	Uncompensated and indigent care cost computation				1.00	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 di	vided by li	ine 202 colum	n 8)	0. 293973	1.00
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid				2, 509, 374	
3.00	Did you receive DSH or supplemental payments from Medicaid?				Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplement			ai d?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments 1	rom Medicai	d		10 5(2) (20	5.00
6.00 7.00	Medicaid charges Medicaid cost (line 1 times line 6)				18, 562, 628 5, 456, 911	6.00 7.00
7.00 8.00	Difference between net revenue and costs for Medicaid program	(line 7 mi)	ous sum of li	nes 2 and 5 if	2, 947, 537	8.00
0.00	< zero then enter zero)				2, 747, 337	0.00
9.00	Children's Health Insurance Program (CHIP) (see instructions f Net revenue from stand-alone CHIP	or each ffr	le)		0	9.00
	Stand-al one CHIP charges				0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)				0	11.00
12.00	Difference between net revenue and costs for stand-al one CHIP	(line 11 mi	inus line 9;	if < zero then	0	
	enter zero)					
	Other state or local government indigent care program (see ins					
	Net revenue from state or local indigent care program (Not ind				0	
14.00	Charges for patients covered under state or local indigent can	re program	(Not included	in lines 6 or	0	14.00
15.00	10) State or local indigent care program cost (line 1 times line 1	(4)			0	15.00
16.00	Difference between net revenue and costs for state or local in	,	e program (Li	ne 15 minus line	-	
10.00	13; if $<$ zero then enter zero)	largent car			Ĭ	10.00
	Grants, donations and total unreimbursed cost for Medicaid, CH	IIP and stat	te/local indi	gent care progra	ams (see	
	instructions for each line)					
	Private grants, donations, or endowment income restricted to 1				0	
	Government grants, appropriations or transfers for support of			6.11	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and loca 8, 12 and 16)	ai indigent	care program	s (sum of lines	2, 947, 537	19.00
			Uni nsured	Insured	Total (col. 1	
			patients	patients	+ col. 2)	
			1.00	2.00	3.00	
20.00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire fa		251, 5	36 91, 921	343, 507	20.00
20.00	(see instructions)	actificy	201, 00	91,921	343, 507	20.00
21.00	Cost of patients approved for charity care and uninsured disco	ounts (see	73, 9	59 91, 921	165, 880	21.00
	instructions)					
22.00	Payments received from patients for amounts previously written	n off as		0 0	0	22.00
	charity care					
23.00	Cost of charity care (line 21 minus line 22)		73, 9	59 <u>91, 921</u>	165, 880	23.00
					1.00	
24.00	Does the amount on line 20 column 2, include charges for patie	ent davs bev	vond a length	of stav limit	N N	24.00
	imposed on patients covered by Medicaid or other indigent care		,	j		
25.00	If line 24 is yes, enter the charges for patient days beyond t	the indigen	t care progra	m's length of	0	25.00
	stay limit					
26.00	Total bad debt expense for the entire hospital complex (see in				541,071	1
27.00	Medicare reimbursable bad debts for the entire hospital comple				85, 613	
	Medicare allowable bad debts for the entire hospital complex (see instruc	errons)		131, 711	
28.00 29.00	Non-Medicare bad debt expense (see instructions) Cost of non-Medicare and non-reimbursable Medicare bad debt ex	nansa (soo	instructions)	409, 360 166, 439	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	cheuse (see)	332, 319	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus l	ine 30)			3, 279, 856	
		/				

REULAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CO		eriod: rom 01/01/2020	u of Form CMS-2 Worksheet A	
				T			
	Cost Center Description	Sal ari es	Other	Total (col 1	Recl assi fi cat	3/31/2021 12: Recl assi fi ed	34 pm
	bost benter beschiptron	Sararres	other	+ col . 2)	i ons (See	Trial Balance	
				, í	A-6)	(col. 3 +-	
		1.00	2.00	3.00	4.00	<u>col. 4)</u> 5.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		2, 278, 407	2, 278, 407	964, 932	3, 243, 339	1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		1, 265, 660		0	1, 265, 660	2.00
3.00 4.00	00300 OTHER CAPI TAL RELATED COSTS 00400 EMPLOYEE BENEFI TS DEPARTMENT	244, 817	0 6, 750, 991	0 6, 995, 808	0	0 6, 995, 808	3.00 4.00
4.00 5.01	01160 COMMUNI CATI ONS	87, 794	82, 863		0	170, 657	5.01
5.02	00550 DATA PROCESSI NG	735, 012	2, 168, 560		0	2, 903, 572	5.02
5.03	00560 PURCHASING RECEIVING AND STORES	139, 028	15, 042	154, 070	287	154, 357	5.03
5.04 5.05	00570 ADMI TTI NG 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	641, 282 285, 243	51, 611 1, 197, 441		0	692, 893 1, 482, 684	5.04 5.05
5.05	00591 OTHER ADMINISTRATIVE AND GENERAL	1, 854, 930	7, 164, 620		-205, 854	8, 813, 696	5.05
7.00	00700 OPERATION OF PLANT	670, 382	1, 511, 803		-49, 459	2, 132, 726	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	69, 901	246, 106		0	316, 007	8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	663, 160 596, 705	185, 904 327, 494		20, 835 -586, 220	869, 899 337, 979	9.00 10.00
	01100 CAFETERI A	540, 705	327, 494	924, 199	-586, 220	586, 220	11.00
	01300 NURSI NG ADMI NI STRATI ON	969, 807	328, 884	1, 298, 691	0	1, 298, 691	13.00
	01400 CENTRAL SERVICE & SUPPLY	219, 567	240, 593		-115, 188	344, 972	14.00
		1,060,908	290, 490		-120, 278	1, 231, 120	
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	471, 302 184, 698	115, 187 2, 645		-6, 241 0	580, 248 187, 343	
	02300 PHARMACY RESIDENCY	67, 270	6, 147		65, 901	139, 318	
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	4,086,674	776, 845		-689, 686	4, 173, 833	30.00
	03100 I NTENSI VE CARE UNI T 04300 NURSERY	1, 146, 640 0	169, 408 0	1, 316, 048 0	-59 428, 372	1, 315, 989 428, 372	31.00 43.00
	04400 SKILLED NURSING FACILITY	0	0		420, 372	420, 372	44.00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	1, 206, 241	2, 407, 281	3, 613, 522	-1, 141, 293		50.00
	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	494, 769 0	95, 485 0		-1, 530 252, 739	588, 724 252, 739	51.00 52.00
	05300 ANESTHESI OLOGY	0	1, 878, 183		-214, 816	1, 663, 367	53.00
	05400 RADI OLOGY-DI AGNOSTI C	823, 967	476, 350		-3, 079	1, 297, 238	
	05401 ULTRASOUND	149, 528	53, 876		-17, 370	186, 034	54.01
	05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN	279, 740 398, 133	152, 876 297, 872		-34, 622 -47, 523	397, 994 648, 482	55.00 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	185, 853	255, 414		-47, 323 -9, 892	431, 375	58.00
	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	59. OC
60.00	06000 LABORATORY	1, 623, 653	2, 644, 501	4, 268, 154	-279	4, 267, 875	60.00
	06001 BLOOD LABORATORY 06500 RESPI RATORY THERAPY	0	105 000	0	0	0	60.01
	03950 SLEEP CLINIC	566, 496 0	125, 082 178, 756		-23, 378 0	668, 200 178, 756	
	06600 PHYSI CAL THERAPY	849, 525	51, 870		-90	901, 305	66. OC
	06700 OCCUPATI ONAL THERAPY	169, 698	12, 060		-1, 770	179, 988	67.00
	06800 SPEECH PATHOLOGY	155, 138	1,645		0	156, 783	68.00
	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	493, 008 0	241, 993 0		0 1, 677, 205	735, 001 1, 677, 205	69.00 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	3, 132, 331	3, 132, 331	0	3, 132, 331	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	2, 248, 258	2, 248, 258	0	2, 248, 258	73.00
91.00	OUTPATIENT SERVICE COST CENTERS	1 274 440	211 010	1 400 400	1 240	1 497 110	
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 376, 669	311, 819	1, 688, 488	-1, 369	1, 687, 119	91.00 92.00
/2.00	OTHER REIMBURSABLE COST CENTERS						,2.00
101. 00	10100 HOME HEALTH AGENCY	675, 891	137, 179	813, 070	- 704	812, 366	101.00
110 00	SPECIAL PURPOSE COST CENTERS		000 450	000.450	7/0.074	50,470	110.00
	11300 I NTEREST EXPENSE 11600 HOSPI CE	13, 018	829, 153 38, 381		-769, 974 -1, 574	59, 179 49, 825	
118.00 118.00		23, 656, 447	40, 747, 066		-45, 757	64, 357, 756	
	NONREIMBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES 19201 PHYSI CI AN CLI NI C	10, 778	203, 682		45, 761	260, 221	
	19202 LI FELI NE	7, 776 0	27, 356 1, 138		0	35, 132	192.01
	19203 CREDIT UNION	0	0		0	0	192.03
92.04	19204 ENT	0	254, 405		0	254, 405	
	19205 HOSPI TALI ST	0	1, 306, 580		0	1, 306, 580	
	19206 ORTHO 19207 ATHLETI C TRAI NERS	0 43, 819	815, 680 3, 748		0	815, 680 47, 567	
	07950 COMMUNITY MENTAL HEALTH	43, 019	3, 748 0	47, 567	0		192.07
194.01	07951 MARKETI NG	107, 982	87, 924		0	195, 906	194.01
194.02	07953 OCCUPATI ONAL HEALTH 07952 PATHS EDUCATI ON	139, 259	40, 378		-4	179, 633	
10.		0	2, 992	2, 992	0	2 002	194.03

Health Financial Systems	DEARBORN COUN	TY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	OF EXPENSES	Provider C		Period: From 01/01/2020	Worksheet A	
				To 10/31/2020		
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cat	Recl assi fi ed	
			+ col. 2)	ions (See	Trial Balance	
				A-6)	(col. 3 +-	
					col. 4)	
	1.00	2.00	3.00	4.00	5.00	
194. 04 07954 FOUNDATI ON	69, 484	5, 445	74, 92	9 0	74, 929	194.04
200.00 TOTAL (SUM OF LINES 118 through 199)	24, 035, 545	43, 496, 394	67, 531, 939	9 0	67, 531, 939	200.00

	nancial Systems FICATION AND ADJUSTMENTS OF TRIAL BALANCE C	DEARBORN COUN F EXPENSES	Provider CCN: 15-00	B6 Period:	u of Form CMS-2552 Worksheet A
				From 01/01/2020 To 10/31/2020	Date/Time Prepare
	Cost Center Description	Adjustments	Net Expenses		3/31/2021 12:34
		(See A-8)	For		
		6.00	Allocation 7.00		
GE	NERAL SERVICE COST CENTERS	0.00	7.00		
00 00	100 NEW CAP REL COSTS-BLDG & FIXT	-144, 826			1
	200 NEW CAP REL COSTS-MVBLE EQUIP	-6, 698			2
	300 OTHER CAPI TAL RELATED COSTS 400 EMPLOYEE BENEFI TS DEPARTMENT	0	0 6, 993, 139		3
	160 COMMUNI CATI ONS	-2, 669 -4, 948			5
	550 DATA PROCESSI NG	0			5
	560 PURCHASING RECEIVING AND STORES	0	154, 357		5
	570 ADMI TTI NG	0	692, 893		5
	580 CASHI ERI NG/ACCOUNTS RECEI VABLE 591 OTHER ADMI NI STRATI VE AND GENERAL	2, 397- 5, 076, 875-			5
	700 OPERATION OF PLANT	-101, 877			7
	800 LAUNDRY & LINEN SERVICE	0	316, 007		8
	900 HOUSEKEEPI NG	0	869, 899		9
		-2, 288			10
1	100 CAFETERI A 300 NURSI NG ADMI NI STRATI ON	-215, 664 0			11
	400 CENTRAL SERVICE & SUPPLY	0			14
00 01	500 PHARMACY	0	1, 231, 120		15
	600 MEDI CAL RECORDS & LI BRARY	-14, 309			16
	700 SOCI AL SERVI CE 300 PHARMACY RESI DENCY	0	187, 343 139, 318		23
	PATIENT ROUTINE SERVICE COST CENTERS	0	137,310		23
	000 ADULTS & PEDIATRICS	-225, 527	3, 948, 306		30
	100 INTENSIVE CARE UNIT	0			31
	300 NURSERY 400 SKI LLED NURSI NG FACI LI TY	0			43
	CILLARY SERVICE COST CENTERS	0	0		
00 05	000 OPERATING ROOM	-50, 500	2, 421, 729		50
	100 RECOVERY ROOM	0			51
	200 DELI VERY ROOM & LABOR ROOM 300 ANESTHESI OLOGY	0 1, 575, 000-	252, 739 88, 367		52
	400 RADI OLOGY-DI AGNOSTI C	-9, 628			54
	401 ULTRASOUND	0			54
	500 RADI OLOGY-THERAPEUTI C	0	397, 994		55
	700 CT SCAN 800 MAGNETIC RESONANCE IMAGING (MRI)	-1, 100 0	647, 382 431, 375		57
	900 CARDI AC CATHETERI ZATI ON	0	0		59
	000 LABORATORY	-133, 622	4, 134, 253		60
	001 BLOOD LABORATORY	0	0		60
	500 RESPI RATORY THERAPY 950 SLEEP CLINIC	-6, 478 0			65
	600 PHYSI CAL THERAPY	0			66
	700 OCCUPATI ONAL THERAPY	0			67
	800 SPEECH PATHOLOGY	0	156, 783		68
	900 ELECTROCARDI OLOGY 100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	-157, 134	577, 867 1, 677, 205		69
	200 I MPL. DEV. CHARGED TO PATIENT	0	3, 132, 331		72
	300 DRUGS CHARGED TO PATIENTS	-691, 445			73
	TPATIENT SERVICE COST CENTERS	02.007	1 (04 022)		
	100 EMERGENCY 200 OBSERVATION BEDS (NON-DISTINCT PART)	-83, 087	1, 604, 032		91 92
	HER REIMBURSABLE COST CENTERS		<u> </u>		
	100 HOME HEALTH AGENCY	0	812, 366		101
	ECIAL PURPOSE COST CENTERS	E0 170			113
	300 I NTEREST EXPENSE 600 HOSPI CE	-59, 179 -280	1 1		113
3. 00 TT	SUBTOTALS (SUM OF LINES 1 through 117)	-8, 565, 531			118
	NREIMBURSABLE COST CENTERS				
	000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 200 PHYSICIANS' PRIVATE OFFICES	0	0 260, 221		190 192
	200 PHYSICIANS PRIVATE OFFICES 201 PHYSICIAN CLINIC	0	35, 132		192
	202 LI FELI NE	0	1, 138		192
2. 03 19	203 CREDIT UNI ON	0	0		192
		0	254, 405		192
	205 HOSPI TALI ST 206 ORTHO		1, 306, 580 815, 680		192 192
	200 ATHLETIC TRAINERS	0	47, 567		192
4. 00 07	950 COMMUNITY MENTAL HEALTH	0	0		194
	951 MARKETI NG	0	195, 906		194
	953 OCCUPATI ONAL HEALTH 952 PATHS EDUCATI ON	0	179, 633 2, 992		194 194
7. 000/	952 PATHS EDUCATION 954 FOUNDATION	0			194

Health Financial Systems	DEARBORN COUN	TY HOSPI TAL		In Lieu	u of Form CMS-	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	OF EXPENSES	Provider C	CN: 15-0086	Period: From 01/01/2020	Worksheet A	
					Date/Time Pre 3/31/2021 12:	
Cost Center Description	Adjustments	Net Expenses			0/01/2021 12	
	(See A-8)	For				
		Allocation				
	6.00	7.00				
200.00 TOTAL (SUM OF LINES 118 through 199)	-8, 565, 531	58, 966, 408				200.00

ASSI FI CATI ONS		DEARBORN COUNT	Provider CCN: 15-0	0086 Period:	Worksheet A-6
				From 01/01/2 To 10/31/2	020
					3/31/2021 12: 34
Cost Center	Li ne #	Salary	Other		
2.00	3.00	4.00	5.00		
A - CAFETERIA	5.00	4.00	5.00		
CAFETERI A	11.00	378, 490	207, 730		1
0		378, 490	207, 730		
B - NURSERY					
D NURSERY	43.00	351, 248	77, 124		1
DELIVERY ROOM & LABOR ROO	M 52.00	<u>207, 2</u> 36	<u>45, 5</u> 03		2
0		558, 484	122, 627		
C - UTILIZATION REVIEW CO			6.044		
OTHER ADMINISTRATIVE AND	5.06	0	6, 241		1
GENERAL	- + +		<u> </u>		
D - SECURI TY GUARD		U	0, 241		
D PHYSICIANS' PRIVATE OFFIC	ES 192.00	46, 702	143		1
0		46, 702	143		
E - MED SUPPLY RECLASS	I				
MEDICAL SUPPLIES CHARGED	T0 71.00	0	1, 677, 205		1
PATI ENTS					
PURCHASING RECEIVING AND STORES	5.03	0	287		2
)	0.00	0	0		3
)	0.00	0	0		4
)	0.00	0	0		5
)	0.00	0	0		6
)	0.00	0	0		7
)	0.00	0	0		8
)	0.00	0	0		9
00	0.00	0	0		10
00	0.00	0	0		11
00	0.00	0	0		12
00	0.00	0	0		13
00	0.00	0	0		14
00	0.00	0	0		15
00	0.00	0	0		16
00	0.00 0.00	0	0		18
	0.00	0	0		19
	0.00	0	0		20
			1,677,492		20
F - POB HOUSEKEEPING			.,		
HOUSEKEEPI NG	9.00	0	20, 835		1
)	0.00	0	0		2
0		0	20, 835		
G – I NSURANCE	1				
NEW CAP REL COSTS-BLDG &	1.00	0	194, 958		1
	FC 400 00		17 107		
D PHYSICIANS' PRIVATE OFFIC	ES 1 <u>92.</u> 00	<u>0</u>	1 <u>7, 137</u>		2
U H – PHARMACY RESIDENCY RE		U	212, 095		
D PHARMACY RESIDENCY RESIDENCY	23.00	65, 901	0		1
TOTALS	$ \frac{23.00}{1}$	<u>65, 901</u>	<u>0</u>		
I - INTEREST RECLASS		00,701	U		
D NEW CAP REL COSTS-BLDG &	1.00	0	769, 974		1
FIXT		5			
	- + +		769,974		
00 Grand Total: Increases		1, 049, 577	3,017,137		500

	nancial Systems		DEARBORN COUNT		CCN: 15-0086	Peri od:	of Form C Worksheet	
02100111				11 OVI del		From 01/01/2020 To 10/31/2020	Date/Time	
						10 10/31/2020	3/31/2021	<u>12: 34 p</u>
	Cost Center	Decreases Line #	Salary	Other	 Wkst. A-7 Re [.]	e		
	6. 00	7.00	Salary 8.00	9.00	10.00	<u>I.</u>		
Δ .	- CAFETERIA	7.00	0.00	9.00	10.00			
	ETARY	10.00	378, 490	207, 730		0		1.
0			378, 490	207, 730				
B -	- NURSERY		070, 170	207,700				
	JLTS & PEDI ATRI CS	30.00	558, 484	122, 627	1	0		1.
00		0.00	0	,		0		2.
0			558, 484	122, 627	·	-		1
С -	- UTILIZATION REVIEW COST				1			
	DI CAL RECORDS & LI BRARY	16.00	0	6, 241		0		1.
0				6, 241				
D -	- SECURI TY GUARD							
	ERATION OF PLANT	7.00	46, 702	143	3	0		1.
0		†	46, 702	143		7		1
Ε -	- MED SUPPLY RECLASS							
	NTRAL SERVICE & SUPPLY	14.00	0	115, 188	3	0		1.
о рна	ARMACY	15.00	0	54, 377		0		2.
	JLTS & PEDIATRICS	30.00	0	8, 575		0		3
	TENSIVE CARE UNIT	31.00	0	59		0		4
	ERATING ROOM	50.00	0	1, 141, 293		0		5
	COVERY ROOM	51.00	0	1, 530		0		6
	ESTHESI OLOGY	53.00	0	214, 816		0		7
	DI OLOGY-DI AGNOSTI C	54.00	0	3, 079		0		8
	TRASOUND	54.01	0	17, 370		0		9.
	DI OLOGY - THERAPEUTI C	55.00	0	34, 622		0		10.
	SCAN	57.00	0	47, 523		0		11.
	GNETIC RESONANCE I MAGING	58.00	0	9, 892		0		12.
	RI)	50.00	0	7,072	-	0		12.
	BORATORY	60.00	0	279	b	0		13.
	SPI RATORY THERAPY	65.00	0	23, 378		0		14.
	YSI CAL THERAPY	66.00	0	23, 370		0		15
	CUPATIONAL THERAPY	67.00	0	1, 770				16.
	ERGENCY	91.00	0	1, 770		0		17
	ME HEALTH AGENCY	101.00	0	704				18
	SPICE	116.00	0	1, 574				10
	CUPATIONAL HEALTH	194.02	0	1, 374	L	Ő		20
		<u>174.02</u>	0	1,677,492	<u> </u>	4		20
F	- POB HOUSEKEEPING		U U	1, 077, 472	-			
	ERATION OF PLANT	7.00	0	2, 614	1	0		1
	YSICIANS' PRIVATE OFFICES	192.00		1 <u>8, 2</u> 21		0		2
			0			4		2
G	- INSURANCE		U	20, 035				
	HER ADMI NI STRATI VE AND	5.06	0	212, 095	5	12		1
	VERAL	5.00	0	212,095		· ~		
0		0.00	0	C		0		2.
	+		— — — <u>o</u>	212, 095		4		2
-	- PHARMACY RESIDENCY RECLASS	I	U	212,095	'I			
	ARMACY	15.00	65, 901			0		1
		15.00	<u>65, 901</u>	0		4		
	- INTEREST RECLASS		05, 701					
	TEREST EXPENSE	113.00	0	769, 974	1	11		1
			¥_	769,974		'4		1.
μ	and Total: Decreases		1,049,577	3, 017, 137				500.

Heal th	Financial Systems	DEARBORN COUNT	TY HOSPI TAL			In Lie	u of Form CMS-2	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider CC	CN: 15-0086	Pe Fr To	riod: om 01/01/2020 10/31/2020	Worksheet A-7 Part I Date/Time Pre 3/31/2021 12:	pared:
				Acqui si ti on	าร			
		Begi nni ng Bal ances	Purchases	Donati on		Total	Disposals and Retirements	
		1.00	2.00	3.00		4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	F BALANCES						
1.00	Land	1, 408, 112	0		0	0	1, 332, 904	1.00
2.00	Land Improvements	2, 615, 940	0		0	0	1,066,970	2.00
3.00	Buildings and Fixtures	75, 035, 220	0		0	0	5, 615, 193	3.00
4.00	Building Improvements	0	0		0	0	0	4.00
5.00	Fixed Equipment	0	0		0	0	0	5.00
6.00	Movable Equipment	68, 056, 494	0		0	0	10, 962, 726	6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	147, 115, 766	0		0	0	18, 977, 793	
9.00	Reconciling Items	0	0		0	0	0	1 1.00
10.00	Total (line 8 minus line 9)	147, 115, 766	0		0	0	18, 977, 793	10.00
		Endi ng	Fully					
		Bal ance	Depreci ated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE		-					
1.00	Land	75, 208	0					1.00
2.00	Land Improvements	1, 548, 970	0					2.00
3.00	Buildings and Fixtures	69, 420, 027	0					3.00
4.00	Building Improvements	0	0					4.00
5.00	Fixed Equipment	0	0					5.00
6.00	Movable Equipment	57, 093, 768	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	128, 137, 973	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	128, 137, 973	0					10.00

Heal th	Financial Systems	DEARBORN COUN	TY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-0086	Period: From 01/01/2020	Worksheet A-7 Part II	
						Date/Time Pre	pared:
						3/31/2021 12:	34 pm
		SUMMARY OF CAPITAL					
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
					(see	instructions)	
					instructions)		
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLU	WN 2, LINES 1 a	and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	2, 278, 407			0 0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1, 265, 660	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	3, 544, 067	0		0 0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1)	1			
	•	Capital -Relat	(sum of cols.				
		ed Costs (see	9 through 14)				
		instructions)	-				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	WN 2, LINES 1 a	and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	2, 278, 407				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	1, 265, 660				2.00
3.00	Total (sum of lines 1-2)	0	3, 544, 067				3.00

Health Financial Systems	DEARBORN COUN	ITY HOSPI TAL		In Lie	u of Form CMS-2	552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	F	Period: From 01/01/2020 To 10/31/2020	Worksheet A-7 Part III Date/Time Prep 3/31/2021 12:3	
	COM	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPI TAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
		Leases	for Ratio	instructions)		
			(col. 1 - col. 2)			
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS C		2100	0100		0100	
1.00 NEW CAP REL COSTS-BLDG & FIXT	128, 137, 973	0	128, 137, 973	1. 000000	0	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0. 000000		2.00
3.00 Total (sum of lines 1-2)	128, 137, 973		128, 137, 973			3.00
	ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY C	F CAPI TAL	
Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
		Capital-Relat				
		ed Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C 1.00 NEW CAP REL COSTS-BLDG & FIXT	ENTERS 0		()	2, 133, 581	0	1.00
2.00 NEW CAP REL COSTS-BLOG & FIXT	0			1, 258, 962	-	2.00
3.00 Total (sum of lines 1-2)	0			3, 392, 543		3.00
		SL	JMMARY OF CAPI			0.00
Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
		(see	instructions)	Capital-Relat		
		instructions)		ed Costs (see instructions)	9 through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS C		12.00	15.00	14.00	13.00	
1.00 NEW CAP REL COSTS-BLDG & FIXT	769, 974	194, 958		0 0	3, 098, 513	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	0	(C	0	1, 258, 962	2.00
3.00 Total (sum of lines 1-2)	769, 974	194, 958	c	0	4, 357, 475	3.00

Heal th	Fi nanci a	al Systems
AD JUST	MENTS TO	EXPENSES

	MENTS TO EXPENSES			Provider CCN: 15-0086 F	Period:	Worksheet A-8	
	WENTS TO EAFENSES			F	From 01/01/2020 To 10/31/2020	Date/Time Pre 3/31/2021 12:	pared:
				Expense Classification on To/From Which the Amount is			
	Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
		<u>(2)</u> 1.00	2.00	3.00	4.00	Ref. 5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter		0	NEW CAP REL COSTS-BLDG & FLXT	1.00	0	1.00
2.00	2) Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other		0		0.00	0	3.00
4.00	(chapter 2) Trade, quantity, and time	В	-5, 667	OTHER ADMINISTRATIVE AND	5.06	0	4.00
5.00	discounts (chapter 8)		0	GENERAL	0.00	0	5.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter	А	-4, 948	COMMUNI CATI ONS	5. 01	0	7.00
8.00	21) Television and radio service (chapter 21)	А	-6, 698	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9. 00 10. 00	Parking lot (chapter 21) Provider-based physician	A-8-2	0 -2, 229, 806		0.00	0 0	
11.00	adjustment Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
	Laundry and linen service	_	0		0.00	0	
	Cafeteria-employees and guests Rental of quarters to employee and others	В	-215, 664 0	CAFETERI A	11. 00 0. 00	0	
16.00	Sale of medical and surgical supplies to other than		0		0.00	0	16.00
17.00	patients Sale of drugs to other than patients	В	-691, 445	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and	В	-14, 309	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	abstracts Nursing and allied health education (tuition, fees,		0		0.00	0	19.00
20.00	books, etc.) Vending machines		0		0.00	0	20.00
	Income from imposition of interest, finance or penalty		0		0.00	0	
22.00	charges (chapter 21) Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22.00
23.00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65.00		23.00
24.00	limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66.00		24.00
25 00	therapy costs in excess of limitation (chapter 14) Utilization review -			*** Cost Center Deleted ***	114 00		25.00
25.00	physicians' compensation (chapter 21)				114.00		20.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FLXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE	2.00	0	27.00
	Non-physician Anesthetist		о	*** Cost Center Deleted ***	19.00		28.00
	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	0.00 67.00	0	29.00 30.00
20.00	therapy costs in excess of limitation (chapter 14)				07.00		
	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30.99

Heal th	Fi nanci	al Systems	
AD.JUSTI	MENTS TO) EXPENSES	

ealth Financial Systems		DEARBORN COUNTY			u of Form CMS-2	
ADJUSTMENTS TO EXPENSES				Period: From 01/01/2020	Worksheet A-8	3
				To 10/31/2020	Date/Time Pre 3/31/2021 12:	epared 34 pm
·			Expense Classification o			
		То	p/From Which the Amount is	to be Adjusted		
Cost Center Descripti		Amount	Cost Center	Line #	Wkst. A-7	
	(2)	2.00	3.00	4.00	<u>Ref.</u> 5.00	
1.00 Adjustment for speech	A-8-3		PEECH PATHOLOGY	4.00	5.00	31.0
pathology costs in excess				00.00		
limitation (chapter 14)						
2.00 CAH HIT Adjustment for		0		0.00	0	32.0
Depreciation and Interest						
3.00 REV - FITNESS CENTER	В		MPLOYEE BENEFITS DEPARTMEN		0	
5.00 SISIC BILLING SERVICES	В		ASHI ERI NG/ACCOUNTS	5.05	0	35.0
			CEIVABLE			
6.00 HEALTH SERV/WIC MANAGMNT F	EE B		THER ADMINISTRATIVE AND	5.06	0	36.
7.00 RENT - LUDLOW HILL CLINIC	В		ENERAL FHER ADMINISTRATIVE AND	5.06	0	37.
7.00 RENT - LODLOW HILL CLINIC	D		ENERAL	5.00	0	37.
9.00 DIET - NUTRITION COUNSELIN	G B	-2, 288 DI		10.00	0	39.0
0.00 REV - COMMUNITY EDUCATION	B	,	DULTS & PEDIATRICS	30,00	0	
PROGRAM	_	_,			-	
0. 01 MI SCELLANEOUS I NCOME	В	-9, 628 RA	ADI OLOGY-DI AGNOSTI C	54.00	0	40.0
2.00 ADVERTI SI NG	A		THER ADMINISTRATIVE AND	5.06	0	42.0
			ENERAL			
3.00 AHA & I HA DUES	AHA & I HA DUES A		THER ADMINISTRATIVE AND	5.06	0	43.0
	٥			F 0/	0	
4.00 MISC. OFFSET	A		THER ADMINISTRATIVE AND	5.06	0	44.0
5.00 MISC. NONALLOWABLE	А	-280H0		116.00	0	45.0
5. 01 ADVERTI SI NG STAFF			THER ADMINI STRATI VE AND	5.06	0	
			ENERAL	0.00	0	
5. 02 NON ALLOWABLE REPAIRS	A		PERATION OF PLANT	7.00	0	45.0
5.03 PHYSICIAN RECRUITMENT & HS	C A		THER ADMINISTRATIVE AND	5.06	0	45.0
LOSS		GE	ENERAL			
5.04 MENTAL HEALTH UTILITIES	A		PERATION OF PLANT	7.00	0	
5. 05 NON-ALLOWABLE DEPRECIATION	A		EW CAP REL COSTS-BLDG &	1.00	9	45.0
	٨			112 00	0	45 (
5.06 NON ALLOWABLE INTEREST 5.07 HAF OFFSET	A		NTEREST EXPENSE	113.00 5.06	0	
			ENERAL	5.00	0	45.0
0.00 TOTAL (sum of lines 1 thru	49)	-8, 565, 531				50.0
(Transfer to Worksheet A,		5, 555, 561				
column 6, line 200.)						
			CMS Pub. 15-1.			

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.

Heal th	Financial Syste	ems	DEARBORN COU	NTY HOSPI TAL		In Lie	eu of Form CMS-	2552-10
PROVIDER BASED PHYSICIAN ADJUSTMENT		Provider CCN: 15-0086		Peri od:	Worksheet A-8-2			
					From 01/01/2020			
					To 10/31/2020	D Date/Time Prepared: 3/31/2021 12:34 pm		
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	222, 885	222, 885	(0 0	0	1.00
2.00	50.00	OPERATING ROOM	50, 500	50, 500	C	0	0	2.00
3.00	53.00	ANESTHESI OLOGY	1, 575, 000	1, 575, 000	C	0	0	3.00
4.00	57.00	CT SCAN	1, 100	1, 100	C	0	0	4.00
5.00		LABORATORY	208, 333	0	208, 333	260, 300	597	5.00
6.00	65.00	RESPI RATORY THERAPY	12, 840	2, 840	10, 000	197, 500	67	6.00
7.00	69.00	ELECTROCARDI OLOGY	157, 134	157, 134	C	0	0	7.00
8.00		EMERGENCY	146, 856	32, 689	114, 167	179,000	741	8.00
9.00	0.00		0	0	C	0	0	9.00
10.00	0.00		0	0	C	0	0	10.00
200.00			2, 374, 648)		200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		l denti fi er	Limit	Unadjusted RCE		Component	of Mal practi ce	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		ADULTS & PEDIATRICS	0	0	0			1.00
2.00		OPERATING ROOM	0	°	C			2.00
3.00		ANESTHESI OLOGY	0	0	0	, U	Ŭ	3.00
4.00		CT SCAN	0	0	0	-	-	4.00
5.00		LABORATORY	74, 711		(0	0	5.00
6.00		RESPI RATORY THERAPY	6, 362		C	0	-	6.00
7.00		ELECTROCARDI OLOGY	0	°	C	0	0	7.00
8.00		EMERGENCY	63, 769		C	0	0	8.00
9.00	0.00		0	0	C	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			144, 842	7,242	(0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		Identifier	Component	Limit	Di sal I owance			
			Share of col.					
	1.00	2.00	14 15.00	16.00	17.00	18.00	-	
1.00		ADULTS & PEDIATRICS	15.00					1.00
2.00		OPERATING ROOM	0	-				2.00
3.00		ANESTHESI OLOGY	0	-	(3.00
4.00		CT SCAN		0		1, 100		4.00
4.00 5.00		LABORATORY	0	74, 711	133, 622			5.00
6.00		RESPIRATORY THERAPY		6, 362	3, 638			6.00
7.00		ELECTROCARDI OLOGY	0		3,030	157, 134		7.00
8.00		EMERGENCY		63, 769	50, 398			8.00
9.00	0.00			03,709	50, 5%	03,007	1	9.00
10.00	0.00		0	0				10.00
200.00	5.00		0	144, 842	187, 658	2, 229, 806		200.00
	ı I					_, _, _, 500	1	

Health Financial Systems COST ALLOCATION - GENERAL SERVICE COSTS	DEARBORN COUN	TY HOSPITAL Provider CC	:N· 15-0086 F	In Lie Period:	u of Form CMS-: Worksheet B	2552-10
			F	rom 01/01/2020 o 10/31/2020	Part I	
		CAPITAL RELATED COSTS			575172021 12.	
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	NEW BLDG & FIXT	NEW MVBLE EQUI P	EMPLOYEE BENEFI TS DEPARTMENT	COMMUNI CATI ON S	
	col. 7) 0	1.00	2.00	4.00	5. 01	
GENERAL SERVICE COST CENTERS				1	1	
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.01 01160 COMMUNI CATIONS S.02 00550 DATA PROCESSI NG	3, 098, 513 1, 258, 962 6, 993, 139 165, 709 2, 903, 572	3, 098, 513 21, 658 3, 088 35, 839	1, 258, 962 8, 800 1, 255 14, 562	7, 023, 597 25, 919	195, 971 11, 575	1.00 2.00 4.00 5.01 5.02
5. 03 00560 PURCHASI NG RECEI VI NG AND STORES 5. 04 00570 ADMI TTI NG	154, 357 692, 893	64, 922 35, 097	26, 379 14, 260	189, 322	2, 251 4, 501	5.03 5.04
5.05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.06 00591 OTHER ADMI NI STRATI VE AND GENERAL 7.00 00700 OPERATI ON OF PLANT 8.00 00800 LAUNDRY & LI NEN SERVI CE	1, 480, 287 3, 736, 821 2, 030, 849 316, 007	21, 465 132, 434 991, 360 16, 172	8, 721 53, 810 402, 802 6, 571	547, 620 184, 125 20, 636		5.05 5.06 7.00 8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON	869, 899 335, 691 370, 556 1, 298, 691	11, 967 40, 633 28, 819 6, 095	4, 862 16, 510 11, 710 2, 476	64, 422 111, 739	2, 894 804 2, 733 2, 572	9.00 10.00 11.00 13.00
14. 00 01400 CENTRAL SERVI CE & SUPPLY 15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE	344, 972 1, 231, 120 565, 939 187, 343	72, 002 15, 065 48, 831 2, 286	29, 255 6, 121 19, 841 929	293, 750 139, 140	3, 055 4, 662 11, 736 2, 251	15.00
23. 00 02300 PHARMACY RESIDENCY INPATIENT ROUTINE SERVICE COST CENTERS	139, 318	2, 976	1, 209			•
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 43. 00 04300 NURSERY 44. 00 04400 SKILLED NURSING FACILITY	3, 948, 306 1, 315, 989 428, 372 0	653, 333 75, 172 4, 063 0	265, 457 30, 543 1, 651	3 338, 516 103, 697	23, 150 2, 733 0 0	31.00 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM 51.00 05100 RECOVERY ROOM	2, 421, 729 588, 724	261, 943 11, 814	106, 430 4, 800		9, 003 2, 572	
52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	252, 739 88, 367 1, 287, 610	5, 120 163 119, 127	2,080 66 48,403	0	0 1, 125 10, 932	•
54. 01 05401 ULTRASOUND 55. 00 05500 RADI OLOGY-THERAPEUTI C	186, 034 397, 994	6, 298 11, 733	2, 559 4, 767	9 44, 144 82, 586	322 965	54.01 55.00
57. 00 05700 CT SCAN 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 59. 00 05900 CARDI AC CATHETERI ZATI ON	647, 382 431, 375 0	0 8, 157 0	3, 314 0	54, 868	0	•
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY	4, 134, 253 0	68, 264 0	27, 736 0	479, 341 0 0	6, 270 0	60.00
65. 00 06500 RESPIRATORY THERAPY 65. 01 03950 SLEEP CLINIC	661, 722 178, 756	11, 824 0	4, 804 0	0 0	1, 125 804	65.01
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	901, 305 179, 988 156, 783	76, 838 8, 066 4, 307	31, 220 3, 277 1, 750	50, 099	2, 894 1, 768 161	67.00
69. 00 06900 ELECTROCARDIOLOGY 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	577, 867 1, 677, 205	33, 126 0	13, 460 0	145, 548	5, 948	69.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	3, 132, 331 1, 556, 813	0 0	((0	•
91. 00 92. 00 92. 00 92. 00 92. 00 09200 0550 071000 07100 07100 0700 07000000 0700000000	1, 604, 032	98, 373	39, 970	406, 426	5, 305	91.00 92.00
101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	812, 366	15, 085	6, 129	199, 539	965	101.00
113.00 11300 INTEREST EXPENSE 116.00 11600 HOSPICE 118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	49, 545 55, 792, 225	3, 200 3, 026, 715	1, 300 1, 229, 789		0 148, 386	113.00 116.00 118.00
190. 00 19000 GI 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	0 260, 221 35, 132 1, 138	24, 786 0 17, 269 0	10, 071 C 7, 017	16, 969	42, 119 1, 447	190.00 192.00 192.01 192.02
192. 03 19203 CREDIT UNI ON 192. 04 19204 ENT	0 254, 405	10, 626 0	4, 317	0 0	1, 768 0	192. 03 192. 04
192. 05 19205 HOSPI TALI ST 192. 06 19206 ORTHO 192. 07 19207 ATHLETI C TRAI NERS	1, 306, 580 815, 680 47, 567	3, 982 0 0	1, 618 ((0 0 0 12, 936	0	192.05 192.06 192.07
194. 00 07950 COMMUNI TY MENTAL HEALTH 194. 01 07951 MARKETI NG	0 195, 906	0 9, 396	0 3, 818	0 0 3 31, 879		194.00 194.01

Health Financial Systems	DEARBORN COUN	TY HOSPI TAL	In Lie	u of Form CMS-2	2552-10	
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	Provider CCN: 15-0086		Worksheet B D Part I D Date/Time Prepared 3/31/2021 12:34 pr	
		CAPI TAL REL	ATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	NEW BLDG & FIXT	NEW MVBLE EQUI P	EMPLOYEE BENEFI TS DEPARTMENT	COMMUNI CATI ON S	
	0	1.00	2.00	4.00	5.01	
194. 02 07953 OCCUPATI ONAL_HEALTH 194. 03 07952 PATHS_EDUCATI ON 194. 04 07954 FOUNDATI ON	179, 633 2, 992 74, 929	0 0 5, 739	2, 33	0 41, 113 0 0 2 20, 513	0 322	194.02 194.03 194.04
200.00Cross Foot Adjustments201.00Negative Cost Centers202.00TOTAL (sum lines 118 through 201)	58, 966, 408	0 3, 098, 513	1, 258, 96	0 0 2 7, 023, 597	0	200. 00 201. 00 202. 00

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	DEARBORN COUN	ITY HOSPITAL Provider CC	`N: 15_0086	In Lie Period:	u of Form CMS-2 Worksheet B	2552-10
C031 F	LEUCATION - GENERAL SERVICE COSTS		FIOVIDEI CC		From 01/01/2020	Part I Date/Time Pre 3/31/2021 12:	pared:
	Cost Center Description	DATA PROCESSI NG	PURCHASI NG RECEI VI NG AND	ADMI TTI NG	CASHI ERI NG/AC COUNTS	<u>3/31/2021 12:</u> Subtotal	34 pm
		5. 02	STORES 5.03	5.04	RECEI VABLE 5. 05	5A. 05	
	GENERAL SERVICE COST CENTERS	5. 02	5.05	5.04	5.05	5A. 05	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 5.01	00400 EMPLOYEE BENEFITS DEPARTMENT 01160 COMMUNICATIONS						4.00 5.01
5.01	00550 DATA PROCESSING	3, 182, 541					5.02
5.03	00560 PURCHASING RECEIVING AND STORES	38, 076					5.03
5.04	00570 ADMI TTI NG	104, 710	706	1, 041, 48	9		5.04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	164, 997			0 1, 767, 854		5.05
5.06 7.00	00591 OTHER ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT	171, 343			0 0 0 0	4,657,038	
7.00 8.00	00800 LAUNDRY & LINEN SERVICE	44, 422			0 0	3, 662, 418 368, 919	•
9.00	00900 HOUSEKEEPI NG	15, 865			0 0	1, 103, 928	•
10.00	01000 DI ETARY	101, 537			o o	560, 411	
11.00	01100 CAFETERI A	C	-		0 0	525, 557	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	53, 941			0 0	1, 660, 489	1
14.00	01400 CENTRAL SERVI CE & SUPPLY 01500 PHARMACY	66, 633				587, 214	1
15.00 16.00	01600 MEDICAL RECORDS & LIBRARY	88, 845 171, 343			0 0	1, 642, 900 957, 288	•
17.00	01700 SOCIAL SERVICE	28, 557			0 0	275, 982	•
23.00	02300 PHARMACY RESIDENCY	9, 519			0 0	193, 827	•
	INPATIENT ROUTINE SERVICE COST CENTERS		1 1		1		
30.00	03000 ADULTS & PEDIATRICS	564, 800		766, 09		7, 387, 261	30.00
31.00 43.00	03100 I NTENSI VE CARE UNI T 04300 NURSERY	85, 672		160, 31		2,062,869	•
43.00	04400 SKI LLED NURSI NG FACI LI TY			115, 07	1 4,088 0 0	656, 942 0	
44.00	ANCI LLARY SERVICE COST CENTERS		<u> </u>		<u> </u>	0	1 44.00
50.00	05000 OPERATING ROOM	199, 900	69, 967		0 407, 710	3, 832, 793	50.00
51.00	05100 RECOVERY ROOM	C	2, 284		0 26, 584	782, 846	•
52.00	05200 DELIVERY ROOM & LABOR ROOM	C	, s		0 12, 782	333, 902	•
53.00	05300 ANESTHESI OLOGY	152.205			0 40, 273	141,040	•
54.00 54.01	05400 RADI OLOGY-DI AGNOSTI C 05401 ULTRASOUND	152, 305	5, 055 781		0 92, 373 0 19, 300	1, 959, 060 259, 438	•
55.00	05500 RADI OLOGY-THERAPEUTI C	31, 730			0 26, 163	558, 542	•
57.00	05700 CT SCAN	C			0 155, 893	924, 619	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	C	1, 063		0 23, 459	522, 236	•
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	215, 765	41,828		0 253, 377 0 0	5, 226, 834 0	60.00 60.01
65.00	06500 RESPI RATORY THERAPY	114, 229	Ŭ		0 26, 518	989, 721	65.00
65.01	03950 SLEEP CLINIC	C	248		0 4, 262	184, 070	•
66.00	06600 PHYSI CAL THERAPY	69, 806			0 25, 089	1, 358, 421	66.00
	06700 OCCUPATI ONAL THERAPY	C	162		0 7, 628	250, 988	
68.00	06800 SPEECH PATHOLOGY	C	52		0 4, 101	212, 954	
	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		508		0 50, 308 0 53, 323	826, 765 1, 730, 528	•
	07200 I MPL. DEV. CHARGED TO PATIENTS		116,010		0 89, 362	3, 337, 703	•
	07300 DRUGS CHARGED TO PATIENTS	C			0 78, 371	1, 635, 184	
	OUTPATIENT SERVICE COST CENTERS		1				
	09100 EMERGENCY	107, 883	5, 307		0 196, 882	2, 464, 178	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
101 00	OTHER REIMBURSABLE COST CENTERS	130, 094	611		0 8, 870	1, 173, 659	101 00
101.00	SPECIAL PURPOSE COST CENTERS	130,074			0,070	1, 173, 037	101.00
113.00	11300 INTEREST EXPENSE						113.00
	11600 HOSPI CE	C	73		0 297		116.00
118.00		2, 731, 972	326, 417	1, 041, 48	9 1, 767, 854	55, 066, 782	118.00
100.00	NONREI MBURSABLE COST CENTERS	0				25 ((1	100.00
	19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	406, 147	-		0 0 0 0	725, 909	190.00
	19201 PHYSI CLAN CLINIC	28, 557			0 0		192.01
192.02	19202 LI FELI NE	C	0		0 0		192.02
	19203 CREDIT UNION	C	0		0 0		192.03
	19204 ENT	0	0		0 0	254, 405	
	19205 HOSPI TALI ST 19206 ORTHO	12, 692	22			1, 324, 894	1
	19206 ORTHO 19207 ATHLETIC TRAINERS					815, 680 60, 503	192.06
	07950 COMMUNITY MENTAL HEALTH		0		o o		194.00
	07951 MARKETI NG	3, 173	51		0 0	244, 705	•
194.02	07953 OCCUPATI ONAL HEALTH	C	57		o o	221, 446	194.02
	07952 PATHS EDUCATION	C	0		0 0		194.03
	07954 FOUNDATION	C	0		0 0	103, 835	
200.00	Cross Foot Adjustments					0	200.00

Health Financial Systems	DEARBORN COUN	ITY HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period:	Worksheet B	
				rom 01/01/2020		
				To 10/31/2020	Date/Time Pre	
					3/31/2021 12:	<u>34 pm</u>
Cost Center Description	DATA	PURCHASI NG	ADMI TTI NG	CASHI ERI NG/AC	Subtotal	
	PROCESSI NG	RECEI VI NG AND		COUNTS		
		STORES		RECEI VABLE		
	5. 02	5.03	5.04	5.05	5A. 05	
201.00 Negative Cost Centers	0	0	(0 0	C	201.00
202.00 TOTAL (sum lines 118 through 201)	3, 182, 541	327, 029	1, 041, 489	9 1, 767, 854	58, 966, 408	202.00

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	DEARBORN COUNT	TY HOSPITAL Provider C	CN: 15-0086	Period:	J of Form CMS-2 Worksheet B	2552-10
					From 01/01/2020 To 10/31/2020	Part I Date/Time Pre 3/31/2021 12:	pared:
	Cost Center Description	OTHER ADMI NI STRATI V	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
		E AND GENERAL 5.06	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						1.00
1.00 2.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP						1.00
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 5.04	00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING						5.03 5.04
5.04	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.05
5.06	00591 OTHER ADMINISTRATIVE AND GENERAL	4, 657, 038					5.06
7.00	00700 OPERATION OF PLANT	314,052	3, 976, 470	40/ 40	7		7.00
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	31, 635 94, 662	35, 873 26, 544	436, 427			8.00 9.00
	01000 DI ETARY	48, 055	90, 133	4, 389		731, 200	•
	01100 CAFETERI A	45, 067	63, 927	7, 613		0	
	01300 NURSI NG ADMI NI STRATI ON	142, 387	13, 520	(0	•
	01400 CENTRAL SERVICE & SUPPLY 01500 PHARMACY	50, 354 140, 879	159, 716 33, 417	5, 93		0	14.00 15.00
	01600 MEDICAL RECORDS & LIBRARY	82, 087	108, 317			0	16.00
	01700 SOCI AL SERVI CE	23, 665	5, 070	(0	17.00
23.00	02300 PHARMACY RESIDENCY	16, 621	6, 602	(2,067	0	23.00
30, 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	633, 465	1, 449, 228	172, 164	453, 619	494, 683	30.00
	03100 I NTENSI VE CARE UNI T	176, 891	166, 746	31, 196		54, 027	31.00
	04300 NURSERY	56, 333	9, 013			0	•
44.00	04400 SKILLED NURSING FACILITY	0	0	(0 0	0	44.00
50.00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	328, 662	581,043	52, 574	181, 872	0	50.00
	05100 RECOVERY ROOM	67, 129	26, 206			795	
	05200 DELIVERY ROOM & LABOR ROOM	28, 632	11, 357	(0	•
	05300 ANESTHESI OLOGY	12,094	361)		0	
	05400 RADI OLOGY-DI AGNOSTI C 05401 ULTRASOUND	167, 989 22, 247	264, 248 13, 971	27, 913 9, 563		0	54.00 54.01
	05500 RADI OLOGY-THERAPEUTI C	47, 895	26, 026	2, 269		0	55.00
	05700 CT SCAN	79, 286	0	(-	0	57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	44, 782	18, 094	(0	58.00
	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0 448, 201	0 151, 424	96		0	59.00 60.00
	06001 BLOOD LABORATORY	0	0	(0	60.01
	06500 RESPI RATORY THERAPY	84, 869	26, 229	7, 992	2 8, 210	0	65.00
	03950 SLEEP CLINIC	15, 784	0	(, i	0	65.01
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	116, 485 21, 522	170, 442 17, 891	7,472		0	
	06800 SPEECH PATHOLOGY	18, 261	9, 554	(0	
	06900 ELECTROCARDI OLOGY	70, 895	73, 481	2, 041	1 23, 000	0	69.00
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	148, 393	0		0	0	•
	07200 I MPL. DEV. CHARGED TO PATI ENT 07300 DRUGS CHARGED TO PATI ENTS	286, 208 140, 217	0			0	•
	OUTPATIENT SERVICE COST CENTERS				-	-	
	09100 EMERGENCY	211, 303	218, 212	98, 620	68, 302	14, 152	
	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
	10100 HOME HEALTH AGENCY	100, 641	33, 462	(10, 474	0	101.00
	SPECIAL PURPOSE COST CENTERS	· · ·			· · ·		
	11300 INTEREST EXPENSE	4 004	7 000			0	113.00
116.00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	4, 996 4, 322, 644	7, 098 3, 817, 205	430, 909	-/	0 563, 657	116.00
110.00	NONREI MBURSABLE COST CENTERS	4, 322, 044	3, 017, 203	430, 70	1, 173, 202	565, 657	110.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	3, 058	54, 981	(17, 210		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	62, 247	0	(0		192.00
	19201 PHYSI CI AN CLI NI C 19202 LI FELI NE	7, 867 98	38, 307		0 11,990		192. 01 192. 02
	19203 CREDIT UNI ON	1, 433	23, 570		7, 378		192.02
	19204 ENT	21, 815	0	(0 0		192.04
	19205 HOSPI TALI ST	113, 610	8, 833		2, 765		192.05
	19206 ORTHO 19207 ATHLETI C TRAI NERS	69, 945 5, 188	0				192.06 192.07
	07950 COMMUNITY MENTAL HEALTH	0	0	5, 518	3 0	167, 543	
194.00			20 042		6, 524		194.01
194.01	07951 MARKETI NG	20, 983	20, 843		0, 524		•
194. 01 194. 02	07953 OCCUPATI ONAL HEALTH	18, 989	20, 843	(0, 524	0	194.02
194. 01 194. 02 194. 03			20, 843 0 0 12, 731		0, 524 0 0 0 0 0 3, 985	0 0	•

Health Financial Systems	DEARBORN COUN	ITY HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		eriod:	Worksheet B	
				rom 01/01/2020		
				o 10/31/2020	Date/Time Pre	
					3/31/2021 12:	<u>34 pm</u>
Cost Center Description	OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	ADMI NI STRATI V	PLANT	LINEN SERVICE			
	E AND GENERAL					
	5.06	7.00	8.00	9.00	10.00	
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	4, 657, 038	3, 976, 470	436, 427	1, 225, 134	731, 200	202.00

Health Financial Systems	DEARBORN COUN	NTY HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-0086	Period: From 01/01/2020	Worksheet B	
				To 10/31/2020	Date/Time Pre	epared:
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	3/31/2021 12: MEDI CAL	34 pm
		ADMI NI STRATI O	SERVICE &		RECORDS &	
	11.00	N 13.00	SUPPLY 14.00	15.00	LI BRARY 16.00	
GENERAL SERVICE COST CENTERS	T					
1.00 00100 NEW CAP REL COSTS-BLDG & FLXT 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP						1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01 01160 COMMUNICATIONS						5.01
5. 02 00550 DATA PROCESSING 5. 03 00560 PURCHASING RECEIVING AND STORES						5.02 5.03
5. 04 00570 ADMI TTI NG						5.04
5. 05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.05
5. 06 00591 OTHER ADMINI STRATI VE AND GENERAL 7. 00 00700 OPERATI ON OF PLANT						5.06 7.00
8.00 00800 LAUNDRY & LI NEN SERVICE						8.00
9. 00 00900 HOUSEKEEPI NG						9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	662, 174	L				10.00
13.00 01300 NURSING ADMINISTRATION	31, 646	1 1				13.00
14.00 01400 CENTRAL SERVICE & SUPPLY	14,043		942, 28			14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL_RECORDS & LI BRARY	27, 842 24, 584	1 1		0 1,855,498 0 0	1, 206, 180	15.00
17.00 01700 SOCIAL SERVICE	7, 255	5 0		0 0	0	
23. 00 02300 PHARMACY RESIDENCY	4, 325	5 O		0 0	0	23.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	152, 022	812, 225		0 0	76, 044	30.00
31. 00 03100 I NTENSI VE CARE UNI T	43, 642			0 0	33, 694	
43. 00 04300 NURSERY	12, 656			0 0	2, 789	
44. 00 04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	C	0		0 0	0	44.00
50. 00 05000 OPERATI NG ROOM	41, 790			0 0	278, 184	
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	17,810			0 0	18, 138 8, 721	
52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESIOLOGY	7,400			0 0	27, 477	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	34, 098	3 0		0 0	63, 024	54.00
54. 01 05401 ULTRASOUND 55. 00 05500 RADI OLOGY-THERAPEUTI C	4, 848 8, 833			0 0 0 0	13, 168	
57. 00 05700 CT_SCAN	0, 033	1		0 0	17, 850 106, 363	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	C			0 0	16, 005	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	78, 080	-		0 0	0 172, 874	
60. 01 06001 BLOOD LABORATORY	78,080			0 0	0	
65. 00 06500 RESPI RATORY THERAPY	21, 236	0		0 0	18, 092	65.00
65. 01 03950 SLEEP CLINIC 66. 00 06600 PHYSICAL THERAPY	29, 798			0 0	2,908	
67.00 06700 OCCUPATI ONAL THERAPY	5, 042	1		0 0	17, 118 5, 204	
68.00 06800 SPEECH PATHOLOGY	4, 124	0		0 0	2, 798	68.00
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	17, 190		942, 28	0 0	34, 324 36, 381	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		-	942, 20	0 0	60, 970	
73.00 07300 DRUGS CHARGED TO PATIENTS	C	0		0 1, 855, 498	53, 471	73.00
91.00 09100 EMERGENCY	57, 257	305, 913		0 0	134, 329	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	57,257	303, 713		0	104, 027	92.00
OTHER REIMBURSABLE COST CENTERS					(
101.00 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	C	0 0		0 0	6, 052	101.00
113.0011300 INTEREST EXPENSE						113.00
116.00 11600 HOSPI CE			040.00	0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	645, 587	1, 852, 274	942, 28	34 1, 855, 498	1, 206, 180	00 118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	0 0		0 0		190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	2, 373	1 1		0 0		192.00
192. 01 19201 PHYSI CLAN CLINIC 192. 02 19202 LI FELINE	639					192.01
192. 03 19203 CREDI T UNI ON				0 0		192.02
192. 04 19204 ENT	C	0		0 0		192.04
192. 05 19205 H0SPI TALI ST 192. 06 19206 ORTHO						192.05
192. 07 19200 0KTHO 192. 07 19207 ATHLETI C TRAI NERS	2,006			0 0	0	192.00
194.0007950 COMMUNITY MENTAL HEALTH	C	0 0		0 0	0	194.00
194. 01 07951 MARKETING 194. 02 07953 0CCUPATIONAL_HEALTH	3, 874 5, 178	1 1		0 0		194.01
194. 02 07953 0000PATTONAL HEALTH 194. 03 07952 PATHS_EDUCATI ON	0, 176			0 0		194.02
194. 04 07954 FOUNDATI ON	2, 517	0		0 0		194.04
200.00 Cross Foot Adjustments						200.00

Health Financial Systems	DEARBORN COUN	ITY HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period:	Worksheet B	
				From 01/01/2020	Part Date/Time Pre	narodi
				10 10/31/2020	3/31/2021 12:	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI O	SERVICE &		RECORDS &	
		N	SUPPLY		LI BRARY	
	11.00	13.00	14.00	15.00	16.00	
201.00 Negative Cost Centers	0	0	0	0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	662, 174	1, 852, 274	942, 284	1, 855, 498	1, 206, 180	202.00

Health Financial Systems	DEARBORN COUNT	TY_HOSPI TAL		In Lieu	of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		om 01/01/2020	Worksheet B Part I	
			To	0 10/31/2020	Date/Time Pre 3/31/2021 12:	pared: 34 pm
Cost Center Description	SOCI AL SERVI CE	PHARMACY RESI DENCY	Subtotal	Intern & Residents	Total	
	SERVICE	RESIDENCI		Cost & Post		
				Stepdown Adjustments		
	17.00	23.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 01 01160 COMMUNI CATI ONS						4.00 5.01
5. 02 00550 DATA PROCESSING						5.01
5. 03 00560 PURCHASING RECEIVING AND STORES						5.03
5. 04 00570 ADMI TTI NG 5. 05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.04 5.05
5. 06 00591 OTHER ADMINI STRATI VE AND GENERAL						5.06
7. 00 00700 OPERATI ON OF PLANT 8. 00 00800 LAUNDRY & LI NEN SERVI CE						7.00 8.00
9. 00 00900 HOUSEKEEPI NG						9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A						10.00 11.00
13. 00 01300 NURSING ADMINISTRATION						13.00
14.00 01400 CENTRAL SERVICE & SUPPLY						14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL_RECORDS_&_LI BRARY						15.00 16.00
17. 00 01700 SOCI AL SERVI CE	313, 559					17.00
23.00 02300 PHARMACY RESIDENCY I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	223, 442				23.00
30. 00 03000 ADULTS & PEDIATRICS	270, 186	0	11, 900, 897	0	11, 900, 897	30.00
31. 00 03100 INTENSIVE CARE UNIT	12, 153	0	2,866,580	0	2, 866, 580	
43.00 04300 NURSERY 44.00 04400 SKILLED NURSING FACILITY	0	0	808, 170 0	0	808, 170 0	43.00 44.00
ANCILLARY SERVICE COST CENTERS		-		-		
50. 00 05000 0PERATI NG ROOM 51. 00 05100 RECOVERY ROOM	13, 829 210	0	5, 534, 024 1, 016, 492	0	5, 534, 024 1, 016, 492	50.00 51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	433, 525	0	433, 525	
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	181, 085 2, 599, 044	0	181, 085 2, 599, 044	
54. 01 05400 ULTRASOUND	0	0	2, 399, 044 327, 608	0	327, 608	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	669, 561	0	669, 561	55.00
57.00 05700 CT SCAN 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI)	0	0	1, 110, 268 606, 781	0	1, 110, 268 606, 781	57.00 58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.00
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY	0	0	6, 124, 906 0	0	6, 124, 906 0	60.00 60.01
65.00 06500 RESPI RATORY THERAPY	0	0	1, 156, 349	0	1, 156, 349	65.00
65. 01 03950 SLEEP CLINIC	0	0	202, 762	0	202, 762	
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY	0	0	1, 753, 086 307, 317	0	1, 753, 086 307, 317	66.00 67.00
68.00 06800 SPEECH PATHOLOGY	0	0	250, 682	0	250, 682	68.00
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	1, 047, 696 2, 857, 586	0	1, 047, 696 2, 857, 586	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	3, 684, 881	0	3, 684, 881	
73. 00 07300 DRUGS CHARGED TO PATI ENTS OUTPATI ENT SERVI CE COST CENTERS	0	223, 442	3, 907, 812	0	3, 907, 812	73.00
91. 00 09100 EMERGENCY	6, 914	0	3, 579, 180	0	3, 579, 180	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
OTHER REIMBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY	314	0	1, 324, 602	0	1, 324, 602	101 00
SPECIAL PURPOSE COST CENTERS	011		1, 02 1, 002	3	1, 02 1, 002	
113. 00 11300 I NTEREST EXPENSE 116. 00 11600 HOSPI CE	9, 953	0	82, 729	о	82, 729	113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	313, 559	223, 442	54, 333, 623	0	54, 333, 623	•
NONREI MBURSABLE COST CENTERS		-			110.010	
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	110, 910 790, 529	0	110, 910 790, 529	
192. 01 19201 PHYSI CLAN CLINIC	0	Ő	150, 550	Ő	150, 550	192.01
192. 02 19202 LI FELI NE 192. 03 19203 CREDI T UNI ON	0	0	1, 236 49, 092	0	1, 236 49, 092	192.02 192.03
192. 04 19203 CREDITE UNION 192. 04 19204 ENT	0	0	49, 092 276, 220	0	49, 092 276, 220	
192. 05 19205 HOSPI TALI ST	0	0	1, 450, 102	0	1, 450, 102	
192. 06 19206 ORTHO 192. 07 19207 ATHLETI C TRAI NERS	0	0	885, 625 67, 697	0 O	885, 625 67, 697	
194.0007950 COMMUNI TY MENTAL HEALTH	0	Ő	173, 061	Ö	173, 061	194.00
194. 01 07951 MARKETING 194. 02 07953 0CCUPATIONAL_HEALTH	0	0	296, 929 245, 613	0	296, 929 245, 613	
194. 03 07952 PATHS_EDUCATION	0	0	3, 249	0		194.02 194.03

Health Financial Systems	DEARBORN COUN	TY HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		eriod:	Worksheet B	
				rom 01/01/2020 o 10/31/2020		narod
				0 10/31/2020	3/31/2021 12:	
Cost Center Description	SOCI AL	PHARMACY	Subtotal	Intern &	Total	
	SERVI CE	RESI DENCY		Resi dents		
				Cost & Post		
				Stepdown		
				Adjustments		
	17.00	23.00	24.00	25.00	26.00	
194. 04 07954 FOUNDATI ON	0	0	131, 972	0	131, 972	194.04
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)	313, 559	223, 442	58, 966, 408	0	58, 966, 408	202.00

	Financial Systems TION OF CAPITAL RELATED COSTS	DEARBORN COUN			In Lieu eriod: rom 01/01/2020 o 10/31/2020	Worksheet B Part II Date/Time Prepare	
			CAPI TAL REL	ATED COSTS		3/31/2021 12:	34 pm
	Cost Center Description	Directly Assigned New Capital	NEW BLDG & FIXT	NEW MVBLE EQUI P	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		Related Costs 0	1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS						
2. 00 3. 00 5. 01 5. 02 5. 03 5. 04 5. 00 5. 00 5. 00 6. 00 0. 00 1. 00 3. 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 CASHI ERING/ACCOUNTS RECEIVABLE 00591 OTHER ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICE & SUPPLY		21, 658 3, 088 35, 839 64, 922 35, 097 21, 465 132, 434 991, 360 16, 172 11, 967 40, 633 28, 819 6, 095 72, 002	8, 800 1, 255 14, 562 26, 379 14, 260 8, 721 53, 810 402, 802 6, 571 4, 862 16, 510 11, 710 2, 476 29, 255	4, 343 50, 401 91, 301 49, 357 30, 186 186, 244 1, 394, 162 22, 743 16, 829 57, 143 40, 529 8, 571	30, 458 112 941 178 821 365 2, 374 798 89 849 279 484 1, 241 281	1.0 2.0 4.0 5.0 5.0 5.0 5.0 5.0 5.0 7.0 8.0 9.0 10.0 11.0 13.0 14.0
5.00 6.00 7.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 02300 PHARMACY RESIDENCY	0 0 0 0	72,002 15,065 48,831 2,286 2,976	29, 255 6, 121 19, 841 929 1, 209	21, 186 68, 672 3, 215	281 1, 274 603 236 170	15.00 16.00 17.00
1.00 3.00	I NPATI ENT ROUTI NE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 03100 I NTENSIVE CARE UNIT 04300 NURSERY 04400 SKI LLED NURSI NG FACI LITY ANCI LLARY SERVICE COST CENTERS	0 0 0 0	653, 333 75, 172 4, 063 0	265, 457 30, 543 1, 651 C	105, 715 5, 714	4, 525 1, 468 450 0	43.0
i1.00 i2.00 i3.00 i4.00 i4.01 i5.00 i7.00 i8.00 i9.00 i0.01 i5.00 i7.00 i8.00 i9.00 i0.01 i5.00 i5.00 i6.00 i7.00 i8.00 i9.00 i1.00	05000 OPERATING ROOM 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY 05400 RADIOLOGY-DIAGNOSTIC 05401 ULTRASOUND 05500 RADIOLOGY-THERAPEUTIC 05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06001 BLOOD LABORATORY 06500 RESPIRATORY THERAPY 06500 RESPIRATORY THERAPY 06500 SLEEP CLINIC 06600 PHYSICAL THERAPY 06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY		$\begin{array}{c} 261,943\\ 11,814\\ 5,120\\ 163\\ 119,127\\ 6,298\\ 11,733\\ 0\\ 8,157\\ 0\\ 68,264\\ 0\\ 11,824\\ 0\\ 76,838\\ 8,066\\ 4,307\\ 33,126\\ 0\\ \end{array}$	106, 430 4, 800 2, 080 48, 403 2, 559 4, 767 0 3, 314 0 27, 736 0 4, 804 0 31, 220 3, 277 1, 750 13, 460 0 0	16, 614 7, 200 229 167, 530 8, 857 16, 500 0 11, 471 0 96, 000 0 16, 628 0 108, 058 11, 343 6, 057	1, 544 633 265 0 1, 055 191 358 510 238 0 2, 078 0 725 0 1, 087 217 199 631 0	51. 0 52. 0 53. 0 54. 0 55. 0 57. 0 57. 0 58. 0 60. 0 60. 0 65. 0 65. 0 65. 0 65. 0 66. 0 67. 0 68. 0 69. 0 71. 0
3.00 1.00	07200 I MPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0 0 98, 373	39, 970	0 0 138, 343 0	0 0 1, 762	73. C
	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	0	15, 085	6, 129		QAE	101.0
13. 00 16. 00 18. 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE 11600 HOSPI CE	0	3, 200 3, 026, 715	1, 300 1, 229, 789	4, 500		113. 0 116. 0
90.00 92.00 92.01 92.02 92.03 92.04 92.05 92.06 92.07	19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CI ANS' PRI VATE OFFI CES 19201 PHYSI CI AN CLI NI C 19202 LI FELI NE 19203 CREDI T UNI ON 19204 ENT 19205 HOSPI TALI ST 19206 ORTHO 19207 ATHLETI C TRAI NERS		24, 786 0 17, 269 0 10, 626 0 3, 982 0 0 0	10, 071 C 7, 017 C 4, 317 C 1, 618 C C C	0 24, 286 0 14, 943 0	74 10 0 0 0 0 0 56	190. 0 192. 0 192. 0 192. 0 192. 0 192. 0 192. 0 192. 0
94.01	07950 COMMUNI TY MENTAL HEALTH 07951 MARKETI NG 07953 OCCUPATI ONAL HEALTH	0 0 0	0 9, 396 0	0 3, 818 0		138	194. C 194. C 194. C

Health Financial Systems	DEARBORN COUNTY HOSPITAL			In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		Period:	Worksheet B		
				From 01/01/2020 To 10/31/2020		pared:	
					3/31/2021 12:		
		CAPI TAL REL	LATED COSTS				
	D						
Cost Center Description	Directly	NEW BLDG &	NEW MVBLE	Subtotal	EMPLOYEE		
	Assigned New	FLXT	EQUI P		BENEFI TS		
	Capi tal				DEPARTMENT		
	Related Costs						
	0	1.00	2.00	2A	4.00		
194. 03 07952 PATHS EDUCATI ON	0	0		0 0	0	194.03	
194. 04 07954 FOUNDATI ON	0	5, 739	2, 33	2 8, 071	89	194.04	
200.00 Cross Foot Adjustments				0		200.00	
201.00 Negative Cost Centers		0		0 0	0	201.00	
202.00 TOTAL (sum lines 118 through 201)	0	3, 098, 513	1, 258, 96	4, 357, 475	30, 458	202.00	

	Financial Systems TION OF CAPITAL RELATED COSTS	DEARBORN COUN		CN. 15 0004 D		u of Form CMS-2	2552-10
ALLUCA	TION OF CAPITAL RELATED CUSIS		Provider C		eriod: com 01/01/2020 p 10/31/2020		
	Cost Center Description	COMMUNI CATI ON S	DATA PROCESSI NG	PURCHASI NG RECEI VI NG AND STORES	ADMI TTI NG	CASHI ERI NG/AC COUNTS RECEI VABLE	
		5. 01	5.02	5.03	5.04	5. 05	
	GENERAL SERVICE COST CENTERS	1		Г			
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	4, 455					5.01
5.02	00550 DATA PROCESSING	263	51, 605				5.02
5.03	00560 PURCHASING RECEIVING AND STORES	51	617	92, 147	50 477		5.03
5.04 5.05	00570 ADMI TTI NG 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	102 183	1, 698	199 38	52, 177 0	33, 447	5.04 5.05
5.05	00591 OTHER ADMINI STRATI VE AND GENERAL	157	2, 675 2, 778	2, 281	0	33, 447	5.05
7.00	00700 OPERATION OF PLANT	153	720	594	0	0	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	11	0	2, 550	0	0	8.00
9.00	00900 HOUSEKEEPI NG	66	257	750	0	0	9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	18 62	1, 646 0	229	0	0	10.00 11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	58	875	2, 931	0	0	13.00
14.00	01400 CENTRAL SERVICE & SUPPLY	69	1, 080	1, 825	0	0	14.00
15.00	01500 PHARMACY	106	1, 441	940	0	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	267	2, 778	129 25	0	0	16.00
17.00 23.00	02300 PHARMACY RESIDENCY	51 26	463 154	103	0	0	17.00 23.00
	INPATIENT ROUTINE SERVICE COST CENTERS				-		
30.00	03000 ADULTS & PEDIATRICS	526	9, 161	3, 676	38, 380	2, 109	30.00
31.00 43.00	03100 I NTENSI VE CARE UNI T 04300 NURSERY	62 0	1, 389 0	1, 279 0	8, 032 5, 765	934 77	31.00 43.00
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
	ANCI LLARY SERVICE COST CENTERS	1		1			
50.00	05000 OPERATING ROOM	205	3, 241	19, 714	0	7,708	50.00
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	58 0	0	644	0	503 242	51.00 52.00
53.00	05300 ANESTHESI OLOGY	26	0	3, 112	0	762	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	249	2, 470	1, 424	0	1, 748	54.00
54.01	05401 ULTRASOUND	7	0	220	0	365	
55.00 57.00	05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN	22	515 0	734 1, 072	0	495 2, 950	55.00 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	299	0	444	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.00
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	143	3, 499	11, 785 0	0	4, 795 0	60. 00 60. 01
65.00	06500 RESPIRATORY THERAPY	26	1, 852	636	0	502	65.00
65.01	03950 SLEEP CLINIC	18	0	70	0	81	65.01
66.00	06600 PHYSI CAL THERAPY	66	1, 132		0	475	
	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	40	0	46	0	144 78	
	06900 ELECTROCARDI OLOGY	135	0	143	0	952	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	1,009	
	07200 I MPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	0	0	32, 692 0	0	1, 691 1, 483	
73.00	OUTPATIENT SERVICE COST CENTERS	0	0	0	0	1,405	/3.00
	09100 EMERGENCY	121	1, 749	1, 495	0	3, 726	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
101.00	10100 HOME HEALTH AGENCY	22	2, 109	172	0	168	101.00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE 11600 HOSPI CE		0	21	0	,	113.00 116.00
118.00		3, 373	44, 299	21 91, 975	52, 177	33, 447	
110100	NONREI MBURSABLE COST CENTERS	0,010	111/2//	,,,,,,,	02,111	00, 117	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	18	0	-	0		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES 19201 PHYSI CLAN CLI NI C	958 33	6, 586 463		0		192.00 192.01
	19202 LI FELI NE	0	403	0	0		192.01
192.03	19203 CREDIT UNI ON	40	0	0	0	0	192.03
	19204 ENT	0	0	0	0		192.04
	19205 HOSPI TALI ST 19206 ORTHO	0	206	6	0		192.05 192.06
	19207 ATHLETIC TRAINERS	0	0	0	0		192.08 192.07
194.00	07950 COMMUNITY MENTAL HEALTH	0	0	0	0	0	194.00
	07951 MARKETI NG	11	51	14	0		194.01
	07953 OCCUPATI ONAL HEALTH 07952 PATHS EDUCATI ON	15 0	0	16 0	0		194.02 194.03
194.04	07954 FOUNDATI ON	7	0	o o	0 0	0	194.04
200.00	Cross Foot Adjustments						200.00

Heal th Financial	l Systems	DEARBORN COUN	TY HOSPI TAL		In Lie	u of Form CMS-	2552-10
ALLOCATION OF C	APITAL RELATED COSTS		Provider C		Peri od:	Worksheet B	
					From 01/01/2020		
					To 10/31/2020		
						3/31/2021 12:	
Cos	t Center Description	COMMUNI CATI ON	DATA	PURCHASI NG	ADMI TTI NG	CASHI ERI NG/AC	
		S	PROCESSI NG	RECEIVING AN	D	COUNTS	
				STORES		RECEI VABLE	
		5. 01	5.02	5.03	5.04	5.05	
201.00 Neg	ative Cost Centers	0	0		0 0	0	201.00
202.00 TOT	AL (sum lines 118 through 201)	4, 455	51, 605	92, 14	17 52, 177	33, 447	202.00

Health Financial Systems ALLOCATION OF CAPITAL RELATED COSTS	DEARBORN COUN	TY HOSPITAL Provider CO		In Lie eriod: rom 01/01/2020	u of Form CMS-: Worksheet B Part II	2552-10
				0 10/31/2020		epared:
Cost Center Description	OTHER ADMI NI STRATI V E AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
	5. 06	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS						1.00
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP						1.00
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 PURCHASI NG RECEI VI NG AND STORES 5. 04 00570 ADMI TTI NG						5.03
5. 05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.05
5. 06 00591 OTHER ADMINI STRATI VE AND GENERAL	193, 834					5.06
7.00 00700 OPERATION OF PLANT	13,071	1, 409, 498				7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG	1, 317 3, 940	12, 716 9, 409				8.00 9.00
10. 00 01000 DI ETARY	2,000	31, 949			94, 400	
11. 00 01100 CAFETERI A	1, 876	22, 660			0	
13. 00 01300 NURSI NG ADMI NI STRATI ON	5, 926	4, 792			0	
14. 00 01400 CENTRAL SERVICE & SUPPLY 15. 00 01500 PHARMACY	2, 096 5, 864	56, 613 11, 845			0	
16. 00 01600 MEDICAL RECORDS & LIBRARY	3, 417	38, 394	0		0	
17.00 01700 SOCIAL SERVICE	985	1, 797			0	
23. 00 02300 PHARMACY RESIDENCY	692	2, 340	0	54	0	23.00
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	26, 367	513, 689	15, 553	11, 887	63, 865	30.00
31. 00 03100 I NTENSI VE CARE UNI T	7, 362	59, 105			6, 975	
43. 00 04300 NURSERY	2, 345	3, 195	0	74	0	43.00
44. 00 04400 SKI LLED NURSI NG FACI LI TY	0	0	0	0	0	44.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	13, 679	205, 956	4, 749	4, 765	0	50.00
51. 00 05100 RECOVERY ROOM	2, 794	9, 289			103	
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 192	4, 026		93	0	52.00
53. 00 05300 ANESTHESI OLOGY	503	128		-	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 05401 ULTRASOUND	6, 992 926	93, 665 4, 952			0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	1, 993	9, 225			0	
57.00 05700 CT SCAN	3, 300	0	0		0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 864	6, 414			0	
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	0 18, 655	0 53, 674	0		0	
60. 01 06001 BLOOD LABORATORY	0	0	0		0	
65. 00 06500 RESPI RATORY THERAPY	3, 532	9, 297	722	215	0	65.00
65. 01 03950 SLEEP CLINIC	657	0	0		0	
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	4, 848 896	60, 415 6, 342	675 97		0	
68. 00 06800 SPEECH PATHOLOGY	760	3, 387			0	
69. 00 06900 ELECTROCARDI OLOGY	2, 951	26, 046	184	603	0	
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	6, 176	0	0		0	
72. 00 07200 I MPL. DEV. CHARGED TO PATI ENT 73. 00 07300 DRUGS CHARGED TO PATI ENTS	11, 912 5, 836	0	0	-	0	
OUTPATIENT SERVICE COST CENTERS	0,000		~			/0.00
91.00 09100 EMERGENCY	8, 795	77, 347	8, 909	1, 790	1, 827	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
101.00 10100 HOME HEALTH AGENCY	4, 189	11, 861	0	274	0	101.00
SPECIAL PURPOSE COST CENTERS	1,107	11,001				101100
113.0011300 INTEREST EXPENSE						113.00
116.00 11600 HOSPICE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	208	2,516				116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	179, 916	1, 353, 044	38, 928	30, 795	12,110	118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	127	19, 489	0	451	0	190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	2, 591	0	0	-		192.00
192. 01 19201 PHYSI CI AN CLI NI C 192. 02 19202 LI FELI NE	327	13, 578	0			192.01 192.02
192. 02 19202 LIFELINE 192. 03 19203 CREDIT UNION	4 60	0 8, 355	-	193		192.02
192. 04 19204 ENT	908	0	0	0		192.04
192. 05 19205 HOSPI TALI ST	4, 729	3, 131	0	· =		192.05
192. 06 19206 ORTHO	2, 911	0	0			192.06
192.07 19207 ATHLETIC TRAINERS 194.00 07950 COMMUNITY MENTAL HEALTH	216 0	0	0 498			192.07 194.00
194. 01 07951 MARKETI NG	873	7, 388				194.00
194. 02 07953 OCCUPATI ONAL HEALTH	790	0	0	0	0	194.02
194. 03 07952 PATHS EDUCATI ON	11	0	0	-		194.03
194.04 07954 FOUNDATION 200.00 Cross Foot Adjustments	371	4, 513	0	104	0	194.04 200.00
						1200.00

Health Fina	ancial Systems	DEARBORN COUN	ITY HOSPI TAL		In Lie	u of Form CMS-	2552-10
ALLOCATI ON	OF CAPITAL RELATED COSTS		Provider C		Period:	Worksheet B	
					From 01/01/2020		
					To 10/31/2020		
					_	3/31/2021 12:	<u>34 pm</u>
	Cost Center Description	OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		ADMI NI STRATI V	PLANT	LINEN SERVICE			
		E AND GENERAL					
		5.06	7.00	8.00	9.00	10.00	
201.00	Negative Cost Centers	0	C)	0 0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	193, 834	1, 409, 498	39, 42	6 32, 100	94, 400	202.00

Health Financial Systems	DEARBORN COUN	ITY HOSPI TAL		In Lieu	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		Period: From 01/01/2020	Worksheet B Part II	
				To 10/31/2020	Date/Time Pre 3/31/2021 12:	pared: 34 pm
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI O N	SERVI CE & SUPPLY		RECORDS & LI BRARY	
	11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS						1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 01 01160 COMMUNI CATI ONS						4.00 5.01
5. 02 00550 DATA PROCESSI NG						5.02
5. 03 00560 PURCHASING RECEIVING AND STORES 5. 04 00570 ADMITTING						5.03 5.04
5. 05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.04
5. 06 00591 OTHER ADMINI STRATI VE AND GENERAL						5.06
7. 00 00700 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE						7.00 8.00
9. 00 00900 HOUSEKEEPI NG						9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	66, 823					10.00 11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	3, 193					13.00
14.00 01400 CENTRAL SERVICE & SUPPLY	1, 417		167, 60			14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY	2, 810 2, 481	0		0 45,740 0 0	117, 629	15.00 16.00
17.00 01700 SOCIAL SERVICE	732	0	(0 0	0	17.00
23. 00 02300 PHARMACY RESI DENCY I NPATI ENT ROUTI NE SERVI CE COST CENTERS	436	0	(0 0	0	23.00
30. 00 03000 ADULTS & PEDIATRICS	15, 345	12, 145	(0 0	7, 411	30.00
31. 00 03100 INTENSIVE CARE UNIT	4, 404			0 0	3, 284	31.00
43. 00 04300 NURSERY 44. 00 04400 SKI LLED NURSI NG FACI LI TY	1, 277 0				272 0	43.00 44.00
ANCI LLARY SERVICE COST CENTERS		-			~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~	
50.00 05000 0PERATING ROOM 51.00 05100 RECOVERY ROOM	4, 217				27, 188	50.00 51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 797 753				1, 768 850	51.00
53.00 05300 ANESTHESI OLOGY	0			0 0	2,678	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 05401 ULTRASOUND	3, 441 489	0			6, 142 1, 283	54.00 54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	891	0			1, 740	55.00
57.00 05700 CT SCAN	0			0	10, 366	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 59.00 05900 CARDIAC CATHETERIZATION	0				1, 560 0	58.00 59.00
60. 00 06000 LABORATORY	7, 879	0		0 0	16, 848	60.00
60. 01 06001 BLOOD LABORATORY 65. 00 06500 RESPI RATORY THERAPY	0 2, 143	0			0 1, 763	60. 01 65. 00
65. 01 03950 SLEEP CLINIC	2, 143	0			283	65.00
66. 00 06600 PHYSI CAL THERAPY	3, 007		(0 0	1, 668	
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	509 416				507 273	
69. 00 06900 ELECTROCARDI OLOGY	1, 735		(3, 345	
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0		167, 60		3, 546	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		45, 740	5, 942 5, 211	72.00 73.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	5, 778	4, 574	(0 0	13, 091	91.00 92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	0	0	(0 0	590	101.00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE						113.00
116. 00 11600 H0SPI CE	0			0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	65, 150	27, 698	167, 60	45, 740	117, 629	118.00
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(0 0	0	190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	239			0	0	192.00
192. 01 19201 PHYSI CLAN CLINIC 192. 02 19202 LI FELINE	64 0	0				192. 01 192. 02
192. 03 19203 CREDI T UNI ON	0	0	(0 0	0	192.03
192. 04 19204 ENT	0	0	(0		192.04 192.05
192. 05 19205 H0SPI TALI ST 192. 06 19206 ORTHO	0	0				192.05
192. 07 19207 ATHLETI C TRAI NERS	202	0	(0	0	192.07
194. 00 07950 COMMUNI TY MENTAL HEALTH 194. 01 07951 MARKETI NG	0 391					194.00 194.01
194. 02 07953 MARKETING 194. 02 07953 OCCUPATIONAL HEALTH	523					194.01 194.02
194. 03 07952 PATHS EDUCATI ON	0	0	(194.03
194.04 07954 FOUNDATION 200.00 Cross Foot Adjustments	254	0		ן ע	0	194. 04 200. 00
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Health Fin	ancial Systems	DEARBORN COUN	ITY HOSPI TAL		In Lie	u of Form CMS-	2552-10
ALLOCATI ON	N OF CAPITAL RELATED COSTS		Provider C		Period:	Worksheet B	
					From 01/01/2020		
					To 10/31/2020		
		_				3/31/2021 12:	<u>34 pm</u>
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
			ADMI NI STRATI O	SERVICE &		RECORDS &	
			N	SUPPLY		LI BRARY	
		11.00	13.00	14.00	15.00	16.00	
201.00	Negative Cost Centers	0	0	(0 C	0	201.00
202.00	TOTAL (sum lines 118 through 201)	66, 823	27, 698	167, 60	6 45, 740	117, 629	202.00

Health Financial Systems	DEARBORN COUN				i of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		eriod: com 01/01/2020 o 10/31/2020	Worksheet B Part II Date/Time Pre	
Cost Center Description	SOCI AL SERVI CE	PHARMACY RESI DENCY	Subtotal	Intern & Residents Cost & Post Stepdown	<u>3/31/2021 12:</u> Total	<u>34 pm</u>
	17.00	23.00	24.00	Adjustments 25.00	26.00	
GENERAL SERVICE COST CENTERS	17.00	20.00	21.00	20.00	20.00	
1.00 00100 NEW CAP REL COSTS-BLDG & FLXT 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.01 01160 COMMUNI CATI ONS 5.02 00550 DATA PROCESSI NG 5.03 00560 PURCHASI NG RECEI VI NG AND STORES 5.04 00570 ADMI TTI NG 5.05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.06 00591 OTHER ADMI NI STRATI VE AND GENERAL						$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 5.\ 03\\ 5.\ 04\\ 5.\ 05\\ 5.\ 06\end{array}$
7.00 00700 OPERATI ON OF PLANT 8.00 00800 LAUNDRY & LI NEN SERVI CE 9.00 00900 HOUSEKEEPI NG 10.00 01 ETARY 11.00 01100 CAFETERI A 13.00 01300 NURSI NG ADMI NI STRATI ON 14.00 01400 CENTRAL SERVI CE & SUPPLY 15.00 01500 PHARMACY 16.00 01600 MEDI CAL RECORDS & LI BRARY 17.00 01700 SOCI AL SERVI CE 23.00 02300 PHARMACY RESI DENCY INPATI ENT ROUTI NE SERVI CE COST CENTERS	7, 546	8, 160				7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00 17.00 23.00
30. 00 03000 ADULTS & PEDIATRICS	6, 502 292		1, 649, 931	0 0	1, 649, 931	30.00
31. 00 03100 I NTENSI VE CARE UNI T 43. 00 04300 NURSERY	0		207, 974 20, 180	0	207, 974 20, 180	31.00 43.00
44.00 O4400 SKI LLED NURSI NG FACI LI TY	0		0	0	0	44.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	333		665, 011	0	665, 011	50.00
51. 00 05100 RECOVERY ROOM 52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	500		35, 846 15, 218 7, 441	0 0 0	35, 846 15, 218 7, 441	51.00 52.00 53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 05401 ULTRASOUND	0		289, 405 18, 269	0	289, 405 18, 269	54.00 54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0		32, 891	0	32, 891	
57. 00 05700 CT SCAN	0		18, 198	0	18, 198	
58.00 05800 MAGNETIC RESONANCE I MAGI NG (MRI) 59.00 05900 CARDI AC CATHETERIZATI ON	0		22, 438	0	22, 438 0	58.00 59.00
60. 00 06000 LABORATORY	0		216, 607	0	216, 607	60.00
60. 01 06001 BLOOD LABORATORY	0		0	0	0	60. 01
65. 00 06500 RESPI RATORY THERAPY	0		38, 041	0	38, 041	
65. 01 03950 SLEEP CLINIC 66. 00 06600 PHYSICAL THERAPY	0		1, 109 182, 961	0	182, 961	65.01 66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0		20, 288	Ő	20, 288	
68. 00 06800 SPEECH PATHOLOGY	0		11, 267	0	11, 267	
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0		83, 311 178, 337	0	83, 311 178, 337	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0		52, 237	0	52, 237	
73.00 07300 DRUGS CHARGED TO PATIENTS	0		58, 270	0	58, 270	73.00
0UTPATI ENT SERVI CE COST CENTERS 91. 00 09100 EMERGENCY	166		269, 473	0	269, 473	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	100		209, 473	0	209, 473	91.00
101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	8		41, 472	0	41, 472	101.00
113.0011300 INTEREST EXPENSE						113.00
116.00 11600 HOSPI CE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	240 7, 546	0	7, 586 4, 143, 761	0 0	7, 586 4, 143, 761	116.00 118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	0		54, 942		54 042	190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFICES	0		10, 576	0	10, 576	
192. 01 19201 PHYSI CI AN CLI NI C	0		39, 083	0	39, 083	192.01
192. 02 19202 LI FELI NE	0		22 501	0		192.02
192. 03 19203 CREDI T UNI ON 192. 04 19204 ENT	0		23, 591 908	0		192.03 192.04
192. 05 19205 HOSPI TALI ST	0		13, 744	0	13, 744	192.05
192. 06 19206 ORTHO	0		2, 911	0		192.06
192. 07 19207 ATHLETI C TRAI NERS 194. 00 07950 COMMUNI TY MENTAL HEALTH	0		474 22, 128	0		192.07 194.00
194. 01 07951 MARKETI NG	0		22, 120	0		194.00
194.0207953 OCCUPATI ONAL HEALTH	0		1, 522	0	1, 522	194. 02
194. 03 07952 PATHS EDUCATI ON	0		11	0	11	194.03

Health Financial Systems	DEARBORN COUN	TY HOSPI TAL		In Lie	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		Period:	Worksheet B	
				From 01/01/2020		narod
				10 10/31/2020	3/31/2021 12:	
Cost Center Description	SOCI AL	PHARMACY	Subtotal	Intern &	Total	
	SERVI CE	RESI DENCY		Resi dents		
				Cost & Post		
				Stepdown		
				Adjustments		
	17.00	23.00	24.00	25.00	26.00	
194. 04 07954 FOUNDATI ON	0		13, 40	9 0	13, 409	194.04
200.00 Cross Foot Adjustments		8, 160	8, 160	0 0	8, 160	200.00
201.00 Negative Cost Centers	0	0	(0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	7, 546	8, 160	4, 357, 47	5 0	4, 357, 475	202.00

COST AL	Financial Systems LOCATION - STATISTICAL BASIS	DEARBORN COUN	Provider CC		Period: From 01/01/2020	u of Form CMS-2 Worksheet B-1	
					o 10/31/2020	Date/Time Pre 3/31/2021 12:	
		CAPI TAL REL	ATED COSTS			5/51/2021 12.	
	Cost Center Description	NEW BLDG & FI XT (SQUARE FEET)	NEW MVBLE EQUI P (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNI CATI ON S (PHONES)	DATA PROCESSI NG (DP EQUI PMENT)	
		1.00	2.00	4.00	5.01	5.02	
	GENERAL SERVICE COST CENTERS	305, 022					1.00
2.00 4.00 5.01 5.02 5.02 5.03 5.04 5.05 5.06 7.00 8.00 0.00 10.00 13.00 14.00 0	D0200 NEW CAP REL COSTS-MVBLE EQUIP D0400 EMPLOYEE BENEFITS DEPARTMENT D01160 COMMUNI CATIONS D0550 DATA PROCESSING D0560 PURCHASING RECEIVING AND STORES D0570 ADMITTING D0580 CASHIERING/ACCOUNTS RECEIVABLE D0591 OTHER ADMINISTRATIVE AND GENERAL D0700 OPERATION OF PLANT D0800 LAUNDRY & LINEN SERVICE D0900 HOUSEKEEPING D1100 DI ETARY D1100 CAFETERIA D1400 CENTRAL SERVICE & SUPPLY	2, 132 304 3, 528 6, 391 3, 455 2, 113 13, 037 97, 591 1, 592 1, 178 4, 000 2, 837 600 7, 088	305, 022 2, 132 304 3, 528 6, 391 3, 455 2, 113 13, 037 97, 591 1, 592 1, 178 4, 000 2, 837 600 7, 088 1, 482	23, 790, 728 87, 794 735, 012 139, 028 641, 282 285, 243 1, 854, 930 623, 680 69, 901 663, 160 218, 215 378, 490 969, 807 219, 567	1, 219 72 14 28 50 43 42 3 42 3 42 3 5 5 17 16 19	1, 003 12 33 52 54 14 0 5 32 0 17 21 21	$\begin{array}{c} 2.\ 00\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 5.\ 03\\ 5.\ 04\\ 5.\ 05\\ 5.\ 06\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00 \end{array}$
	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	1, 483 4, 807	1, 483 4, 807	995, 007 471, 302		28 54	15.00 16.00
17.00 C 23.00 C	01700 SOCIAL SERVICE 02300 PHARMACY RESIDENCY NPATIENT ROUTINE SERVICE COST CENTERS	225 293	225 293	184, 698 133, 171	14	9	17.00 23.00
30.00	D3000 ADULTS & PEDIATRICS	64, 315	64, 315	3, 528, 190	144	178	30.00
	D3100 I NTENSI VE CARE UNI T D4300 NURSERY	7, 400 400	7, 400 400	1, 146, 640 351, 248		27 0	31.00 43.00
44.00	04400 SKILLED NURSING FACILITY	0	0	0017210		0	44.00
	ANCILLARY SERVICE COST CENTERS	25, 786	25, 786	1, 206, 241	56	63	50.00
51.00 0	D5100 RECOVERY ROOM	1, 163	1, 163	494, 769	16	0	51.00
	D5200 DELIVERY ROOM & LABOR ROOM D5300 ANESTHESI OLOGY	504 16	504 16	207, 236 0		0	52.00 53.00
54.00 0	05400 RADI OLOGY-DI AGNOSTI C	11, 727	11, 727	823, 967		48	54.00
	05401 ULTRASOUND 05500 RADI OLOGY-THERAPEUTI C	620 1, 155	620 1, 155	149, 528 279, 740		0 10	54.01 55.00
	D5700 CT SCAN D5800 MAGNETIC RESONANCE IMAGING (MRI)	0 803	0 803	398, 133 185, 853		0	57.00 58.00
	D5900 CARDI AC CATHETERI ZATI ON	0	0	165, 855		0	59.00
		6, 720 0	6, 720	1, 623, 653 0		68	60.00
	06001 BLOOD LABORATORY 06500 RESPI RATORY THERAPY	0 1, 164	0 1, 164	566, 496		0 36	
	03950 SLEEP CLINIC	0	0	C	5	0	65.01
	D6600 PHYSI CAL THERAPY D6700 OCCUPATI ONAL THERAPY	7, 564 794	7, 564 794	849, 525 169, 698		22 0	66.00 67.00
	06800 SPEECH PATHOLOGY	424	424	155, 138		0	68.00
	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	3, 261 0	3, 261 0	493, 008 C		0 0	69.00 71.00
	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0		0	72.00
	D7300 DRUGS CHARGED TO PATIENTS DUTPATIENT SERVICE COST CENTERS	0	U	U	0 0	0	73.00
92.00	D9100 EMERGENCY D9200 OBSERVATION BEDS (NON-DISTINCT PART) DTHER REIMBURSABLE COST CENTERS	9, 684	9, 684	1, 376, 669	33	34	91.00 92.00
	10100 HOME HEALTH AGENCY	1, 485	1, 485	675, 891	6	41	101.00
	SPECIAL PURPOSE COST CENTERS						113.00
116.001	11600 HOSPI CE	315	315	13, 018			116.00
	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	297, 954	297, 954	23, 364, 928	923		118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	2, 440	2, 440	0 57,480			190.00 192.00
192.011	19201 PHYSI CLAN CLINIC	1, 700	1, 700	7, 776	9	9	192.01
	19202 LI FELI NE 19203 CREDI T UNI ON	0 1, 046	0 1, 046	C	0 0 0 11		192. 02 192. 03
192 025	19203 CREDIT UNION 19204 ENT	0	0	C	0	0	192.04
192.041				_			400 05
192.041 192.051	19205 HOSPI TALI ST	392	392	0	0		192.05
192. 04 1 192. 05 1 192. 06 1	19205 HOSPI TALI ST 19206 ORTHO 19207 ATHLETI C TRAI NERS	392 0 0	392 0 0	0 0 43, 819		0	192.05 192.06 192.07

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0086 Period: From 01/01/2020 To 10/31/2020 Workshee Date/Tin 3/31/202 Cost Center Description NEW BLDG & FIXT (SOUARE FEET) NEW MVBLE EQUIP (SOUARE FEET) EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES) COMMUNICATION S (PHONES) DATA PROCESS (PHONES) 194. 02/07953 OCCUPATIONAL HEALTH OVERST 0 0 139, 259 4 194. 02/07954 FOUNDATION 565 565 69, 484 2 200. 00 Cross Foot Adjustments 201. 00 Negative Cost Centers 565 69, 484 2	Prepared:
Cost Center Description CAPITAL RELATED COSTS COMMUNICATION Date/Tim 3/31/202 NEW BLDG & FIXT (SOUARE FEET) NEW MVBLE EQUIP (SOUARE FEET) EMPLOYEE BENEFITS (SOUARE FEET) COMMUNICATION BENEFITS (SOUARE FEET) COMMUNICATION BENEFITS (SOUARE FEET) COMMUNICATION (GROSS SALARIES) DATA PROCESS (PHONES) 194. 02 07953 OCCUPATIONAL HEALTH (SOUARE FOUNDATION 0 0 0 5.01 5.02 194. 02 07954 FOUNDATION 0 0 0 0 0 0 194. 02 07954 FOUNDATION 565 565 69, 484 2 2 200. 00 Cross Foot Adjustments 565 565 69, 484 2	Prepared: 12:34 pm
Cost Center Description NEW BLDG & FIXT NEW MVBLE EQUIP EMPLOYEE BENEFITS COMMUNICATION DATA PROCESS (PHONES) 1.00 2.00 4.00 5.01 5.02 194.02/07953 0CCUPATIONAL HEALTH 0 0 139,259 4 194.04/07954 FOUNDATION 565 565 69,484 2 200.00 Cross Foot Adjustments 565 565 69,484 2	· _ · o · p · · ·
FIXT (SQUARE FEET) EQUI P (SQUARE FEET) BENEFITS DEPARTMENT (GROSS SALARI ES) S (PHONES) PROCESS (DP EQUI PME 1.00 2.00 4.00 5.01 5.02 194.02/07953 OCCUPATI ONAL HEALTH 0 0 139,259 4 194.03/07952 PATHS EDUCATI ON 0 0 0 0 0 194.04/07954 FOUNDATI ON 565 565 69,484 2 200.00 Cross Foot Adj ustments	
Image: Construction of the construction of	
FEET) FEET) GROSS SALARI ES) EQUIPME 194.02/07953 0CCUPATI ONAL HEALTH 0 0 139, 259 4 194.03/07952 PATHS EDUCATI ON 0 0 0 0 0 194.04/07954 FOUNDATI ON 565 565 69, 484 2 20	G
Image: Note of the second se	
194. 02 07953 OCCUPATI ONAL HEALTH 0 0 139, 259 4 194. 03 07952 PATHS EDUCATI ON 0 0 0 0 194. 04 07954 FOUNDATI ON 565 565 69, 484 2 200. 00 Cross Foot Adjustments Cross Foot Adjustment Cross Foot A)
194.03 07952 PATHS EDUCATION 0 0 0 194.04 07954 FOUNDATION 565 565 69, 484 2 200.00 Cross Foot Adjustments Cross Foot	
194.04 07954 FOUNDATION 565 569, 484 2 200.00 Cross Foot Adjustments 565 69, 484 2	0 194.02
200.00 Cross Foot Adjustments	0 194.03
	0 194.04
201.00 Negative Cost Centers	200.00
	201.00
202.00 Cost to be allocated (per Wkst. B, 3,098,513 1,258,962 7,023,597 195,971 3,18 Part I)	541 202. 00
203.00 Unit cost multiplier (Wkst. B, Part I) 10.158326 4.127447 0.295224 160.763741 3,173.0	934 203.00
204.00 Cost to be allocated (per Wkst. B, Part II) 30,458 4,455 5	605 204. 00
205.00 Unit cost multiplier (Wkst. B, Part 0.001280 3.654635 51.4	648 205. 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

	ancial Systems ATION - STATISTICAL BASIS	DEARBORN COUN	TY HOSPITAL Provider CO		eriod:	u of Form CMS-2 Worksheet B-1	
				F	rom 01/01/2020 o 10/31/2020	Date/Time Pre 3/31/2021 12:	pared:
	Cost Center Description	PURCHASI NG RECEI VI NG AND STORES (SUPPLY EXPENSE) 5. 03	ADMI TTI NG (ADMI SSI ONS) 5. 04	CASHI ERI NG/AC COUNTS RECEI VABLE (ADJUSTED CHARGES) 5. 05	Reconciliatio n 5A.06	OTHER ADMI NI STRATI V E AND GENERAL (ACCUM. COST) 5. 06	
GENE	RAL SERVICE COST CENTERS	0.00	0.01	0.00	011.00	0.00	
$\begin{array}{cccccc} 2.00 & 0020\\ 4.00 & 0040\\ 5.01 & 0116\\ 5.02 & 0055\\ 5.03 & 0056\\ 5.04 & 0057\\ 5.05 & 0058\\ 5.06 & 0059\\ 7.00 & 0070\\ 8.00 & 0080\\ 9.00 & 0090\\ 10.00 & 0100\\ 11.00 & 0100\\ 11.00 & 0110\\ 13.00 & 0130\\ 14.00 & 0140\\ 15.00 & 0150\\ 16.00 & 0160\\ 17.00 & 0170\\ 23.00 & 0230\\ \end{array}$	00 NEW CAP REL COSTS-BLDG & FIXT 00 NEW CAP REL COSTS-MVBLE EQUIP 00 EMPLOYEE BENEFITS DEPARTMENT 00 COMMUNI CATIONS 00 DATA PROCESSING 00 PURCHASING RECEIVING AND STORES 01 ADMITTING 02 CASHIERING/ACCOUNTS RECEIVABLE 01 DHER ADMINISTRATIVE AND GENERAL 00 DPERATION OF PLANT 01 LAUNDRY & LINEN SERVICE 02 DO HOUSEKEEPING 03 DO LETARY 04 CAFETERIA 05 NURSING ADMINISTRATION 06 CAFETERIA 07 MURSING ADMINISTRATION 08 CAFETERIA 09 MEDICAL RECORDS & LIBRARY 09 MEDICAL RECORDS & LIBRARY 00 SOCIAL SERVICE 00 PHARMACY 00 PHARMACY 00 PHARMACY 00 PHARMACY RESIDENCY 01 TIENT ROUTINE SERVICE COST CENTERS	8, 830, 150 19, 075 3, 634 218, 635 56, 912 244, 390 71, 832 21, 977 0 280, 912 174, 863 90, 115 12, 359 2, 394 9, 848	2, 670 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	184, 825, 045 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	-4, 657, 038 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	54, 309, 370 3, 662, 418 368, 919 1, 103, 928 560, 411 525, 557 1, 660, 489 587, 214 1, 642, 900 957, 288 275, 982 193, 827	8.00 9.00 10.00 11.00 13.00 14.00 15.00
30.00 0300 31.00 0310 43.00 0430	00 ADULTS & PEDIATRICS 10 INTENSIVE CARE UNIT 10 NURSERY 10 SKILLED NURSING FACILITY	352, 267 122, 601 0 0	1, 964 411 295 0	11, 652, 541 5, 162, 980 427, 357 0	0	7, 387, 261 2, 062, 869 656, 942 0	43.00
	LLARY SERVICE COST CENTERS	0	0	0		0	44.00
50.00 0500 51.00 0510 52.00 0520 53.00 0530 54.01 0540 55.00 0550 57.00 0570 58.00 0580 59.00 0590 60.00 0600 65.01 0395 66.00 0660 67.00 0670 68.00 0680 69.00 0690 71.00 0710 72.00 0720 73.00 0730 0UTP 0UTP	DO OPERATING ROOM DO OPERATING ROOM DO DELIVERY ROOM DO DELIVERY ROOM & LABOR ROOM DO DELIVERY ROOM & LABOR ROOM DO ANESTHESIOLOGY DO ANESTHESIOLOGY DO RADIOLOGY-DIAGNOSTIC DI ULTRASOUND DO RADIOLOGY-THERAPEUTIC DO CASON DO CASIONACE IMAGING (MRI) DO CARDIAC CATHETERIZATION DO CARDIAC CATHETERIZATION DO CARDIAC CATHETERIZATION DO LABORATORY DI BLOOD LABORATORY DO RESPIRATORY THERAPY DO SEEPCLINIC DO PHYSICAL THERAPY DO CCUPATIONAL THERAPY DO SPEECH PATHOLOGY DO ELECTROCARDIOLOGY DO ELECTROCARDIOLOGY DO EMEDICAL SUPPLIES CHARGED TO PATIENTS DO IMPL. DEV. CHARGED TO PATIENTS DO INPL. DEV. CHARGED TO PATIENTS DO RUGS CHARGED TO PATIENTS A	1, 889, 221 61, 673 0 298, 270 136, 494 21, 082 70, 325 102, 763 28, 692 0 1, 129, 411 0 60, 919 6, 692 12, 675 4, 385 1, 392 13, 706 0 3, 132, 331 0		2, 623, 049 797, 499 428, 736 5, 259, 609 5, 574, 790 9, 342, 592 8, 193, 493		3, 832, 793 782, 846 333, 902 141, 040 1, 959, 060 259, 438 558, 542 924, 619 522, 236 0 5, 226, 834 0 989, 721 184, 070 1, 358, 421 250, 988 212, 954 826, 765 1, 730, 528 3, 337, 703 1, 635, 184	51.00 52.00 53.00 54.00 54.01 55.00 57.00 58.00 59.00 60.01 65.01 66.00 67.00 68.00 69.00 71.00 72.00 73.00
92.00 0920	OBSERVATION BEDS (NON-DISTINCT PART)	,				_,,	92.00
101.001010	R REIMBURSABLE COST CENTERS	16, 509	0	927, 357	0	1, 173, 659	101.00
113. 00 1130 116. 00 1160 118. 00	I AL PURPOSE COST CENTERS O I NTEREST EXPENSE O HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) REIMBURSABLE COST CENTERS	1, 978 8, 813, 623		31, 015 184, 825, 045	-		113.00 116.00 118.00
190. 00 1900 192. 00 1920 192. 01 1920 192. 02 1920 192. 03 1920 192. 03 1920 192. 04 1920 192. 06 1920 192. 07 1920 194. 00 0795 194. 01 0795	00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 00 PHYSICIANS' PRIVATE OFFICES 11 PHYSICIAN CLINIC 22 LIFELINE 33 CREDIT UNION 24 ENT 15 HOSPITALIST	0 12, 238 793 0 0 593 0 0 0 0 1, 366 1, 526 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 0 0 0 0 0	725, 909 91, 747 1, 138 16, 711 254, 405 1, 324, 894 815, 680 60, 503 0 244, 705 221, 446	192. 01 192. 02 192. 03 192. 04 192. 05 192. 06 192. 07 194. 00 194. 01

Health F	inancial Systems	DEARBORN COUN	TY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST AL	LOCATION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1	
					rom 01/01/2020		
				1	o 10/31/2020	Date/Time Pre 3/31/2021 12:	34 nm
	Cost Center Description	PURCHASI NG	ADMI TTI NG	CASHI ERI NG/AC	Reconciliatio		
		RECEI VI NG AND	(ADMI SSI ONS)	COUNTS		ADMI NI STRATI V	
		STORES	. ,	RECEI VABLE		E AND GENERAL	
		(SUPPLY		(ADJUSTED		(ACCUM.	
		EXPENSE)		CHARGES)		COST)	
		5.03	5.04	5.05	5A. 06	5.06	
194.040	7954 FOUNDATI ON	11	0	(C	0 0	103, 835	194.04
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	327, 029	1, 041, 489	1, 767, 854	ļ	4, 657, 038	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 037035	390. 070787	0.009565	5	0. 085750	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	92, 147	52, 177	33, 447	7	193, 834	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0. 010435	19. 541948	0. 000181		0. 003569	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

	Financial Systems LLOCATION - STATISTICAL BASIS	DEARBORN COUN	ITY HOSPI TAL Provi der C	CN: 15-0086 F	In Lieu Veriod:	u of Form CMS-2 Worksheet B-1	
5551 A	LESSING CHARTON CHARTON			F	rom 01/01/2020 o 10/31/2020	Date/Time Pre	pared:
	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DI ETARY (MEALS SERVED)	3/31/2021 12: CAFETERIA (MAN HOURS)	34 pm
		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
$\begin{array}{c} 2. \ 00\\ 4. \ 00\\ 5. \ 01\\ 5. \ 02\\ 5. \ 03\\ 5. \ 04\\ 5. \ 05\\ 5. \ 06\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 15. \ 00\\ 17. \ 00\\ \end{array}$	00100 NEW CAP REL COSTS-BUDG & TTAT 00200 NEW CAP REL COSTS-BUBG & TTAT 00400 EMPLOYEE BENEFITS DEPARTMENT 01160 COMMUNI CATI ONS 00550 DATA PROCESSI NG 00550 DATA PROCESSI NG 00560 PURCHASI NG RECEI VI NG AND STORES 00570 ADMI TTI NG 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00591 OTHER ADMI NI STRATI VE AND GENERAL 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CE & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE 02300 PHARMACY RESI DENCY INPATI ENT ROUTI NE SERVI CE COST CENTERS	176, 471 1, 592 1, 178 4, 000 2, 837 600 7, 088 1, 483 4, 807 225 293	313, 302 0 3, 151 5, 465 0 4, 262 0 0 0 0	173, 701 4, 000 2, 837 600 7, 088 1, 483 4, 807 225	29, 450 0 0 0 0 0 0 0 0	553, 312 26, 443 11, 734 23, 265 20, 542 6, 062 3, 614	$\begin{array}{c} 2.\ 00\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 5.\ 03\\ 5.\ 04\\ 5.\ 05\\ 5.\ 06\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$
	03000 ADULTS & PEDI ATRI CS	64, 315		64, 315	19, 924	127, 030	30.00
	03100 I NTENSI VE CARE UNI T 04300 NURSERY	7, 400 400				36, 467 10, 575	31.00 43.00
	04400 SKILLED NURSING FACILITY	400				10, 373	44.00
50.00	ANCI LLARY SERVICE COST CENTERS	05.70/					50.00
	05000 OPERATING ROOM 05100 RECOVERY ROOM	25, 786 1, 163				34, 920 14, 882	50.00 51.00
	05200 DELIVERY ROOM & LABOR ROOM	504				6, 239	52.00
	05300 ANESTHESI OLOGY	16				0	53.00
	05400 RADI OLOGY-DI AGNOSTI C 05401 ULTRASOUND	11, 727 620				28, 492 4, 051	54.00 54.01
	05500 RADI OLOGY-THERAPEUTI C	1, 155				7, 381	55.00
	05700 CT SCAN	0	-		-	0	57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	803				0	58.00 59.00
	06000 LABORATORY	6, 720	-		-	65, 244	60.00
	06001 BLOOD LABORATORY	0			-	0	60.01
	06500 RESPI RATORY THERAPY 03950 SLEEP CLINIC	1, 164 0				17, 745 0	65.00 65.01
	06600 PHYSI CAL THERAPY	7, 564				24, 899	
67.00	06700 OCCUPATI ONAL THERAPY	794	768	794	0	4, 213	67.00
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	424 3, 261				3, 446 14, 364	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 201				14, 304	71.00
	07200 IMPL. DEV. CHARGED TO PATIENT	0	0		-	0	
73.00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	0	C	0	0	73.00
91.00	09100 EMERGENCY	9, 684	70, 797	9, 684	570	47, 844	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS	1, 485	0	1, 485	0	0	101.00
101.00	SPECIAL PURPOSE COST CENTERS	1,400	0	1,400	0	0	101.00
	11300 INTEREST EXPENSE						113.00
116.00 118.00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	315				0 539, 452	116.00
118.00	NONREIMBURSABLE COST CENTERS	169, 403	309, 341	166, 633	22, 702	539, 452	118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 440	0	2,440	0		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	-	-	-		192.00
	19201 PHYSICIAN CLINIC 19202 LIFELINE	1, 700	0	1,700	0		192. 01 192. 02
	19203 CREDIT UNION	1, 046	0	1,046	0		192.03
	19204 ENT	0	-	C	-		192.04
	19205 HOSPI TALI ST 19206 ORTHO	392 0		392 0			192.05 192.06
192.07	19207 ATHLETI C TRAI NERS	0	0	C	0	1, 676	192.07
	07950 COMMUNITY MENTAL HEALTH	0					194.00
	07951 MARKETI NG 07953 OCCUPATI ONAL HEALTH	925 0		925 C			194. 01 194. 02
	07952 PATHS EDUCATION	0		C			194.02
194.04	07954 FOUNDATI ON	565	0	565	0	2, 103	194.04

Heal th Fi	nancial Systems	DEARBORN COUN	TY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALL	DCATION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1	
					From 01/01/2020 To 10/31/2020		
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG		CAFETERI A	
			LINEN SERVICE	x · · - ·	(MEALS	(MAN HOURS)	
		(SQUARE	(POUNDS OF	FEET)	SERVED)		
		FEET)	LAUNDRY)				
		7.00	8.00	9.00	10.00	11.00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B,	3, 976, 470	436, 427	1, 225, 13	4 731, 200	662, 174	202.00
000.00	Part I)	00 500077	1 000001	7 05010	04 000500	4 40/74/	
203.00	Unit cost multiplier (Wkst. B, Part I)						
204.00	Cost to be allocated (per Wkst. B, Part II)	1, 409, 498	39, 426	32, 10	94, 400	66, 823	204.00
205.00	Unit cost multiplier (Wkst. B, Part	7. 987137	0. 125840	0. 18480	3. 205433	0. 120769	205.00
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 ALLOCATION - STATISTICAL BASIS	DEARBORN COUNT	Y HOSPITAL Provider CC	N: 15-0086	In Lie Period:	u of Form CMS-2 Worksheet B-1	
					From 01/01/2020 To 10/31/2020	Date/Time Pre	pared:
	Cost Center Description	NURSI NG ADMI NI STRATI O N (GROSS HOURS)	CENTRAL SERVI CE & SUPPLY (100%)	PHARMACY (100%)	MEDI CAL RECORDS & LI BRARY (ADJUSTED CHARGES)	3/31/2021 12: SOCI AL SERVI CE (TI ME SPENT)	34 pm
	GENERAL SERVICE COST CENTERS	13.00	14.00	15.00	16.00	17.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 5.\ 03\\ 5.\ 04\\ 5.\ 05\\ 5.\ 06\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 23.\ 00\\ \end{array}$	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 01160 COMMUNI CATI ONS 00550 DATA PROCESSI NG 00560 PURCHASI NG RECEI VI NG AND STORES 00570 ADMITTI NG 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00591 OTHER ADMI NI STRATI VE AND GENERAL 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CE & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE 02300 PHARMACY RESI DENCY	289, 691 11, 734 0 0 0	100 0 0 0 0	1	00 0 184, 825, 045 0 0 0 0	2, 993 0	$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 5.\ 03\\ 5.\ 04\\ 5.\ 05\\ 5.\ 06\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 23.\ 00 \end{array}$
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	127,030	0		0 11, 652, 541	2, 579	30.00
31.00 43.00	03100 I NTENSI VE CARE UNI T 04300 NURSERY	36, 467 10, 575	0		0 5, 162, 980 0 427, 357	116 0	31.00 43.00
44.00	04400 SKILLED NURSING FACILITY	10, 373	0		0 427, 337	0	44.00
50.00	ANCILLARY SERVICE COST CENTERS	34, 920	0		0 42, 625, 077	132	50.00
$\begin{array}{c} 51.\ 00\\ 52.\ 00\\ 53.\ 00\\ 54.\ 01\\ 55.\ 00\\ 57.\ 00\\ 58.\ 00\\ 59.\ 00\\ 60.\ 01\\ 65.\ 01\\ 65.\ 01\\ 66.\ 00\\ \end{array}$	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY 05400 RADIOLOGY-DIAGNOSTIC 05401 ULTRASOUND 05500 RADIOLOGY-THERAPEUTIC 05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06000 RESPIRATORY 06500 RESPIRATORY THERAPY 03950 SLEEP CLINIC 06600 PHYSICAL THERAPY	14, 882 6, 239 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			$ \begin{array}{cccccccccccccccccccccccccccccccccccc$	2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 51.\ 00\\ 52.\ 00\\ 53.\ 00\\ 54.\ 00\\ 54.\ 01\\ 55.\ 00\\ 57.\ 00\\ 58.\ 00\\ 59.\ 00\\ 60.\ 01\\ 65.\ 01\\ 65.\ 01\\ 66.\ 00\\ \end{array}$
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0		0 797, 499 0 428, 736	0	67.00 68.00
69.00 71.00 72.00		0 0 0	0 100 0 0	1	0 5, 259, 609 0 5, 574, 790 0 9, 342, 592 00 8, 193, 493	0	69.00 71.00 72.00 73.00
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	47, 844	0		0 20, 583, 629	66	91.00 92.00
	OTHER REIMBURSABLE COST CENTERS	0	0		0 927, 357	3	92.00 101.00
113.00	SPECIAL PURPOSE COST CENTERS						113.00
116.00 118.00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0 289, 691	0 100	1	0 31, 015 00 184, 825, 045		116. 00 118. 00
192.00 192.01 192.02 192.03 192.04 192.05 192.06 192.07 194.00 194.01 194.02	19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CI ANS' PRI VATE OFFI CES 19201 PHYSI CI AN CLI NI C 19202 LI FELI NE 19203 CREDI T UNI ON 19204 ENT 19205 HOSPI TALI ST 19206 ORTHO 19207 ATHLETI C TRAI NERS 07950 COMMUNI TY MENTAL HEALTH 07951 MARKETI NG 207953 OCCUPATI ONAL HEALTH 307952 PATHS EDUCATI ON		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	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	190.00 192.00 192.01 192.02 192.03 192.05 192.06 192.07 194.00 194.01 194.02 194.03

Heal th Fi	nancial Systems	DEARBORN COUN	TY HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALL	OCATION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1	
					rom 01/01/2020 To 10/31/2020		
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	
		ADMI NI STRATI O	SERVICE &	(100%)	RECORDS &	SERVI CE	
		N	SUPPLY		LI BRARY	(TIME	
		(GROSS HOURS)	(100%)		(ADJUSTED	SPENT)	
		10.00	44.00	15.00	CHARGES)	17.00	
101.010-		13.00	14.00	15.00	16.00	17.00	101.01
	7954 FOUNDATI ON	0	0	. (0	0	194.04
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1, 852, 274	942, 284	1, 855, 498	3 1, 206, 180	313, 559	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	6. 393965	9, 422. 840000	18, 554. 98000	0. 006526	104. 764116	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	27, 698	167, 606	45, 740) 117, 629	7, 546	204.00
205.00	Unit cost multiplier (Wkst. B, Part	0. 095612	1, 676. 060000	457.40000	0. 000636	2. 521216	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

Health Financial Systems COST ALLOCATION - STATISTICAL BA	SIS	DEARBORN COUNT	Provi der CCN: 15-0086	Peri od:	i of Form CMS-2552- Worksheet B-1
				From 01/01/2020 To 10/31/2020	Date/Time Prepared 3/31/2021 12:34 pm
Cost Center Descript	i on	PHARMACY RESI DENCY (ASSI GNED TI ME) 23.00		1 .	<u>3/31/2021 12.34 pi</u>
GENERAL SERVICE COST CENTE					
1.00 00100 NEW CAP REL COSTS-BL 2.00 00200 NEW CAP REL COSTS-MV					1.0
4.00 00400 EMPLOYEE BENEFITS DE					4.0
5. 01 01160 COMMUNICATIONS					5.0
. 02 00550 DATA PROCESSI NG					5.0
. 03 00560 PURCHASI NG RECEI VI NG	AND STORES				5.0
. 04 00570 ADMI TTI NG . 05 00580 CASHI ERI NG/ACCOUNTS					5.0
. 05 00580 CASHI ERI NG/ACCOUNTS . 06 00591 OTHER ADMI NI STRATI VE					5. (
00 00700 OPERATION OF PLANT	THE GENERAL				7.0
3.00 00800 LAUNDRY & LINEN SERV	'I CE				8.0
. 00 00900 HOUSEKEEPI NG					9. (
0. 00 01000 DI ETARY 1. 00 01100 CAFETERI A					10. (
3. 00 01300 NURSING ADMINISTRATI	ON				13.0
4. 00 01400 CENTRAL SERVICE & SU					14.0
5. 00 01500 PHARMACY					15.0
6.00 01600 MEDICAL RECORDS & LI	BRARY				16.0
7.00 01700 SOCIAL SERVICE		100			17.0
23.00 02300 PHARMACY RESIDENCY	COST CENTERS	100			23.0
0. 00 03000 ADULTS & PEDI ATRI CS		0			30.0
1.00 03100 INTENSIVE CARE UNIT		0			31.0
3. 00 04300 NURSERY		0			43.0
4.00 04400 SKILLED NURSING FACI		0			44. (
0.00 05000 OPERATING ROOM	NIEKS	0			50.0
1. 00 05100 RECOVERY ROOM		0			51.0
2.00 05200 DELIVERY ROOM & LABO	R ROOM	0			52.0
3. 00 05300 ANESTHESI OLOGY		0			53.0
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0			54.0
4. 01 05401 ULTRASOUND 5. 00 05500 RADI OLOGY-THERAPEUTI	C	0			54. (55. (
7. 00 05700 CT SCAN	0	0			57.0
8.00 05800 MAGNETIC RESONANCE I	MAGING (MRI)	0			58.0
9.00 05900 CARDIAC CATHETERIZAT	T ON	0			59.0
0.00 06000 LABORATORY 0.01 06001 BLOOD LABORATORY		0			60. (60. (
5. 00 06500 RESPIRATORY THERAPY		0			65.0
5. 01 03950 SLEEP CLINIC		0			65.0
6. 00 06600 PHYSI CAL THERAPY		o			66.0
57. 00 06700 OCCUPATI ONAL THERAPY	,	0			67.0
58. 00 06800 SPEECH PATHOLOGY 59. 00 06900 ELECTROCARDI OLOGY		0			68. (69. (
1.00 07100 MEDICAL SUPPLIES CHA	RGED TO PATIENTS	0			71.0
2.00 07200 IMPL. DEV. CHARGED T		0			72.0
3.00 07300 DRUGS CHARGED TO PAT		100			73.0
OUTPATIENT SERVICE COST CE 91.00 09100 EMERGENCY	INTERS	0			91.0
22.00 09200 OBSERVATION BEDS (NO	N-DISTINCT PART)	0			92.0
OTHER REIMBURSABLE COST CE	ENTERS				
01.00 10100 HOME HEALTH AGENCY		0			101. (
SPECIAL PURPOSE COST CENTE 13. 00 11300 INTEREST EXPENSE	-RS				113. (
16. 00 11600 H0SPI CE		o			113.0
18.00 SUBTOTALS (SUM OF LI	NES 1 through 117)	100			118. (
NONREI MBURSABLE COST CENTE	ERS	1			
90. 00 19000 GI FT, FLOWER, COFFEE		0			190. (
92. 00 19200 PHYSI CLANS' PRI VATE 92. 01 19201 PHYSI CLAN CLINIC	UFFICES	0			192. (192. (
92. 02 19201 PHYSICIAN CEINIC 92. 02 19202 LI FELINE					192. (
92. 03 19203 CREDI T UNI ON		o			192. (
92. 04 19204 ENT		o			192. (
92. 05 19205 HOSPI TALI ST		0			192. (
92. 06 19206 ORTHO		0			192. (192. (
92.07 19207 ATHLETIC TRAINERS 94.00 07950 COMMUNITY MENTAL HEA	I TH				192.0
194. 01 07951 MARKETI NG		o			194.0
94. 02 07953 OCCUPATI ONAL HEALTH		0			194. (
94. 03 07952 PATHS EDUCATI ON		0			194. (
94. 04 07954 FOUNDATI ON		0			194. (

Health Fir	nancial Systems	DEARBORN COUNT	Y HOSPI TAL	In Lieu	u of Form CMS-2552-10
COST ALLO	CATION - STATISTICAL BASIS		Provider CCN: 15-0086	Peri od:	Worksheet B-1
				From 01/01/2020 To 10/31/2020	Date/Time Prepared: 3/31/2021 12:34 pm
	Cost Center Description	PHARMACY			
		RESI DENCY			
		(ASSI GNED			
		TIME)			
		23.00			
200.00	Cross Foot Adjustments				200.00
201.00	Negative Cost Centers				201.00
202.00	Cost to be allocated (per Wkst. B,	223, 442			202.00
	Part I)				
203.00	Unit cost multiplier (Wkst. B, Part I)	2, 234. 420000			203.00
204.00	Cost to be allocated (per Wkst. B,	8, 160			204.00
	Part II)				
205.00	Unit cost multiplier (Wkst. B, Part	81.600000			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)				
1		1			I

Health Financial Systems	DEARBORN COUN	ITY HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0086	Peri od:	Worksheet C	
				From 01/01/2020 To 10/31/2020	Part I	nored.
				10 10/31/2020	Date/Time Pre 3/31/2021 12:	
		Title	XVIII	Hospi tal	PPS	<u>54 piii</u>
				Costs	110	
Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
	(from Wkst.	Adj.		Di sal I owance	lotal booto	
	B, Part I,					
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS			•			
30. 00 03000 ADULTS & PEDI ATRI CS	11, 900, 897		11, 900, 89	97 0	11, 900, 897	30.00
31.00 03100 INTENSIVE CARE UNIT	2, 866, 580		2, 866, 58	30 0	2, 866, 580	31.00
43.00 04300 NURSERY	808, 170		808, 17		808, 170	
44.00 04400 SKILLED NURSING FACILITY	0			0 0	0	
ANCI LLARY SERVICE COST CENTERS			•			
50.00 05000 OPERATING ROOM	5, 534, 024		5, 534, 02	24 0	5, 534, 024	50.00
51.00 05100 RECOVERY ROOM	1, 016, 492		1, 016, 49	92 0	1, 016, 492	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	433, 525		433, 52	25 0	433, 525	52.00
53. 00 05300 ANESTHESI OLOGY	181, 085		181, 08		181, 085	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 599, 044		2, 599, 04		2, 599, 044	
54. 01 05401 ULTRASOUND	327, 608		327,60		327, 608	
55. 00 05500 RADI OLOGY-THERAPEUTI C	669, 561		669, 56		669, 561	
57. 00 05700 CT SCAN	1, 110, 268		1, 110, 26		1, 110, 268	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	606, 781		606, 78		606, 781	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0			0 0	0	
60. 00 06000 LABORATORY	6, 124, 906		6, 124, 90	133, 622	6, 258, 528	
60. 01 06001 BLOOD LABORATORY	0			0 0	0	1
65. 00 06500 RESPI RATORY THERAPY	1, 156, 349	l o	1, 156, 34	3, 638	1, 159, 987	
65. 01 03950 SLEEP CLINIC	202, 762	0			202, 762	
66.00 06600 PHYSI CAL THERAPY	1, 753, 086	0			1, 753, 086	
67.00 06700 OCCUPATI ONAL THERAPY	307, 317				307, 317	
68.00 06800 SPEECH PATHOLOGY	250, 682				250, 682	
69. 00 06900 ELECTROCARDI OLOGY	1,047,696		1,047,69		1,047,696	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 857, 586		2, 857, 58		2, 857, 586	
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	3, 684, 881		3, 684, 88		3, 684, 881	1
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 907, 812		3, 907, 8		3, 907, 812	
OUTPATIENT SERVICE COST CENTERS	0,,0,,012		0,707,0		011011012	/ 01 00
91. 00 09100 EMERGENCY	3, 579, 180		3, 579, 18	30 50, 398	3, 629, 578	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 688, 938		1, 688, 93		1, 688, 938	
OTHER REIMBURSABLE COST CENTERS	.,		.,		.,	
101. 00 10100 HOME HEALTH AGENCY	1, 324, 602		1, 324, 60	12	1, 324, 602	101 00
SPECIAL PURPOSE COST CENTERS	., 02 1, 002		., 02., 00		., 62 ., 562	1
113. 00 11300 I NTEREST EXPENSE						1113.00
116. 00 11600 H0SPI CE	82, 729		82, 72	29	82, 729	116.00
200.00 Subtotal (see instructions)	56, 022, 561				56, 210, 219	
201.00 Less Observation Beds	1, 688, 938		1, 688, 93		1, 688, 938	
202.00 Total (see instructions)	54, 333, 623					

Health Financial Systems	DEARBORN COUNT	TY HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0086	Peri od:	Worksheet C	
				From 01/01/2020 To 10/31/2020	Part I Date/Time Pre	narod
				10 10/ 51/ 2020	3/31/2021 12:	34 pm
		Title	XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	Inpatient	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpati ent	
					Rati o	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	9, 972, 971		9, 972, 97	/1		30.00
31.00 03100 INTENSIVE CARE UNIT	5, 162, 980		5, 162, 98	30		31.00
43. 00 04300 NURSERY	427, 357		427, 35	57		43.00
44.00 04400 SKILLED NURSING FACILITY	0			0		44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	13, 740, 367	28, 884, 710	42, 625, 07	7 0. 129830	0.000000	50.00
51.00 05100 RECOVERY ROOM	545, 601	2, 233, 668	2, 779, 26	0. 365741	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 206, 477	129, 873	1, 336, 35	0. 324410	0.000000	52.00
53. 00 05300 ANESTHESI OLOGY	1, 219, 433	2, 990, 970			0.000000	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	1, 581, 987	8,075,446	9,657,43		0.000000	
54.01 05401 ULTRASOUND	232, 649	1, 785, 160			0.000000	
55. 00 05500 RADI OLOGY-THERAPEUTI C	1, 279, 051	1, 456, 186	2, 735, 23		0.000000	
57. 00 05700 CT SCAN	3, 435, 695	12, 862, 624	16, 298, 3		0.000000	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	218, 607	2, 233, 941	2, 452, 54		0.000000	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	_// .	0 0.000000	0.000000	
60. 00 06000 LABORATORY	6, 471, 224	20, 018, 809	26, 490, 03		0.000000	
60. 01 06001 BLOOD LABORATORY	0	0		0 0.000000	0.000000	
65. 00 06500 RESPI RATORY THERAPY	2, 306, 759	465, 610	2, 772, 36		0.000000	
65. 01 03950 SLEEP CLINIC	0	445, 551	445, 55		0.000000	
66.00 06600 PHYSI CAL THERAPY	638, 142	1, 984, 907	2, 623, 04		0.000000	
67.00 06700 OCCUPATI ONAL THERAPY	452, 076	345, 423			0.000000	
68.00 06800 SPEECH PATHOLOGY	148, 699	280, 037	428, 73		0.000000	
69. 00 06900 ELECTROCARDI OLOGY	1, 365, 890	3, 893, 719	5, 259, 60		0.000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 414, 631	2, 160, 159			0.000000	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	4, 636, 521	4, 706, 071	9, 342, 59		0. 000000	
73. 00 07300 DRUGS CHARGED TO PATIENTS	5, 161, 235	3, 032, 258			0. 000000	
OUTPATIENT SERVICE COST CENTERS	0,101,200	0,002,200	0,170,11	0. 170711	0.00000	/ 0.00
91. 00 09100 EMERGENCY	3, 727, 119	16, 856, 510	20, 583, 62	0. 173885	0. 000000	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	793, 665	885, 905			0. 000000	
OTHER REIMBURSABLE COST CENTERS	770,000	000, 700	1,077,01	1.000070	0.000000	/2.00
101.00 10100 HOME HEALTH AGENCY	0	927, 357	927, 35	57		101.00
SPECIAL PURPOSE COST CENTERS	<u> </u>	727,007	727,00	,,,		101.00
113. 00 11300 I NTEREST EXPENSE						113.00
116. 00 11600 H0SPI CE	0	31, 015	31.01	5		116.00
200.00 Subtotal (see instructions)	68, 139, 136	116, 685, 909				200.00
201.00 Less Observation Beds	00, 107, 100	. 10, 000, 707	101, 020, 0			201.00
202.00 Total (see instructions)	68, 139, 136	116, 685, 909	184, 825, 04	15		202.00
	00, 137, 130	110,000, 707	107,020,04			1202.00

lical the Financial Sustana				of Form CMS	2552 10
Health Financial Systems COMPUTATION OF RATIO OF COSTS TO CHARGES	DEARBORN COUNTY	Provi der CCN: 15-0086	Peri od: From 01/01/2020 To 10/31/2020	of Form CMS- Worksheet C Part I Date/Time Pre 3/31/2021 12:	pared:
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS	1				
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	1 1				
50.00 05000 OPERATING ROOM	0. 129830				50.00
51.00 05100 RECOVERY ROOM	0. 365741				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 324410				52.00
53. 00 05300 ANESTHESI OLOGY	0. 043009				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 269124				54.00
54.01 05401 ULTRASOUND	0. 162358				54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 244791				55.00
57.00 05700 CT SCAN	0. 068122				57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 247408				58.00
59.00 05900 CARDI AC CATHETERI ZATI ON	0. 000000				59.00
60.00 06000 LABORATORY	0. 236260				60.00
60.01 06001 BLOOD LABORATORY	0. 000000				60.01
65. 00 06500 RESPI RATORY THERAPY	0. 418410				65.00
65. 01 03950 SLEEP CLINIC	0. 455081				65.01
66.00 06600 PHYSI CAL THERAPY	0. 668339				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 385351				67.00
68.00 06800 SPEECH PATHOLOGY	0. 584700				68.00
69.00 06900 ELECTROCARDI OLOGY	0. 199197				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 512591				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 394417				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 476941				73.00
OUTPATIENT SERVICE COST CENTERS					
91.00 09100 EMERGENCY	0. 176333				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.005578				92.00
OTHER REIMBURSABLE COST CENTERS					1
101.00 10100 HOME HEALTH AGENCY					101.00
SPECIAL PURPOSE COST CENTERS	I. I.				1
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
	1				

COMPUTATION OF RATIO OF COSTS TO CHARGES Cost Center Description Cost Center Description B, Par	kst. t I, 26)	Provider CC Title herapy Limit Adj.		Period: From 01/01/2020 To 10/31/2020 Hospital Costs RCE	Worksheet C Part I Date/Time Pre 3/31/2021 12: Cost	
. (from W	kst. t I, 26)	herapy Limit	e XIX	To 10/31/2020 Hospi tal Costs	Date/Time Pre 3/31/2021 12: Cost	
. (from W	kst. t I, 26)	herapy Limit	e XIX	Hospi tal Costs	3/31/2021 12: Cost	
. (from W	kst. t I, 26)	herapy Limit		Costs	Cost	<u>34 piii</u>
. (from W	kst. t I, 26)	herapy Limit		Costs		
. (from W	kst. t I, 26)		Total Costs			
. (from W	kst. t I, 26)		TOTAL COSTS		Total Costs	
	tI, 26)	Auj.		Di sal I owance	TOTAL COSTS	
	26)			Di Sai i Owanee		
col . 2						
1.00	ר ו	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS		2.00	3.00	4.00	3.00	
	00, 897		11, 900, 89	7 0	11, 900, 897	30.00
	56, 580		2, 866, 58		2, 866, 580	
	08, 170		808, 17		808, 170	
44.00 04400 SKILLED NURSING FACILITY	0			0 0	000,170	43.00
ANCI LLARY SERVICE COST CENTERS	0			<u>v</u> <u>v</u>	0	44.00
	34, 024	1	5, 534, 02	4 0	5, 534, 024	50.00
	16, 492		1, 016, 49		1, 016, 492	
	33, 525		433, 52		433, 525	
	33, 525 31, 085		433, 52			1
					181,085	
	99,044		2, 599, 04		2, 599, 044	
	27,608		327,60		327,608	54.01
	59, 561		669, 56		669, 561	
	10, 268		1, 110, 26		1, 110, 268	
	06, 781		606, 78		606, 781	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY 6, 12	0			0 0	0	59.00
	24, 906		6, 124, 90	6 133, 622	6, 258, 528	
		0	1 15/ 04		0	60.01
	56, 349	0	1, 156, 34		1, 159, 987	
	02, 762	-	202, 76		202, 762	
	53,086	0	1, 753, 08		1, 753, 086	
	07, 317	0	307, 31		307, 317	
	50, 682	0	250, 68		250, 682	1
	47,696		1,047,69		1,047,696	
	57, 586		2,857,58		2,857,586	•
	34, 881		3, 684, 88		3, 684, 881	
	07, 812		3, 907, 81	2 0	3, 907, 812	73.00
	70 100		2 570 10	0 50.000	2 (20 570	01 00
	79, 180		3, 579, 18		3, 629, 578	
	38, 938		1, 688, 93	8	1, 688, 938	92.00
OTHER REI MBURSABLE COST CENTERS	1 (00		4 004 /0		1 004 (00	101 00
	24, 602		1, 324, 60	2	1, 324, 602	101.00
SPECIAL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE				1		112 00
	22 720		00 70		00 700	113.00
	32, 729		82, 72		82, 729	
	22, 561	0	56, 022, 56		56, 210, 219	
	38, 938		1, 688, 93		1, 688, 938	
202.00 Total (see instructions) 54,33	33, 623	0	54, 333, 62	3 187, 658	54, 521, 281	202.00

Health Financial Systems	DEARBORN COUN	TY_HOSPI TAL		In Lie	u of Form CMS-	2552-10	
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0086	Period:	Worksheet C		
				From 01/01/2020 To 10/31/2020	Part I Date/Time Pre	narod	
				10 10/ 51/ 2020	3/31/2021 12:	34 pm	
		Ti tl	e XIX	Hospi tal	Cost		
		Charges					
Cost Center Description	Inpatient	Outpati ent	Total (col.	6 Cost or Other	TEFRA		
			+ col. 7)	Ratio	Inpati ent		
			í í		Rati o		
	6.00	7.00	8.00	9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS			•				
30. 00 03000 ADULTS & PEDIATRICS	9, 972, 971		9, 972, 97	/1		30.00	
31.00 03100 INTENSIVE CARE UNIT	5, 162, 980		5, 162, 98	30		31.00	
43. 00 04300 NURSERY	427, 357		427, 35	57		43.00	
44.00 04400 SKILLED NURSING FACILITY	0			0		44.00	
ANCILLARY SERVICE COST CENTERS							
50. 00 05000 OPERATI NG ROOM	13, 740, 367	28, 884, 710	42, 625, 07	7 0. 129830	0.000000	50.00	
51.00 05100 RECOVERY ROOM	545, 601	2, 233, 668	2, 779, 26	0. 365741	0.000000	51.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 206, 477	129, 873		0. 324410	0.000000	52.00	
53. 00 05300 ANESTHESI OLOGY	1, 219, 433	2, 990, 970			0.000000	53.00	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 581, 987	8,075,446			0.000000		
54. 01 05401 ULTRASOUND	232, 649	1, 785, 160			0.000000		
55. 00 05500 RADI OLOGY-THERAPEUTI C	1, 279, 051	1, 456, 186			0.000000	1	
57. 00 05700 CT SCAN	3, 435, 695	12, 862, 624			0.000000		
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	218, 607	2, 233, 941	2, 452, 54		0.000000		
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0.000000	0.000000		
60. 00 06000 LABORATORY	6, 471, 224	20, 018, 809	26, 490, 03		0. 000000		
60. 01 06001 BLOOD LABORATORY	0, 11, 22, 1	20,010,000	201 170100	0 0.000000	0. 000000		
65. 00 06500 RESPI RATORY THERAPY	2, 306, 759	465,610	2, 772, 36		0. 000000		
65. 01 03950 SLEEP CLINIC	2,000,707	445, 551	445, 55		0. 000000		
66. 00 06600 PHYSI CAL THERAPY	638, 142	1, 984, 907	2, 623, 04		0. 000000		
67. 00 06700 OCCUPATI ONAL THERAPY	452, 076	345, 423			0. 000000		
68. 00 06800 SPEECH PATHOLOGY	148, 699	280, 037	428, 73		0. 000000		
69. 00 06900 ELECTROCARDI OLOGY	1, 365, 890	3, 893, 719			0. 000000		
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 414, 631	2, 160, 159			0. 000000		
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	4, 636, 521	4, 706, 071			0. 000000		
73. 00 07300 DRUGS CHARGED TO PATIENTS	5, 161, 235	3, 032, 258			0.000000		
OUTPATIENT SERVICE COST CENTERS	3, 101, 233	3,032,230	0,173,42	0. 470741	0.00000	/ 5. 00	
91. 00 09100 EMERGENCY	3, 727, 119	16, 856, 510	20, 583, 62	0. 173885	0. 000000	91.00	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	793, 665	885, 905			0.000000		
OTHER REIMBURSABLE COST CENTERS	793,003	003, 703	1,077,37	1.003370	0.000000	72.00	
101.00 10100 HOME HEALTH AGENCY	0	927, 357	927, 35	57		101.00	
SPECIAL PURPOSE COST CENTERS	0	721, 331	727, 30			101.00	
113. 00 11300 INTEREST EXPENSE						113.00	
116. 00 11600 HOSPI CE	0	31, 015	31, 01	5		116.00	
200.00 Subtotal (see instructions)	68, 139, 136	116, 685, 909				200.00	
201.00 Less Observation Beds	00, 139, 130	110,000,909	104, 020, 04	10		200.00	
201.00 Total (see instructions)	68, 139, 136	116, 685, 909	184, 825, 04			201.00	
	00, 139, 130	110,000,909	104, 023, 02	10		1202. UU	

Health Financial Systems	DEARBORN COUNTY	HOSPI TAI	Inlieu	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0086	Period: From 01/01/2020 To 10/31/2020	Worksheet C Part I Date/Time Pre 3/31/2021 12:	epared:
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS	1				
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
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING 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 IMAGING (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 RESPIRATORY THERAPY	0. 000000				65.00
65. 01 03950 SLEEP CLINIC	0.000000				65.00
	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 IMPL. DEV. CHARGED TO PATIENT	0. 000000				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
OUTPATIENT SERVICE COST CENTERS	· · · ·				-
91.00 09100 EMERGENCY	0. 000000				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.00
OTHER REIMBURSABLE COST CENTERS					
101.00 10100 HOME HEALTH AGENCY					101.00
SPECIAL PURPOSE COST CENTERS					
113.00 11300 INTEREST 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 COUN	TY HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITA	_ COSTS	Provider C		Period: From 01/01/2020 To 10/31/2020	Date/Time Pre 3/31/2021 12:	
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col. 2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	1, 649, 931	0	1, 649, 93	1 7, 448	221.53	30.00
31.00 INTENSIVE CARE UNIT	207, 974		207, 97	4 1, 679	123.87	31.00
43.00 NURSERY	20, 180		20, 18	0 500	40.36	43.00
44.00 SKILLED NURSING FACILITY	0			0 0	0.00	44.00
200.00 Total (lines 30 through 199)	1, 878, 085		1, 878, 08	5 9, 627		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	3, 181	704, 687				30.00
31.00 INTENSIVE CARE UNIT	740	91, 664				31.00
43.00 NURSERY	0	0				43.00
44.00 SKILLED NURSING FACILITY	0	0				44.00
200.00 Total (lines 30 through 199)	3, 921	796, 351				200.00

Health Financial Systems	DEARBORN COUN	ITY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS			Period: From 01/01/2020 To 10/31/2020		
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS	1	-		- F		
50.00 05000 OPERATI NG ROOM	665, 011					•
51.00 05100 RECOVERY ROOM	35, 846					51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	15, 218	1, 336, 350				52.00
53. 00 05300 ANESTHESI OLOGY	7, 441	4, 210, 403				53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	289, 405	9, 657, 433			15, 308	
54.01 05401 ULTRASOUND	18, 269	2, 017, 809	0. 00905	4 100, 582	911	54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	32, 891	2, 735, 237	0. 01202	5 806, 788	9, 702	
57.00 05700 CT SCAN	18, 198	16, 298, 319	0. 00111	7 2,009,712	2, 245	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	22, 438	2, 452, 548	0. 00914	9 115, 955	1, 061	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0. 00000	0 0	0	59.00
60. 00 06000 LABORATORY	216, 607	26, 490, 033	0. 00817	7 3, 457, 786	28, 274	60.00
60.01 06001 BLOOD LABORATORY	0	0	0. 00000	0 0	0	60.01
65. 00 06500 RESPI RATORY THERAPY	38, 041	2, 772, 369	0. 01372	1, 126, 154	15, 452	65.00
65.01 03950 SLEEP CLINIC	1, 109	445, 551	0.00248	9 0	0	65.01
66. 00 06600 PHYSI CAL THERAPY	182, 961	2, 623, 049	0. 06975	369, 670	25, 785	66.00
67.00 06700 OCCUPATI ONAL THERAPY	20, 288	797, 499	0. 02544	0 269, 507	6, 856	67.00
68.00 06800 SPEECH PATHOLOGY	11, 267	428, 736	0. 02628	95, 077	2, 499	68.00
69. 00 06900 ELECTROCARDI OLOGY	83, 311	5, 259, 609	0. 01584	0 1, 081, 955	17, 138	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	178, 337	5, 574, 790	0. 03199	0 1, 781, 011	56, 975	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	52, 237	9, 342, 592	0.00559	2, 469, 989	13, 810	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	58, 270	8, 193, 493	0.00711	2 2, 522, 361	17, 939	73.00
OUTPATIENT SERVICE COST CENTERS						1
91.00 09100 EMERGENCY	269, 473	20, 583, 629	0. 01309	2, 164, 346	28, 336	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	234, 153	1, 679, 570	0. 13941	2 755, 841	105, 373	92.00
200.00 Total (lines 50 through 199)	2, 450, 771	168, 303, 365	j l	26, 733, 748	449, 324	200.00

Health Financial Systems	DEARBORN COUN	TY HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTH	IER PASS THROUGH COS			Period: From 01/01/2020 To 10/31/2020	Date/Time Pre 3/31/2021 12:	
			XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Healt	h Allied Health	All Other	
	School	School	Post-Stepdow	n Cost	Medi cal	
	Post-Stepdown		Adjustments		Educati on	
	Adj ustments				Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS			_			
30. 00 03000 ADULTS & PEDIATRICS	0	0		0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		0 0	0	31.00
43.00 04300 NURSERY	0	0		0 0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	l o		0 0		44.00
200.00 Total (lines 30 through 199)	0	l o		0 0	0	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patien	t Per Diem	I npati ent	
	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,		col. 6)	0 9	
	instructions)	minus col. 4)				
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	7,44	8 0.00	3, 181	30.00
31.00 03100 INTENSIVE CARE UNIT		0	1,67	0.00	740	31.00
43.00 04300 NURSERY		0	50	0.00	0	43.00
44.00 04400 SKILLED NURSING FACILITY		0)	0 0.00	0	44.00
200.00 Total (lines 30 through 199)		0	9,62	27	3, 921	200.00
Cost Center Description	I npati ent					
· ·	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31.00 03100 INTENSIVE CARE UNIT	0					31.00
43.00 04300 NURSERY	0					43.00
44.00 04400 SKILLED NURSING FACILITY	0					44.00
200.00 Total (lines 30 through 199)	0					200.00
		1				

Health Financial Systems	DEARBORN COUN	TY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PAS	S Provider C	CN: 15-0086	Period: From 01/01/2020 To 10/31/2020		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anesthetist	School	School	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0	0		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
54. 01 05401 ULTRASOUND	0	0		0 0	0	54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55.00
57.00 05700 CT SCAN	0	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
60.01 06001 BLOOD LABORATORY	0	0		0 0	0	60.01
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
65. 01 03950 SLEEP CLINIC	0	0		0 0	0	65.01
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	223, 442	73.00
OUTPATIENT SERVICE COST CENTERS						1
91.00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
200.00 Total (lines 50 through 199)	0	0		0 0	223, 442	200.00

Health Financial Systems	DEARBORN COUN	TY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PAS	S Provider C		Period:	Worksheet D	
THROUGH COSTS				From 01/01/2020 To 10/31/2020		narod
				10 10/31/2020	3/31/2021 12:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Education	1, 2, 3, and	Cost (sum of		(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
		5.00	(00	7.00	instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS		0		0 40 (05 077	0,000000	F0 00
50. 00 05000 OPERATING ROOM 51. 00 05100 RECOVERY ROOM	0	0		0 42, 625, 077		50.00 51.00
	0	0		0 2,779,269		
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 1, 336, 350		52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 4, 210, 403		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 9, 657, 433		54.00
54. 01 05401 ULTRASOUND 55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 2,017,809		54.01 55.00
57. 00 05700 CT SCAN	0	0		0 2, 735, 237 0 16, 298, 319		55.00 57.00
	0	0				
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 59.00 05900 CARDIAC CATHETERIZATION	0	0		0 2, 452, 548	0.000000	58.00 59.00
60. 00 06000 LABORATORY	0	0		0 0 0 26, 490, 033		59.00 60.00
60. 01 06000 LABORATORY	0	0		0 20, 490, 033	0.000000	60.00 60.01
65. 00 06500 RESPIRATORY THERAPY	0	0		0 2, 772, 369	0.000000	65.00
65. 01 03950 SLEEP CLINIC	0	0		0 2, 772, 309	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 2, 623, 049		66.00
67. 00 06700 0CCUPATI ONAL THERAPY	0	0		0 2, 023, 049		67.00
68. 00 06800 SPEECH PATHOLOGY	0	0		0 428, 736		68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 5, 259, 609		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 5, 574, 790		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 9, 342, 592		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	223, 442	223, 44			73.00
OUTPATIENT SERVICE COST CENTERS		220, 112	220, 1	2 0, 170, 170	0.027271	70.00
91. 00 09100 EMERGENCY	0	0		0 20, 583, 629	0.000000	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 1, 679, 570		
200.00 Total (lines 50 through 199)	0	223, 442	223, 44			200.00

Health Financial Systems	DEARBORN COUNT	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PASS			Period: From 01/01/2020 To 10/31/2020	Worksheet D Part IV Date/Time Pre 3/31/2021 12:	
		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 ÷		Costs (col. 8	3	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	6, 239, 971		0 6, 210, 881	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	244, 025		0 682, 644	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	8, 453		0 0	0	52.00
53.00 05300 ANESTHESI OLOGY	0. 000000	603, 742		0 641, 832	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	510, 823		0 2, 226, 571	0	54.00
54. 01 05401 ULTRASOUND	0. 000000	100, 582		0 309, 406	0	54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	806, 788		0 336, 536	0	55.00
57.00 05700 CT SCAN	0. 000000	2,009,712		0 3, 580, 267	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	115, 955		0 628, 267	0	58.00
59.00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59.00
60. 00 06000 LABORATORY	0. 000000	3, 457, 786		0 1, 563, 961	0	60.00
60.01 06001 BLOOD LABORATORY	0. 000000	0		0 0	0	60.01
65. 00 06500 RESPI RATORY THERAPY	0. 000000	1, 126, 154		0 122, 991	0	65.00
65. 01 03950 SLEEP CLINIC	0. 000000	0		0 136, 177	0	65.01
66.00 06600 PHYSI CAL THERAPY	0. 000000	369, 670		0 10, 849	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0, 000000	269, 507		9,675	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	95,077		0 2,434	0	68,00
69.00 06900 ELECTROCARDI OLOGY	0, 000000	1,081,955		0 1, 577, 187	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	1, 781, 011		436,960	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	2, 469, 989		0 955, 639		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 027271	2, 522, 361	68, 78			73.00
OUTPATI ENT SERVI CE COST CENTERS		_/ / /			,	
91. 00 09100 EMERGENCY	0. 000000	2, 164, 346		0 2, 823, 193	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0, 000000	755, 841		879,062	0	92.00
200.00 Total (lines 50 through 199)		26, 733, 748			24, 665	

Health Financial Systems	DEARBORN COUN	ITY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-0086	Period: From 01/01/2020 To 10/31/2020		epared: 34 pm
		Title	e XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Reimbursed	Rei mbursed	Reimbursed	(see inst.)	
	From	Services (see	Servi ces	Services Not		
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.		Ded. & Coins	. Ded. & Coins.		
	9		(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS			-			
50.00 05000 OPERATING ROOM	0. 129830	6, 210, 881		0 0	806, 359	50.00
51.00 05100 RECOVERY ROOM	0. 365741	682, 644		0 0	249, 671	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 324410	0		0 0	0	52.00
53.00 05300 ANESTHESI OLOGY	0. 043009	641, 832		0 0	27, 605	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 269124	2, 226, 571		0 0	599, 224	54.00
54. 01 05401 ULTRASOUND	0. 162358	309, 406		0 0	50, 235	54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 244791	336, 536		0 0	82, 381	55.00
57.00 05700 CT SCAN	0. 068122	3, 580, 267		0 0	243, 895	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 247408	628, 267		0 0	155, 438	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59.00
60. 00 06000 LABORATORY	0. 231215	1, 563, 961		0 0	361, 611	60.00
60.01 06001 BLOOD LABORATORY	0. 000000	0		0 0	0	60.01
65. 00 06500 RESPI RATORY THERAPY	0. 417098	122, 991		0 0	51, 299	65.00
65. 01 03950 SLEEP CLINIC	0. 455081	136, 177		0 0	61, 972	65.01
66. 00 06600 PHYSI CAL THERAPY	0. 668339	10, 849		0 0	7, 251	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 385351	9, 675		0 0	3, 728	67.00
68.00 06800 SPEECH PATHOLOGY	0. 584700	2, 434		0 0	1, 423	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 199197	1, 577, 187		0 0	314, 171	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 512591	436, 960		0 0	223, 982	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 394417	955, 639		0 0	376, 920	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 476941	904, 437		0 674	431, 363	73.00
OUTPATIENT SERVICE COST CENTERS			·			1
91.00 09100 EMERGENCY	0. 173885	2, 823, 193		0 0	490, 911	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 005578	879, 062		0 0	883, 965	92.00
200.00 Subtotal (see instructions)		24, 038, 969		0 674	5, 423, 404	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		24, 038, 969	1	0 674	5, 423, 404	202.00

Health Financial Systems	DEARBORN COUN	ITY HOSPI TAL		In Lieu	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES ANI	D VACCINE COST	Provider C		Period: From 01/01/2020 To 10/31/2020	3/31/2021 12	epared: :34 pm
			XVIII	Hospi tal	PPS	
	Cos					
Cost Center Description	Cost Reimbursed	Cost Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00	-			
ANCI LLARY SERVI CE COST CENTERS	0.00	7.00				
50. 00 05000 OPERATING ROOM	0	0				50.00
51. 00 05100 RECOVERY ROOM	0	0				51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0					52.00
53. 00 05300 ANESTHESI OLOGY	0					53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0					54.00
54. 01 05401 ULTRASOUND	0					54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0					55.00
57. 00 05700 CT SCAN	0					57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0					58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0					59.00
60. 00 106000 LABORATORY	0					60.00
60. 01 06001 BLOOD LABORATORY	0					60.01
65. 00 06500 RESPI RATORY THERAPY	0					65.00
65. 01 03950 SLEEP CLINIC	0					65.01
66. 00 06600 PHYSI CAL THERAPY	0					66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0					67.00
68. 00 06800 SPEECH PATHOLOGY	0					68.00
69. 00 06900 ELECTROCARDI OLOGY	0					69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0	-				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0					73.00
OUTPATIENT SERVICE COST CENTERS	0	521				/3.00
91. 00 09100 EMERGENCY	0	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	1			92.00
200.00 Subtotal (see instructions)	0	321				200.00
201.00 Less PBP Clinic Lab. Services-Program	0	521				200.00
Only Charges	0					201.00
202.00 Net Charges (line 200 - line 201)	0	321				202.00
	0	1 321	1			1-02.00

	Financial Systems DEARBORN COUNTY ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0086	Period: From 01/01/2020	u of Form CMS-2 Worksheet D-1	
			To 10/31/2020	Date/Time Pre 3/31/2021 12:	epare 34 j
	Cost Center Description	Title XVIII	Hospi tal	PPS	
	PART I - ALL PROVIDER COMPONENTS			1.00	
20	INPATIENT DAYS			7 440	
)0)0	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			7, 448 7, 448	
00	Private room days (excluding swing-bed and observation bed da		rivate room days,	0	
0	do not complete this line. Semi-private room days (excluding swing-bed and observation b	ed days)		6, 391	4
00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	0,071	
00	reporting period Total swing-bed SNF type inpatient days (including private ro	om dave) after Decomber	21 of the cost	0	6
0	reporting period (if calendar year, enter 0 on this line)	on days) arter becenber	ST OF THE COST	0	
00	Total swing-bed NF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	0	7
00	reporting period Total swing-bed NF type inpatient days (including private roc	om davs) after December	31 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)	5.			
00	Total inpatient days including private room days applicable t newborn days) (see instructions)	the Program (excludin	g swing-bed and	3, 181	9
00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days)	0	10
00	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII of		room days) after	0	11
00	December 31 of the cost reporting period (if calendar year, e	enter 0 on this line)	- ·	0	''
00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including priva	te room days)	0	12
00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI	X only (including priva	te room days)	0	13
	after December 31 of the cost reporting period (if calendar y	vear, enter 0 on this li	ne)	_	
	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	ram (excluding swing-bed	days)	0	
	Nursery days (title V or XIX only)			0	
00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	es through December 31	of the cost	0.00	1 17
00	reporting period	through becember 31	or the cost		
00	Medicare rate for swing-bed SNF services applicable to servic reporting period	ces after December 31 of	the cost	0.00	18
00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 o	f the cost	0.00	19
00	reporting period Medicaid rate for swing-bed NF services applicable to service	as after December 31 of	the cost	0.00	20
00	reporting period			0.00	20
00	Total general inpatient routine service cost (see instruction		ting posted (lind	11, 900, 897	
00	Swing-bed cost applicable to SNF type services through Decemb 5 x line 17)	der 31 of the cost repor	ting period (ine	0	22
00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporti	ng period (line 6	0	23
00	x line 18) Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost report	ing period (line	0	24
	7 x line 19)		0 1 1	_	
. 00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reportin	g period (line 8	0	25
00	Total swing-bed cost (see instructions)			0	
00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		11, 900, 897	27
00	General inpatient routine service charges (excluding swing-be	ed and observation bed c	harges)	0	28
	Private room charges (excluding swing-bed charges)			0	
00	Semi-private room charges (excluding swing-bed charges)			0	
00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
00	Average per diem private room charge differential (line 32 mi		CTIONS)	0.00	
00	Average per diem private room cost differential (line 34 x li	ne 31)		0.00	
00	Private room cost differential adjustment (line 3 x line 35)	and making the second second		0	
00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost d	irrerential (line	11, 900, 897	37
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ Adjusted general inpatient routine service cost per diem (see			1, 597. 86	20
. 00	Program general inpatient routine service cost per drem (see	-		5, 082, 793	
$\cap \cap$	TIOUTAM GENERAL TIDALIENT TOULTHE SELVICE COST (TIME 9 X TIME	5 JU/		J, UOZ, 193	1 37
. 00 . 00	Medically necessary private room cost applicable to the Progr	-	I	0	

2. 00 N 1 3. 00 I 4. 00 C 5. 00 B 6. 00 S 7. 00 C 8. 00 P 9. 00 T P. 0. 00 P 1 1. 00 P 2. 00 T	TION OF INPATIENT OPERATING COST Cost Center Description UURSERY (title V & XIX only) ntensive Care Type Inpatient Hospital Units NTENSIVE CARE UNIT CORONARY CARE UNIT SURN INTENSIVE CARE UNIT SURN INTENSIVE CARE UNIT SURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) Cost Center Description Program inpatient ancillary service cost (Wks Cotal Program inpatient costs (sum of lines Cass through costs applicable to Program input II) Pass through costs applicable to Program input II) Cotal Program excludable cost (sum of lines	41 through 48)(: atient routine :	Total Inpatient Days 2.00 0 1,679 , Line 200) see instruction	2 XVIII Average Per Diem (col. 1 ÷ col. 2) 3.00 0.0	4.00	Date/Time Pro 3/31/2021 12: Program Cost (col. 3 x col. 4) 5.00 1, 263, 409 1, 263, 409	eparec : 34 pr
3. 00 I 4. 00 C 5. 00 B 6. 00 S 7. 00 C 8. 00 P 9. 00 T 9. 00 T 1. 00 P 1. 00 P 2. 00 T	UURSERY (title V & XIX only) ntensive Care Type Inpatient Hospital Units NTENSIVE CARE UNIT CORONARY CARE UNIT SURN INTENSIVE CARE UNIT URGICAL INTENSIVE CARE UNIT DTHER SPECIAL CARE (SPECIFY) Cost Center Description Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines ASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpatient 11) ass through costs applicable to Program inpatient ASS THROUGH COST ADJUSTMENTS Cost Center Description	Inpati ent <u>Cost</u> 1.00 0 2,866,580 st. D-3, col. 3 41 through 48) (state of the state of t	Total Inpatient Days 2.00 0 1,679 , Line 200) see instruction	<pre>XVIII Average Per Diem (col. 1 ÷ col. 2) 3.00 0.0 1,707.3</pre>	Hospi tal Program Days 4.00 0 0	3/31/2021 12: PPS Program Cost (col. 3 x col. 4) 5.00 0 1, 263, 409 1, 263, 409 1, 00 7, 587, 007	20 42.0 9 43.0 44.0 45.0
3. 00 I 4. 00 C 5. 00 B 6. 00 S 7. 00 C 8. 00 P 9. 00 T 9. 00 T 1. 00 P 2. 00 T	UURSERY (title V & XIX only) ntensive Care Type Inpatient Hospital Units NTENSIVE CARE UNIT CORONARY CARE UNIT SURN INTENSIVE CARE UNIT URGICAL INTENSIVE CARE UNIT DTHER SPECIAL CARE (SPECIFY) Cost Center Description Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines ASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpatient 11) ass through costs applicable to Program inpatient ASS THROUGH COST ADJUSTMENTS Cost Center Description	Inpati ent <u>Cost</u> 1.00 0 2,866,580 st. D-3, col. 3 41 through 48) (state of the state of t	Total Inpatient Days 2.00 0 1,679 , Line 200) see instruction	Average Per Di em (col. 1 ÷ col. 2) 3.00 0.0	Program Days 4.00 0 0	PPS Program Cost (col. 3 x col. 4) 5.00 1, 263, 409 1, 263, 409 1.00 7, 587, 007	0 42.0 7 43.0 44.0 45.0 46.0 46.0
3. 00 I 4. 00 C 5. 00 B 6. 00 S 7. 00 C 8. 00 P 9. 00 T 9. 00 T 1. 00 P 2. 00 T	UURSERY (title V & XIX only) ntensive Care Type Inpatient Hospital Units NTENSIVE CARE UNIT CORONARY CARE UNIT SURN INTENSIVE CARE UNIT URGICAL INTENSIVE CARE UNIT DTHER SPECIAL CARE (SPECIFY) Cost Center Description Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines ASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpatient 11) ass through costs applicable to Program inpatient ASS THROUGH COST ADJUSTMENTS Cost Center Description	Inpati ent <u>Cost</u> 1.00 0 2,866,580 st. D-3, col. 3 41 through 48) (state of the state of t	Inpatient Days 2.00 0 1,679 , Line 200) see instruction	Di em (col. 1 ÷ col. 2) 3.00 0.0 1,707.3	4.00	(col. 3 x col. 4) 5.00 1, 263, 409 1.00 7, 587, 007) 42.0) 43.0) 44.0) 45.0) 46.0
3. 00 I 4. 00 C 5. 00 B 6. 00 S 7. 00 C 8. 00 P 9. 00 T 9. 00 T 1. 00 P 1. 00 P 2. 00 T	ntensive Care Type Inpatient Hospital Units NTENSIVE CARE UNIT COROWARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) Cost Center Description Program inpatient ancillary service cost (Wks otal Program inpatient costs (sum of lines ASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpatient Program inpatient costs (sum of lines) ASS through costs applicable to Program inpatient Net State (SPECIAL CARE (SPECIFY)) Cass through costs applicable to Program inpatient State (SPECIAL CARE (SPECIFY))	Cost 1.00 0 2,866,580 st. D-3, col. 3 41 through 48) (s atient routine s	Days 2.00 0 1,679 , line 200) see instructio	+ col. 2) 3.00 0.0	4.00	col. 4) 5.00 0 1, 263, 409 1.00 7, 587, 007	9 43.0 44.0 45.0 46.0
3. 00 I 4. 00 C 5. 00 B 6. 00 S 7. 00 C 3. 00 P 9. 00 T 9. 00 T 1. 00 P 1. 00 P 2. 00 T	ntensive Care Type Inpatient Hospital Units NTENSIVE CARE UNIT COROWARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) Cost Center Description Program inpatient ancillary service cost (Wks otal Program inpatient costs (sum of lines ASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpatient Program inpatient costs (sum of lines) ASS through costs applicable to Program inpatient Net State (SPECIAL CARE (SPECIFY)) Cass through costs applicable to Program inpatient State (SPECIAL CARE (SPECIFY))	1.00 0 2,866,580 st. D-3, col. 3 41 through 48)(; atient routine ;	2.00 0 1,679 , line 200) see instructio	3.00 0.0	0 0	5.00 0 1,263,409 1.00 7,587,007	9 43. 44. 45. 46.
3. 00 I 4. 00 C 5. 00 B 6. 00 S 7. 00 C 8. 00 P 9. 00 T 9. 00 T 1. 00 P 1. 00 P 2. 00 T	ntensive Care Type Inpatient Hospital Units NTENSIVE CARE UNIT COROWARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) Cost Center Description Program inpatient ancillary service cost (Wks otal Program inpatient costs (sum of lines ASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpatient Program inpatient costs (sum of lines) ASS through costs applicable to Program inpatient Net State (SPECIAL CARE (SPECIFY)) Cass through costs applicable to Program inpatient State (SPECIAL CARE (SPECIFY))	0 2,866,580 st. D-3, col. 3 41 through 48)(; atient routine ;	0 1,679 , line 200) see instructio	0.0	0 0	1, 263, 409 1, 263, 409 1, 00 7, 587, 007	9 43. 44. 45. 46.
3. 00 I 4. 00 C 5. 00 B 6. 00 S 7. 00 C 8. 00 P 9. 00 T 9. 00 T 1. 00 P 1. 00 P 2. 00 T	ntensive Care Type Inpatient Hospital Units NTENSIVE CARE UNIT COROWARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) Cost Center Description Program inpatient ancillary service cost (Wks otal Program inpatient costs (sum of lines ASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpatient Program inpatient costs (sum of lines) ASS through costs applicable to Program inpatient Net State (SPECIAL CARE (SPECIFY)) Cass through costs applicable to Program inpatient State (SPECIAL CARE (SPECIFY))	st. D-3, col. 3 41 through 48)(: atient routine :	, line 200) see instructi	1, 707. 3		1, 263, 409 1, 00 7, 587, 007	9 43. 44. 45. 46.
4. 00 C 5. 00 B 5. 00 S 7. 00 C 3. 00 P 7. 00 T P. 00 T P. 00 P 1 1. 00 P a 2. 00 T	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT DTHER SPECIAL CARE (SPECIFY) Cost Center Description Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines ASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp. 11) ass through costs applicable to Program inp. and IV)	st. D-3, col. 3 41 through 48)(: atient routine :	, line 200) see instructi		1 740	<u> </u>	44. 45. 46.
5.00 B 6.00 S 7.00 C 8.00 P 9.00 T P.00 P 1.00 P 1.00 P 2.00 T	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT DTHER SPECIAL CARE (SPECIFY) Cost Center Description Program inpatient ancillary service cost (Wkk Total Program inpatient costs (sum of lines ASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program input Pass through costs applicable to Program input and IV)	41 through 48)(: atient routine :	see instructi	ons)		7, 587, 007	45. 46.
6. 00 S 7. 00 C 8. 00 P 9. 00 T P. 0. 00 P 1 1. 00 P a 2. 00 T	SURGICAL INTENSIVE CARE UNIT DTHER SPECIAL CARE (SPECIFY) Cost Center Description Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines ASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program input II) Pass through costs applicable to Program input and IV)	41 through 48)(: atient routine :	see instructi	ons)		7, 587, 007	46.
7.00 C B.00 P 9.00 T P.00 P 1.00 P 1.00 P 2.00 T	DTHER SPECIAL CARE (SPECIFY) Cost Center Description Program inpatient ancillary service cost (Wki Total Program inpatient costs (sum of lines) ASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpation Pass through costs applicable to Program inpation Pass through costs applicable to Program inpation	41 through 48)(: atient routine :	see instructi	ons)		7, 587, 007	
3. 00 P 9. 00 T P. 0. 00 P 1 1. 00 P a 2. 00 T	Cost Center Description Program inpatient ancillary service cost (Wki Total Program inpatient costs (sum of lines ASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program input ll) Pass through costs applicable to Program input and IV)	41 through 48)(: atient routine :	see instructi	ons)		7, 587, 007	
9.00 T P. 0.00 P 1.00 P a 2.00 T	otal Program inpatient costs (sum of lines ASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp II) Pass through costs applicable to Program inp and IV)	41 through 48)(: atient routine :	see instructi	ons)		7, 587, 007	
P. 00 T P. P. D. 00 P I I 1. 00 P 2. 00 T	otal Program inpatient costs (sum of lines ASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp II) Pass through costs applicable to Program inp and IV)	41 through 48)(: atient routine :	see instructi	ons)			
D. 00 P I 1. 00 P 2. 00 T	ASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp II) Pass through costs applicable to Program inp and IV)	atient routine :		ons)		10 000 000	
0.00 P I 1.00 P 2.00 T	Pass through costs applicable to Program inp. II) Pass through costs applicable to Program inp. and IV)		services (fro			13, 933, 209	9 49.
I.00 P 2.00 T	<pre>II) Pass through costs applicable to Program inpl ind IV)</pre>			m Wkst. D. sur	n of Parts I and	796, 351	1 50.
2.00 T	and IV)	CARLS OF A STATE OF A STATE OF A		,			
2.00 T		atient ancillar	y services (f	rom Wkst. D, s	sum of Parts II	518, 111	51.
	USL (SUIL OF THESE	50 and 51				1, 314, 462	2 52.
3. 00 T	otal Program inpatient operating cost exclu		lated. non-ph	vsician anesti	netist and	1, 314, 462	
	nedical education costs (line 49 minus line 1		acou, non pri		lotrot, and	.2,010,711	00.
	ARGET AMOUNT AND LIMIT COMPUTATION						
	Program di scharges					0	
	arget amount per discharge arget amount (line 54 x line 55)					0.00	
)ifference between adjusted inpatient operat	ing cost and ta	rget amount (line 56 minus	line 53)		
	Bonus payment (see instructions)		. g			0	
. 00 L	esser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and co	ompounded by the	0.00	59.
	narket basket						
	esser of lines 53/54 or 55 from prior year fline 53/54 is less than the lower of line					0.00	
	which operating costs (line 53) are less that					Ĭ	/ 01.
	amount (line 56), otherwise enter zero (see		, i i i i i i i i i i i i i i i i i i i		J		
	Relief payment (see instructions)					0	
	Allowable Inpatient cost plus incentive paym ROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ctions)			0) 63.
	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of th	e cost reporti	ing period (See	0	64.
	nstructions)(title XVIII only)						
	ledicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the	cost reporting	g period (See	0	65.
	nstructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	na anata (lina	(1 plup lipp	(E) (+; + o V)/			
	CAH (see instructions)	ne costs (inne	o4 prus rine	os)(li li e XVI	T ONLY). FOR	0	66.
1	itle V or XIX swing-bed NF inpatient routing	e costs through	December 31	of the cost re	eporting period	c c	67.
1 1	(line 12 x line 19)	0					
	itle V or XIX swing-bed NF inpatient routing	e costs after D	ecember 31 of	the cost rep	orting period	0	68.
1 1	line 13 x line 20) Total title V or XIX swing-bed NF inpatient 1	routine costs (lino 67 ∔ lin	o 68)		0	69.
	ART III - SKILLED NURSING FACILITY, OTHER NU						1 07.
	Skilled nursing facility/other nursing facil)		70.
	djusted general inpatient routine service c		ine 70 ÷ line	2)			71.
	Program routine service cost (line 9 x line) Modically pocossary private room cost applic		(line 14 v l	ino 25)			72.
	Medically necessary private room cost applica Total Program general inpatient routine serv	0	•				73.
	Capital-related cost allocated to inpatient	•		·	Part II, column	1	75.
2	26, line 45)			· · ·			
	Per diem capital-related costs (line 75 ÷ lin	,					76.
	Program capital-related costs (line 9 x line npatient routine service cost (line 74 minu:						77.
	Aggregate charges to beneficiaries for excess		rovi der recor	ds)		1	79.
	fotal Program routine service costs for comp				nus line 79)	1	80.
	npatient routine service cost per diem limit						81.
1	npatient routine service cost limitation (I						82.
	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		5)				83. 84.
	Itilization review - physician compensation		ns)			1	85.
	Total Program inpatient operating costs (sum	•				<u> </u>	86.
P	ART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST					
	otal observation bed days (see instructions)	,	line 2)			1,057	
	Adjusted general inpatient routine cost per o Observation bed cost (line 87 x line 88) (se		rine 2)			1, 597. 86 1, 688, 938	

Health Financial Systems	DEARBORN COUN	TY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider C		Period: From 01/01/2020	Worksheet D-1	
				To 10/31/2020 Date/Time P 3/31/2021 1		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	1, 649, 931	11, 900, 897	0. 13863	9 1, 688, 938	234, 153	90.00
91.00 Nursing School cost	0	11, 900, 897	0.00000	0 1, 688, 938	0	91.00
92.00 Allied health cost	0	11, 900, 897	0.00000	0 1, 688, 938	0	92.00
93.00 All other Medical Education	0	11, 900, 897	0.00000	0 1, 688, 938	0	93.00

OMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0086	Period: From 01/01/2020 To 10/31/2020	Worksheet D-1 Date/Time Pre 3/31/2021 12:	pared:
		Title XIX	Hospi tal	Cost	
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
00	INPATIENT DAYS			7 440	1 1 0
. 00 . 00	Inpatient days (including private room days and swing-bed da Inpatient days (including private room days, excluding swing			7, 448 7, 448	
. 00	Private room days (excluding swing-bed and observation bed o	5	rivate room days,	0	3.0
	do not complete this line.		-	(
. 00 . 00	Semi-private room days (excluding swing-bed and observation Total swing-bed SNF type inpatient days (including private		er 31 of the cost	6, 391 0	4.0 5.0
. 00	reporting period	the output of th		0	0.0
. 00	Total swing-bed SNF type inpatient days (including private	room days) after December	31 of the cost	0	6.0
. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private re	and days) through Decombo	r 21 of the cost	0	7.0
. 00	reporting period	Join days) thi ough beceinse	a ST OF THE COST	0	/.0
. 00	Total swing-bed NF type inpatient days (including private re	oom days) after December	31 of the cost	0	8.0
. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable	to the Dreason (avaludin	a owing had and	309	9.0
. 00	newborn days) (see instructions)		ig swiftg-bed and	307	9.0
0.00	Swing-bed SNF type inpatient days applicable to title XVIII		room days)	0	10.0
1.00	through December 31 of the cost reporting period (see instru Swing-bed SNF type inpatient days applicable to title XVIII		room dave) ofter	0	11.0
1.00	December 31 of the cost reporting period (if calendar year,		room days) arter	0	
2.00	Swing-bed NF type inpatient days applicable to titles V or 2		te room days)	0	12.0
2 00	through December 31 of the cost reporting period	VIV only (including privo	to room dowo)	0	12 0
3.00	Swing-bed NF type inpatient days applicable to titles V or X after December 31 of the cost reporting period (if calendar			0	13.0
	Medically necessary private room days applicable to the Prog	gram (excluding swing-bed	days)	0	
	Total nursery days (title V or XIX only)				15.0
6.00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT		I	0	16.0
7.00	Medicare rate for swing-bed SNF services applicable to servi	ices through December 31	of the cost	0.00	17.0
~ ~~	reporting period			0.00	
8.00	Medicare rate for swing-bed SNF services applicable to servi reporting period	ices after December 31 of	the cost	0.00	18.0
9.00	Medicaid rate for swing-bed NF services applicable to service	ces through December 31 c	of the cost	0.00	19.0
0 00	reporting period		the cost	0.00	
0.00	Medicaid rate for swing-bed NF services applicable to service reporting period	ces after December 31 of	the cost	0.00	20.0
	Total general inpatient routine service cost (see instruction			11, 900, 897	21.0
2.00	Swing-bed cost applicable to SNF type services through Decen	mber 31 of the cost repor	ting period (line	0	22.0
3.00	5 x line 17) Swing-bed cost applicable to SNF type services after December	er 31 of the cost reporti	ng period (line 6	0	23.0
0.00	x line 18)		ng por rou (rrno c	0	20.0
4.00	Swing-bed cost applicable to NF type services through Deceml	per 31 of the cost report	ing period (line	0	24.0
5.00	7 x line 19) Swing-bed cost applicable to NF type services after December	r 31 of the cost reportin	a period (line 8	0	25. C
	x line 20)		.g p	-	
6.00	Total swing-bed cost (see instructions)			0	
7.00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	t (The 21 minus The 26)		11, 900, 897	27.0
8.00	General inpatient routine service charges (excluding swing-	bed and observation bed c	harges)	0	28.0
	Private room charges (excluding swing-bed charges)			0	29.0
	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 2)	7 ÷ line 28)		0 0. 000000	30.0 31.0
	Average private room per diem charge (line 29 ÷ line 3)	/ ÷ Trhe 20)		0.00	1
3.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 m		icti ons)	0.00	
5.00 6.00	Average per diem private room cost differential (line 34 x Private room cost differential adjustment (line 3 x line 35			0. 00 0	35.0 36.0
	General inpatient routine service cost net of swing-bed cost		lifferential (line	-	37.0
	27 minus line 36)				-
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AU				-
8.00	Adjusted general inpatient routine service cost per diem (se			1, 597. 86	38.0
9.00	Program general inpatient routine service cost (line 9 x lin	ne 38)		493, 739	39.0
	Medically necessary private room cost applicable to the Prog	5		0	40.0
ı. UU	Total Program general inpatient routine service cost (line 3	57 + TTHE 40)		493, 739	41.

Heal th Financia		DEARBORN COUNT		01 45 000 0		u of Form CMS-2	
COMPUTATION OF	I NPATI ENT OPERATI NG COST		Provider C	F	Period: From 01/01/2020 To 10/31/2020	Worksheet D-1 Date/Time Pre 3/31/2021 12:	pared:
			Titl	e XIX	Hospi tal	Cost	<u> </u>
Co	st Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	(title V & XIX only)	808, 170	500	1, 616. 34	0	0	42.00
	e Care Type Inpatient Hospital Units		1 (70	1 707 21		0	1 42 00
	/E CARE UNIT / CARE UNIT	2, 866, 580	1, 679	1, 707. 31	0	0	43.00
	ENSIVE CARE UNIT						45.00
	INTENSIVE CARE UNIT						46.00
	PECIAL CARE (SPECIFY)						47.00
Co	st Center Description					1.00	
48.00 Program	inpatient ancillary service cost (Wk	(st D-3 col 3	line 200)			1.00 369,180	48.00
0	rogram inpatient costs (sum of lines			ons)		862, 919	
	OUGH COST ADJUSTMENTS						
	rough costs applicable to Program inp	atient routine :	services (fro	m Wkst. D, sum	of Parts I and	0	50.00
				whet D		0	F1 00
51.00 Pass thr and IV)	rough costs applicable to Program inp	atient anciitar	y services (r	FOM WKSt. D, S	um or Parts II	0	51.00
	ogram excludable cost (sum of lines	50 and 51)				0	52.00
	ogram inpatient operating cost exclu		lated, non-ph	ysician anesth	etist, and	0	
	education costs (line 49 minus line	52)		-			
	MOUNT AND LIMIT COMPUTATION					0	1 54 00
	discharges mount per discharge					0 0.00	
	amount (line 54 x line 55)					0.00	
5	nce between adjusted inpatient operat	ing cost and ta	rget amount (line 56 minus	line 53)	0	•
58.00 Bonus pa	ayment (see instructions)	-				0	58.00
	of lines 53/54 or 55 from the cost re	eporting period	endi ng 1996,	updated and co	mpounded by the	0.00	59.00
market b		aget report up	datad by the	markat baakat		0.00	60.00
	of lines 53/54 or 55 from prior year 53/54 is less than the lower of line				the amount by	0.00	
	perating costs (line 53) are less that					0	01.00
	(line 56), otherwise enter zero (see				5		
	payment (see instructions)					0	
	e Inpatient cost plus incentive paym	nent (see instru	ctions)			0	63.00
	INPATIENT ROUTINE SWING BED COST e swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of th	e cost reporti	na period (See	0	64.00
	ions)(title XVIII only)	thi dugii boool				Ū	
	e swing-bed SNF inpatient routine cos	sts after Decemb	er 31 of the	cost reporting	period (See	0	65.00
	ions)(title XVIII only)		(
	edicare swing-bed SNF inpatient routi e instructions)	ne costs (line	64 plus line	65)(TITIE XVII	i oniy). For	0	66.00
	or XIX swing-bed NF inpatient routir	ne costs through	December 31	of the cost re	porting period	0	67.00
	2 x line 19)	5			51		
	or XIX swing-bed NF inpatient routir	ne costs after D	ecember 31 of	the cost repo	rting period	0	68.00
	3 x line 20)	routino costs (lino 47 i lin	o 49)		0	40.00
	 tle V or XIX swing-bed NF inpatient SKILLED NURSING FACILITY, OTHER N 					0	69.00
	nursing facility/other nursing facil						70.00
	I general inpatient routine service o		ine 70 ÷ line	2)			71.00
	routine service cost (line 9 x line		(lin- 11)	ing 25)			72.00
	y necessary private room cost applic rogram general inpatient routine serv	U	•				73.00
	related cost allocated to inpatient				art II. column		75.00
26, line				,			
	n capital-related costs (line 75 ÷ li						76.00
	capital-related costs (line 9 x line						77.00
	nt routine service cost (line 74 minu te charges to beneficiaries for exces		rovi der recor	(sh			78.00
55 55	ogram routine service costs for comp	· · ·		· ·	us line 79)		80.00
81.00 Inpatier	nt routine service cost per diem limi				,		81.00
	t routine service cost limitation (I		•				82.00
	ole inpatient routine service costs (s)				83.00
	inpatient ancillary services (see ir ion review - physician compensation		ns)				84.00 85.00
	ogram inpatient operating costs (sur	•					85.00
	- COMPUTATION OF OBSERVATION BED PAS						1 22.00
	- COMPUTATION OF OBSERVATION BED FAS						
PART IV 87.00 Total ob	oservation bed days (see instructions	5)				1, 057	
PART IV 87.00 Total ob 88.00 Adjusted		s) diem (line 27 ÷	line 2)			1, 057 1, 597. 86 1, 688, 938	88.00

Health Financial Systems	DEARBORN COUN	TY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider C		Period: From 01/01/2020	Worksheet D-1	
				To 10/31/2020		pared: 34 pm
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	1, 649, 931	11, 900, 897	0. 13863	9 1, 688, 938	234, 153	90.00
91.00 Nursing School cost	0	11, 900, 897	0. 00000	0 1, 688, 938	0	91.00
92.00 Allied health cost	0	11, 900, 897	0. 00000	0 1, 688, 938	0	92.00
93.00 All other Medical Education	0	11, 900, 897	0.00000	0 1, 688, 938	0	93.00

	UNTY_HOSPI TAL		In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0086	Peri od:	Worksheet D-3	3
			From 01/01/2020		
			To 10/31/2020	Date/Time Pre 3/31/2021 12:	
	Title	e XVIII	Hospi tal	PPS	<u>34 pili</u>
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x	
			ondriges	col. 2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1			
30. 00 03000 ADULTS & PEDIATRICS			3, 306, 855		30.00
31. 00 03100 INTENSIVE CARE UNIT			2, 132, 969		31.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 1298	30 6, 239, 971	810, 135	50.00
51.00 05100 RECOVERY ROOM		0.3657	41 244, 025	89, 250	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 3244			52.00
53. 00 05300 ANESTHESI OLOGY		0.0430	603, 742	25, 966	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2691			
54. 01 05401 ULTRASOUND		0. 1623			
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 2447			
57.00 05700 CT SCAN		0. 0681			
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 2474	08 115, 955	28, 688	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.0000		0	1
60. 00 06000 LABORATORY		0. 2362		816, 937	60.00
60. 01 06001 BLOOD LABORATORY		0.0000		0	1
65. 00 06500 RESPI RATORY THERAPY		0. 4184		471, 194	
65. 01 03950 SLEEP CLINIC		0. 4550			1
66. 00 06600 PHYSI CAL THERAPY		0. 6683		247,065	
67.00 06700 OCCUPATI ONAL THERAPY		0. 3853			
68.00 06800 SPEECH PATHOLOGY		0. 5847			
69. 00 06900 ELECTROCARDI OLOGY		0. 1991			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 5125			
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 3944			
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 4769			
OUTPATI ENT SERVI CE COST CENTERS				1	
91. 00 09100 EMERGENCY		0. 1763	33 2, 164, 346	381, 646	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1.0055			
200.00 Total (sum of lines 50 through 94 and 96 through 98	5)		26, 733, 748		
201.00 Less PBP Clinic Laboratory Services-Program only ch			C		201.00
202.00 Net charges (line 200 minus line 201)	5		26, 733, 748		202.00

Health Financial Systems DEARBORN COUN	NTY HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0086	Peri od:	Worksheet D-3	
			From 01/01/2020 To 10/31/2020		norod.
			To 10/31/2020	3/31/2021 12:	
	Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
			U U U U U U U U U U U U U U U U U U U	col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			356, 197		30.00
31. 00 03100 INTENSIVE CARE UNIT			101, 965		31.00
43. 00 04300 NURSERY			21,069	9	43.00
ANCI LLARY SERVICE COST CENTERS		1		1	
50. 00 05000 OPERATI NG ROOM		0. 1298			50.00
51.00 05100 RECOVERY ROOM		0. 3657			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 3244			
53. 00 05300 ANESTHESI OLOGY		0.0430			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2691			
54. 01 05401 ULTRASOUND		0. 1623			54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 2447			55.00
57.00 05700 CT SCAN		0.0681			57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0.24740			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.0000		0 0	59.00
60. 00 06000 LABORATORY		0. 2312			60.00
60. 01 06001 BLOOD LABORATORY		0.0000		0	60.01
65. 00 06500 RESPI RATORY THERAPY		0.4170			65.00
65. 01 03950 SLEEP CLINIC		0.4550		-	65.01
66.00 06600 PHYSI CAL THERAPY		0.6683			66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0.3853			
68. 00 06800 SPEECH PATHOLOGY		0.58470			68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 1991			69.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 72. 00 07200 I MPL. DEV. CHARGED TO PATIENT		0.5125			71.00 72.00
		0.3944			
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 4769	11 177, 668	8 84, 737	73.00
0UTPATI ENT_SERVI CE_COST_CENTERS 91. 00 09100 EMERGENCY		0. 1738	92, 312	2 16, 052	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 0055		0	91.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)		1.0055	1, 534, 326		
201.00 Less PBP Clinic Laboratory Services-Program only cha	raes (line 61)		1, 004, 020		200.00
202.00 Net charges (line 200 minus line 201)	iges (inte of)		1, 534, 326		201.00
		I	1, 554, 520	1	202.00

	Financial Systems DEARBORN COUNTY ATION OF REIMBURSEMENT SETTLEMENT	/ HOSPITAL Provider CCN: 15-0086	In Lie Period: From 01/01/2020 To 10/31/2020	u of Form CMS-2 Worksheet E Part A Date/Time Pre 3/31/2021 12:	pared:
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				1
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occur instructions)	ring prior to October 1	(see	0 7, 514, 367	1.00 1.01
1. 02	DRG amounts other than outlier payments for discharges occur instructions)	ring on or after October	1 (see	977, 768	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI 1 (see instructions)	for discharges occurring	prior to October	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI October 1 (see instructions)	for discharges occurring	on or after	0	1.04
2.00	Outlier payments for discharges. (see instructions)			0	2.00
2.01 2.02	Outlier reconciliation amount	ti anc)		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instruc Outlier payments for discharges occurring prior to October 1	-		431, 419	
2.03	Outlier payments for discharges occurring on or after October			8, 883	
3.00	Managed Care Simulated Payments			0,005	3.00
4.00	Bed days available divided by number of days in the cost rep Indirect Medical Education Adjustment	orting period (see instr	ructions)	58.53	4.00
5.00	FTE count for allopathic and osteopathic programs for the mo or before 12/31/1996. (see instructions)	st recent cost reporting	period ending on	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet new programs in accordance with 42 CFR 413.79(e)				
7.00 7.01	MMA Section 422 reduction amount to the LME cap as specified ACA § 5503 reduction amount to the LME cap as specified unde		0.00 0.00	7.00 7.01	
8. 00	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for allop affiliated programs in accordance with 42 CFR 413.75(b), 413 1998) and 67 EP 50069 (August 1, 2002)	0.00	8.00		
8. 01	 1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions. 				
8. 02					
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus li instructions)			0.00	
	FTE count for allopathic and osteopathic programs in the cur	rent year from your reco	ords	0.00	
11.00	FTE count for residents in dental and podiatric programs.			0.00	•
12.00	Current year allowable FTE (see instructions)				
13.00 14.00	Total allowable FTE count for the prior year. Total allowable FTE count for the penultimate year if that y otherwise enter zero.	ear ended on or after Se	ptember 30, 1997,	0.00 0.00	
15.00	Sum of lines 12 through 14 divided by 3.			0.00	15.00
	Adjustment for residents in initial years of the program				16.00
17.00	Adjustment for residents displaced by program or hospital cl	osure		0.00	17.00
18.00	Adjusted rolling average FTE count			0.00	18.00
	Current year resident to bed ratio (line 18 divided by line	4).		0.00000	
	Prior year resident to bed ratio (see instructions)			0.00000	
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	
	IME payment adjustment (see instructions)			0	
	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 4: Number of additional allopathic and osteopathic IME FTE resi		CEP 412 105	0.00	1
23.00	(f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions)	dont dap si ots under 42	51 N T12. 103	0.00	
	If the amount on line 24 is greater than -0-, then enter the instructions)	lower of line 23 or lin	ne 24 (see	0.00	
26.00	Resident to bed ratio (divide line 25 by line 4)			0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)			0.000000	27.00
	IME add-on adjustment amount (see instructions)			0	
	IME add-on adjustment amount - Managed Care (see instruction	is)		0	•
29. 00 29. 01	Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28. Dispersortiepate Share Adjustment	01)		0	
20 00	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A	pationt days (coo instri	ictions)	2 02	20.00
		patrent days (see instru		3.93	•
31.00 32.00	Percentage of Medicaid patient days (see instructions) Sum of lines 30 and 31			19.67 23.60	
	Allowable disproportionate share percentage (see instruction	is)		23.60	
33.00					

Heal th	Financial Systems DEARBORN COUNTY H	IOSPI TAL	In Lie	u of Form CMS-2	2552-10
		Provider CCN: 15-0086	Peri od:	Worksheet E	
			From 01/01/2020 To 10/31/2020		pared:
		Title XVIII	Hocni tal	3/31/2021 12: PPS	34 pm
			Hospital Prior to 10/1		
			1.00	2.00	
	Uncompensated Care Adjustment				
	Total uncompensated care amount (see instructions)			8, 290, 014, 521	
	Factor 3 (see instructions) Hospital uncompensated care payment (If line 34 is zero, enter	zero on this line) (se	0. 000102247 e 853, 827	0. 000117476 973, 876	
00.02	instructions)		000,027	710,070	00.02
35.03	Pro rata share of the hospital uncompensated care payment amou	nt (see instructions)	639, 204	82, 713	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03		721, 917		36.00
40.00	Additional payment for high percentage of ESRD beneficiary dis Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 68		gh 46) 0		40.00
40.00	instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 68	3, 684 an 685. (see	0		41.00
	instructions)				
41.01	Total ESRD Medicare covered and paid discharges excluding MS-D	RGs 652, 682, 683, 684	0		41.01
42.00	an 685. (see instructions) Divide line 41 by line 40 (if less than 10%, you do not qualif	v for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682	· ·	0.00		43.00
	instructions)				
44.00	Ratio of average length of stay to one week (line 43 divided b	y line 41 divided by 7	0. 000000		44.00
45.00	days) Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
	Total additional payment (line 45 times line 44 times line 41.		0.00		45.00
47.00	Subtotal (see instructions)		9, 838, 634		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, sm	all rural hospitals	0		48.00
	only. (see instructions)			A	
				Amount 1.00	
49.00	Total payment for inpatient operating costs (see instructions)			9, 838, 634	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and	Pt. II, as applicable)		740, 559	50.00
	Exception payment for inpatient program capital (Wkst. L, Pt.			0	51.00
52.00 53.00	Direct graduate medical education payment (from Wkst. E-4, lin Nursing and Allied Health Managed Care payment	ie 49 see instructions).		0	52.00 53.00
	Special add-on payments for new technologies			0	54.00
54.01	Islet isolation add-on payment			0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69			0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intru			0	56.00
57.00 58.00	Routine service other pass through costs (from Wkst. D, Pt. II Ancillary service other pass through costs from Wkst. D, Pt. I		nrougn 35).	0 68, 787	57.00 58.00
59.00	Total (sum of amounts on lines 49 through 58)	v, cor. If fine 200)		10, 647, 980	
60.00	Primary payer payments			14, 208	
61.00	Total amount payable for program beneficiaries (line 59 minus	line 60)		10, 633, 772	61.00
62.00	Deductibles billed to program beneficiaries			1, 023, 220	
63.00 64.00	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions)			36, 608 48, 330	63.00 64.00
	Adjusted reimbursable bad debts (see instructions)			31, 415	
	Allowable bad debts for dual eligible beneficiaries (see instr	uctions)		25, 516	
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			9, 605, 359	67.00
68.00	Credits received from manufacturers for replaced devices for a			0	68.00 69.00
69.00 70.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	FOI SCH SEE THSTIUCTION	5)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstr	ation) adjustment (see	instructions)	0	70.50
70.87	Demonstration payment adjustment amount before sequestration	· · · ·	-	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.88
70. 89 70. 90	Pioneer ACO demonstration payment adjustment amount (see instructions)	uctions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)			0	70. 90 70. 91
70. 92	Bundled Model 1 discount amount (see instructions)			0	70.92
70. 93	HVBP payment adjustment amount (see instructions)			-5, 523	
70.94	HRR adjustment amount (see instructions)			-137, 265	70.94
70.95	Recovery of accel erated depreciation				70.95

	Financial Systems DEARBORN COUNTY ATION OF REIMBURSEMENT SETTLEMENT		CN: 15-0086	Peri od:	u of Form CMS-2 Worksheet E	-002
				From 01/01/2020 To 10/31/2020	Part A	
		Title	XVIII	Hospi tal	PPS	34 pii
				(уууу)	Amount	
				0	1.00	
0. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter i	in column O		2020	507, 341	70.9
0. 97	the corresponding federal year for the period prior to 10/1) Low volume adjustment for federal fiscal year (yyyy) (Enter i the corresponding federal year for the period ending on or at		:	2021	76, 799	70. 9
D. 98	Low Volume Payment-3				0	70.9
0.99	HAC adjustment amount (see instructions)				97, 845	
1.00	Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			9, 948, 866	71.0
1. 01	Sequestration adjustment (see instructions)				78, 596	
1.02	Demonstration payment adjustment amount after sequestration				0	
1.03 2.00	Sequestration adjustment-PARHM pass-throughs Interim payments				9, 742, 280	71.0
2.00	Interim payments-PARHM				9, 142, 200	72.0
3.00	Tentative settlement (for contractor use only)				0	
3.01	Tentative settlement-PARHM (for contractor use only)					73.0
4.00	Balance due provider/program (line 71 minus lines 71.01, 71.073)	02, 72, and			127, 990	74.0
4.01 5.00	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accorda CMS Pub. 15-2, chapter 1, §115.2	ance with			242, 456	74.0 75.0
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
0. 00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum	of 2.03			0	90.
	plus 2.04 (see instructions)					
1.00	Capital outlier from Wkst. L, Pt. I, line 2	ruationa)			0	91.
2.00 3.00	Operating outlier reconciliation adjustment amount (see instruction adjustment amount (see instruction)				0	92. 93.
	The rate used to calculate the time value of money (see instruct				0.00	
5.00	Time value of money for operating expenses (see instructions)				0	
6.00	Time value of money for capital related expenses (see instruct				0	96.0
				Prior to 10/1		
				1.00	2.00	
00 00	HSP Bonus Payment Amount HSP bonus amount (see instructions)			0	0	100.0
00.00	HVBP Adjustment for HSP Bonus Payment			0	0	100.
01.00	HVBP adjustment factor (see instructions)			0. 000000000	0. 000000000	101.
	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructior	ns)		0. 000000000000000000000000000000000000	0. 000000000000000000000000000000000000	
		ns)				101. (102. (
02. 00 03. 00	HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions)	,		0.0000	0.0000	102. 103.
02.00 03.00	HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions	s)		0	0.0000	102. 103.
02.00 03.00 04.00	HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst	s) tration) Adju		0.0000	0.0000	102. 103. 104.
02.00 03.00 04.00	HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe	s) tration) Adju		0.0000	0.0000	102. 103. 104.
02.00 03.00 04.00	HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no.	s) tration) Adju		0.0000	0.0000	102. 103.
02.00 03.00 04.00	HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe	s) tration) Adji eriod under		0.0000	0.0000	102. 103. 104. 200.
02.00 03.00 04.00 00.00	HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement	s) tration) Adji eriod under		0.0000	0.0000	102. 103. 104. 200. 201. 201.
02.00 03.00 04.00 00.00 01.00 02.00	HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare di scharges (see instructions) Case-mix adjustment factor (see instructions)	s) tration) Adju eriod under ne 49)	the 21st	0.0000	0.0000	102. 103. 104. 200. 201. 201.
02.00 03.00 04.00 00.00 01.00 02.00	HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions)	s) tration) Adju eriod under ne 49)	the 21st	0.0000	0.0000	102. 103. 104. 200. 201. 202.
02.00 03.00 04.00 00.00 01.00 02.00 03.00	HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in	s) tration) Adju eriod under ne 49)	the 21st	0.0000	0.0000 0	102. 103. 104. 200. 201. 202. 203.
02.00 03.00 04.00 00.00 01.00 02.00 03.00 03.00	HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204)	s) tration) Adju eriod under ne 49) n first year	the 21st	0.0000	0.0000 0	102. 103. 104. 200. 201. 202. 203. 203. 204. 205.
02.00 03.00 04.00 00.00 01.00 02.00 03.00 04.00 05.00	HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)	s) tration) Adju eriod under ne 49) n first year	the 21st	0.0000	0.0000 0	 102. 103. 104. 200. 201. 202. 203. 204. 205.
D2.00 D3.00 D4.00 D0.00 D1.00 D2.00 D3.00 D4.00 D5.00 D6.00 D6.00 D6.00 D6.00	HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement	s) tration) Adju eriod under ne 49) n first year)	the 21st	0.0000	0.0000 0	102. 103. 104. 200. 201. 202. 203. 204. 205. 206.
 02.00 03.00 04.00 00.00 01.00 02.00 03.00 04.00 05.00 06.00 07.00 	HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst	s) tration) Adju eriod under ne 49) n first year) tructions)	the 21st	0.0000	0.0000 0	102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207.
D2.00 D3.00 D4.00 D0.00 D1.00 D2.00 D3.00 D4.00 D5.00 D4.00 D5.00 D4.00 D5.00 D4.00 D5.00 D6.00 D6.00 D7.00 D8.00	HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A,	s) tration) Adju eriod under ne 49) n first year) tructions)	the 21st	0.0000	0 0.0000 0 trati on	 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 208.
02.00 03.00 04.00 00.00 01.00 02.00 03.00 05.00 06.00 07.00 08.00 09.00	HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions)	s) tration) Adju eriod under ne 49) n first year) tructions)	the 21st	0.0000	0.0000 0	102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 206. 207. 208. 209.
02. 00 03. 00 04. 00 00. 00 01. 00 02. 00 03. 00 04. 00 05. 00 06. 00 07. 00 08. 00 09. 00 10. 00	HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A,	s) tration) Adji eriod under ne 49) n first year) tructions) , line 59)	the 21st	0.0000	0.0000 0 trati on	102. 103. 104. 200. 201. 202. 203. 203. 204. 205.
02. 0C 03. 00 04. 0C 00. 0C 01. 0C 02. 0C 03. 0C 04. 0C 05. 0C 06. 0C 07. 0C 08. 0C 09. 0C	HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A ir period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use	s) tration) Adji eriod under ne 49) n first year) tructions) , line 59)	the 21st	0.0000	0.0000 0 trati on	102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210.
02. 00 03. 00 04. 00 00. 00 01. 00 02. 00 03. 00 04. 00 05. 00 06. 00 07. 00 08. 00 09. 00 11. 00 11. 00	HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pro Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare Part A IPPS payments (from line	s) tration) Adji eriod under ne 49) n first year) tructions) , line 59)	the 21st	0.0000	0.0000 0 trati on	102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 211.
02. 00 03. 00 04. 00 00. 00 01. 00 02. 00 03. 00 04. 00 05. 00 06. 00 07. 00 08. 00 09. 00 11. 00 11. 00 11. 00 11. 00	HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A ir period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	s) tration) Adji eriod under ne 49) n first year) tructions) , line 59)) 211)	the 21st	0.0000	0.0000 0 trati on	102. 1 103. 1 200. 1 200. 1 201. 2 203. 1 204. 1 205. 1 206. 1 207. 2 208. 1 209. 1 209. 1 209. 1

	Financial Systems LUME CALCULATION EXHIBIT 4		DEARBORN COUN	Provider C		Period: From 01/01/2020 To 10/31/2020	Date/Time Pre	t 4 pare
				Title	XVIII	Hospi tal	3/31/2021 12: PPS	34 p
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01		Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
00	DRG amounts other than outlier	1.00	0	0		0 0	0	1.
01	payments DRG amounts other than outlier payments for discharges	1.01	7, 514, 367	0	7, 514, 36	7	7, 514, 367	1.
)2	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	977, 768	0		977, 768	977, 768	1
)3	1 DRG for Federal specific operating payment for Model 4 BPCl occurring prior to	1.03	0	0		D	0	1
)4	October 1 DRG for Federal specific operating payment for Model 4 BPCl occurring on or after	1.04	0	0		0	0	1
0	October 1 Outlier payments for	2.00						2
	discharges (see instructions)		0	^		0 0	~	
)1	Outlier payments for discharges for Model 4 BPCI	2.02	0	0		0 0	0	2
)2	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	431, 419	0	431, 41	9	431, 419	2
3	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	8, 883	0		8, 883	8, 883	2
0	Operating outlier reconciliation	2. 01	0	0		0 0	0	3
0	Managed care simulated payments	3.00	0	0		0 0	0	4
	Indirect Medical Education Adju	ustment						
0	Amount from Worksheet E, Part	21.00	0. 000000	0.000000	0. 00000	0.000000		5
0	A, line 21 (see instructions) IME payment adjustment (see	22.00	0	0		0 0	0	6
1	instructions) IME payment adjustment for	22.01	0	0		0 0	0	6
	managed care (see instructions)							
	Indirect Medical Education Adju	ustment for th	e Add-on for Se	ection 422 of t	the MMA			
0	IME payment adjustment factor	27.00	0. 000000	0. 000000		0.000000		7
0	(see instructions) IME adjustment (see	28.00	0	0		0 0	0	8
1	instructions) IME payment adjustment add on for managed care (see	28.01	0	0		0 0	0	8
0	instructions) Total IME payment (sum of lines 6 and 8)	29.00	0	0		0 0	0	9
1	Total IME payment for managed care (sum of lines 6.01 and	29.01	0	0		0 0	0	9
	8.01) Disproportionate Share Adjustme	ent	I		l			
	Al I owable di sproporti onate share percentage (see i nstructi ons)	33.00	0. 0868	0. 0868	0. 086	8 0. 0868		10
00	Disproportionate share adjustment (see instructions)	34.00	184, 280	0	163, 06	2 21, 218	184, 280	11
	Additional payment for high per	36.00	721, 917	0 di schargos	639, 20	4 82, 713	721, 917	11
00	Total ESRD additional payment	46.00		n scharyes		0 0	0	12
	(see instructions)			0				
00 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH,	47.00 48.00	9, 838, 634 0	0 0	8, 748, 05	2 1, 090, 582 0 0 0	9, 838, 634 0	
00	small rural hospitals only.) (see instructions) Total payment for inpatient operating costs (see instructions)	49.00	9, 838, 634	0	8, 748, 05	2 1, 090, 582	9, 838, 634	15

	Financial Systems		DEARBORN COUN		01 45 0004		u of Form CMS-	2552-I
LOW VC	DLUME CALCULATION EXHIBIT 4			Provider C		Period: From 01/01/2020 To 10/31/2020	Date/Time Pre 3/31/2021 12:	pared:
					XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Period Prior		Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	0n/After 10/01	through 4)	
	1	0	1.00	2.00	3.00	4.00	5.00	
6.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	740, 559	0	664, 57	74 75, 985	740, 559	16. C
7.00	Special add-on payments for new technologies	54.00	0	0		0 0	C	
7.01	Net organ aquisition cost							17. C
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0		0 0	O	17.0
18.00	Capital outlier reconciliation adjustment amount (see		0	0		0 0	C	18.0
9.00	instructions) SUBTOTAL			0	9, 412, 62	26 1, 166, 567	10, 579, 193	19.0
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20. 00 20. 01	Capital DRG other than outlier Model 4 BPCI Capital DRG other than outlier		662, 815 0	0		14 74, 501 0 0	662, 815 0	
1.00	Capital DRG outlier payments	2.00	77, 744	0	76, 26	50 1, 484	77, 744	21.0
1.01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0		0 0	C	
2.00	Indirect medical education percentage (see instructions)	5.00	0. 0000					22.0
3.00	Indirect medical education adjustment (see instructions)	6.00	0	0		0 0	C	
.4.00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0000	0. 0000	0.000	0. 0000		24.0
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0		0 0	C	25.C
26.00	Total prospective capital payments (see instructions)	12.00	740, 559	0	664, 57	74 75, 985	740, 559	26. C
		W/S E, Part A	(Amounts to					
		line	E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00 28.00	Low volume adjustment factor Low volume adjustment (transfer amount to Wkst. E,	70. 96			0. 05390 507, 34		507, 341	27.0 28.0
29.00	Pt. A, line) Low volume adjustment (transfer amount to Wkst. E,	70. 97				76, 799	76, 799	29. C
100.00	Pt. A, line) Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 0

	Financial Systems	DEARBORN COUN				u of Form CMS-2	2552-10
HOSPI 1	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	5 Provider CC		eriod: rom 01/01/2020 o 10/31/2020	Date/Time Pre	pared:
				XVIII		3/31/2021 12: PPS	34 pm
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt.	Period to 10/01	Hospital Period on after 10/01	Total (cols. 2 and 3)	
			A)			,	
1 00	DDC amounts other than outlier normants	0	1.00	2.00	3.00	4.00	1.00
1. 00 1. 01	DRG amounts other than outlier payments DRG amounts other than outlier payments for discharges occurring prior to October 1	1.00	7, 514, 367	7, 514, 367		7, 514, 367	1.00
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	977, 768		977, 768	977, 768	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1.03	0	0		0	1.03
. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	0	0	2.01
2. 02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	431, 419	431, 419		431, 419	2.02
2. 03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	8, 883		8, 883	8, 883	2.03
3.00 4.00	Operating outlier reconciliation Managed care simulated payments	2. 01 3. 00	0	0	-	0	3.00 4.00
	Indirect Medical Education Adjustment	01.00	0.000000	0,000000	0.000000		F 00
. 00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 000000				5.00
. 00 . 01	IME payment adjustment (see instructions) IME payment adjustment for managed care (see instructions)	22. 00 22. 01	0	0	0	0 0	6.00 6.01
	Indirect Medical Education Adjustment for the	e Add-on for S	ection 422 of 1	the MMA	<u> </u>		
. 00	IME payment adjustment factor (see i nstructions)	27.00	0. 000000	0. 000000	0. 000000		7.00
. 00 . 01	IME adjustment (see instructions) IME payment adjustment add on for managed	28. 00 28. 01	0	0	-	0 0	8.0 8.0
. 00	care (see instructions) Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.0
. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	0	0	0	0	9.0
	Disproportionate Share Adjustment	22.00	0.00(0	0.00/0	0.00(0		10.0
). 00	Allowable disproportionate share percentage (see instructions)	33.00	0. 0868				10.0
1.00 1.01	Disproportionate share adjustment (see instructions)	34. 00 36. 00	184, 280 721, 917				
1.01	Uncompensated care payments Additional payment for high percentage of ESI			039, 204	02,713	721, 917	11.0
2.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.0
3.00 4.00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see	47.00 48.00	9, 838, 634 0	8, 748, 052 0	1, 090, 582 0	9, 838, 634 0	
5.00	instructions) Total payment for inpatient operating costs (see instructions)	49.00	9, 838, 634	8, 748, 052	1, 090, 582	9, 838, 634	15.0
5. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	740, 559	664, 574	75, 985	740, 559	16. 0
7.00 7.01	Special add-on payments for new technologies Net organ acquisition cost	54.00	0	0	0	0	17.0 17.0
7.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.0
8.00		93.00	0	0	0	0	18.0
9.00	SUBTOTAL			9, 412, 626	1, 166, 567	10, 579, 193	19.00

	Financial Systems	DEARBORN COUN			In Lie	u of Form CMS-2	2552-10
HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	ATION EXHIBIT 5			Period: From 01/01/2020 To 10/31/2020	Date/Time Pre 3/31/2021 12:	pared:
				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	662, 815	588, 31	74, 501	662, 815	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	77, 744	76, 26	1, 484	77, 744	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2. 01	0		0 0	0	21.01
	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	740, 559	664, 57	74 75, 985	740, 559	26.00
		Wkst. E, Pt.	(Amt. from				
		A, line	Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00				2100	0100		27.00
28.00	Low volume adjustment prior to October 1	70, 96	507, 341	507, 34	11	507, 341	
29.00	Low volume adjustment on or after October 1	70, 97	76, 799		76, 799		
30.00	HVBP payment adjustment (see instructions)	70, 93	-5, 523			-5, 523	
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0		0 0		1
31.00	HRR adjustment (see instructions)	70. 94	-137, 265	-129, 24	-8, 018	-137, 265	31 00
31.00	IRR adjustment (see HSP bonus payment (see instructions)	70. 91	0	127,2-	0 0	0	
						(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		97, 84			32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

	Financial Systems DEARBORN COUNTY ATION OF REIMBURSEMENT SETTLEMENT	HOSPITAL Provider CCN: 15-0086	In Lie Period:	u of Form CMS-2 Worksheet E	2552-10
CALCUL			From 01/01/2020 To 10/31/2020	Part B	nared
		T: +1 - 20/111		3/31/2021 12:	
		Title XVIII	Hospi tal	PPS	
				1.00	
1.00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)			321	1.00
2.00	Medical and other services reimbursed under OPPS (see instru	ctions)		5, 398, 739	
3.00 4.00	OPPS payments Outlier payment (see instructions)			4, 023, 606 91, 173	
4.00	Outlier reconciliation amount (see instructions)			0	
5.00	Enter the hospital specific payment to cost ratio (see instru-	uctions)		0.000	
6.00 7.00	Line 2 times line 5 Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
8.00	Transitional corridor payment (see instructions)			0	8.00
9.00 10.00	Ancillary service other pass through costs from Wkst. D, Pt. Organ acquisitions	IV, col. 13, line 200		24, 665 0	
11.00	Total cost (sum of lines 1 and 10) (see instructions)			321	
	COMPUTATION OF LESSER OF COST OR CHARGES				
12.00	Reasonable charges Ancillary service charges			674	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4,	line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13) Customary charges			674	14.00
15.00	Aggregate amount actually collected from patients liable for	payment for services on	a charge basi s	0	15.00
16.00	Amounts that would have been realized from patients liable f		on a chargebasi s	0	16.00
17.00	had such payment been made in accordance with 42 CFR §413.13 Ratio of line 15 to line 16 (not to exceed 1.000000)	(e)		0. 000000	17.00
18.00	Total customary charges (see instructions)			674	18.00
19.00	Excess of customary charges over reasonable cost (complete or instructions)	nlyifline 18 exceeds l	ine 11) (see	353	19.00
20.00	Excess of reasonable cost over customary charges (complete o	nlyifline 11 exceeds l	ine 18) (see	0	20.00
01 00	instructions)			001	01.00
21.00 22.00	Lesser of cost or charges (see instructions) Interns and residents (see instructions)			321	
23.00	Cost of physicians' services in a teaching hospital (see ins	tructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			4, 139, 444	24.00
25.00	Deductibles and coinsurance amounts (for CAH, see instruction	ns)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on li			835, 867	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) instructions)	plus the sum of lines 2	2 and 23] (see	3, 303, 898	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4,			0	
29.00 30.00	ESRD direct medical education costs (from Wkst. E-4, line 36 Subtotal (sum of lines 27 through 29))		0 3, 303, 898	
	Primary payer payments			3, 303, 898	
32.00	Subtotal (line 30 minus line 31)	1.050)		3, 303, 504	32.00
33 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERV Composite rate ESRD (from Wkst. I-5, line 11)	ICES)		0	33.00
	Allowable bad debts (see instructions)			83, 381	
35.00 36.00	Adjusted reimbursable bad debts (see instructions)	tructions)		54, 198 66, 332	
37.00	Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (see instructions)	ti ucti ons)		3, 357, 702	
38.00	MSP-LCC reconciliation amount from PS&R			51	38.00
39.00 39.50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction	ns)		0	39.00 39.50
39.97	Demonstration payment adjustment amount before sequestration			0	39.97
39.98	Partial or full credits received from manufacturers for repla RECOVERY OF ACCELERATED DEPRECIATION	aced devices (see instru	ctions)	0	
39.99 40.00	Subtotal (see instructions)			3, 357, 651	
40. 01	Sequestration adjustment (see instructions)			26, 525	40.01
40. 02 40. 03	Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs			0	40.02
	Interim payments			3, 381, 677	
41.01	Interim payments-PARHM				41.01
42.00 42.01	Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only)			0	42.00 42.01
43.00	Balance due provider/program (see instructions)			-50, 551	43.00
43.01 44.00	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accord	ance with CMS Dub 15 2	chanter 1	0	43.01 44.00
44. UU	§115. 2			0	-++. UC
00.00	TO BE COMPLETED BY CONTRACTOR			-	
	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	
92.00	The rate used to calculate the Time Value of Money			0.00	92.00
	Time Value of Money (see instructions)			0	
74.UU	Total (sum of lines 91 and 93)			ı 0	94.00

ANALY	n Financial Systems DEARBORN COUN SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	TY HOSPITAL Provider CO	CN: 15-0086	Period: From 01/01/2020 To 10/31/2020	Date/Time Pre	pared:
		Titlo	XVIII	Hospi tal	3/31/2021 12: PPS	34 pm
			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 3.00	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 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)		9, 602, 3	20 0	3, 253, 857 0	1.00 2.00 3.00
	Program to Provider					
3. 01 3. 02 3. 03 3. 04 3. 05	ADJUSTMENTS TO PROVI DER	07/10/2020 10/31/2020	52, 5 87, 4		127, 820 0 0 0 0	3.01 3.02 3.03 3.04 3.04
	Provider to Program					
3.50 3.51 3.52 3.53 3.54 3.99	ADJUSTMENTS TO PROGRAM Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		139, 9	0 0 0 0 0 60	0 0 0 127, 820	3. 50 3. 51 3. 52 3. 53 3. 54 3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR		9, 742, 2	80	3, 381, 677	4.00
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) Program to Provider					5.00
5. 01	TENTATIVE TO PROVIDER			0	0	5.0 [°]
5. 02 5. 03				0 0	0	5.02
5.50	Provider to Program TENTATIVE TO PROGRAM			0	0	5.50
5. 50 5. 51 5. 52 5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0 0 0	0 0 0	5.50 5.51 5.52 5.99
5. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6. 01 6. 02 7. 00	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		127, 9 9, 870, 2	0 70 Contractor	0 50, 551 3, 331, 126 NPR Date	6. 0 ² 6. 02 7. 00
		()	Number	(Mo/Day/Yr)	
8.00	Name of Contractor	()	1.00	2.00	8.00

Heal th	Financial Systems DEARBORN COUNTY	Y HOSPI TAL	In Lie	u of Form CMS-	2552-10				
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0086	Period: From 01/01/2020 To 10/31/2020	Date/Time Pr 3/31/2021 12	epared:				
		Title XVIII	Hospi tal	PPS					
				1.00					
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS			1.00					
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATIO	N			-				
1.00	1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14								
2.00	2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12								
3.00	3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. Line 2								
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1,	8-12			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	line 20			6.00				
7.00	CAH only - The reasonable cost incurred for the purchase of line 168	certified HIT technology	Wkst. S-2, Pt. I		7.00				
8.00	Calculation of the HIT incentive payment (see instructions)				8.00				
9.00	Sequestration adjustment amount (see instructions)				9.00				
10.00	Calculation of the HIT incentive payment after sequestration) (see instructions)			10.00				
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH								
	Initial/interim HIT payment adjustment (see instructions)				30.00				
	Other Adjustment (specify)				31.00				
32.00	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instructio	ns)		32.00				

	Financial Systems DEARBORN COUNTY			u of Form CMS-2 Worksheet E-3	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0086	Period: From 01/01/2020 To 10/31/2020	Part VII	pared:
		Title XIX	Hospi tal	Cost	<u>o i piii</u>
		· .	I npati ent	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SE	RVICES FOR TITLES V OR 2	XIX SERVICES		-
	COMPUTATION OF NET COST OF COVERED SERVICES		0(0.040		1
1.00	Inpatient hospital/SNF/NF services		862, 919	0	1.00
2.00 3.00	Medical and other services Organ acquisition (certified transplant centers only)		0	0	2.00
4.00	Subtotal (sum of lines 1, 2 and 3)		862, 919	0	•
5.00	Inpatient primary payer payments	002, 717	0	5.00	
6.00	Outpatient primary payer payments			0	•
7.00	Subtotal (line 4 less sum of lines 5 and 6)		862, 919	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
8.00	Routine service charges		479, 231		8.00
9.00	Ancillary service charges		1, 534, 326	0	
10.00 11.00	Organ acquisition charges, net of revenue Incentive from target amount computation		0		10.00
12.00	Total reasonable charges (sum of lines 8 through 11)		2, 013, 557	0	12.00
12.00	CUSTOMARY CHARGES		2,013,337	0	12.00
13.00	Amount actually collected from patients liable for payment fo	r services on a charge	0	0	13.00
14.00	basis Amounts that would have been realized from patients liable fo	r payment for services	on 0	0	14.00
	a charge basis had such payment been made in accordance with			-	
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	,	0. 000000	0.000000	15.00
16.00	Total customary charges (see instructions)		2, 013, 557	0	16.00
17.00	Excess of customary charges over reasonable cost (complete on	ly if line 16 exceeds	1, 150, 638	0	17.00
10.00	line 4) (see instructions)				10.00
18.00	Excess of reasonable cost over customary charges (complete on	ly if line 4 exceeds li	ne 0	0	18.00
19.00	16) (see instructions) Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see inst	ructions)	0	0	
21.00	Cost of covered services (enter the lesser of line 4 or line		862, 919	0	
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be			-	
22.00	Other than outlier payments	· · ·	0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		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	
28.00 29.00	Customary charges (title V or XIX PPS covered services only) Titles V or XIX (sum of lines 21 and 27)		862, 919	0	
29.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		002, 717	0	29.00
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)	862, 919	0	
32.00	Deducti bl es	,	0	0	•
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 an	862, 919	0	•	
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0		
38.00 39.00	Subtotal (line $36 \pm \text{line } 37$)	862, 919	0	38.00 39.00	
39.00 40.00	Direct graduate medical education payments (from Wkst. E-4) Total amount payable to the provider (sum of lines 38 and 39)	862, 919	0	•	
40.00	Interim payments		976, 950	0	•
42.00	Balance due provider/program (line 40 minus line 41)		-114,031	0	1
	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub 15-2.	0	0	•
43.00				•	

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C		eriod: com 01/01/2020 o 10/31/2020	Worksheet G Date/Time Pre 3/31/2021 12:	
	-	General Fund	Speci fi c Purpose Fund	Endowment Fund	Plant Fund	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
	Cash on hand in banks	11, 934, 121	0	0	0	1.0
00	Temporary investments	0	0	0	0	
	Notes receivable	71 750 404	0	0	0	3.0
	Accounts receivable Other receivable	71, 759, 694 0	0	0	0	4.0
	Allowances for uncollectible notes and accounts receivable	-26, 542, 125	0	0	0	
	Inventory	1, 504, 348	0	0	0	
	Prepaid expenses	20, 596	0	0	0	
	Other current assets Due from other funds	1, 462, 655	0	0	0	9.0
	Total current assets (sum of lines 1-10)	60, 139, 289	0	0	0	
	FIXED ASSETS		· · · ·	- 1		
	Land	75, 208	0	0	0	
	Land improvements	1, 548, 970 -1, 378, 788	0	0	0	13.0
	Accumulated depreciation Buildings	57, 283, 306	0	0	0	14.
	Accumulated depreciation	-39, 738, 200	0	0	0	16.
	Leasehold improvements	12, 136, 721	0	0	0	17.
	Accumulated depreciation	-9, 662, 454	0	0	0	18.
	Fixed equipment	18, 642, 045	0	0	0	19. 20.
	Accumulated depreciation Automobiles and trucks	-15, 153, 795 277, 439	0	0	0	
	Accumulated depreciation	-250, 656	0	0	0	
. 00	Major movable equipment	38, 169, 509	0	0	0	23.
	Accumulated depreciation	-32, 814, 449	0	0	0	24.
	Minor equipment depreciable	4,775	0	0	0	25.
	Accumulated depreciation HIT designated Assets	-4, 775	0	0	0	26.
	Accumulated depreciation	0	0	0	0	28.
	Minor equipment-nondepreciable	0	0	0	0	29.
	Total fixed assets (sum of lines 12-29)	29, 134, 856	0	0	0	30.
	OTHER ASSETS	0	0	ol	0	31.
	Deposits on Leases	0	0	0	0	32.
	Due from owners/officers	0	0	0	0	33.
	Other assets	24, 546, 564	0	0	0	34.
	Total other assets (sum of lines 31-34)	24, 546, 564	0	0	0	35.
	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	113, 820, 709	0	0	0	36.
	Accounts payable	5,066,502	0	0	0	37.
	Sal ari es, wages, and fees payable	-19	0	0	0	38.
	Payroll taxes payable	644, 995	0	0	0	
	Notes and Loans payable (short term)	0	0	0	0	40.
	Deferred income Accelerated payments	0	0	0	0	41.
	Due to other funds	52, 593, 513	0	0	0	
	Other current liabilities	1, 273, 662	0	0	0	44.
	Total current liabilities (sum of lines 37 thru 44)	59, 578, 653	0	0	0	45.
	LONG TERM LI ABI LI TI ES	0		0	0	1
	Mortgage payable Notes payable	4, 644, 975	0	0	0	
	Unsecured Loans	4, 044, 773	0	0	0	
	Other long term liabilities	0	0	0	0	49.
	Total long term liabilities (sum of lines 46 thru 49)	4, 644, 975	0	0	0	50.
	Total liabilities (sum of lines 45 and 50)	64, 223, 628	0	0	0	51.
	CAPITAL ACCOUNTS General fund balance	49, 597, 081				52.
	Specific purpose fund	47, 377, 001	о			53.
	Donor created - endowment fund balance - restricted		J J	о		54.
00	Donor created - endowment fund balance - unrestricted			0		55.
	Governing body created - endowment fund balance			0	_	56.
	Plant fund balance - invested in plant				0	57.
. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.
. 00	Total fund balances (sum of lines 52 thru 58)	49, 597, 081	0	О	0	59.
			-	-		60.

Health Financial Systems	DEARBORN COUNT				u of Form CMS	
STATEMENT OF CHANGES IN FUND BALANCES		Provider CC		Period: From 01/01/2020 To 10/31/2020	Date/Time Pr 3/31/2021 12	epared:
	General	Fund	Speci al	Purpose Fund	Endowment Fund	
	1.00	2.00	3.00	4.00	5.00	
1.00Fund balances at beginning of period2.00Net income (loss) (from Wkst. G-3, line 29)3.00Total (sum of line 1 and line 2)4.00Additions (credit adjustments) (specify)5.00IMMATERIAL ADJUSTMENT6.007.008.009.0010.00Total additions (sum of line 4-9)11.00Subtotal (line 3 plus line 10)12.00Deductions (debit adjustments) (specify)13.0014.0015.0016.0017.00Fund balance at end of period per balance sheet (line 11 minus line 18)		2, 287 50, 631, 596 -1, 036, 802 49, 594, 794 2, 287 49, 597, 081 0 49, 597, 081				$ \begin{array}{c} 1.00\\ 2.00\\ 3.00\\ 0.4.00\\ 5.00\\ 0.5.00\\ 0.6.00\\ 0.7.00\\ 0.7.00\\ 0.7.00\\ 0.7.00\\ 10.00\\ 11.00\\ 12.00\\ 0.13.00\\ 0.14.00\\ 0.15.00\\ 0.15.00\\ 14.00\\ 0.15.00\\ 15.00\\ 14.00\\ 0.17.00\\ 18.00\\ 19.00\\ \end{array} $
	Endowment Fund	PI ant	Fund			
	6.00	7.00	8.00			
 1.00 Fund balances at beginning of period 2.00 Net income (loss) (from Wkst. G-3, line 29) 3.00 Total (sum of line 1 and line 2) 4.00 Additions (credit adjustments) (specify) 5.00 IMMATERIAL ADJUSTMENT 6.00 7.00 8.00 9.00) 0			0		$ \begin{array}{c} 1.00\\ 2.00\\ 3.00\\ 4.00\\ 5.00\\ 6.00\\ 7.00\\ 8.00\\ 9.00 \end{array} $
10.00 Total additions (sum of line 4-9) 11.00 Subtotal (line 3 plus line 10) 12.00 Deductions (debit adjustments) (specify) 13.00 14.00 15.00 16.00 17.00 18.00 Total deductions (sum of lines 12-17)	0	0 0 0 0 0 0		0		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00
19.00 Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0		19.00

	Financial Systems DEARBORN COUNTY				III LIE	u of Form CMS	
STATEN	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider C	CN: 15-0086	Period: From 01/0 To 10/3	01/2020 31/2020	Worksheet G- Parts I & II Date/Time Pr 3/31/2021 12	epared:
	Cost Center Description		I npati ent	0utpa		Total	
			1.00	2.0	00	3.00	
	PART I – PATIENT REVENUES						
	General Inpatient Routine Services		1				
1.00	Hospi tal		10, 595, 9	16		10, 595, 91	
2.00	SUBPROVIDER - IPF						2.00
3.00	SUBPROVIDER - IRF						3.00
4.00	SUBPROVI DER						4.00
5.00	Swing bed - SNF			0			0 5.00
6.00	Swing bed - NF			0			0 6.00
7.00	SKILLED NURSING FACILITY			0			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)		10, 595, 9	16		10, 595, 91	6 10.00
	Intensive Care Type Inpatient Hospital Services						
11.00	I NTENSI VE CARE UNI T		5, 162, 9	80		5, 162, 98	
12.00	CORONARY CARE UNIT						12.00
13.00	BURN INTENSIVE CARE UNIT						13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T						14.00
15.00	OTHER SPECIAL CARE (SPECIFY)						15.00
16.00	Total intensive care type inpatient hospital services (sum o 11-15)	flines	5, 162, 9	80		5, 162, 98	0 16.00
17.00	Total inpatient routine care services (sum of lines 10 and 1	6)	15, 758, 8	96		15, 758, 89	6 17.00
18.00	Ancillary services		48, 055, 0	44 97, 9	985, 122	146, 040, 16	6 18.00
19.00	Outpatient services		4, 926, 1	01 17, 1	141, 510	22, 067, 61	1 19.00
20.00	RURAL HEALTH CLINIC			0	0		0 20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0	0		0 21.00
22.00	HOME HEALTH AGENCY			ç	927, 357	927, 35	7 22.00
23.00	AMBULANCE SERVICES						23.00
24.00	СМНС						24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)						25.00
26.00	HOSPI CE			0	31, 015	31, 01	5 26.00
27.00	OCCUPATIONAL HEALTH			0 2	221, 810	221, 81	
27.01	PROFESSIONAL FEES				999, 876	999, 87	
28.00	Total patient revenues (sum of lines 17-27)(transfer column	3 to Wkst.	68, 740, 0		306, 690	186, 046, 73	
	G-3, line 1)						
	PART II - OPERATING EXPENSES						
29.00	Operating expenses (per Wkst. A, column 3, line 200)			67, 5	531, 939		29.00
30.00	ADD (SPECIFY)			0			30.00
31.00				0			31.00
32.00				0			32.00
33.00			1	0			33.00
34.00			1	0			34.00
35.00			1	0			35.00
36.00	Total additions (sum of lines 30-35)		1		0		36.00
37.00	DEDUCT (SPECIFY)			0	0		37.00
38.00				0			38.00
39.00			1	0			39.00
40.00				0			40.00
40.00				0			41.00
41.00	Total deductions (sum of lines 37-41)			J J	0		41.00
⊤∠. UU					531, 939		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line	4/)(Transtor	·	6/ 1			

Heal th	Financial Systems	DEARBORN COUNTY	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
STATEM	IENT OF REVENUES AND EXPENSES		Provi der CCN: 15-0086	Period: From 01/01/2020 To 10/31/2020	Worksheet G-3 Date/Time Pre 3/31/2021 12:	pared:
					1.00	
1.00	Total patient revenues (from Wkst. G-2, Pa	art I, column 3, lin	e 28)		186, 046, 731	1.00
2.00	Less contractual allowances and discounts	on patients' accoun	ts		128, 730, 762	2.00
3.00	Net patient revenues (line 1 minus line 2)	57, 315, 969	3.00			
4.00	Less total operating expenses (from Wkst.	67, 531, 939	4.00			
5.00	Net income from service to patients (line	-10, 215, 970	5.00			
	OTHER INCOME					
6.00	Contributions, donations, bequests, etc				0	6.00
7.00	Income from investments				0	7.00
8.00	Revenues from telephone and other miscella	aneous communication	servi ces		0	8.00
9.00	Revenue from television and radio service				0	9.00
10.00	Purchase di scounts				0	10.00
11.00	Rebates and refunds of expenses				0	11.00
12.00	Parking lot receipts				0	12.00
13.00	Revenue from Laundry and Linen service				0	13.00
14.00	Revenue from meals sold to employees and g	juests			0	14.00
15.00	Revenue from rental of living quarters				0	15.00
16.00	Revenue from sale of medical and surgical		han patients		0	16.00
17.00	Revenue from sale of drugs to other than p				0	17.00
18.00	Revenue from sale of medical records and a				0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms	s, etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops,	and canteen			0	20.00
21.00	Rental of vending machines				0	21.00
22.00	Rental of hospital space				0	22.00
23.00	Governmental appropriations				0	23.00
24.00	OTHER REVENUE				4, 335, 570	24.00
24.01	OTHER NON-OPERATING REVENUE				-6, 830, 868	24.01
24.50	COVI D-19 PHE Fundi ng				11, 674, 466	24.50
25.00	Total other income (sum of lines 6-24)				9, 179, 168	25.00
	Total (line 5 plus line 25)				-1, 036, 802	
	OTHER EXPENSES (SPECIFY)		0	27.00		
	Total other expenses (sum of line 27 and s				0	28.00
29.00	Net income (or loss) for the period (line	26 minus line 28)			-1, 036, 802	29.00

	Financial Systems		DEARBORN COUN	TY HOSPI TAL		In Lie	u of Form CMS-:	2552-10
ANALYS	IS OF HOSPITAL-BASED HOME HEALT	TH AGENCY COSTS	5	Provider C		Period: From 01/01/2020	Worksheet H	
				HHA CCN:	15-7055	To 10/31/2020	3/31/2021 12:	
						Home Health Agency I	PPS	
		Sal ari es	Employee Benefits	Transportatio n (see	Contracted/Pu rchased		Total (sum of cols. 1 thru	
		1.00		instructions)	Servi ces	5.00	5)	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	6.00	
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable			0		0	0	2.00
3.00	Equipment Plant Operation & Maintenance	0	0	0	(o o	0	
4.00 5.00	Transportation Administrative and General	0 158, 487	0	0 47, 487		0 0 7 19,341	0 294, 962	
	HHA REIMBURSABLE SERVICES	1						
6.00 7.00	Skilled Nursing Care Physical Therapy	326, 546 151, 573		0	1	0 0 0 0	326, 546 151, 573	•
8.00 9.00	Occupational Therapy Speech Pathology	16, 396 3, 220		0			16, 396 3, 220	•
10.00	Medical Social Services	0		0			3, 220	
11.00 12.00	Home Health Aide Supplies (see instructions)	19, 669 0		0			19, 669 0	
13.00	Drugs	0	0	0		0 0	0	13.00
14.00	DME HHA NONREIMBURSABLE SERVICES	0	0	0	<u> (</u>	0 0	0	14.00
15.00 16.00	Home Dialysis Aide Services Respiratory Therapy	0	-	0		0 0 0 0	0	
17.00	Private Duty Nursing	0	0	0		0 0	0	17.00
18.00 19.00	Clinic Health Promotion Activities	0	0	0			0	
20.00	Day Care Program	0	0	0		0 0	0	20.00
21.00 22.00	Home Delivered Meals Program Homemaker Service	0	0	0			0	
23.00	All Others (specify)	0	0	0		0	0	23.00
23.50 24.00	Telemedicine Total (sum of lines 1–23)	675, 891	0	47, 487	69, 64	7 19, 341	0 812, 366	
		Recl assi fi cat i on	Reclassified Trial Balance	Adjustments	Net Expenses for			
			(col. 6 +		Allocation			
			col . 7)		(col. 8 + col. 9)			
	GENERAL SERVICE COST CENTERS	7.00	8.00	9.00	10.00			
1.00	Capital Related - Bldg. &	0	0	0)	D		1.00
2.00	Fixtures Capital Related - Movable	0	0	0	(D		2.00
3.00	Equipment Plant Operation & Maintenance	0	0	C		2		3.00
4.00	Transportation	0	-	C	(2		4.00
5.00	Administrative and General HHA REIMBURSABLE SERVICES	0	294, 962	C	294, 96	2		5.00
6.00 7.00	Skilled Nursing Care Physical Therapy	0	326, 546 151, 573	0				6.00 7.00
8.00	Occupational Therapy	0	16, 396	0	16, 39	6		8.00
9. 00 10. 00	Speech Pathology Medical Social Services	0	3, 220	0				9.00 10.00
11.00	Home Health Aide	0	19, 669	0	19, 66	-		11.00
12.00 13.00	Supplies (see instructions) Drugs	0	0	0				12.00 13.00
14.00		0	0	0		D		14.00
15.00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0		0		D		15.00
16.00 17.00	Respiratory Therapy Private Duty Nursing	0	0	0				16.00 17.00
18.00	Clinic	0	0	0		D		18.00
19.00 20.00	Health Promotion Activities Day Care Program	0	0	0	1			19.00 20.00
21.00	Home Delivered Meals Program	0	0	0				21.00
22.00 23.00	Homemaker Service All Others (specify)	0	0	0		2 2		22.00 23.00
	Telemedicine Total (sum of lines 1–23)	0	0 812, 366	0		5		23.50 24.00
21.00		. 0	012,000		1 012, 300	- 1		1 2 1.00

Heal th	Financial Systems		DEARBORN COUNT	Y HOSPI TAL		In Lie	u of Form CMS-:	2552-10
	LLOCATION - HHA GENERAL SERVICE	E COST		Provider C	CN: 15-0086	Period: From 01/01/2020	Worksheet H-1 Part I	
				HHA CCN:	15-7055	To 10/31/2020		pared: 34 pm
						Home Health	PPS	<u>94 piii</u>
	· · · · · · · · · · · · · · · · · · ·		Capital Rela	ated Costs		Agency I		
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	BI dgs & Fi xtures	Movable Equipment	Plant Operation & Maintenance		Subtotal (col s. 0-4)	-
		0	1.00	2.00	3.00	4.00	4A. 00	
1.00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &	0	0				0	1.00
	Fixtures		-	0				
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00 4.00	Plant Operation & Maintenance Transportation	0	0	0		0 0	0	3.00 4.00
5.00	Administrative and General	294, 962	0	0		0 0	294, 962	
6.00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	326, 546	0	0		0 0	326, 546	6.00
7.00	Physi cal Therapy	151, 573	0	0		0 0	151, 573	7.00
8.00 9.00	Occupational Therapy Speech Pathology	16, 396 3, 220	0	0		0 0	16, 396 3, 220	•
10.00	Medical Social Services	0	0	0		0 0	0	10.00
11.00 12.00	Home Health Aide Supplies (see instructions)	19, 669 0	0	0		0 0	19, 669 0	1
13.00	Drugs	0	0	0		0	0	
14.00	DME HHA NONREI MBURSABLE SERVI CES	0	0	0		0 0	0	14.00
15.00 16.00	Home Dialysis Aide Services Respiratory Therapy	0	0	0		0 0 0 0	0	
17.00	Private Duty Nursing	0	0	0		0 0	0	
18. 00 19. 00	Clinic Health Promotion Activities	0	0	0		0 0	0	
20.00	Day Care Program	0	0	0		0 0	0	20.00
21.00 22.00	Home Delivered Meals Program Homemaker Service	0	0	0		0 0	0	
23.00	All Others (specify)	0	0	0		0 0	0	23.00
23.50 24.00	Telemedicine Total (sum of lines 1-23)	0 812, 366	0	0		0 0	0 812, 366	23.50 24.00
		Administrativ	Total (col s.					
		e & General 5.00	4A + 5) 6.00					-
1.00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &							1.00
	Fixtures							
2.00	Capital Related – Movable Equipment							2.00
3.00	Plant Operation & Maintenance							3.00
4.00 5.00	Transportation Administrative and General	294, 962						4.00 5.00
6.00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	186, 157	512, 703					6.00
7.00	Physical Therapy	86, 409	237, 982					7.00
8.00 9.00	Occupational Therapy Speech Pathology	9, 347 1, 836	25, 743 5, 056					8.00 9.00
10.00	Medical Social Services	0	0					10.00
11. 00 12. 00	Home Health Aide Supplies (see instructions)	11, 213	30, 882					11.00 12.00
13.00	Drugs	0	0					13.00
14.00	DME HHA NONREI MBURSABLE SERVI CES	0	0					14.00
15.00	Home Dialysis Aide Services	0	0					15.00
16. 00 17. 00		0	0 0					16.00 17.00
18.00	Clinic	0	0					18.00
19.00 20.00	Health Promotion Activities Day Care Program	0	0					19.00 20.00
21.00	Home Delivered Meals Program	0	0					21.00
23.00		0	0					22.00 23.00
	Telemedicine Total (sum of lines 1-23)	0	0 812, 366					23.50 24.00
21.00		1	0.2,000					1 - 1. 00

Heal th	Financial Systems		DEARBORN COUN	TY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	LLOCATION - HHA STATISTICAL BAS	SI S		Provider C HHA CCN:		Period: From 01/01/2020 To 10/31/2020	Worksheet H-1 Part II	pared:
						Home Health Agency I	PPS	<u>54 piii</u>
		Capital Rel	ated Costs					
		BI dgs & Fi xtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation n (MILEAGE)	Reconciliatio n	Administrativ e & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A. 00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. &	0				0		1.00
	Fixtures							
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see	0	0	0		0		4.00
	instructions)							
5.00	Administrative and General	0	0	0		0 -294, 962	517, 404	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0		0 0	020,010	
7.00	Physical Therapy	0	0	0		0 0	101/0/0	
8.00	Occupational Therapy	0	0	0		0 0	16, 396	
9.00	Speech Pathology	0	0	0		0 0	3, 220	
10.00	Medical Social Services	0	0	0		0 0	0	
11.00	Home Health Aide	0	0	0		0 0		11.00
12.00	Supplies (see instructions)	0	0	0		0 0	0	
13.00	Drugs	0	0	0		0	0	
14.00	DME	0	0	0		0 0	0	14.00
45 00	HHA NONREI MBURSABLE SERVI CES			-				1 4 5 4 4
15.00	Home Dialysis Aide Services	0	0	0		0 0	-	
16.00	Respiratory Therapy	0	0	0		0 0	0	1
17.00	Private Duty Nursing	0	0	0		0 0	0	
18.00	Clinic	0	0	0		0 0	0	
19.00	Health Promotion Activities	0	0	0		0 0	0	
20.00	Day Care Program	0	0	0		0 0	0	
21.00	Home Delivered Meals Program	0	0	0		0 0	0	
22.00	Homemaker Service	0	0	0			0	22.00
23.00	All Others (specify) Telemedicine	0	0	0		0 0	0	
23.50		0	0	0			0 517 404	
24.00	Total (sum of lines 1-23)	0	0	0		0 -294, 962		
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0			294, 962	
26.00	Unit Cost Multiplier	0. 000000	0. 000000	0.00000	0. 00000	U	0. 570081	26.00

LOCATION OF GENERAL SERVICE COSTS T	O HHA COST CEN	TERS	Provider C		Period:	Worksheet H-2	
			HHA CCN:		rom 01/01/2020 o 10/31/2020	Date/Time Pre 3/31/2021 12:	parec 34 pm
					Home Health	PPS	
		CAPI TAL REL	ATED COSTS		Agency I		
						DATA	
Cost Center Description	HHA Trial Balance (1)	NEW BLDG & FIXT	NEW MVBLE EQUI P	EMPLOYEE BENEFITS DEPARTMENT	COMMUNI CATI ON S	DATA PROCESSI NG	
	0	1.00	2.00	4.00	5.01	5.02	
 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 O Clinic Halth Promotion Activities Day Care Program Home Health Orbers (specify) Telemedicine O Home Delivered Meals Program Home All Others (specify) Telemedicine O Total (sum of lines 1-19) (2) 	0 512, 703 237, 982 25, 743 5, 056 0 30, 882 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	15, 085 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				130, 094 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20.
.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to <u>6 decimal places.</u> Cost Center Description	PURCHASI NG RECEI VI NG AND STORES	ADMI TTI NG	CASHI ERI NG/AC COUNTS RECEI VABLE	Subtotal	OTHER ADMI NI STRATI V E AND GENERAL	OPERATI ON OF PLANT	21.
	5.03	5.04	5.05	5A. 05	5.06	7.00	
 Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs O MME O Home Dialysis Aide Services Respiratory Therapy O Private Duty Nursing O Clinic 	611 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		8, 870 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	361, 293 512, 703 237, 982 25, 743 5, 056 0 30, 882 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	43, 964 20, 407 2, 207 434 0	33, 462 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	14. 15.

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

Health Financial Systems ALLOCATION OF GENERAL SERVICE COSTS	TO HHA COST CEN	DEARBORN COUNT	Provider C	CN: 15-0086	Period: From 01/01/2020	u of Form CMS-2 Worksheet H-2 Part I	
			HHA CCN:	15-7055	To 10/31/2020	Date/Time Pre 3/31/2021 12:	pared: 34 pm
					Home Health Agency I	PPS	
Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI O N	CENTRAL SERVI CE & SUPPLY	
	8.00	9.00	10. 00	11.00	13.00	14.00	
 Administrative and General OSkilled Nursing Care OSkilled Nursing Care OCcupational Therapy OCcupational Therapy OSpeech Pathology OMedical Social Services OHome Health Aide OSupplies (see instructions) OD Drugs OD DME OMED Home Dialysis Aide Services OMED Home Dialysis Aide Services OR Respiratory Therapy OC Respiratory Therapy OD Private Duty Nursing OD Linic OMED Health Promotion Activities OD Day Care Program OM Home Delivered Meals Program OM Home Service OM All Others (specify) So Telemedicine OM Total (sum of lines 1-19) (2) OM Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 1, rounded to 6 decimal places. 		10, 474 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0 0 0 0		2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 19.50
Cost Center Description	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	PHARMACY RESI DENCY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	15.00	16.00	17.00	23.00	24.00	25.00	
 Administrative and General OSkilled Nursing Care OSkilled Nursing Care OCcupational Therapy OCcupational Therapy OSpeech Pathology OM Medical Social Services OHome Health Aide OSupplies (see instructions) OD Drugs OD DME OM Home Dialysis Aide Services OR Respiratory Therapy OR Respiratory Therapy OD Health Promotion Activities OD Day Care Program OM Home Delivered Meals Program OM Home Delivered Meals Program OM Home Dial (sum of lines 1-19) (2) OM Total (sum of lines 1-19) (2) OM Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 1, rounded to 6 decimal places. 		6, 052 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	314 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		$ \begin{smallmatrix} 0 & 442, 576 \\ 0 & 556, 667 \\ 0 & 258, 389 \\ 0 & 27, 950 \\ 0 & 5, 490 \\ 0 & 0 \\ 0$		2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

Health Financial Systems		DEARBORN COUN	TY HOSPI TAL		In Lie	u of Form CMS-	2552-10
ALLOCATION OF GENERAL SERVICE COSTS 1	TO HHA COST CEN	ITERS	Provider CC	CN: 15-0086 15-7055	Peri od: From 01/01/2020 To 10/31/2020	3/31/2021 12:	pared:
					Home Health	PPS	
Cost Center Description	Subtotal	Allocated HHA	Total HHA		Agency I		
		A&G (see Part II)	Costs				
	26.00	27.00	28.00				
 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) (2) 21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 1, rounded to 6 decimal places. 	442, 576 556, 667 258, 389 27, 950 5, 490 0 33, 530 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	279, 320 129, 652 14, 025 2, 755 0 16, 824 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	835, 987 388, 041 41, 975 8, 245 0 50, 354 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				$\begin{array}{c} 1.00\\ 2.00\\ 3.00\\ 4.00\\ 5.00\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 12.00\\ 13.00\\ 14.00\\ 15.00\\ 14.00\\ 15.00\\ 16.00\\ 17.00\\ 18.00\\ 19.00\\ 19.50\\ 20.00\\ 21.00\\ \end{array}$

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

Health Financial Systems		DEARBORN COUN				u of Form CMS-2	
ALLOCATION OF GENERAL SERVICE COSTS T BASIS	O HHA COST CEN	TERS STATISTIC	CAL Provider C HHA CCN:		Period: From 01/01/2020 To 10/31/2020		pared:
					Home Health Agency I	PPS	<u>o i pii </u>
	CAPI TAL REL	ATED COSTS			Agency I		
Cost Center Description	NEW BLDG & FI XT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNI CATI O S (PHONES)	N DATA PROCESSI NG (DP EQUI PMENT)	PURCHASI NG RECEI VI NG AND STORES (SUPPLY EXPENSE)	
	1.00	2.00	4.00	5. 01	5.02	5.03	
 Administrative and General O Skilled Nursing Care O Physical Therapy O Occupational Therapy O Speech Pathology O Medical Social Services O Home Health Aide O Drugs O DRE O Respiratory Therapy O Respiratory Therapy O Clinic O Day Care Program O Home Mealth Promotion Activities O DAY Care Program O Home Delivered Meals Program O All Others (specify) 	1,485 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 485 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			6 41 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 19.00
19.50 Tel emedi ci ne	0	0	0		0 0	0	19. 50
20.00 Total (sum of lines 1-19) 21.00 Total cost to be allocated	1, 485 15, 085	1, 485 6, 129			6 41 5 130, 094	16, 509 611	
22.00 Unit cost multiplier	10. 158249	4. 127273					22.00
Cost Center Description	ADMI TTI NG (ADMI SSI ONS)	COUNTS RECEI VABLE (ADJUSTED CHARGES)	Reconciliatio n	OTHER ADMI NI STRATI E AND GENERA (ACCUM. COST)	L (SQUARE FEET)	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)	
1.00 Administrative and Conoral	5.04	5.05	5A. 06	5.06	7.00	8.00	1 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 Unit cost multiplier 		927, 357 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		512, 70 237, 98 25, 74 5, 05 30, 88	33 0 32 0 33 0 36 0 02 0 032 0 04 0 05 0 06 0 07 0 08 0 09 0 09 0 00 </td <td></td> <td>13.00 14.00 15.00 16.00 17.00 18.00 19.00 19.50 20.00 21.00</td>		13.00 14.00 15.00 16.00 17.00 18.00 19.00 19.50 20.00 21.00

Heal th	Financial Systems		DEARBORN COUNTY	(HOSPI TAI		Inlie	u of Form CMS-2	2552-10
ALLOCA	TION OF GENERAL SERVICE COSTS	TO HHA COST CEN			CN: 15-0086	Peri od:	Worksheet H-2	
BASI S				HHA CCN:	15-7055	From 01/01/2020 To 10/31/2020	Part II Date/Time Pre 3/31/2021 12:	pared: 34 pm
						Home Health	PPS	
	Cost Center Description	HOUSEKEEPING	DI ETARY	CAFETERIA	NURSI NG	Agency I CENTRAL	PHARMACY	
		(SQUARE		(MAN HOURS)	ADMI NI STRATI		(100%)	
		FEET)	SERVED)		N	SUPPLY		
		9.00	10.00	11.00	(GROSS HOURS 13.00	(100%) 14.00	15.00	
1.00	Administrative and General	9.00	0	0		0 0	15.00	1.00
2.00	Skilled Nursing Care	0	Ő	0		0 0	0	
3.00	Physical Therapy	0	О	0		0 0	0	
4.00	Occupational Therapy	0	0	0		0 0	0	
5.00	Speech Pathology	0	0	0		0 0	0	
6.00 7.00	Medical Social Services Home Health Aide	0	0	0		0 0	0	6.00 7.00
8.00	Supplies (see instructions)	0	0	0		0 0	0	
9.00	Drugs	0	О	0		0 0	0	9.00
10.00	DME	0	0	0		0 0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0		0 0	0	11.00
12.00 13.00	Respiratory Therapy Private Duty Nursing	0	0	0		0 0	0	12.00 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	
17.00	Home Delivered Meals Program	0	0	0		0 0	0	
18.00 19.00	Homemaker Service All Others (specify)	0	0	0		0 0	0	18.00 19.00
19.50	Tel emedi ci ne	0	0	0		0 0	0	
20.00	Total (sum of lines 1-19)	1, 485	ō	0		0 0	0	20.00
21.00	Total cost to be allocated	10, 474	О	0		0 0	0	21.00
22.00	Unit cost multiplier	7. 053199	0. 000000	0.00000	0.0000	0. 000000	0. 000000	22.00
	Cost Center Description	MEDI CAL RECORDS &	SOCI AL SERVI CE	PHARMACY RESI DENCY				
		LI BRARY	(TI ME	(ASSI GNED				
		(ADJUSTED	SPENT)	TIME)				
		CHARGES)	17.00		-			
1.00	Administrative and General	16.00 927,357	17.00	23.00				1.00
2.00	Skilled Nursing Care	^{727, 337}	0	0	1			2.00
3.00	Physical Therapy	0	0	0				3.00
4.00	Occupational Therapy	0	0	0				4.00
5.00	Speech Pathology	0	0	0				5.00
6.00 7.00	Medical Social Services Home Health Aide	0	0	0				6.00 7.00
8.00	Supplies (see instructions)	0	o	0				8.00
9.00	Drugs	0	О	0				9.00
10.00	DME	0	0	0				10.00
	Home Dialysis Aide Services	0	0	0 0				11.00 12.00
12.00 13.00	Respiratory Therapy Private Duty Nursing	0	0	0				12.00
14.00	Clinic	0	Ő	0				14.00
15.00	Health Promotion Activities	0	О	0				15.00
16.00	Day Care Program	0	0	0				16.00
17.00 18.00	Home Delivered Meals Program Homemaker Service	0	0	0	1			17.00 18.00
18.00	All Others (specify)	0	0	0				18.00 19.00
19.50	Tel emedi ci ne	0	ő	0				19.50
20.00	Total (sum of lines 1-19)	927, 357	3	0				20.00
21.00	Total cost to be allocated	6, 052	314	0				21.00
22.00	Unit cost multiplier	0. 006526	104. 666667	0.00000	1		I	22.00

Heal th	Financial Systems		DEARBORN COUN	ITY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	IONMENT OF PATIENT SERVICE COST	ſS			CN: 15-0086	Period:	Worksheet H-3	
				HHA CCN:	15-7055	From 01/01/2020 To 10/31/2020		pared: 34 pm
				Title	e XVIII	Home Health	PPS	
	Cost Center Description	From, Wkst.	Facility	Shared	Total HHA	Agency I Total Visits	Average Cost	
		H-2, Part I,	Costs (from	Ancillary	Costs (cols.		Per Visit	
		col. 28, line	Wkst. H-2,	Costs (from	1 + 2)		(col. 3 ÷	
			Part I)	Part II)			col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER COST LIMITATION	OF AGGREGATE	PRUGRAM CUST,	AGGREGATE OF T	HE PROGRAM LI	MITATION COST, C	JR BENEFICIARY	
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00			835, 98		355.59	
2.00	Physical Therapy	3.00		0			204.02	
3.00	Occupational Therapy	4.00			,			
4.00 5.00	Speech Pathology Medical Social Services	5.00 6.00			8, 24	5 46 0 0		
5.00 6.00	Home Heal th Ai de	7.00			50, 35			
7.00	Total (sum of lines 1-6)	7.00	1, 324, 602	0				7.00
7.00			1, 524, 002	-	Program Visit			7.00
					Pa	nrt B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject	Subject to		
					to	Deducti bl es		
					Deducti bl es			
			1.00	0.00	Coinsurance		5.00	
	Limitation Cost Computation	0	1.00	2.00	3.00	4.00	5.00	
8.00	Skilled Nursing Care		17140	0	1, 17	6		8.00
8.01	Skilled Nursing Care		99915	0				8.01
9.00	Physical Therapy		17140	0				9.00
9.01	Physical Therapy		99915	0				9.01
10.00	Occupational Therapy		17140	0	18	3		10.00
10.01	Occupational Therapy		99915	0) 3	0		10.01
11.00	Speech Pathology		17140	0) 1	6		11.00
11.01	Speech Pathology		99915	0		0		11.01
12.00	Medical Social Services		17140	0		0		12.00
12.01	Medical Social Services		99915	0		0		12.01
13.00	Home Health Aide		17140	0				13.00
13.01	Home Health Aide		99915	0		3		13.01
14.00	Total (sum of lines 8-13)	From Wkst.	Facility	0 Shared	1.5		Datio (apl 2	14.00
	Cost Center Description	H-2 Part I,	Facility Costs (from	Ancillary	Total HHA Costs (cols.		Ratio (col. 3 ÷ col. 4)	
		col. 28, line		Costs (from	1 + 2	Records)	÷ COI. 4)	
			Part I)	Part II)	1 + 2)	Kecor us)		
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Comput							
	Cost of Medical Supplies	8.00				0 14, 400		
16.00	Cost of Drugs	9.00				0 0	0. 000000	16.00
			Program Visits		Cost of			
			D		Servi ces	D. I. D.		
	Cast Castas Description	Davet A		t B Subject to	Doub A	Part B	Subject to	
	Cost Center Description	Part A	Not Subject to	Deductibles &	Part A	Not Subject to	Deductibles &	
			Deductibles &	Coi nsurance		Deductibles &	Coi nsurance	
			Coi nsurance	corrisor ance		Coi nsurance	cor nour ance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	1, 376			0 489, 292		1.00
2.00	Physical Therapy					0 191, 983		2.00
3.00	Occupational Therapy	0				0 20, 840		3.00
4.00	Speech Pathology	0				0 2,868		4.00
5.00	Medical Social Services	0				0 0		5.00
6.00	Home Health Aide	0				0 46, 340		6.00
7.00	Total (sum of lines 1-6)	0	2, 673			0 751, 323		7.00

	ONMENT OF PATIENT SERVICE COS	rs		Provider CO	CN: 15-0086	Period:	Worksheet H-3	
				HHA CCN:	15-7055	From 01/01/2020 To 10/31/2020		parec
				Title	XVIII	Home Health	PPS	<u>04 pi</u>
	Cost Center Description					Agency I		
	Limitation Cost Computation	6.00	7.00	8.00	9.00	10.00	11.00	
00 01 00 01 0.00 0.01 1.00 1.01 2.00 2.01	Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Medical Social Services Medical Social Services Home Health Aide							8. 9. 9. 10. 10. 11. 11. 12. 12. 13.
	Home Health Aide							13. (
4.00	Total (sum of lines 8-13)							14.(
		Prog	ram Covered Cha	rges	Cost of Services			
			Par	t B		Part B		
	Cost Center Description	Part A	Not Subject	Subject to	Part A	Not Subject	Subject to	
			to	Deductibles &		to	Deductibles &	
			Deductibles &	Coi nsurance		Deductibles & Coinsurance	Coi nsurance	
		6.00	Coi nsurance 7.00	8.00	9.00	10. 00	11.00	
	Supplies and Drugs Cost Comput		7.00	0.00	7.00	10.00	11.00	
	Cost of Medical Supplies	0	14, 400	0		0 0	0	15.
6.00	Cost of Drugs		0	0		0	0	16.
	Cost Center Description	Total Program Cost (sum of cols. 9-10) 12.00						-
	PART I – COMPUTATION OF LESSER COST LIMITATION	OF AGGREGATE	PROGRAM COST, A	AGGREGATE OF TH	IE PROGRAM L	MITATION COST, O	R BENEFICIARY	
	Cost Per Visit Computation							
. 00	Skilled Nursing Care	489, 292						1.
. 00 . 00	Physical Therapy	191, 983						2.
. 00 . 00 . 00	Physical Therapy Occupational Therapy	191, 983 20, 840						2. 3.
. 00 . 00 . 00 . 00	Physical Therapy	191, 983						2.
. 00 . 00 . 00 . 00 . 00	Physical Therapy Occupational Therapy Speech Pathology	191, 983 20, 840 2, 868						2. 3. 4.
. 00 . 00 . 00 . 00 . 00 . 00	Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	191, 983 20, 840 2, 868 0						2. 3. 4. 5.
. 00 . 00 . 00 . 00 . 00 . 00	Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	191, 983 20, 840 2, 868 0 46, 340 751, 323						2. 3. 4. 5. 6.
. 00 . 00 . 00 . 00 . 00 . 00 . 00	Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description	191, 983 20, 840 2, 868 0 46, 340						2. 3. 4. 5. 6.
. 00 . 00 . 00 . 00 . 00 . 00 . 00	Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation	191, 983 20, 840 2, 868 0 46, 340 751, 323						2. 3. 4. 5. 6. 7.
00 00 00 00 00 00 00 00 00	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	191, 983 20, 840 2, 868 0 46, 340 751, 323						2. 3. 4. 5. 6. 7. 8.
00 00 00 00 00 00 00 00 00 00 00	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 Skilled Nursing Care	191, 983 20, 840 2, 868 0 46, 340 751, 323						2. 3. 4. 5. 6. 7. 8. 8.
00 00 00 00 00 00 00 00 00 00 01 00	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 Skilled Nursing Care Physical Therapy	191, 983 20, 840 2, 868 0 46, 340 751, 323						2. 3. 4. 5. 6. 7. 8. 8. 8. 9.
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	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 Skilled Nursing Care Physical Therapy Physical Therapy	191, 983 20, 840 2, 868 0 46, 340 751, 323						2. 3. 4. 5. 6. 7. 8. 8. 9. 9.
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	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 Skilled Nursing Care Physical Therapy	191, 983 20, 840 2, 868 0 46, 340 751, 323						2. 3. 4. 5. 6. 7. 8. 8. 8. 9. 9. 10.
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 01 . 00 . 01 0. 00 0. 01	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 Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy	191, 983 20, 840 2, 868 0 46, 340 751, 323						2. 3. 4. 5. 6. 7. 8. 8. 9. 9. 10. 10.
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	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 Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy	191, 983 20, 840 2, 868 0 46, 340 751, 323						2. 3. 4. 5. 6. 7. 7. 8. 8. 9. 9. 10. 10. 11.
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	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 Physical Therapy Occupational Therapy Speech Pathology	191, 983 20, 840 2, 868 0 46, 340 751, 323						2. 3. 4. 5. 6.
. 00 . 01 . 00 . 01 . 00 . 01	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 Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology	191, 983 20, 840 2, 868 0 46, 340 751, 323						2. 3. 4. 5. 6. 7. 7. 8. 8. 8. 9. 9. 10. 10. 11. 11. 12. 12. 12.
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00 . 01 . 00 . 01 0. 00 0. 01 1. 00 1. 01 2. 00 2. 01 3. 00	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 Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Medical Social Services Medical Social Services Home Health Aide	191, 983 20, 840 2, 868 0 46, 340 751, 323						2. 3. 4. 5. 6. 7. 7. 8. 8. 8. 9. 9. 10. 10. 11. 11. 11. 12. 12. 13.
. 00 . 01 . 00 . 01 . 00 . 01 0. 00 . 01 1. 00 1. 01 2. 00 3. 0	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 Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Medical Social Services Medical Social Services	191, 983 20, 840 2, 868 0 46, 340 751, 323						2. 3. 4. 5. 6. 7. 7. 8. 8. 8. 9. 9. 10. 10. 11. 11. 12. 12. 12.

Health Financial Systems		DEARBORN COUN	ITY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF PATIENT SERVICE COS	TS		Provider C	CN: 15-0086	Peri od:	Worksheet H-3	
			HHA CCN:	15-7055	From 01/01/2020 To 10/31/2020		pared:
			Title	e XVIII	Home Health	PPS	<u>34 pili</u>
			_		Agency I		
Cost Center Description	From Wkst. C,	Cost to	Total HHA	HHA Shared	Transfer to		
	Part I, col.	Charge Ratio	Charge (from	Ancillary	Part I as		
	9, line		provi der	Costs (col.	1 Indicated		
			records)	x col. 2)			
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COS	T OF HHA SERVI	CES FURNI SHED E	BY SHARED HOSP	ITAL DEPARTME	ENTS		
1.00 Physical Therapy	66.00	0. 668339	0		0 col. 2, line 2	. 00	1.00
2.00 Occupational Therapy	67.00	0. 385351	0		0 col. 2, line 3	. 00	2.00
3.00 Speech Pathology	68.00	0. 584700	0		0 col. 2, line 4	. 00	3.00
4.00 Cost of Medical Supplies	71.00	0. 512591	0		0 col. 2, line 1	5.00	4.00
5.00 Cost of Drugs	73.00	0. 476941	0)	0 col. 2, line 1	6.00	5.00

	Financial Systems DEARBORN COUNTY		N 45 000/		eu of Form CMS-2	
CALCUL	ATION OF HHA REIMBURSEMENT SETTLEMENT	Provider CO	CN: 15-0086	Period: From 01/01/2020	Worksheet H-4	
		HHA CCN:	15-7055	To 10/31/2020		
		Title	XVIII	Home Health	PPS	<u>o i piii</u>
				Agency I		
			Dort A		t B	
			Part A	Not Subject to	Subject to Deductibles &	
				Deductibles &		
				Coi nsurance		
			1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUST	IOMARY CHARGE	<u>-S</u>			-
. 00	Reasonable Cost of Part A & Part B Services Reasonable cost of services (see instructions)			0 0	0	1.0
. 00	Total charges			0 0		2.0
	Customary Charges					
. 00	Amount actually collected from patients liable for payment for	or services		0 0	0	3. C
	on a charge basis (from your records)					
1.00	Amount that would have been realized from patients liable for for services on a charge basis had such payment been made in	r payment		0 0	0	4.0
	with 42 CFR §413.13(b)	accor dance				
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)		0. 0000	0. 000000	0. 000000	5.0
. 00	Total customary charges (see instructions)			0 0	0	6.0
. 00	Excess of total customary charges over total reasonable cost	(complete		0 0	0	7.0
00	only if line 6 exceeds line 1)	nlv if line		0 0	0	8.0
. 00	Excess of reasonable cost over customary charges (complete or 1 exceeds line 6)	niy ii iine		0 0	0	8.0
. 00	Primary payer amounts			0 0	0	9.0
				Part A	Part B	
				Servi ces	Servi ces	
				1.00	2.00	
0.00	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT Total reasonable cost (see instructions)			0	0	10.0
	Total PPS Reimbursement - Full Episodes without Outliers			0		
2.00	Total PPS Reimbursement - Full Episodes with Outliers			0		
	Total PPS Reimbursement - LUPA Episodes			0		
4.00	Total PPS Reimbursement - PEP Episodes	_		0		
5.00 6.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes	S		0		15. 16.
	Total Other Payments			0	0	17.
8.00	DME Payments			0	0	18.
9.00	Oxygen Payments			0	0	19.
	Prosthetic and Orthotic Payments			0	-	20.
1.00	Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21)	surance)			0	21.0
	Excess reasonable cost (from line 8)			0		22.
	Subtotal (line 22 minus line 23)			0	°,	
5.00	Coinsurance billed to program patients (from your records)				0	25.
6.00	Net cost (line 24 minus line 25)			0	525, 490	26.
	Reimbursable bad debts (from your records)					27.0
	Reimbursable bad debts for dual eligible beneficiaries (see i)		505 400	28.0
9.00	Total costs - current cost reporting period (line 26 plus lin	ne 27)		0		
0.00 0.50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction	ns)		0		30. 30.
0.99	Demonstration payment adjustment amount before sequestration			0		30.
	Subtotal (see instructions)			0		
1.00	Sequestration adjustment (see instructions)			0		
1.01				0		31.
1. 01 1. 02	Demonstration payment adjustment amount after sequestration					1 22 1
1.01 1.02 2.00	Interim payments (see instructions)			0		
3.00	Interim payments (see instructions) Tentative settlement (for contractor use only)	and 33)		0	0	33.
1. 01 1. 02 2. 00	Interim payments (see instructions)	,	S Pub. 15-2		0	32. 33. 34. 35.

	SIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED	Provider C	CN: 15-0086		eriod:	Worksheet H-5	
PRO	DGRAM BENEFI CI ARI ES	HHA CCN:	15-7055	Fi Ti	rom 01/01/2020 p 10/31/2020	Date/Time Prep 3/31/2021 12:3	
					Home Health	PPS	<u>34 p</u>
		I npati en	it Part A		Agency I Par	t B	
	-	mm/dd/yyyy	Amount		mm/dd/yyyy	Amount	
00	Tatal interim normante paid te provider	1.00	2.00	0	3.00	4.00	1
00 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		520, 630 0	1. 2.
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)						3
	Program to Provider		1	0			~
)1)2)3				0 0 0		0 0 0	3 3 3
)4)5				0		0	3 3
	Provider to Program						
0				0		0	3
51 52				0		0	3
53				0		0	3
54				0		0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0		0	3
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		520, 630	4
0	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after		1				5
0	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						0
1	Program to Provider		1	0		0	5
)1)2				0		0	5
3				0		0	5
	Provider to Program						
50 51				0		0	5
2				0		0	5
9	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0		0	5
0	Determined net settlement amount (balance due) based on the cost report. (1)						6
01	SETTLEMENT TO PROVIDER			0		0	6
)2	SETTLEMENT TO PROGRAM			0		0	6
00	Total Medicare program liability (see instructions)		I	0	Contractor	520,630 NPR Date	7
					Number	(Mo/Day/Yr)	
		(<u>с</u>		1.00	2.00	

ANALYS	SIS OF HOSPITAL-BASED HOSPICE COSTS		Provider CC Hospice CC	1	Period: From 01/01/2020 To 10/31/2020 Hospice I	Worksheet O Date/Time Pre 3/31/2021 12:	
		SALARI ES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSI FI - CATI ONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		0		0 0	0	
2.00	CAP REL COSTS-MVBLE EQUIP*		0	(0 0	0	2.00
3.00 4.00	EMPLOYEE BENEFITS DEPARTMENT* ADMINISTRATIVE & GENERAL*	8, 543	0 731	9, 274	4 -1,574	0 7, 700	3.00
+. 00 5. 00	PLANT OPERATION & MAINTENANCE*	0, 543	0	7,27	-1, 374	0,700	5.00
5.00	LAUNDRY & LINEN SERVICE*	0	0	(0	
7.00	HOUSEKEEPI NG*	0	0	(0 0	0	7.00
3.00	DI ETARY*	0	0	(0 0	0	•
9.00	NURSING ADMINISTRATION*	0	0	(o c	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	(0 0	0	10.00
11.00	MEDI CAL RECORDS*	1, 361	0	1, 36	1 0	1, 361	11.00
12.00	STAFF TRANSPORTATI ON*	0	0	(0 0	0	
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	(0 0	0	
14.00	PHARMACY*	0	0	(0 0	0	
15.00	PHYSI CLAN ADMI NI STRATI VE SERVI CES*	0	500	500		500	
16.00 17.00	OTHER GENERAL SERVICE* PATIENT/RESIDENTIAL CARE SERVICES	0	35, 297	35, 29	/ 0	35, 297	16.00
17.00	DIRECT PATIENT CARE SERVICE COST CENTERS						1 17.00
25.00	INPATIENT CARE-CONTRACTED**		0	(0 0	0	25.00
26.00	PHYSI CI AN SERVI CES**	0	0		0	0	
27.00	NURSE PRACTI TI ONER**	0	0	(0 0	0	
28.00	REGI STERED NURSE**	2, 906	0	2,900	6 0	2, 906	28.00
29.00	LPN/LVN**	0	0	(o c	0	29.00
30.00	PHYSI CAL THERAPY**	0	0	(0 0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	(0 0	0	
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0		0 0	0	
33.00	MEDICAL SOCIAL SERVICES**	0	0		0 0	0	
34.00	SPIRITUAL COUNSELING**	89	0	89		89	•
35.00 36.00	DI ETARY COUNSELI NG** COUNSELI NG - OTHER**	0	0			0	
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	118	0	118	-	118	
38.00	DURABLE MEDICAL EQUI PMENT/OXYGEN**	0	0			0	
39.00	PATIENT TRANSPORTATION**	0	0	(0	
40.00	I MAGI NG SERVI CES**	0	0	(0 0	0	
41.00	LABS & DI AGNOSTI CS**	0	0	(o o	0	41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE**	0	1, 574	1, 574	4 0	1, 574	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	
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	(0 0	0	
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	(0 0	0	46.00
60 00	NONREI MBURSABLE COST CENTERS BEREAVEMENT PROGRAM *	0	0		lo lo	0	60.00
60.00		0	0			0	
51.00 52.00		0	0			0	
	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	(0	
54.00	PALLIATIVE CARE PROGRAM*	0	0	(0	
	OTHER PHYSICIAN SERVICES*	0	0	(o o	0	1
66.00	RESI DENTI AL CARE*	0	0	(o c	0	66.00
57.00	ADVERTI SI NG*	0	0	(o c	0	67.00
58.00		0	0	(o o	0	
59.00		0	0	(0 0	0	
	NURSING FACILITY ROOM & BOARD*	0	0		0 0	0	
	OTHER NONREI MBURSABLE (SPECI FY)*	0	280	280		280	
100 00) TOTAL	13, 017	38, 382	51, 399	9 -1, 574	49, 825	1100.00

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ENERAL SERVICE COST CENTERS AP REL COSTS-BLDG & FIXT* AP REL COSTS-MVBLE EQUIP* MPLOYEE BENEFITS DEPARTMENT* DMINISTRATIVE & GENERAL*	ADJUSTMENTS 6.00	Hospi ce CCN: TOTAL (col . 5 <u>± col . 6)</u> 7.00	15-1531	From 01/01/2020 To 10/31/2020 Hospi ce I	Date/Time Pr 3/31/2021 12	epare 1:34 p
AP REL COSTS-BLDG & FIXT* AP REL COSTS-MVBLE EQUIP* MPLOYEE BENEFITS DEPARTMENT*	6.00	TOTAL (col. 5 ± col. 6)	13-1331		3/31/2021 12	<u>2:34 r</u>
AP REL COSTS-BLDG & FIXT* AP REL COSTS-MVBLE EQUIP* MPLOYEE BENEFITS DEPARTMENT*	6.00	± col. 6)		Hospi ce I		_
AP REL COSTS-BLDG & FIXT* AP REL COSTS-MVBLE EQUIP* MPLOYEE BENEFITS DEPARTMENT*	6.00	± col. 6)				
AP REL COSTS-BLDG & FIXT* AP REL COSTS-MVBLE EQUIP* MPLOYEE BENEFITS DEPARTMENT*	0	7.00				
AP REL COSTS-BLDG & FIXT* AP REL COSTS-MVBLE EQUIP* MPLOYEE BENEFITS DEPARTMENT*						
AP REL COSTS-MVBLE EQUIP* MPLOYEE BENEFITS DEPARTMENT*		0				1
MPLOYEE BENEFITS DEPARTMENT*		0				2
	0	o				3
	-280	7, 420				4
LANT OPERATION & MAINTENANCE*	0	0				1 5
AUNDRY & LINEN SERVICE*	0	О				1 6
OUSEKEEPI NG*	0	o				7
I ETARY*	0	0				8
URSING ADMINISTRATION*	0	0				9
OUTINE MEDICAL SUPPLIES*	0					10
	0					11
	0					12
	0					13
	0					14
						15
	0	35, 297				16
						- ''
	0	0				25
						20
	0					2
	0					28
PN/LVN**	0	0				20
HYSI CAL THERAPY**	0	0				30
CCUPATIONAL THERAPY**	0	0				3
PEECH/LANGUAGE PATHOLOGY**	0	0				32
EDICAL SOCIAL SERVICES**	0	0				33
PIRITUAL COUNSELING**	0					34
	0					35
	0					36
	0					3
	0					38
	0					39
	0					4
	0					42
	0					42
	0					4
ALLIATIVE RADIATION THERAPY**	0	o				44
ALLI ATI VE CHEMOTHERAPY**	0	o				45
THER PATIENT CARE SERVICES (SPECIFY)**	0	o				46
ONREIMBURSABLE COST CENTERS	· · ·					
EREAVEMENT PROGRAM *	0	0				60
OLUNTEER PROGRAM *	0	0				61
UNDRAI SI NG*	0	0				62
OSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0				63
	0					64
THER PHYSI CI AN SERVI CES*	0	0				65
ESI DENTI AL CARE*	0	0				66
	0	-				6
	0					68
	0					69
	0					70
	0					100
	JURSI NG ADMI NI STRATI ON* DUTI NE MEDI CAL SUPPLI ES* EDI CAL RECORDS* TAFF TRANSPORTATI ON* DUUNTEER SERVI CE COORDI NATI ON* HARMACV* HYSI CI AN ADMI NI STRATI VE SERVI CES* THER GENERAL SERVI CE COST CENTERS NECT PATI ENT CARE SERVI CE COST CENTERS NPATI ENT CARE-CONTRACTED** HYSI CI AN SERVI CES** JURSE PRACTI TI ONER** EGI STERED NURSE** PN/LVN** HYSI CAL THERAPY** CCUPATI ONAL THERAPY** PEECH/LANGUAGE PATHOLOGY** EDI CAL SOCI AL SERVI CES** PI RI TUAL COUNSELI NG** OUNSELI NG - OTHER** DUNSELI NG - OTHER** DUNSELI NG - OTHER** SSPI CE AI DE & HOMEMAKER SERVI CES** JURABLE MEDI CAL EQUI PMENT/OXYGEN** ATI ENT TRANSPORTATI ON** MAGI NG SERVI CES** ABS & DI AGNOSTI CS** EDI CAL SUPPLI ES-NON-ROUTI NE** RUGS CHARGED TO PATI ENTS** JUPATI ENT SERVI CES** ALLI ATI VE CHEMOTHERAPY** ALLI ATI VE CAE SERVI CES (SPECI FY)** DVMET IMBURSABLE COST CENTERS EREAVEMENT PROGRAM * DUNNEL ING* DSPI CE/PALLI ATI VE MEDI CI NE FELLOWS* ALLI ATI VE CAE PROGRAM * DUNTEER PRO	JRSI NG ADMI NI STRATI ON* 0 JUTI NE MEDI CAL SUPPLI ES* 0 TAFF TRANSPORTATI ON* 0 JUTITER SERVI CE COORDI NATI ON* 0 JARMACY* 0 JARMACY* 0 JARMACY* 0 ATI ENT CARE SERVI CE COST CENTERS 0 ATI ENT/RESI DENTI AL CARE SERVI CES VPATI ENT CARE SERVI CE COST CENTERS VPATI ENT CARE SERVI CE COST CENTERS VPATI ENT CARE SERVI CE COST CENTERS 0 ISES PRACTI TI ONE** 0 ISES PRACTU CES** 0 ISES PRACTI TI ONE** 0 ISES PRACTI ONAL THERAPY** 0 IST OS CHARGED TO PATI ENTS** 0 ISES PRACTI SERVI CES** 0 ISES CHARGED TO PATI ENTS** 0 ISES PRACTI SERVI CES (SPECI FY)** 0 INTERI MURSABLE COST CENTERS EREVEMENT PROGRAM * 0 ISES ISENTI AL CARE * 0 ISES PROGRAM * 0 ISES ISENTI AL CARE * 0 ISALLI ATI VE MEDICI NE FELLOWS* 0 ISES ISENTI AL CARE * 0 ISES ISENTI AL CARE * 0 ISES ISENTI AL CARE * 0 ISES ISENTI AL CARE	JRSI NG ADMI NI STRATI ON* 0 0 DUTI NE MEDI CAL SUPPLIES* 0 0 DOLAL RECORDS* 0 1, 361 TAFF TRANSPORTATI ON* 0 0 DOLUNTEER SERVI CE COORDI NATI ON* 0 0 ARMACY* 0 0 THER GENERAL SERVI CE* 0 0 ATH ENT CARE -CONTRACTED** 0 0 HYSI CI AN SERVI CE* 0 0 ATH ENT CARE-CONTRACTED** 0 0 HYSI CI AN SERVI CE** 0 0 RECT PATIENT CARE-CONTRACTED** 0 0 HYSI CI AN SERVI CES** 0 0 URSE PRACTI TI ONER** 0 0 INSE ING CARE -CONTRACTED** 0 0 HYSI CAL THERAPY** 0 0 CUPATI ONAL THERAPY** 0 0 CUPATI ONAL THERAPY** 0 0 CUPATIONAL THERAPY** 0 0 DINSELI NG * 0 89 I ETARY COUNSELI NG** 0 0 UNSEL NG * 0 0 OUNSELING * <td< td=""><td>JRSI NG ADMI NI STRATI ON* 0 DUTI NE MEDI CAL SUPPLI ES* 0 DUTI NE MEDI CAL SUPPLI ES* 0 DUTI TERN SPORTATI ON* 0 TAFF TRANSPORTATI ON* 0 JUNTEER SERVI CE COORDINATI ON* 0 JUNTEER SERVI CE COORDINATI ON* 0 JUNTEER SERVI CE* 0 YSI CI AN ADMI NI STRATI VE SERVI CES* 0 THE GENERAL SERVI CE* 0 VPATI ENT CARE SERVI CE COST CENTERS 0 VPATI ENT CARE SERVI CE COST CENTERS 0 VPATI ENT CARE SERVI CE COST CENTERS 0 VPATI ENT CARE SERVI CES** 0 VPATI ENT CARE SERVI CES** 0 VPAT IN SERVI CES** 0 VPAT IN MALT MERAPY** 0 CCUPATI ONAL THERAPY** 0 CCUPATI ONAL THERAPY** 0 CUPATI ONAL THERAPY** 0 DUNSELING - OTHER** 0 ONSPI CE AID E & HOMEMAKER SERVI CES** 0 ONSPI CE AID E & HOMEMAKER SERVI CES** 0 ONSPI CE AID E & HOMEMAKER SERVI CES** 0 ONSPI CE AID E & HOMEMAKER SERVI CES** 0 ONSELING - OTHER**</td><td>URSING ADMINISTRATION* 0 0 UDITINE MEDICAL SUPPLIES* 0 0 EDICAL RECORDS* 0 1,361 TAFF TRANSPORTATION* 0 0 JUNTEER SERVICE COORDINATION* 0 0 JUNTEER SERVICE COORDINATION* 0 0 JUNTEER SERVICE COORDINATION* 0 0 JARMACY* 0 0 THER GENERAL SERVICE* 0 0 INTENT/RESIDENTIAL CARE SERVICES* 0 0 INTERT PATIENT CARE SERVICE COST CENTERS 0 0 VARIENT CARE SERVICES* 0 0 VARIES PRACTITIONE** 0 0 VARIES PRACTITION** 0 0 VARIES PRACTICE S** 0 0 VARIES PRACTITION*** 0 0 <td< td=""><td>JRSI NG ADMI NI STRATI ON* 0 0 DI CLA. SUPPLIES* 0 0 DI CLA. RECORDS* 1,361 TAFF TANSPORTATI ON* 0 0 DUINTER SERVICE COORDINATI ON* 0 0 DUINTERS SERVICE COORDINATI ON* 0 0 TAFF TANSPORTATI ON* 0 0 HARMACY* 0 0 TAFE STATION* 0 0 TAFE STATION* 0 0 RECT PATIENT CARE SERVICE COST CENTERS 0 0 PATIENT CARE-CONTRACTED** 0 0 RES PRACTI TORE** 0 0 RES PRACTI TORE*** 0 0 VALVE** 0 0 VALVE</td></td<></td></td<>	JRSI NG ADMI NI STRATI ON* 0 DUTI NE MEDI CAL SUPPLI ES* 0 DUTI NE MEDI CAL SUPPLI ES* 0 DUTI TERN SPORTATI ON* 0 TAFF TRANSPORTATI ON* 0 JUNTEER SERVI CE COORDINATI ON* 0 JUNTEER SERVI CE COORDINATI ON* 0 JUNTEER SERVI CE* 0 YSI CI AN ADMI NI STRATI VE SERVI CES* 0 THE GENERAL SERVI CE* 0 VPATI ENT CARE SERVI CE COST CENTERS 0 VPATI ENT CARE SERVI CE COST CENTERS 0 VPATI ENT CARE SERVI CE COST CENTERS 0 VPATI ENT CARE SERVI CES** 0 VPATI ENT CARE SERVI CES** 0 VPAT IN SERVI CES** 0 VPAT IN MALT MERAPY** 0 CCUPATI ONAL THERAPY** 0 CCUPATI ONAL THERAPY** 0 CUPATI ONAL THERAPY** 0 DUNSELING - OTHER** 0 ONSPI CE AID E & HOMEMAKER SERVI CES** 0 ONSPI CE AID E & HOMEMAKER SERVI CES** 0 ONSPI CE AID E & HOMEMAKER SERVI CES** 0 ONSPI CE AID E & HOMEMAKER SERVI CES** 0 ONSELING - OTHER**	URSING ADMINISTRATION* 0 0 UDITINE MEDICAL SUPPLIES* 0 0 EDICAL RECORDS* 0 1,361 TAFF TRANSPORTATION* 0 0 JUNTEER SERVICE COORDINATION* 0 0 JUNTEER SERVICE COORDINATION* 0 0 JUNTEER SERVICE COORDINATION* 0 0 JARMACY* 0 0 THER GENERAL SERVICE* 0 0 INTENT/RESIDENTIAL CARE SERVICES* 0 0 INTERT PATIENT CARE SERVICE COST CENTERS 0 0 VARIENT CARE SERVICES* 0 0 VARIES PRACTITIONE** 0 0 VARIES PRACTITION** 0 0 VARIES PRACTICE S** 0 0 VARIES PRACTITION*** 0 0 <td< td=""><td>JRSI NG ADMI NI STRATI ON* 0 0 DI CLA. SUPPLIES* 0 0 DI CLA. RECORDS* 1,361 TAFF TANSPORTATI ON* 0 0 DUINTER SERVICE COORDINATI ON* 0 0 DUINTERS SERVICE COORDINATI ON* 0 0 TAFF TANSPORTATI ON* 0 0 HARMACY* 0 0 TAFE STATION* 0 0 TAFE STATION* 0 0 RECT PATIENT CARE SERVICE COST CENTERS 0 0 PATIENT CARE-CONTRACTED** 0 0 RES PRACTI TORE** 0 0 RES PRACTI TORE*** 0 0 VALVE** 0 0 VALVE</td></td<>	JRSI NG ADMI NI STRATI ON* 0 0 DI CLA. SUPPLIES* 0 0 DI CLA. RECORDS* 1,361 TAFF TANSPORTATI ON* 0 0 DUINTER SERVICE COORDINATI ON* 0 0 DUINTERS SERVICE COORDINATI ON* 0 0 TAFF TANSPORTATI ON* 0 0 HARMACY* 0 0 TAFE STATION* 0 0 TAFE STATION* 0 0 RECT PATIENT CARE SERVICE COST CENTERS 0 0 PATIENT CARE-CONTRACTED** 0 0 RES PRACTI TORE** 0 0 RES PRACTI TORE*** 0 0 VALVE** 0 0 VALVE

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

Heal th Financial		DEARBORN COUNT				u of Form CMS-2	2552-10
	TAL-BASED HOSPICE COSTS FOR HOS	SPICE ROUTINE HOME	Provider C	CN: 15-0086	Peri od:	Worksheet 0-2	
CARE			Hospi ce. CC	N: 15-1531	From 01/01/2020 To 10/31/2020		nared
			nospi ce oo	10 1001	10 10/01/2020	3/31/2021 12:	
					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL	RECLASSI FI -	SUBTOTAL	
				(col. 1 +	CATIONS		
				col. 2)			
		1.00	2.00	3.00	4.00	5.00	
	IENT CARE SERVICE COST CENTERS			1			
	CARE-CONTRACTED						25.00
26.00 PHYSI CI AN		0	0		0 0	0	
27.00 NURSE PRAC	TITIONER	0	0		0 0	0	27.00
28.00 REGI STERED	NURSE	2, 244	0	2, 2,	44 0	2, 244	28.00
29.00 LPN/LVN		0	0		0 0	0	29.00
30.00 PHYSICAL T	HERAPY	0	0		0 0	0	30.00
31.00 OCCUPATION	AL THERAPY	0	0		0 0	0	31.00
32.00 SPEECH/LAN	GUAGE PATHOLOGY	0	0		0 0	0	32.00
33.00 MEDICAL SO	CIAL SERVICES	0	0		0 0	0	33.00
34.00 SPI RI TUAL	COUNSELING	69	0		69 0	69	34.00
35.00 DI ETARY CO	UNSELING	0	0		0 0	0	35.00
36.00 COUNSELING	- OTHER	0	0		0 0	0	36.00
37.00 HOSPICE AI	DE & HOMEMAKER SERVICES	91	0		91 0	91	37.00
	DI CAL EQUI PMENT/OXYGEN	0	0		0 0	0	
	ANSPORTATION	0	0		0 0	0	39.00
40 00 I MAGING SE			0		0 0	0	

38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATI ENT TRANSPORTATI ON	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	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	1, 344	1, 344	0	1, 344	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 *	2, 404	1, 344	3, 748	0	3, 748	100.00
* Trans	fer the amount in column 7 to Wkst. 0-5, col	umn 1, line 51.					

		ADJUSTMENTS	TOTAL (col. 5	
		(00	± col. 6)	
	DUDENT DATIENT ANDE OFDULAE ADAT AFNTEDO	6.00	7.00	
	DI RECT PATI ENT CARE SERVI CE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED	_		25.00
26.00	PHYSI CI AN SERVI CES	0	0	26.00
27.00	NURSE PRACTI TI ONER	0	0	27.00
28.00	REGI STERED NURSE	0	2, 244	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	0	33.00
34.00	SPI RI TUAL COUNSELI NG	0	69	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	91	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	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	1, 344	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	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
	TOTAL *	0	3, 748	100.00
* Tran	sfer the amount in column 7 to Wkst. 0-5, col	umn 1. line 51		L

Health Financial Systems	DEARBORN COUNT				u of Form CMS-2	2552-10
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPI	CE GENERAL	Provider CC	N: 15-0086	Period:	Worksheet 0-4	
INPATIENT CARE		Hospi ce CCN	: 15-1531	From 01/01/2020 To 10/31/2020	Date/Time Pre 3/31/2021 12:	
				Hospi ce I		
	SALARI ES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSI FI - CATI ONS	SUBTOTAL	
	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 PHYSICIAN SERVICES	0	0		0 0	0	26.00
27.00 NURSE PRACTITIONER	0	0		0 0	0	27.00
28.00 REGI STERED NURSE	662	0	6	62 0	662	28.00
29.00 LPN/LVN	0	0		0 0	0	
30. 00 PHYSI CAL THERAPY	0	0		0 0	0	30.00
31.00 OCCUPATIONAL 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	20	0		20 0	20	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	27	0		27 0	27	37.00
38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		0 0	0	38.00
39.00 PATIENT 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 & DI AGNOSTI CS	0	0		0 0	0	41.00
42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE	0	230	2	30 0	230	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 *	709	230	9	39 0	939	100.00

 44.00
 PALLIATIVE RADIATION THERAPY
 0

 45.00
 PALLIATIVE CHEMOTHERAPY
 0

 46.00
 OTHER PATIENT CARE SERVICES (SPECIFY)
 0

 100.00
 TOTAL *
 709

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

		ADJUSTMENTS	TOTAL (col. 5	
		6.00	<u>± col. 6)</u> 7.00	
DL	RECT PATIENT CARE SERVICE COST CENTERS	0.00		
25.00 IN	NPATIENT CARE-CONTRACTED	0	0	25.00
26.00 PH	HYSI CI AN SERVI CES	0	0	26.00
27.00 NU	JRSE PRACTI TI ONER	0	0	27.00
28.00 RE	EGI STERED NURSE	0	662	28.00
29.00 LP	PN/LVN	0	0	29.00
30.00 PH	HYSI CAL THERAPY	0	0	30.00
31.00 00	CCUPATIONAL THERAPY	0	0	31.00
32.00 SP	PEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00 ME	EDI CAL SOCI AL SERVI CES	0	0	33.00
34.00 SP	PERETUAL COUNSELENG	0	20	34.00
	ETARY COUNSELING	0	0	35.00
	DUNSELING - OTHER	0	0	36.00
	OSPICE AIDE & HOMEMAKER SERVICES	0	27	37.00
	JRABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
	ATI ENT TRANSPORTATI ON	0	0	39.00
	MAGI NG SERVI CES	0	0	40.00
	ABS & DIAGNOSTICS	0	0	41.00
	EDI CAL SUPPLI ES-NON-ROUTI NE	0	230	42.00
	RUGS CHARGED TO PATIENTS	0	0	42.50
	JTPATI ENT SERVI CES	0	0	43.00
	ALLIATIVE RADIATION THERAPY	0	0	44.00
	ALLIATIVE CHEMOTHERAPY	0	0	45.00
	THER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00 T0	DTAL *	0	939	100.00
* Transfe	er the amount in column 7 to Wkst. 0-5, col	umn 1, line 53		

Heal th	Financial Systems DEARBORN COUNT	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST A	LLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET	Provider C		Period:	Worksheet 0-5	
EXPENS	ES FOR ALLOCATION			rom 01/01/2020		
		Hospi ce CC	N: 15-1531	To 10/31/2020		
				Hospi ce I	3/31/2021 12:	<u>34 pm</u>
	Descriptions		HOSPI CE	GENERAL	TOTAL	
	Descriptions		DI RECT	SERVI CE	EXPENSES (sum	
				EXPENSES FROM		
				WKST B PART I	2)	
				(see	2)	
				instructions)		
			1.00	2,00	3.00	
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT			3, 200	3, 200	1.00
2.00	CAP REL COSTS-MVBLE EQUIP			1, 300	1, 300	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT			3, 843	3, 843	3.00
4.00	ADMI NI STRATI VE & GENERAL		7,42	5, 366	12, 786	4.00
5.00	PLANT OPERATION & MAINTENANCE			7, 098	7, 098	5.00
6.00	LAUNDRY & LINEN SERVICE			0 0	0	6.00
7.00	HOUSEKEEPING			2, 222	2, 222	7.00
8.00	DI ETARY			0 0	0	8.00
9.00	NURSING ADMINISTRATION			0 0	0	9.00
10.00	ROUTI NE MEDI CAL SUPPLI ES			0 0	0	10.00
11.00	MEDI CAL RECORDS		1, 36	1 202	1, 563	11.00
12.00	STAFF TRANSPORTATION			D	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION			D	0	13.00
14.00	PHARMACY			0 0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES		50	C	500	15.00
16.00	OTHER GENERAL SERVICE		35, 29	7 0	35, 297	16.00
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES			9, 953	9, 953	17.00
	LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE			D	0	50.00
51.00	HOSPICE ROUTINE HOME CARE		3, 74	3	3, 748	51.00
52.00	HOSPI CE I NPATI ENT RESPI TE CARE			C	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE		93	9	939	53.00
	NONREI MBURSABLE COST CENTERS			-		
60.00	BEREAVEMENT PROGRAM			0	0	60.00
61.00	VOLUNTEER PROGRAM			D	0	61.00
62.00	FUNDRAL SI NG				0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			D	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	64.00
65.00	OTHER PHYSI CI AN SERVI CES				0	65.00
66.00	RESIDENTIAL CARE)	0	66.00
67.00	ADVERTI SI NG				0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG				0	68.00
69.00	THRIFT STORE				0	69.00
	NURSING FACILITY ROOM & BOARD				0	70.00
71.00	OTHER NONREI MBURSABLE (SPECI FY)		28		280	
99.00 100.00	NEGATI VE COST CENTER		49, 54) 5 33, 184	0 82, 729	99.00
100.00	1 IVIAL		47,04	53, 104	02,729	100.00

	Financial Systems	DEARBORN COUNT				u of Form CMS-2	
COST A	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL	SERVICE COSTS	Provider C Hospice CC		Period: From 01/01/2020 To 10/31/2020	Date/Time Pre	pared:
			-			3/31/2021 12:	34 pm
	Descriptions	TOTAL	CAP REL BLDG	CAP REL MVBL	Hospice I E EMPLOYEE	SUBTOTAL	
	Descriptions	EXPENSES	& FIX	EQUI P	BENEFITS	SUBTUTAL	
			u i i i	20011	DEPARTMENT		
		0	1.00	2.00	3.00	ЗA	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	3, 200	3, 200				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1, 300		1, 3			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	3, 843	0		0 3, 843		3.00
4.00	ADMI NI STRATI VE & GENERAL	12, 786	0		0 0	12, 786	4.00
5.00	PLANT OPERATION & MAINTENANCE	7, 098	0		0 0	7, 098	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0		0 0	0	6.00
7.00	HOUSEKEEPING	2, 222	0		0 0	2, 222	7.00
8.00	DI ETARY	0	0		0 0	0	8.00
9.00	NURSI NG ADMI NI STRATI ON	0	0		0 0	0	9.00
10.00	ROUTI NE MEDI CAL SUPPLI ES	0	0		0 0	0	10.00
11.00	MEDI CAL RECORDS	1, 563	0		0 0	1, 563	11.00
12.00	STAFF TRANSPORTATION	0	0		0 0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0		0 0	0	13.00
14.00	PHARMACY	0	0		0 0	0	14.00
15.00	PHYSI CI AN ADMI NI STRATI VE SERVI CES	500	0		0 0	500	15.00
16.00	OTHER GENERAL SERVICE	35, 297	0		0 0	35, 297	16.00
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES		0		0	9, 953	17.00
	LEVEL OF CARE			•			1
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	3, 748			2, 968	6, 716	51.00
52.00	HOSPI CE I NPATI ENT RESPI TE CARE	0	0		0 0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	939	3, 200	1, 3	00 875	6, 314	53.00
	NONREIMBURSABLE COST CENTERS						1
60.00	BEREAVEMENT PROGRAM	0	0		0 0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	1	0 0	0	61.00
62.00	FUNDRAI SI NG	0	0	1	0 0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0 0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	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	66.00
67.00	ADVERTI SI NG	0	0		0 0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0	0		0 0	0	68.00
	THRI FT STORE	0	0		0 0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0				0	70.00
	OTHER NONREIMBURSABLE (SPECIFY)	280	0		0 0	280	
	NEGATI VE COST CENTER	0	0		0 0		99.00
	TOTAL	82, 729	3, 200	1, 3	3, 843		100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL S	SERVICE COSTS	Provider C	CN: 15-0086	Period:	Worksheet 0-	
		Hospi ce CC		From 01/01/2020 To 10/31/2020	Part I	epared:
				Hospi ce I		
Descriptions	ADMI NI STRATI V E & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVIC	HOUSEKEEPING	DI ETARY	
	4.00	5.00	6.00	7.00	8.00	
GENERAL SERVICE COST CENTERS						
1.00 CAP REL COSTS-BLDG & FIXT						1.00
2.00 CAP REL COSTS-MVBLE EQUIP			1			2.00
3.00 EMPLOYEE BENEFITS DEPARTMENT						3.00
4. 00 ADMI NI STRATI VE & GENERAL	12, 786					4.00
5.00 PLANT OPERATION & MAINTENANCE	1, 298	8, 396				5.00
6.00 LAUNDRY & LINEN SERVICE	0	0		0		6.00
7. 00 HOUSEKEEPI NG	406	0		2, 628		7.00
8. 00 DI ETARY	0	0		0	(8.00
9. 00 NURSI NG ADMI NI STRATI ON	0	0		0		9.00
10.00 ROUTINE MEDICAL SUPPLIES	0	0		0		10.00
11.00 MEDICAL RECORDS	286	0		0		11.00
12.00 STAFF TRANSPORTATION	0	0		0		12.00
13.00 VOLUNTEER SERVICE COORDINATION	0	0		0		13.00
14.00 PHARMACY	0	0		0		14.00
15.00 PHYSI CLAN ADMINI STRATI VE SERVI CES	91	0		0		15.00
16.00 OTHER GENERAL SERVICE	6, 453	0		0		16.00
17.00 PATIENT/RESIDENTIAL CARE SERVICES	1, 819	0		0		17.00
LEVEL OF CARE			1			
50.00 HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00 HOSPICE ROUTINE HOME CARE	1, 228					51.00
52.00 HOSPICE INPATIENT RESPITE CARE	0	0		0 0	C	1
53.00 HOSPICE GENERAL INPATIENT CARE	1, 154	8, 396		0 2,628	C	53.00
NONREI MBURSABLE COST CENTERS			I			
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 RESIDENTIAL CARE	0	0		0 0	(66.00
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 NONREI MBURSABLE (SPECI FY)	51	0		0 0	(71.00
99.00 NEGATI VE COST CENTER	0	0		0 0	(99.00
100. 00 TOTAL	12, 786	8, 396		0 2,628	(100.00

Heal th	Financial Systems	DEARBORN COUNTY	' HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COST A	LLOCATI ON - HOSPI TAL-BASED HOSPI CE GENERAL	SERVICE COSTS	Provider CC Hospice CCN		Period: From 01/01/2020 To 10/31/2020	Worksheet 0-6 Part I Date/Time Pre 3/31/2021 12:	epared:
					Hospi ce I	3/31/2021 12.	<u>34 pili</u>
	Descriptions	NURSING ADMINISTRATIO N	ROUTI NE MEDI CAL SUPPLI ES	MEDI CAL RECORDS	STAFF TRANSPORTATIO N	VOLUNTEER SERVI CE COORDI NATI ON	
		9,00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	10100		12.00	10100	
1.00 2.00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP						1.00 2.00
3.00 4.00	EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL						3.00
5.00 6.00 7.00	PLANT OPERATION & MAINTENANCE LAUNDRY & LINEN SERVICE HOUSEKEEPING						5.00 6.00 7.00
8.00 9.00	DI ETARY NURSI NG ADMI NI STRATI ON	0					8.00 9.00
11.00	ROUTINE MEDICAL SUPPLIES MEDICAL RECORDS	0	0	1, 8	49		10.00
	STAFF TRANSPORTATION VOLUNTEER SERVICE COORDINATION	0			0	0	12.00 13.00
	PHARMACY	0			0	0	1
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
	OTHER GENERAL SERVICE	0			0	0	
	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	HOSPICE CONTINUOUS HOME CARE	0	0		0 0	0	
	HOSPICE ROUTINE HOME CARE	0	0	1, 5		0	
	HOSPICE INPATIENT RESPITE CARE HOSPICE GENERAL INPATIENT CARE	0	0	2	0 0 70 0	0	
55.00	NONREI MBURSABLE COST CENTERS	U	0	2	70 0	0	33.00
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
	FUNDRAI SI NG	0			0	0	
	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	
	PALLIATIVE CARE PROGRAM	0			0	0	
	OTHER PHYSI CI AN SERVI CES	0			0	0	
	RESI DENTI AL CARE ADVERTI SI NG	0			0	0	
	TELEHEALTH/TELEMONI TORI NG	0			0	0	
	THRIFT STORE	0			0	0	
	NURSING FACILITY ROOM & BOARD				0	0	70.00
	OTHER NONREI MBURSABLE (SPECIFY)	0			0	0	
	NEGATI VE COST CENTER	0	0		0 0	0	
100 00	TOTAL	0	0	1, 8	49 0	0	100.00

COST A	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL	SERVICE COSTS		CN: 15-0086 N: 15-1531	Period: From 01/01/2020 To 10/31/2020	Worksheet 0-6 Part I Date/Time Pre 3/31/2021 12:	pared:
					Hospi ce I		
	Descriptions	PHARMACY	PHYSI CI AN ADMI NI STRATI V E SERVI CES	OTHER GENERA SERVI CE	L PATI ENT/ RESI DENTI AL CARE SERVI CES	TOTAL	
		14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS		1				
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMI NI STRATI VE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DI ETARY						8.00
9.00	NURSI NG ADMI NI STRATI ON						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		(501				14.00
15.00	PHYSI CLAN ADMI NI STRATI VE SERVI CES		591		- 0		15.00
16.00	OTHER GENERAL SERVICE			41, 7			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				11, 772		17.00
50.00	HOSPICE CONTINUOUS HOME CARE			7	0	0	50.00
51.00	HOSPICE CONTINUOUS HOME CARE		-		0	45, 689	
52.00	HOSPICE INPATIENT RESPITE CARE					45,009	
53.00	HOSPICE GENERAL INPATIENT CARE		-		0	36, 709	•
55.00	NONREI MBURSABLE COST CENTERS			0,00	57 11, 772	30,707	33.00
60.00	BEREAVEMENT PROGRAM	(b		0	0	60.00
61.00	VOLUNTEER PROGRAM	(0	0	
62.00	FUNDRAI SI NG	(0	0	
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	(0	0	
64.00	PALLIATIVE CARE PROGRAM	(0	0	
65.00	OTHER PHYSICIAN SERVICES	(0	0	
66.00	RESI DENTI AL CARE	(0 0	0	
67.00	ADVERTI SI NG	(0	0	
68.00	TELEHEALTH/TELEMONI TORI NG	(0	0	68.00
69.00	THRI FT STORE	(b		0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD			1		0	70.00
71.00	OTHER NONREI MBURSABLE (SPECI FY)	(0 0	331	71.00
99.00	NEGATI VE COST CENTER	() c		0 0	0	99.00
100 00	TOTAL	(591	41, 7	50 11, 772	82, 729	100 00

	Financial Systems	DEARBORN COUN	TY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	LLOCATION - HOSPITAL-BASED HOSPICE GENER	RAL SERVICE COSTS	Provider CO	CN: 15-0086	Peri od:	Worksheet 0-6	
STATI S	TI CAL BASI S		Hospi ce CCI	N: 15-1531	From 01/01/2020 To 10/31/2020	Part II Date/Time Pre	pared.
			10391 00 001	. 10 1001	10 10/01/2020	3/31/2021 12:	34 pm
					Hospi ce I		
	Cost Center Descriptions	CAP REL BLDG	CAP REL MVBLE	EMPLOYEE	RECONCI LI ATI O		
		& FLX	EQUI P	BENEFITS	N	E & GENERAL	
		(SQUARE FEET)	(DOLLAR	DEPARTMENT		(ACCUMULATED	
			VALUE)	(GROSS		COSTS)	
		1.00	2.00	SALARI ES) 3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4A	4.00	
1.00	CAP REL COSTS-BLDG & FIXT	100					1.00
2.00	CAP REL COSTS-MVBLE EQUIP	100	100				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	13, 01	7		3.00
4.00	ADMI NI STRATI VE & GENERAL	0	0	10701	0 -12, 786	69, 943	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0		0 0	7,098	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0		0 0	0	6.00
7.00	HOUSEKEEPING	0	0		0 0	2, 222	7.00
8.00	DI ETARY	0	0		0 0	0	8.00
9.00	NURSING ADMINISTRATION	0	0		0 0	0	9.00
10.00	ROUTI NE MEDI CAL SUPPLI ES	0	0		0 0	0	10.00
11.00	MEDI CAL RECORDS	0	0		0 0	1, 563	11.00
12.00	STAFF TRANSPORTATION	0	0		0 0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0		0 0	0	13.00
14.00	PHARMACY	0	0		0 0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0 0	500	15.00
16.00	OTHER GENERAL SERVICE	0	0		0 0	35, 297	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	9, 953	17.00
	LEVEL OF CARE				_		
50.00	HOSPICE CONTINUOUS HOME CARE				0 0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			10, 05		6, 716	
52.00	HOSPICE INPATIENT RESPITE CARE	0	0		0 0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	100	100	2, 96	5 0	6, 314	53.00
(0.00	NONREI MBURSABLE COST CENTERS		0				1 / 0 . 00
60.00	BEREAVEMENT PROGRAM	0	0		0 0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0		0 0	0	61.00
62.00 63.00	FUNDRALSING	0	0		0 0	0	62.00 63.00
	HOSPICE/PALLIATIVE MEDICINE FELLOWS PALLIATIVE CARE PROGRAM	0	0		0 0	0	64.00
64.00 65.00	OTHER PHYSICIAN SERVICES	0	0		0 0	0	65.00
66.00	RESIDENTIAL CARE	0	0		0 0	0	66.00
67.00	ADVERTI SI NG	0	0		0 0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0	0		0 0	0	68.00
69.00	THRI FT STORE	0	0		0 0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0	0		0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0 0	280	
	NEGATI VE COST CENTER	0	0		- 0	200	99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Pa	art I) 3,200	1, 300	3, 84	3	12, 786	100.00
	UNIT COST MULTIPLIER	32. 000000				0. 182806	
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Heal th	Financial Systems	DEARBORN COUN	TY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST A	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL S	ERVICE COSTS	Provider C	CN: 15-0086	Period:	Worksheet 0-6	
STATI S	TI CAL BASI S				From 01/01/2020		
			Hospi ce CC	N: 15-1531	To 10/31/2020		
					Hospi ce I	3/31/2021 12:	<u>34 pili</u>
	Cost Center Descriptions	PLANT	LAUNDRY &	HOUSEKEEPIN		NURSI NG	
	cost center bescriptions		LINEN SERVICE			ADMI NI STRATI O	
		MAINTENANCE	(IN-FACILITY	(SOUARE ILLI	DAYS)	N	
		(SQUARE FEET)	DAYS)		DATS	(DI RECT NURS.	
			DATS)			HRS.)	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS	0.00	0.00	7.00	0.00	7.00	
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMI NI STRATI VE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	100					5.00
6.00	LAUNDRY & LI NEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0	0		00		7.00
8.00	DI ETARY	0			0 0		8.00
9.00	NURSI NG ADMI NI STRATI ON	0			0	0	9.00
10.00	ROUTI NE MEDI CAL SUPPLI ES	0			0	0	10.00
11.00	MEDI CAL RECORDS	0			0	0	11.00
12.00	STAFF TRANSPORTATION	0			0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	0	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	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0			0		17.00
17.00	LEVEL OF CARE						17.00
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		0 0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	100	0		0 0		53.00
00.00	NONREI MBURSABLE COST CENTERS						00100
60, 00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRALSING	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	66.00
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 NONREI MBURSABLE (SPECIFY)	0	0		0 0	0	71.00
99.00	NEGATI VE COST CENTER						99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	8, 396	0	2,6	28 0	0	100.00
	UNIT COST MULTIPLIER	83. 960000	0. 000000	26. 2800	0. 000000	0. 000000	101.00
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Health Financial Systems		DEARBORN COUNTY	HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - HOSPITAL-BASED HOSF STATISTICAL BASIS	PICE GENERAL SE	RVICE COSTS	Provider C Hospice CC		Period: From 01/01/2020 To 10/31/2020		epared:
					Hospi ce I		•
Cost Center Descriptions		ROUTI NE MEDI CAL SUPPLI ES (PATI ENT DAYS)	MEDI CAL RECORDS (PATI ENT DAYS)	STAFF TRANSPORTATI N (MI LEAGE)	VOLUNTEER	PHARMACY (CHARGES)	
	-	10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS		10.00	11.00	12.00	13.00	14.00	
1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-BLDG & FIXT 3.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 ADMI NI STRATI VE & GENERAL 5.00 PLANT OPERATI ON & MAI NTENANCE 6.00 LAUNDRY & LINEN SERVI CE 7.00 HOUSEKEEPI NG 8.00 DI ETARY 9.00 NURSI NG ADMI NI STRATI ON 10.00 ROUTI NE MEDI CAL SUPPLI ES 11.00 MEDI CAL RECORDS 12.00 STAFF TRANSPORTATI ON 13.00 VOLUNTEER SERVI CE COORDI NATI ON 14.00 PHARMACY 15.00 PHYSI CI AN ADMI NI STRATI VE SERVI 16.00 OTHER GENERAL SERVI CE 17.00 PATI ENT/RESI DENTI AL CARE SERVI	CES	48	48		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		15.00
LEVEL OF CARE							
50.00HOSPICE CONTINUOUS HOME CARE51.00HOSPICE ROUTINE HOME CARE52.00HOSPICE INPATIENT RESPITE CARE53.00HOSPICE GENERAL INPATIENT CARE		0 41 0 7	0 41 0 7		0 0 0 0 0 0 0 0 0 0	0	51.00 52.00
NONREI MBURSABLE COST CENTERS60.00BEREAVEMENT PROGRAM61.00VOLUNTEER PROGRAM62.00FUNDRAI SI NG63.00HOSPI CE/PALLI ATI VE MEDI CI NE FE64.00PALLI ATI VE CARE PROGRAM65.00OTHER PHYSI CI AN SERVI CES66.00RESI DENTI AL CARE67.00ADVERTI SI NG68.00TELEHEALTH/TELEMONI TORI NG69.00THRI FT STORE70.00NURSI NG FACI LI TY ROOM & BOARD71.00OTHER NONREI MBURSABLE (SPECI FY99.00NEGATI VE COST CENTER100.00COST TO BE ALLOCATED (per Wkst101.00UNI T COST MULTI PLI ER)	0 0. 000000	1, 849 38. 520833		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		61.00 62.00 63.00 64.00 65.00 65.00 66.00 67.00 68.00 69.00 70.00 71.00 99.00 100.00

COST ALLOATION - INOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS Provider CON: 15-068 Period: Period: To 10/31/2020 Worksheet 0-6 Period: To 10/31/2020 Cost Center Descriptions PHYSICIAN DAININ STRATIVE Cost Center Descriptions PHYSICIAN DAININ STRATIVE DAYS) OTHER GENERAL DAYS) Hospice 1 Cost Center Descriptions PHYSICIAN DAYS) OTHER GENERAL DAYS) PHYSICIAN DAYS) DIACS Hospice 1 Cost Center Descriptions PHYSICIAN DAYS) OTHER GENERAL DAYS) PHYSICIAN DAYS) DIACS Hospice 1 0 CAP REL COSTS-BLOC & FITURES 16:00 17:00 17:00 10:00 1.00 CAP REL COSTS-BLOC & FITURES 16:00 17:00 10:00 2:00 3:00 1.00 CAP REL COSTS-BLOC & FITURES 16:00 17:00 10:00 10:00 10:00 10:00 1.00 CAP REL COSTS-MERAL SERVICE 0:00 10:00 10:00 10:00 10:00 10:00 1.00 CAP REL COSTS-MERAL SERVICES 0:00 10:00 10:00 10:00 10:00 10:00 10:00 1.00 CAP REL COSTS-MERAL SER	Heal th	Financial Systems	DEARBORN COUN	TY HOSPI TAL		In Lieu	u of Form CMS	-2552-10		
Environmentation Hospice CCN: 15.15.31 To 10/31/2021 Deter/Time Prepared: 3/31/2021 3/31/2021 12.34 pm Cost Center Descriptions PHYSICIAN ADMINISTRATIV E SERVICE (PATLENT BASIS) OTHER GENERAL SERVICE (SPECIPY) PATLENT BASIS PATLENT CARE SERVICES (IN-FACILITY DAYS) Interview Prepared: 3/31/2021 12.34 pm 100 CAR PEL COSTS-ENVELE COSTS-ENVELE EQUIP 2.00 ENVERSE (PATLENT DAYS) 16.00 17.00 10.00 2.00 CAP FEL COSTS-ENVELE COSTS-ENVELE EQUIP 2.00 ENVERSE (PATLENT DAYS) 10.00 17.00 10.00 2.00 CAP FEL COSTS-ENVELE COSTS-ENVELE 2.00 ENVERSE (PATLENT DAYS) 11.00 10.00 3.00 0.00 CHARDY E BAVETTIS DAYS EDVERSE (PATLENT DAYS) 11.00 10.00 3.00 0.00 CAR PEL COSTS-ENVELE DAYS EDVERSE (PATLENT DAYS 11.00 3.00 0.00 CARDIN STRATION (PATLENT DAYS 11.00 12.00 11.00 12.00 10.00 DOTARY ALINEN SERVICES 48 48 7 11.00 10.00 DAYSENTAL SERVICES 48			_ SERVICE COSTS	Provider C	CN: 15-0086			6		
Cost Center Descriptions PHYSICIAN ADM IN STRATIV (SERVICE (PATIENT) OTHER CENERAL SERVICE (SPECIE) PATIENT/ CARE SERVICES (IN-FACILITY DAYS) PATIENT/ CARE SERVICES (IN-FACILITY DAYS) 00 CAP REL COST-SHDC & FIXT 2.00 2.00 00 CAP REL COSTS-BLDC & FIXT 2.00 2.00 00 CAP REL COSTS-BLDC & FIXT 2.00 2.00 00 CAP REL COSTS-BLDC & FIXT 2.00 2.00 00 CAP REL COSTS-MURE EQUIP 3.00 3.00 3.00 EMPLOYCE EDEPTISAL EQUIP 3.00 3.00 3.00 MINISTRATIVE & CAREMAL 5.00 6.00 0.00 DLANT OPERATION & MAINTERVICE 4.00 6.00 0.01 MINISTRATIVE & CAREMAL 5.00 6.00 0.00 MINISTRATIVE & CAREMAL 5.00 6.00 1.00 MINISTRATIVE & CAREMAL 5.00 7.00 1.00 MINISTRATIVE & CAREMAL 5.00 6.00 1.00 MINISTRATIVE & CAREMAL 7.00 8.00 1.00 MINISTRATIVE & CAREMAL 7.00 7.00	STATI S	TI CAL BASI S		Hospi ce CC	N: 15-1531		Date/Time Pr	epared:		
Cost Center Descriptions PHYSICIAN (DMINISTERS) Differ GENERAL (SPECIFY (BASIS) PATIENT/ (ESPECIFY (BASIS) PATIENT/ (ESPECIFY (BASIS) 0 CAP REL COSTS-BLDG & FIXT (CAP REL COSTS-WDEL EQUIP 2.00) 15.00 16.00 17.00 1.00 CAP REL COSTS-WDEL EQUIP 2.00 16.00 17.00 10.00 2.00 0.00 CAP REL COSTS-WDEL EQUIP 2.00 16.00 17.00 10.00 2.00 0.00 LANDARY & LINEN SERVICE 0.00 CAP REL COSTS-WDEL EQUIP 2.00 10.00 2.00 2.00 2.00 0.00 LANDARY & LINEN SERVICE 0.00 10.00 2.00 3.00 4.00 4.00 4.00 0.00 LANDARY & LINEN SERVICE 0.00 10.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td>Hospico</td><td>3/31/2021 12</td><td>2:34 pm</td></t<>						Hospico	3/31/2021 12	2:34 pm		
ADMI MI STRATIVE E SERVICE (PATIENT DAYS) SERVICE SERVICE (PATIENT DAYS) SERVICE CARE SERVICE (ARE SERVICE DAYS) 10:00 CAP REL COSTS-MUCE AFIXT DAYS) 15:00 16:00 17:00 10:00 CAP REL COSTS-MUCE FOULP & CAPE LOSTS-MURE FOULP 1:00 1:00 1:00 20:00 CAP REL COSTS-MURE FOULP & CAPE LOSTS-MURE FOULP 1:00 1:00 1:00 3:00 EMPLOYEE BERFITS DEPARTMENT 0:00 1:00 1:00 1:00 0:00 DEMPLOYEE GENEFITS DEPARTMENT 0:00 1:00 1:00 1:00 0:00 DEAMINY & LINEN SERVICE 0:00 1:00 1:00 1:00 0:00 DEAMIN STRATIVE & SERVICE COORDINATION 1:00 1:00 1:00 1:00 1:00 MURSING ADMI MI STRATIVE & SERVICE 4:8 1:00 1:00 1:00 1:00 MURSING ADMI MI STRATIVE & SERVICE 4:8 4:8 7 1:00 0:00 DETARY 4:8 7 7 1:00 1:00 1:00 MURSING ADMI MI STRATIVE & SERVICE 4:8 7		Cost Center Descriptions	PHYSI CLAN	OTHER GENERAL	PATI FNT/	nospice i				
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63.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS 0 63.00 64.00 PALLIATIVE CARE PROGRAM 0 64.00 65.00 OTHER PHYSICIAN SERVICES 0 65.00 66.00 RESIDENTIAL CARE 0 0 67.00 ADVERTISING 0 66.00 68.00 TELEHEALTH/TELEMONITORING 0 67.00 69.00 THRIFT STORE 0 68.00 70.00 NURSING FACILITY ROOM & BOARD 70.00 69.00 71.00 OTHER NONREI MBURSABLE (SPECIFY) 0 0 0 99.00 NEGATIVE COST CENTER 99.00 11,772 100.00	61.00	VOLUNTEER PROGRAM		0)			61.00		
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65.00 OTHER PHYSICIAN SERVICES 0 65.00 66.00 RESIDENTIAL CARE 0 0 67.00 ADVERTISING 0 66.00 68.00 TELEHEALTH/TELEMONITORING 0 68.00 69.00 THRIFT STORE 0 69.00 70.00 NURSING FACILITY ROOM & BOARD 70.00 71.00 71.00 OTHER NONREIMBURSABLE (SPECIFY) 0 0 99.00 NEGATIVE COST CENTER 99.00 71.70 100.00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 591 41,750 11,772	63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0				63.00		
66.00 RESIDENTIAL CARE 0 0 0 66.00 67.00 ADVERTISING 0 0 67.00 68.00 TELEHEALTH/TELEMONITORING 0 68.00 69.00 THRIFT STORE 0 69.00 70.00 NURSING FACILITY ROOM & BOARD 70.00 71.00 71.00 OTHER NONREIMBURSABLE (SPECIFY) 0 0 71.00 99.00 NEGATIVE COST CENTER 99.00 99.00 11,772	64.00	PALLIATIVE CARE PROGRAM		0				64.00		
67.00 ADVERTISING 67.00 68.00 TELEHEALTH/TELEMONITORING 0 69.00 THRIFT STORE 0 70.00 NURSING FACILITY ROOM & BOARD 69.00 71.00 OTHER NONREIMBURSABLE (SPECIFY) 0 0 99.00 NEGATIVE COST CENTER 99.00 100.00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 591 41,750 11,772	65.00	OTHER PHYSICIAN SERVICES		0				65.00		
68.00 TELEHEALTH/TELEMONITORING 0 68.00 69.00 THRIFT STORE 0 69.00 70.00 NURSING FACILITY ROOM & BOARD 70.00 71.00 OTHER NONREIMBURSABLE (SPECIFY) 0 0 99.00 NEGATIVE COST CENTER 99.00 100.00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 591 41,750 11,772	66.00		0	0		0		66.00		
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70.00 NURSING FACILITY ROOM & BOARD 70.00 71.00 OTHER NONREIMBURSABLE (SPECIFY) 0 0 71.00 99.00 NEGATIVE COST CENTER 99.00 99.00 11,772 100.00				-						
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100.00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 591 41,750 11,772 100.00			0	0		0				
101. UUUNII CUSI MULTIPLIER 12. 312500 869. 791667 1, 681. 714286 [101. 00		4	· · · · · · · · · · · · · · · · · · ·							
	101.00	UNII CUSI MULIIPLIER	12. 312500	869. 791667	1,681.7142	86		101.00		

Heal th F	inancial Systems	DEARBORN COUN	TY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIC	DNMENT OF HOSPITAL-BASED HOSPICE SHARED SEF F CARE	RVICE COSTS BY	Provider C	CN: 15-0086 N: 15-1531	Period: From 01/01/2020 To 10/31/2020	Worksheet 0-7 Date/Time Pre	
			Tiospi ce co	N. 15-1551		3/31/2021 12:	34 pm
					Hospi ce I		
				Charges by	LOC (from Provi	der Records)	
	Cost Center Descriptions	From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	НСНС	HRHC	HI RC	
		0	1.00	2.00	3.00	4.00	
	NCILLARY SERVICE COST CENTERS						
	PHYSICAL THERAPY	66.00	0. 668339 0. 385351		0 0	0	1
	ICCUPATIONAL THERAPY SPEECH PATHOLOGY	67.00 68.00	0. 385351		0 0	0	2.00 3.00
	PRUGS CHARGED TO PATIENTS	73.00			0 0	0	1
	URABLE MEDICAL EQUIP-RENTED	96.00	0. 470741		0	0	5.00
	ABORATORY	60.00	0. 231215		0 0	0	
	BLOOD LABORATORY	60.01	0. 000000		0 0	0	6.01
	IEDI CAL SUPPLI ES CHARGED TO PATI ENTS	71.00	0. 512591		0 0	0	7.00
8.00 0	THER OUTPATIENT SERVICE COST CENTER	93.00					8.00
	ADI OLOGY-THERAPEUTI C	55.00	0. 244791		0 0	0	1 1.00
	THER ANCILLARY SERVICE COST CENTERS otals (sum of lines 1–11)	76.00					10.00
		Charges by		Shared Servi	ce Costs by LOC		
		LOC (from			Ĵ		
		Provi der					
		Records)					
	Cost Center Descriptions	HGI P	HCHC (col. 1	HRHC (col.		HGIP (col. 1	
		5.00	x col. 2) 6.00	x col. 3) 7.00	x col. 4) 8.00	<u>x col. 5)</u> 9.00	
Δ	NCILLARY SERVICE COST CENTERS	5.00	0.00	7.00	0.00	9.00	
	PHYSICAL THERAPY	0	0		0 0	0	1.00
	OCCUPATIONAL THERAPY	0	0		0 0	0	2.00
3.00 S	PEECH PATHOLOGY	0	0		0 0	0	3.00
	RUGS CHARGED TO PATIENTS	0	0		0 0	0	4.00
	DURABLE MEDICAL EQUIP-RENTED						5.00
	ABORATORY	0	0		0 0	0	
	BLOOD LABORATORY	0	0		0 0	0	
	IEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0		0 0	0	1 1.00
	THER OUTPATIENT SERVICE COST CENTER	0	0		0 0	0	8.00 9.00
	THER ANCI LLARY SERVICE COST CENTERS	0	0		0 0	0	9.00
	otals (sum of lines 1-11)		0		0 0	0	11.00

lealth Financial Systems	DEARBORN COUNTY				eu of Form CMS-	
CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST		Provider C	CN: 15-0086	Peri od:	Worksheet 0-8	3
		Hospi ce CC	N: 15-1531	From 01/01/202 To 10/31/202		epared
					3/31/2021 12:	
				Hospi ce I		
			TITLE XVIII		TOTAL	
			MEDICARE	MEDI CAI D		
			1.00	2.00	3.00	
HOSPICE CONTINUOUS HOME CARE	and 10 line FO also What O	7	1			1 1 .
	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7, col. 6, line 11)				0	1.0
					0	2.0
00 Total unduplicated days (Wkst. S-9, col. 4, line 10) 00 Total average cost per diem (line 1 divided by line 2)					0.00	
0 Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)				0	0	4.0
00 Program cost (line 3 times line 4)				0	0	5.
HOSPICE ROUTINE HOME CARE			1	-	-	
.00 Total cost (Wkst. 0-6, Part I, o	col. 18, line 51 plus Wkst. O	-7, col. 7,			45, 689	6.
line 11)						
.00 Total unduplicated days (Wkst. S					41	7.
00 Total average cost per diem (line 6 divided by line 7)					1, 114. 37	
0 Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)				41	0	9.
0.00 Program cost (line 8 times line	9)		45,6	89	0	10.
HOSPICE INPATIENT RESPITE CARE			1		-	1
1.00 Total cost (Wkst. 0-6, Part I, o	col. 18, line 52 plus Wkst. 0	-7, col. 8,			0	11.
line 11) 2.00 Total unduplicated days (Wkst. S	S_{0} col 4 line 12)				0	12.
						12.
				0	0.00	14.
5.00 Program cost (line 13 times line		1110 12)		0	0	15.
HOSPICE GENERAL INPATIENT CARE				0		
6.00 Total cost (Wkst. 0-6, Part I, o	col. 18, line 53 plus Wkst. O	-7, col. 9,			36, 709	16.
line 11)						
7.00 Total unduplicated days (Wkst. S					7	17.
0 Total average cost per diem (line 16 divided by line 17)					5, 244. 14	
				7	0	19.
0.00 Program cost (line 18 times line	e 19)		36, 7	09	0	20.
TOTAL HOSPICE CARE					00.000	0.00
1.00 Total cost (sum of line 1 + line					82, 398	
2.00 Total unduplicated days (Wkst. 9					48 1, 716. 63	
3.00 Average cost per diem (line 21 d	arviueu by fine 22)		l	I	1,710.03	23.

Health Financial Systems DEARBOR CALCULATION OF CAPITAL PAYMENT DEARBOR		Provider CCN: 15-0086	Peri od:	u of Form CMS-2 Worksheet L		
			From 01/01/2020 To 10/31/2020		noro	
			10 10/31/2020	3/31/2021 12:		
		Title XVIII Hospital				
				1.00		
PART I - FULLY PROSPECT	I VE METHOD			1.00		
CAPITAL FEDERAL AMOUNT						
.00 Capital DRG other than	662, 815					
01 Model 4 BPCI Capital DR	0 77, 744					
1 1 1 3						
		e cost reporting period (see ins	tructions)	26.58 0.00		
		5 by the sum of lines 1 and 1.0	1 columns 1 and	0.00		
1.01) (see instructions)		by the sum of three t and the		Ũ	0.	
00 Percentage of SSI recip 30) (see instructions)	pient patient days to Medicare	Part A patient days (Worksheet	E, part A line	0.00	7.	
00 Percentage of Medicaid	0.00	8.				
0 Sum of lines 7 and 8					9.	
.00 Allowable disproportion	0.00	10.				
00 Disproportionate share adjustment (see instructions)					11	
.00 Total prospective capit	tal payments (see instructions))		740, 559	12.	
				1.00		
PART II - PAYMENT UNDER						
0 Program inpatient routine capital cost (see instructions)				0		
0 Program inpatient ancillary capital cost (see instructions)				0	1	
	n capital cost (line 1 plus lir actor (see instructions)	ie 2)		0		
	n capital cost (line 3 x line 4	1)		0		
		·/				
PART III - COMPUTATION				1.00		
				0	1 1	
 Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances (see instructions) 				0		
Net program inpatient capital costs (line 1 minus line 2)				0		
Applicable exception percentage (see instructions)				0.00	4.	
Capital cost for comparison to payments (line 3 x line 4)				0	5.	
	Percentage adjustment for extraordinary circumstances (see instructions)					
00 Percentage adjustment f				0.00		
00 Percentage adjustment f 00 Adjustment to capital m	1 3	aordinary circumstances (line 2	x line 6)	0		
00 Percentage adjustment f 00 Adjustment to capital m 00 Capital minimum payment	t level (line 5 plus line 7)	aordinary circumstances (line 2	x line 6)	0 0	8.	
200Percentage adjustment f200Adjustment to capital m200Capital minimum payment200Current year capital pa	t level (line 5 plus line 7) ayments (from Part I, line 12,	aordinary circumstances (line 2) as applicable)	·	0 0 0	8. 9.	
200Percentage adjustment f200Adjustment to capital m200Capital minimum payment200Current year capital pa200Current year comparison	t level (line 5 plus line 7) ayments (from Part I, line 12, n of capital minimum payment le	aordinary circumstances (line 2 as applicable) evel to capital payments (line 8	less line 9)	0 0 0 0	8. 9. 10.	
 Percentage adjustment f Adjustment to capital m Capital minimum payment Current year capital pa Current year comparisor Carryover of accumulate 	t level (line 5 plus line 7) ayments (from Part I, line 12, n of capital minimum payment le ed capital minimum payment leve	aordinary circumstances (line 2) as applicable)	less line 9)	0 0 0	8. 9. 10.	
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