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

(Si gned)

Officer or Administrator of Provider(s)

Title

Date

		Title	XVIII			
Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	806, 719	1, 186, 594	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing Bed - SNF	0	82, 611	0		0	5.00
6.00 Swing Bed - NF	0				0	6.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00 RURAL HEALTH CLINIC I	0		540, 333		0	10.00
10.01 RURAL HEALTH CLINIC II	0		268, 843		0	10.01
200. 00 Total	0	889, 330	1, 995, 770	0	0	200.00
The above amounts represent "due to" or "due from"	the applicable	program for t	he element of t	the above comp	ex indicated.	

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

	AL AND HOSPITAL HEALTH CARE COMPLEX	I DENTIFICATION DATA	Provi c	ler CCN:	15-1332	Period: From 01/01/ To 12/31/		Workshe Part I Date/Ti 6/22/20	me Pre	epare
	1.00	2.00		3.00		Z	1.00			
	Hospital and Hospital Health Care (
	Street: 720 NORTH LINCOLN STREET	PO Box:	7 n Cod	a. 17210	1200 Cours					1.
00	City: GREENSBURG	State: IN Component Name	CCN	CBSA	Provi dei	ty: DECATUR	Doum	ent Syst	om (D	2.
		component name	Number	Number		Certified		, 0, or		
			Number		lipe		V			-
		1.00	2.00	3.00	4.00	5.00	6.00			1
	Hospital and Hospital-Based Compone		2100		1 11 00	0100	0.00	1 // 00	1 01 00	
	Hospi tal	DECATUR CO. MEMORIAL	151332	99915	1	12/01/2005	N	0	Р	3.
		HOSPI TAL								
00	Subprovider - IPF									4.
00	Subprovider - IRF									5.
00	Subprovider - (Other)									6.
00	Swing Beds - SNF	DECATUR CO. SWING BED	15Z332	99915		12/01/2005	N	0	N	7.
00	Swing Beds - NF									8.
00	Hospital-Based SNF									9.
. 00	Hospital-Based NF									10.
. 00	Hospital-Based OLTC									11.
. 00	Hospital-Based HHA									12.
. 00	Separately Certified ASC									13.
. 00	Hospital-Based Hospice									14.
00	Hospital-Based Health Clinic - RHC	TREE CITY MEDICAL	158522	99915		05/04/2017	N	N	N	15.
		PARTNERS								
01	Hospital-Based Health Clinic - RHC	DECATUR COUNTY PRIMARY	158521	99915		05/04/2017	N	N	N	15.
	11	CARE								
	Hospital-Based Health Clinic - FQHO									16.
	Hospital-Based (CMHC) I									17.
	Renal Dialysis									18.
. 00	Other									19.
						From:		To		-
00	Cast Danasting Danied (my (dd (max))					1.00	220	2. (20
	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)					01/01/20	J20	12/31,	2020	20.
. 00	Type of control (see this fue trolis)					7				21.
					1.00	2.00		3. (0	-
	Inpatient PPS Information									
00	Does this facility qualify and is i	t currently receiving pa	vments fo	r	N					22.
	disproportionate share hospital adj									
	§412.106? In column 1, enter "Y" 1									
	facility subject to 42 CFR Section									
	hospital?) In column 2, enter "Y" 1									
01	Did this hospital receive interim u	incompensated care paymen	ts for th	is	Ν	N				22
	cost reporting period? Enter in col									
	the portion of the cost reporting p	period occurring prior to	0ctober	1.						
	Enter in column 2, "Y" for yes or '									
	reporting period occurring on or at	fter October 1. (see inst	ructions)							
. 02	Is this a newly merged hospital that	at requires final uncompe	nsated ca	re	N	N				22
	payments to be determined at cost r									
	Enter in column 1, "Y" for yes or '	'N" for no, for the porti	on of the							
	cost reporting period prior to Octo	ober 1. Enter in column 2	, "Y" for	yes						
	or "N" for no, for the portion of t	the cost reporting period	on or af	ter						
	October 1.									
03	Did this hospital receive a geogra				N	N		N		22
	rural as a result of the OMB standa									
	adopted by CMS in FY2015? Enter in									
	for the portion of the cost reporti			er						
	in column 2, "Y" for yes or "N" for									
	reporting period occurring on or at									
	Does this hospital contain at least									
	counted in accordance with 42 CFR 4	112.105)? Enter in column	3, "Y" f	or						
	yes or "N" for no.									1 0 0
	<code>Which method is used to determine M</code>					0				23
	Which method is used to determine M below? In column 1, enter 1 if date	e of admission, 2 if cens	us days,	or 3		0				23
	<code>Which method is used to determine M</code>	e of admission, 2 if cens d of identifying the days	us days, in this	or 3		0				23

If the provider is an IPP heat is entry in the provider is entry in the provider is an IPP heat is entry in the provider is an IPP heat is entry in the provider is an IPP heat is entry in the provider is an IPP heat is entry in the provider is an IPP heat is entry in the provider is an IPP heat is entry in the provider is an IPP heat is entr	2	CO. MEMORIAL				In Lieu			2552-10
Noticiaid Noticiaid Statu Noticiaid No	HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D.						Part I Date/Ti	me Pre	epared:
0.00 [F this provider is an IPS heapital, enter the instate Medical dial diags in colum 2, instate Medical dial diags in colum 2, colume 3, colume 4, Medical dial diags in colum 1, 2 colume 3, colume 4, Medical dial diags in colum 2, colume 4, medical dial diags in colum 6, colume 4, Medical diags in colum 1, the in-state 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0,		Medicaid paid days	Medi cai d el i gi bl e unpai d days	State Medicaid paid days	State Medi cai d el i gi bl e unpai d	HMO da	ys Meo	di cai d days	_
Medical digital expandidays in colum 2, out-of-state Medical digital expandidays in colum 3, expandidation of the spectra of						5.00			24.00
00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural. 26.00 26.00 27.00 26.00 27.00 26.00 27.00 26.00 27.00 27.00 26.00 27.00 26.00 27.00 20.00 <	 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. 25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid eligible unpaid days in column 4, Medicaid 	0	o	0 0	0		0		25.00
0.00 Enter your standard geographic classification (not wage) status at the beginning of the cost cost reporting period. Enter "1" for urban or "2" for rural. 2 26.00 0.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter "1" for urban or "2" for rural. 1 2 3 5 0									-
1:00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2. 2 2 2.00 00 If this is a sole community hospital (SCH), enter the number of periods SCH status in o 8 8 9 35.00 35.00 00 Inter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods MDH status is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period. 36.00 37.00 10 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with PY 2016 OPS final rule? Enter "Y" for yes or "N" for no. (see instructions) in status accordance with PY 2016 OPS final rule? Enter "Y" for yes or "N" for no. (see instructions) N N 39.00 0.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(1), (1), or (11)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) N N N 40.00 0.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospital subject to the MAC program roduction adjustment? Enter "Y" for yes or "N" for no. (see instructions) N N N 40.00 0.00 Does this facility qualify do			s at the be	gi nni ng of			۷. ۱		26.00
effect In the cost reporting period. Beginning: Ending: 1.00 2.00 So 0 Enter applicable beginning and ending dates of SCH status. Subscript I line 36 for number of periods MDH status is a Medicare dependent hospital (WDH), enter the number of periods MDH status is in effect in the cost reporting period. 36.00 1.00 2.00 36.00 0 If this is a Medicare dependent hospital (WDH), enter the number of periods MDH status is a medicare dependent hospital rule? Enter "Y" for yes or "N" for no. (see instructions) 37.01 V/N V/N V/N 97.01 0.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(1), (11), or (111)? Enter in column 1, 00 2.00 1.00 2.00 1.00 2.01 39.00 1.00 2.02 39.00 1.00 2.02 39.00 1.00 2.04 39.00 1.00 2.04 39.00 1.00 2.04 39.00 1.00 2.04 39.00	27.00 Enter your standard geographic classification (not w reporting period. Enter in column 1, "1" for urban c	wage) status or "2" for r	rural. If a		st	2			27.00
00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates. 1.00 2.00 01 Ft his is a Medicare dependent hospital (WDM), enter the number of periods MDH status is in effect in the cost reporting period. 36.00 01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 0PPS final rule? Enter "Y" for yes or "N" for no. (see instructions) 37.00 100 Dest this 1. enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. Y/N Y/N 100 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR 412.101(b) (2)(i), (ii), or (ii)? Enter in column 1 "N" for no lose the facility meet the mileage requirements in accordance with 42 CFR 412.101(b) (2)(i), (ii), or (ii)? Enter in column 2 "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. Enter "Y" for yes or "N" for no lin column 2, for discharges on or after October 1. Enter "Y" for yes or "N" for no. N N 40.000 0 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR 412.348(f)? If yes, complete Wst. L. Pt. III and Wst. L-1, Pt. I through PT. III. N N N 45.00 0	5 1 2 3	ne number of	f periods S	CH status i		-	Endi	na:	35.00
of periods in excess of one and enter subsequent dates. 37.00 00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period. 37.00 101 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see Instructions) 37.01 100 If thine 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. V/N V/N 200 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2."" for yes or "N" for no. (see instructions) N N 39.00 100 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to 0ctober 1. Enter "Y" for yes or "N" for no in column 2, for discharges prior to 0ctober 1. (see instructions) N N 40.00 100 Does this facility qualify and receive Capital pursuant to 42 CFR 412.101 (see instructions) N N N 45.00 100 Is this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR 5412.348(f)? If yes, complete WKst. L. Pt. III and Wkst. L. Pt. II through Pt. III. N N N 45.00 100 Is this a new hospital under 42 CFR §412.300(b) PPS cap					1. (
Is in effect in the cost reporting period. 10 Is this hospital a former MOH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions) 10.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. 10.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR \$412.10(b)(2)(i), (ii), or (iii)? Enter in column 1. 'Y' for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR \$412.10(b)(2)(i), (ii), or (iii)? Enter in column 1. 'Y' for yes or "N" for no. (see instructions) 10.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. Enter "Y" for yes or "N" for no. (see instructions) 10.00 Is this facility qualify and receive Capital payment for disproportionate share in accordance N N N N 40.00 with 42 CFR \$412.30(b) PPS-capital 10.01 Is this facility qualify and receive Capital payment for disproportionate share in accordance N N N N 46.00 with 42 CFR \$412.346(f)? If yes, complete Wkst. L, Pt. III and Wkst. L., Pt. Ithrough Pt. III. 10.01 Is this a new hospital under 42 CFR \$412.30(b) PPS capital? Enter "Y" for yes or "N" for no. 10.02 Is this a new hospital under 42 CFR \$412.30(b) PPS capital? Enter "Y" for yes or "N" for no. 10.03 Is this a new hospital under 42 CFR \$412.30(b) PPS capital? Enter "Y" for yes or "N" for no. 10.04 If line 56 is yes, is this the first cost reporting period during which residents in approved MM GME payment reduction? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" and you impacted by CR 11642 (or subsequ			script line	36 for num	ber				36.00
accordance with FY 2016 0PPS final rule? Enter "Y" for yes or "N" for no. (see instructions) 38.00 100 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. Y/N Y/N 100 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(1), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no in column 1, for no in column 1, for no in column 1, for no in coluber 1. Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 1, for additional payment exception for extraordinary circumstances no with 42 CFR §412.320? (see instructions) N N 40.00 00 Does this facility qualify and receive Capital N N N 40.00 0.00 Is facility qualify and receive Capital payment for disproportionate share in accordance N N N N 40.00 0.01 Is this facility qualify and receive Capital payment? Enter "Y" for yes or "N" for no. N N N 45.00 0.02 Is facility qualify and receive Capital payment? Enter "Y" for yes or "N" for no. N N N 46.00 0.01 Is thacility eligible for additional payment? Enter "Y" fo	is in effect in the cost reporting period.				us	0			37.00
1.00 If line 37 is 1, enter the beginning and ending dates of MOH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. 38.00 1.00 Image: Number of the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(1), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(1), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. (see instructions) N N 40.00 1.00 2.00 3.00 1.00 2.00 3.00 1.01 schardater with 42 CFR §412.200(b) (2)(1), (ii), or (iii)? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. (see instructions) N N 40.00 1.00 2.00 3.00 Image: prior to October 1. (see instructions) V XVIII XIX 1.00 2.00 3.00 Image: prior to October 1. (see instructions) N N N 45.00 1.00 Does this facility qualify and receive Capital payment exception for extraordinary circumstances N N N N 45.00 1.00 Is this facility eligible for additional payment exceptio	accordance with FY 2016 OPPS final rule? Enter "Y" f								37.01
Product 1.00 2.00 0.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(1), (ii), or (iii)? Enter in column 1 'Y" for yes or 'N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) N N 40.00 0.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to 0 Ctober 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions) N N 40.00 Prospective Payment System (PPS)-Capital 1.00 2.00 3.00 0.00 Is this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR §412.3207 (see instructions) N N N 45.00 0.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III. N N N 45.00 1.00 Is the facility electing full federal capital payment? Enter "Y for yes or "N" for no. N N N N 46.00 0.01 Is this a nospital involved in training residents in approved GME programs	38.00 If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number of					N	X		38.00
hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column I 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 'Y' for yes or 'N'' for no. (see instructions) N 40.00 0.00 Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N'' for no in column 2, for discharges prior to 0ctober 1. Enter 'Y' for yes or 'N'' for on oin column 2, for discharges prior to 0ctober 1. (see instructions) N N 40.00 0.00 Is this facility qualify and receive Capital V XVIII XIX 0.00 Is this facility eligible for additional payment for disproportionate share in accordance with 42 CFR §412.320? (see instructions) N N N 45.00 0.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III. N N N 45.00 0.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter 'Y' for yes or 'N'' for no. N N N 45.00 0.00 Is this a new hospital involved in training residents in approved GME programs? Enter 'N'' for yes or 'N'' for no. N N 45.00 0.00 Is this a hospital involved in training residents in approved GME programs? Enter 'N'' for yes or 'N'' for no in column 1. If column 1 is 'Y'', are you impa									-
0.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. Enter "Y" for yes or "N" for no in column 2, for discharges prior to October 1. Enter "Y" for yes or "N" for no. N N N 40.00 0 Dees this facility qualify and receive Capital payment for disproportionate share in accordance pursuant to 42 CFR Section \$412.320? (see instructions) N N N N 45.00 0.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR \$412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III. N N N 46.00 1.00 Is this a new hospital under 42 CFR \$412.300(b) PPS capital? Enter "Y" for yes or "N" for no. N N N 48.00 0.01 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. N N N 48.00 0.00 Is this a hospital Involved in training residents	hospitals in accordance with 42 CFR §412.101(b)(2)(i 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i), (ii), or the mileage	r (iii)? En e requireme	ter in colu nts in	mn		Ν	I	39.00
V XVIII XIX 1.00 2.00 3.00 2.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions) N N N 45.00 2.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III. N N N 46.00 2.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. N N N 47.00 3.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. N N N 48.00 Teaching Hospitals Teaching Hospitals N N N N 48.00 GME payment reduction? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA 56.00 GME payment reduction? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", or yes or "N" for no in column 1. If column 1 is "Y" for yes or "N" for no in column 1. If column 1 is "Y", or yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 57.00 GME pr	"N" for no in column 1, for discharges prior to Octo	ber 1. Ente	er "Y" for				Ν	I	40.00
Prospective Payment System (PPS)-Capital N N N 45.00 0.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions) N N N 45.00 0.00 Is this facility eligible for additional payment exception for extraordinary circumstances N N N 46.00 pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III. N N N 46.00 0.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. N N N 47.00 8.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. N N N 48.00 6.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA 56.00 7.00 If line 56 is yes, is this the first cost reporting period during which residents in approved 57.00 GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 57.00 Is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" 57.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>									
<pre>with 42 CFR Section §412. 320? (see instructions) .000 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412. 348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III. .00 Is this a new hospital under 42 CFR §412. 300(b) PPS capital? Enter "Y for yes or "N" for no. .00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. .00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or .00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or .00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or .00 If this 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. .1 f column 2. .00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. .1 f column 2. .00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as .00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as .00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as .00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as .00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as .00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as .00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as .00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as .00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as .00 If line 56 is yes the facilit</pre>									
pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III. N S		ent for disp	proporti ona	te share in	accordance	N	N	N	45.00
1.5 this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. N N N 47.00 1.5 the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. N N N 47.00 8.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. N N N 48.00 Teaching Hospitals 56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2. N S6.00 1.6 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wstst. D, Parts III & IV and D-2, Pt. II, if applicable. N S8.00 8.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as N S8.00	46.00 Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks					N	N	N	46.00
 b. 00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or N "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2. c) 00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. B. 00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as 	47.00 Is this a new hospital under 42 CFR §412.300(b) PPS 48.00 Is the facility electing full federal capital paymen							1	47.00 48.00
Y. 00 If line 56 is yes, is this the first cost reporting period during which residents in approved 57.00 GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 16 column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" 57.00 for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. 58.00 8.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as N 58.00	56.00 Is this a hospital involved in training residents in "N" for no in column 1. If column 1 is "Y", are you	impacted by	/ CR 11642						56.00
8.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as N 58.00	57.00 If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is "	period duri or yes or "M oth of this 'Y", complet	ng which r N" for no i cost repor te Workshee	n column 1. ting period	lf column ? Enter "Y				57.00
	58.00 If line 56 is yes, did this facility elect cost reim	nbursement f	°or physici	ans' servic	es as	N			58.00
defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. 0.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I. N 59.00				, Pt. I.		N			59.00

Health Financial Systems DECATUR CO	D. MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider C	CN: 15-1332	Peri od: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Pre 6/22/2021 8:2	pared:
			NAHE 413.85 Y/N	5 Worksheet A Line #	Pass-Through Qualification Criterion Code	
			1.00	2.00	3.00	
60.00 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 col is "Y", are you impacted by CR 11642 (or subsequent C adjustement? Enter "Y" for yes or "N" for no in col	85? (s umn 1. CR) NAHI	see If column 1	N			60.00
	Y/N	IME	Direct GME		Direct GME	
	1.00	2.00	3.00	4.00	5.00	
 61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 61.01 Enter the average number of unweighted primary care 	N			0.00	0.00	61.00
FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
	Pro	ogram Name	Program Cod	e Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	(1.10
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
 61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see 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	61.20
					1.00	
ACA Provisions Affecting the Health Resources and Ser						
62.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruct		d in this cost	reporting p	eriod for which	0.00	62.00
62.01 Énter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog	a Teachi aram. (s	see instructio		to your hospital	0.00	62.01
63.00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, completing	ettings	during this o			N	63.00

OSPI 1	n Financial Systems TAL AND HOSPITAL HEALTH CARE COMP		CO. MEMORIAL HOSPITAL ATA Provider CO		eri od:	Worksheet S-2	2
				To	rom 01/01/2020 0 12/31/2020	Part I Date/Time Pre 6/22/2021 8:2	
				Unweighted	Unweighted	Ratio (col.	
				FTÉs Nonprovi der	FTEs in Hospital	1/ (col. 1 + col. 2))	
				Si te	2.00	2.00	-
	Section 5504 of the ACA Base Yea	r FTF Residents in N	Ionnrovider Settinas-	1.00 This base year	2.00	<u> </u>	
	period that begins on or after J			This base year		r opor tring	
4.00	Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in yo of (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	0.00	0. 000000	64.0
		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	4.00	E 00	-
5.00	Enter in column 1, if line 63	1.00	2.00	3.00	4.00	5.00 0.000000	65 0
	is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			Unwei ghted	Unweighted	Ratio (col.	
				FTEs Nonprovider Site	FTEs in Hospital	1/ (col. 1 + col. 2))	
			n Namana 1 I. O tri	1.00	2.00	3.00	
	Section 5504 of the ACA Current beginning on or after July 1, 20		n wonprovider Setting	JSETTECTIVE f	or cost report	ing periods	
5. 00	Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column	rovider settings. ry care resident 3 the ratio of	0.00	0.00	0. 000000	66.(
		Program Name	Program Code	Unwei ghted FTEs Nonprovi der	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
				Si te			
	Enton in column 1. dia	1.00	2.00	3.00	4.00	5.00 0.000000	17
. 00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column						

	Financial Systems DECATUR CO. MEMORIAL HOSPITAL	In Lie	u of Form CN	IS-2552-10
HOSPI T		eriod: com 01/01/2020 0 12/31/2020		Prepared:
		1.0	0 2.00 3.0	
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subj			70.00
71.00	Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for id 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teach program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for id Column 3: If column 2 is Y, indicate which program year began during this cost reporting (see instructions)	the most no. (see ning no.	C	71.00
75.00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF	N		75.00
	subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes on no. Column 2: Did this facility train residents in a new teaching program in accordance CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y indicate which program year began during this cost reporting period. (see instructions)	r "N" for with 42	c	76.00
			1.00	
80.00	Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N	80.00
	Is this a LTCH co-located within another hospital for part or all of the cost reporting "Y" for yes and "N" for no.	period? Enter		80.00
86.00	TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes o Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section S412.40(5)(1)(i)2 Fores "Y" for year and "W" for pe		N	85.00 86.00
	§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N	87.00
		V 1.00	XI X 2.00	
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
	yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost report either in	Ν	N	91.00
92.00	full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	Ν	N	93.00
94.00	applicable column.	Ν	N	94.00
	If line 94 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	0. 00 N	0. 00 N	95.00 96.00
	If line 96 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	0. 00 N	0. 00 N	97.00 98.00
98. 01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Ν	Y	98.01
98. 02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Ν	Y	98. 02
98. 03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1	Ν	N	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 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and	Ν	N	98.04
	in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in	Ν	Y	98.05
98.06	column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Ν	Y	98.06
105.00	Rural Providers Does this hospital qualify as a CAH?	Y		105.00
	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Ν		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an	Ν		107.00
	approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			

Health Financial Systems DECATUR CO. MEM	ORIAL HOSPITAL		In Lieu	u of Form CMS-	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C			Worksheet S- Part I Date/Time Pr 6/22/2021 8:	epared:
			V 1.00	XI X 2.00	-
108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	e CRNA fee sch	edul e? See 42	N N	2.00	108.00
	Physi cal	Occupati onal	Speech	Respi ratory	
109.00 If this hospital qualifies as a CAH or a cost provider, are	1.00 Y	2.00 N	3.00 Y	4.00 N	109.00
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					
110.00 Did this hospital participate in the Rural Community Hospit Demonstration)for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable.	"Y" for yes o	r "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 Health Integration Project (FCHIP) demonstration for this of "Y" for yes or "N" for no in column 1. If the response to of integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a for tele-health services.	cost reporting column 1 is Y, articipating in	period? Enter enter the n column 2.	N		111.00
		1.00	2.00	3.00	-
112.00 Did this hospital participate in the Pennsylvania Rural Heademonstration for any portion of the current cost reporting Enter "Y" for yes or "N" for no in column 1. If column 1 i in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital certicipation in the demonstration, if applicable.	g period? s "Y", enter the	N	2.00	0.00	112.00
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes of in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either " for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provided the definition in CMS Pub. 15-1, chapter 22, §2208.1.	B, or E only) '93" percent (includes	N			0115.00
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 insu	urance? Enter	Y			117.00
"Y" for yes or "N" for no. 118.00 Is the malpractice insurance a claims-made or occurrence po if the policy is claim-made. Enter 2 if the policy is occur	2	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
		374, 337			
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sche 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 Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that of Hold Harmless provision in ACA §3121 and applicable amendment	n column 1, " qualifies for	Y" 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 impl patients? Enter "Y" for yes or "N" for no.	antable devic	es charged to	Y		121.00
patients? Enter "Y" for yes or "N" for no. 122.00Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.					122.00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" f	for yes and "N	" for no. If	N		125.00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 f this is a Medicare certified kidney transplant center, e	enter the cert	ification date			126.00
in column 1 and termination date, if applicable, in column	2.				
127.00 f this is a Medicare certified heart transplant center, er in column 1 and termination date, if applicable, in column	2.				127.00
128.00 If this is a Medicare certified liver transplant center, er in column 1 and termination date, if applicable, in column	2.				128.00
129.00 f this is a Medicare certified lung transplant center, ent column 1 and termination date, if applicable, in column 2.	ter the certif	ıcatıon date in			129.00

alth Financial Systems SPITAL AND HOSPITAL HEALTH CARE COMPLE		MEMORIAL HOSPIT/ A Provider	CCN: 15-133	From			-2 repared
					1.00		_
0.00 If this is a Medicare certified pa	ancreas transplant ce	nter enter the (ertificatio	n	1.00	2.00	130.0
date in column 1 and termination							150.0
1.00 If this is a Medicare certified in			certi fi cat	ion			131.0
date in column 1 and termination (2.001f this is a Medicare certified is			ification d	ate			132.0
in column 1 and termination date,	if applicable, in co	lumn 2.					
3.00Removed and reserved 4.00If this is an organ procurement o	rappization (OPO) on	tor the OPO numbe	r in column	1			133.0
and termination date, if applicable	5						134.0
All Providers						1	
0.00 Are there any related organization chapter 10? Enter "Y" for yes or '					Y		140.0
are claimed, enter in column 2 the		umber. (see instr		.0313			
<u> </u>	in organization onto	2.00	rough 142 t	ho namo	3.00	of the home	
office and enter the home office				The manie			
1.00Name:	Contractor's Na	me:	Contr	actor's	Number:		141.0
2.00 Street: 3.00 Ci ty:	PO Box: State:		71.0.0	odo.			142. 143.
	state.		Zip C	Jude.			143.
						1.00	
1.00 Are provider based physicians' co	sts included in Works	heet A?				Y	144.
					1.00	2.00	-
5.00 If costs for renal services are c							145.
inpatient services only? Enter "Y' no, does the dialysis facility ind							
period? Enter "Y" for yes or "N"			st reportin	9			
5.00 Has the cost allocation methodolog					Ν		146.
Enter "Y" for yes or "N" for no i	n column 1. (See CMS	Pub. 15-2. chapte	er 40, §4020	1) f			
	dd/www) in column 2	· · · · · · · · · · · · · · · · · · ·		·			
yes, enter the approval date (mm/d	dd/yyyy) in column 2.						
yes, enter the approval date (mm/o				·		1.00	- 147
yes, enter the approval date (mm/o 7.00Was there a change in the statisti	i cal basi s? Enter "Y"	for yes or "N" f	or no.	·		N	
	ical basis? Enter "Y" f allocation? Enter "	for yes or "N" f Y" for yes or "N"	or no. for no.	- 		N N N	148.
yes, enter the approval date (mm/o 7.00Was there a change in the statisti 8.00Was there a change in the order o	ical basis? Enter "Y" f allocation? Enter "	for yes or "N" f Y" for yes or "N" od? Enter "Y" for Part A	for no. for no. yes or "N" Part	for no. B	Title V	N N Title XIX	148.
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Health Financial Systems	DECATUR CO. MEMOR	I AL HOSPI TAL	In Lieu	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX I	AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1332)
			To 12/31/2020	Date/Time Pre 6/22/2021 8:2	
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR beg period respectively (mm/dd/yyyy)			170.00		
			1.00	2.00	
171.00 If line 167 is "Y", does this provide	171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in				
section 1876 Medicare cost plans rep					
"Y" for yes and "N" for no in column	1. If column 1 is yes, e	enter the number of sectio	n		
1876 Medicare days in column 2. (see	instructions)				

IOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-1332	Period: From 01/01/2020 To 12/31/2020	6/22/2021 8	Prepared
				Y/N 1.00	Date 2.00	_
	General Instruction: Enter Y for all YES responses. Enter N	for all NO r	esponses En			_
	mm/dd/yyyy format.	for all no r	coponece: 21		the	
	COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation					
. 00	Has the provider changed ownership immediately prior to the			- N		1.0
	reporting period? If yes, enter the date of the change in c	orumn 2. (see	Y/N	Date	V/I	_
			1.00	2.00	3.00	-
2. 00	Has the provider terminated participation in the Medicare P	rogram? If	N			2.0
	yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.					
3. 00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home o or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members o of directors through ownership, control, or family and othe relationships? (see instructions)	ffices, drug er or its f the board	N			3. (
			Y/N	Туре	Date	
			1.00	2.00	3.00	
	Financial Data and Reports					
1.00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	or Compiled,	Y	A		4.0
5.00	Are the cost report total expenses and total revenues diffe		N			5.0
	those on the filed financial statements? If yes, submit rec	onciliation.		Y/N	Legal Oper	_
				1.00	2.00	·
	Approved Educational Activities					
o. 00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	-	he provider			6.0
7.00 3.00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.		d during the	N N		7.0
. 00	Are costs claimed for Interns and Residents in an approved		cal education	n N		9. (
0.00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated o cost reportions		the current	Ν		10.0
1.00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an Ap	proved	N		11. (
				-	<u>Y/N</u> 1.00	
	Bad Debts				1.00	_
2.00	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			cost reporting	Y N	12. (13. (
	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement				N	14.0
5.00	Did total beds available change from the prior cost reporti				N	15.0
	-	Par Y/N	rt A	Par Y/N		
		1.00	Date 2.00	3.00	Date 4.00	
	PS&R Data		2.00	0.00		
6.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	03/31/2021	Y	03/31/2021	16.0
7.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Ν		Ν		17.(
8. 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	Ν		Ν		18.
9. 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	Ν		Ν		19.

Health Financial Systems

DECATUR CO. MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CO	F	Period: From 01/01/2020 Fo 12/31/2020		
					6/22/2021 8	:27 pm
		Descri		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	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		Ν		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	PEDT CULLIDDENS L			1.00	_
	Completed by cost retribursed and terra hospitals oner (exc	LET CHILDRENS I	IUSFTTALS)			
22.00	Have assets been relifed for Medicare purposes? If yes, se	o instructions			N	22.00
	Have changes occurred in the Medicare depreciation expense		cale mado duri	ng the cost	N	22.00
	reporting period? If yes, see instructions.	0				
24.00	Were new leases and/or amendments to existing leases enter If yes, see instructions	orting period?	N	24.00		
25.00	Have there been new capitalized leases entered into during instructions.	lf yes, see	Ν	25.00		
26.00	Were assets subject to Sec.2314 of DEFRA acquired during t	the cost reporti	ing period? If	yes, see	Ν	26.00
27.00	instructions. Has the provider's capitalization policy changed during th	ne cost reportir	na period?lf	ves. submit	N	27.00
	сору.			J,		
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit e period? If yes, see instructions.	reporting	N	28.00		
29.00	Did the provider have a funded depreciation account and/or	serve Fund)	Y	29.00		
30.00	treated as a funded depreciation account? If yes, see inst Has existing debt been replaced prior to its scheduled mat	600	N	30.00		
30.00	instructions.	turity with new	debt? IT yes,	See	IN I	30.00
31.00	Has debt been recalled before scheduled maturity without i instructions.	ssuance of new	debt? If yes,	see	N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care se		ed through con	tractual	N	32.00
33.00	arrangements with suppliers of services? If yes, see instr If line 32 is yes, were the requirements of Sec. 2135.2 ap		na to compotit	ivo bidding? If	-	33.00
55.00	no, see instructions.		ig to competit	ive broating: II		55.00
	Provi der-Based Physi ci ans					
34.00	Are services furnished at the provider facility under an a	arrangement with	h provider-bas	ed physicians?	Y	34.00
35.00	If yes, see instructions. If line 34 is yes, were there new agreements or amended ex	visting agreemen	nts with the n	rovi der-based	N	35.00
55.00	physicians during the cost reporting period? If yes, see i		nts with the p		1	33.00
				Y/N	Date	
_	Home Office Costs			1.00	2.00	_
	Were home office costs claimed on the cost report?			N		26.00
	If line 36 is yes, has a home office cost statement been p	propored by the	home office?	IN		36.00 37.00
37.00	If yes, see instructions.	biepareu by the	nome office?			37.00
38.00	If line 36 is yes, was the fiscal year end of the home of	ffice different	from that of			38.00
	the provider? If yes, enter in column 2 the fiscal year er	nd of the home o	offi ce.			
39.00	If line 36 is yes, did the provider render services to oth see instructions.	ner chain compor	nents? If yes,			39.00
40.00	If line 36 is yes, did the provider render services to the	e home office?	lfyes, see			40.00
	instructions.					
		1.	00	2.	00	
	Cost Report Preparer Contact Information			2.		
	Enter the first name, last name and the title/position	KERRY		BEJARANO		41.00
	held by the cost report preparer in columns 1, 2, and 3,					
	respectively.					
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP				42.00
43.00	Enter the telephone number and email address of the cost	3173834000		KBEJARANO@BKD.	СОМ	43.00
	report preparer in columns 1 and 2, respectively.					

Health Financial Systems DECATUR CO.	MEMORIAL HOSPITAL	In Lie	In Lieu of Form CMS-2552-10			
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIR	Provi der CCN: 15-1332	Period: From 01/01/2020 To 12/31/2020				
		10 12/31/2020	6/22/2021 8:2	7 pm		
	3.00					
Cost Report Preparer Contact Information						
41.00 Enter the first name, last name and the title/position	DI RECTOR			41.00		
held by the cost report preparer in columns 1, 2, and	3,					
respecti vel y.						
42.00 Enter the employer/company name of the cost report				42.00		
preparer.						
43.00 Enter the telephone number and email address of the c	st			43.00		
report preparer in columns 1 and 2, respectively.						

HOSPI 1	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C		Period: From 01/01/2020 To 12/31/2020	Worksheet S-3 Part I Date/Time Pre 6/22/2021 8:2	pared
	Component	Worksheet A Line Number	No. of Beds	Bed Days Avai I abl e	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
2.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider	30.00	25			0	1. (2. (3. (
. 00 . 00 . 00 . 00 . 00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)		25	9, 15	i0 74, 448. 00	0 0 0	3. 4. 5. 6. 7.
3.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00	I NTENSIVE CARE UNIT CORONARY CARE UNIT BURN I NTENSIVE CARE UNIT SURGICAL I NTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - I PF SUBPROVIDER - I RF SUBPROVIDER	43. 00	25	9, 15	i0 74, 448. 00	0 0 0	8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19.
0.00 1.00 2.00 3.00 4.00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.) HOSPICE	101.00				0	20. 21. 22. 23. 24.
24. 10 25. 00 26. 01 26. 25 27. 00 28. 00 29. 00 30. 00	HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC RURAL HEALTH CLINIC II FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambul ance Trips Employee discount days (see instruction)	30.00 88.00 88.01 89.00	25			0 0 0	 24. 25. 26. 26. 27. 28. 29. 30.
1.00 2.00 2.01 3.00	Employee discount days (see first detroit) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges		0		0		30. 31. 32. 32. 33. 33.

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC		Period: From 01/01/2020 To 12/31/2020		pare
	I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1, 513	135			10.00	1.
.00 HMO and other (see instructions) .00 HMO IPF Subprovider	0	307 0				2.
00 HMO IRF Subprovider 00 Hospital Adults & Peds. Swing Bed SNF	0 246	0	28	5		4.
.00 Hospital Adults & Peds. Swing Bed NF .00 Total Adults and Peds. (exclude observation beds) (see instructions)	1, 759	0 135	3 3, 42			6. 7.
. 00 I NTENSI VE CARE UNI T . 00 CORONARY CARE UNI T 0. 00 BURN I NTENSI VE CARE UNI T 1. 00 SURGI CAL I NTENSI VE CARE UNI T 2. 00 OTHER SPECI AL CARE (SPECI FY) 3. 00 NURSERY		239	39	2		8. 9. 10. 11. 12. 13.
 4.00 Total (see instructions) 5.00 CAH visits 5.00 SUBPROVIDER - IPF 7.00 SUBPROVIDER - IRF 8.00 SUBPROVIDER 9.00 SKILLED NURSING FACILITY 0.00 NURSING FACILITY 	1, 759 0	374 0	3, 81		321.74	14 15 16 17 18 19 20
1. 00 OTHER LONG TERM CARE 2. 00 HOME HEALTH AGENCY 3. 00 AMBULATORY SURGICAL CENTER (D. P.) 4. 00 HOSPICE	0	0		0 0.00	0. 00	21 22 23 24
.10 HOSPICE (non-distinct part) .00 CMHC - CMHC				0		24 25
 0.00 RURAL HEALTH CLINIC 0.01 RURAL HEALTH CLINIC II 0.25 FEDERALLY QUALIFIED HEALTH CENTER 7.00 Total (sum of lines 14-26) 	5, 388 4, 171 0	2, 359 3, 447 0		6 0. 00 0 0. 00 0. 00	25. 09 0. 00	26 26 27
 .00 Observation Bed Days .00 Ambulance Trips .00 Employee discount days (see instruction) .00 Employee discount days - IRF 	1, 160	0		0		28 29 30 31
 Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) 	0	0	9	2 0		32
3.00 LTCH non-covered days 3.01 LTCH site neutral days and discharges	0 0					33

	SPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICA		Provider CCN: 15-1332		Period: From 01/01/2020 To 12/31/2020	Worksheet S-3 Part I Date/Time Prepar <u>6/22/2021 8:27 p</u>	
		Full Time		Di s	charges		
	Component	Equi val ents Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
8 Ho fo fo 2.00 HM 3.00 HM 4.00 HM 5.00 HO 5.00 HO 6.00 HO 7.00 TO 8.00 IN 9.00 CO 10.00 BU 11.00 SU 12.00 OT 13.00 NU 14.00 To 15.00 CA 16.00 SU 17.00 SU 19.00 SK 20.00 HO 21.00 OT 22.00 HO 23.00 AM 24.10 HO 25.00 CM 26.01 RU 26.02 FE 27.00 TO 28.00 Ob 29.00 Am	Associated as a series of the	0.00 0.00 0.00 0.00 0.00 0.00 0.00	0	4	14.00 20 289 0 0 20 289 20 289	1, 536	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 11. 00 12. 00 13. 00
31.00 Em 32.00 La 32.01 To ou	ployee discount days - IRF bor & delivery days (see instructions) tal ancillary labor & delivery room tpatient days (see instructions) CH non-covered days				0		31. 0 32. 0 32. 0 33. 0

Heal th	Financial Systems DI	ECATUR CO. MEM	IORI AL HOSPI TAL		In Li	eu of Form CMS-	2552-10
HOSPI T	AL-BASED RHC/FQHC STATISTICAL DATA		Provider C		Period:	Worksheet S-8	3
			Component		From 01/01/2020 To 12/31/2020		
					RHC I		
					1	. 00	-
	Clinic Address and Identification						
1.00	Street			4	955 N MI CHI GAI		1.00
				ty 00	State 2.00	ZIP Code 3.00	
2.00	City, State, ZIP Code, County		GREENSBURG	00		V47240	2.00
						1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rur	ral or "U" for		Award	Date 0	3.00
					. 00	2.00	
	Source of Federal Funds						
4.00	Community Health Center (Section 330(d), PHS						4.00
5.00	Migrant Heal th Center (Section 329(d), PHS A						5.00
6.00 7.00	Health Services for the Homeless (Section 34 Appalachian Regional Commission	U(U), PHS ACT)					6.00 7.00
8.00	Look-Alikes						8.00
9.00	OTHER (SPECI FY)						9.00
					1.00	0.00	
10.00	Does this facility operate as other than a h	osni tal -hased	RHC or EOHC2 E	nter "Y" for	1.00 N	2.00	10.00
10.00	yes or "N" for no in column 1. If yes, indic 2. (Enter in subscripts of line 11 the type o hours.)	ate number of	other operatio	ons in column			10.00
		Sur	nday	Mor	ndav	Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
11 00	Facility hours of operations (1) CLINIC	09: 00	12:00	08: 00	07: 00	08: 00	1 11 00
11.00		09:00	12:00	08:00	07:00	08:00	11.00
					1.00	2.00	
	Have you received an approval for an excepti				Y		12.00
13.00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report.	umn 1. lf yes,	enter in colu	ımn 2 the	N	0	13.00
	numbers below.						
					ler name	CCN number	
14.00	DUC (FOUG name CON number			1.	. 00	2.00	14.00
14.00	RHC/FQHC name, CCN number	Y/N	V	XVIII	XIX	Total Visits	14.00
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all						15.00
	GME cost? Enter "Y" for yes or "N" for no in						
	column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by						
	Intern & Residents for titles V, XVIII, and						
	XIX, as applicable. Enter in column 5 the						
	number of total visits for this provider. (see instructions)						
		L	Сог	unty			
				00			
2.00	City, State, ZIP Code, County		DECATUR				2.00
		Tuesday		esday tota		rsday to	
		to 6.00	from 7.00	to 8.00	from 9.00	to 10.00	
	Facility hours of operations (1)						
11.00	CLINIC	07: 00	08: 00	07: 00	08: 00	07: 00	11.00

						2552-10
HOSPI TAL-BASED RHC/FQHC STATI STI CAL DATA	Provider C		Peri od:	Worksheet S-8		
		Component		From 01/01/2020 To 12/31/2020	Data/Tima Dra	narod
		component	CCN. 15-6522	10 12/31/2020	Date/Time Pre 6/22/2021 8:2	
	_			RHC I		
	Fri	day	Sat	turday		
	from	to	from	to		
	11.00	12.00	13.00	14.00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 00	07:00	09: 00	12:00		11.00

Heal th	Financial Systems D	ECATUR CO. MEM	ORIAL HOSPITAL		In Li	eu of Form CMS-	2552-10
	AL-BASED RHC/FQHC STATI STI CAL DATA		Provider C		Period:	Worksheet S-8	
			Component		rom 01/01/202 o 12/31/202	0 Date/Time Pre	
					RHC II	6/22/2021 8:2	27 pm
							4
	Clinic Address and Identification				1	. 00	
1.00	Street				718 N LINCOLN	STREET	1.00
	1		Ci	ty	State	ZIP Code	
	1			00	2.00	3.00	
2.00	City, State, ZIP Code, County		GREENSBURG			N 47240	2.00
						1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rur	al or "U" for	urban		0	3.00
					Award	Date	
				1.	00	2.00	
4.00	Source of Federal Funds Community Health Center (Section 330(d), PHS	Act				1	4.00
4.00 5.00	Migrant Heal th Center (Section 329(d), PHS A						5.00
6.00	Health Services for the Homeless (Section 34						6.00
7.00	Appalachian Regional Commission						7.00
8.00	Look-Alikes						8.00
9.00	OTHER (SPECI FY)						9.00
					1.00	2.00	
10.00	Does this facility operate as other than a h	ospi tal -based	RHC or FQHC? E	nter "Y" for	N	0	10.00
	yes or "N" for no in column 1. If yes, indic						
	2. (Enter in subscripts of line 11 the type o	f other operat	ion(s) and the	operating			
	hours.)	Sun	iday	Mor	nday	Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
11 00	Facility hours of operations (1)		1	07.00	05.00	107.00	111 00
11.00	CLINIC			07: 30	05: 00	07: 30	11.00
					1.00	2.00	
12.00	Have you received an approval for an excepti	on to the prod	uctivity stand	ard?	Y		12.00
13.00	Is this a consolidated cost report as define				N	0	13.00
	30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report.						
	numbers below.						
					er name	CCN number	
11.00				1.	00	2.00	
14.00	RHC/FQHC name, CCN number	Y/N	V	XVIII	XIX	Total Visits	14.00
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all						15.00
	GME cost? Enter "Y" for yes or "N" for no in						
	column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by						
	Intern & Residents for titles V, XVIII, and						
	XIX, as applicable. Enter in column 5 the						
	number of total visits for this provider.						
	(see instructions)		Col	l Inty			
				00	-		
2.00	City, State, ZIP Code, County		DECATUR				2.00
		Tuesday		esday	-	irsday	
		to	from 7.00	to 8.00	from 9.00	to	
	Facility hours of operations (1)	6.00	7.00	0.00	9.00	10.00	
11.00		05: 00	07: 30	05: 00	07: 30	05: 00	11.00

Health Financial Systems [DECATUR CO. MEM	ORIAL HOSPITAL	In Lieu of Form CMS-2552-10			
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider C	CN: 15-1332	Period:	Worksheet S-8	
		Component	CCN: 15-8521	From 01/01/2020 To 12/31/2020	Date/Time Pre 6/22/2021 8:2	
				RHC II		
	Fri	day	Sa	turday		
	from	to	from	to		
	11.00	12.00	13.00	14.00		
Facility hours of operations (1)						
11. 00 CLINIC	07: 30	05:00				11.00

Heal th	Financial Systems DECATUR CO. MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
		Provider CCN: 15-1332	Peri od:	Worksheet S-1	
			From 01/01/2020		
			To 12/31/2020	Date/Time Pre 6/22/2021 8:2	
				0/22/2021 0.2	7 pm
				1.00	
	Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	<u>vided by line 202 colu</u>	mn 8)	0. 439837	1.00
	Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid			4, 203, 726	2.00
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		cal d?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments fr	om medical d		1, 347, 861	5.00
6.00	Medicaid charges		27, 342, 520	6.00 7.00	
7.00 8.00				12, 026, 252 6, 474, 665	7.00 8.00
0.00	<pre>< zero then enter zero)</pre>	THES Z and S, TT	0, 474, 003	8.00	
	Children's Health Insurance Program (CHIP) (see instructions fo	r each line)		L	
9.00	Net revenue from stand-al one CHIP			0	9.00
10.00	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-alone CHIP (line 11 minus line 9;	if < zero then	0	12.00
	enter zero)	•			
	Other state or local government indigent care program (see inst	ructions for each lin	e)		
13.00	Net revenue from state or local indigent care program (Not incl			0	13.00
14.00	Charges for patients covered under state or local indigent care	e program (Not include	d in lines 6 or	0	14.00
	10)				
15.00	State or local indigent care program cost (line 1 times line 14			0	15.00
16.00	Difference between net revenue and costs for state or local ind	ligent care program (l	ine 15 minus line	0	16.00
	13; if < zero then enter zero)	D and state (Less) ind	lacet core preas		
	Grants, donations and total unreimbursed cost for Medicaid, CHI instructions for each line)	P and state/local ind	rgent care progra	IIIS (See	
17.00	Private grants, donations, or endowment income restricted to fu	unding charity care		0	17.00
	Government grants, appropriations or transfers for support of h			0	18.00
	Total unreimbursed cost for Medicaid , CHIP and state and local		ms (sum of lines	6, 474, 665	
	8, 12 and 16)				
		Uni nsured		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 fac	ility 1,745,4	23 0	1, 745, 423	20.00
20.00	(see instructions)	1,745,4	23 0	1, 745, 425	20.00
21.00	Cost of patients approved for charity care and uninsured discou	ints (see 767, 7	02 0	767, 702	21.00
	instructions)			,	
22.00	Payments received from patients for amounts previously written	off as	0 0	0	22.00
	chari ty care				
23.00	Cost of charity care (line 21 minus line 22)	767, 7	/02 0	767, 702	23.00
				1.00	
24.00	Does the amount on line 20 column 2, include charges for patien		h of stay limit	N	24.00
25 00	imposed on patients covered by Medicaid or other indigent care			0	25 00
25.00	If line 24 is yes, enter the charges for patient days beyond th stay limit	ie findigent care progr	all S rength of	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see ins	tructions)		5, 001, 477	26.00
20.00	Medicare reimbursable bad debts for the entire hospital complex (see his			402, 104	20.00
27.00	Medicare allowable bad debts for the entire hospital complex (s		618, 621	27.00	
28.00	Non-Medicare bad debt expense (see instructions)			4, 382, 856	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt exp	ense (see instruction	s)	2, 144, 259	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		,	2, 911, 961	30.00
	Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)		9, 386, 626	
		-			

	Financial Systems DE IFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	CATUR CO. MEMOR F EXPENSES	Provi der C		eriod:	u of Form CMS-2 Worksheet A	2552-10
					rom 01/01/2020 o 12/31/2020	Date/Time Pre 6/22/2021 8:2	
	Cost Center Description	Sal ari es	Other		Recl assi fi cat	Recl assi fi ed	
				+ col. 2)	ions (See A-6)	Trial Balance (col. 3 +-	
					A 0)	col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS		0.004.050	0.004.050		0.004.050	1 1 00
	00100 CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT	206, 087	3, 934, 252 7, 886, 384	3, 934, 252 8, 092, 471		3, 934, 252 8, 092, 471	1.00
	00500 ADMI NI STRATI VE & GENERAL	4, 908, 173	8, 685, 916			13, 306, 197	5.00
	00600 MAINTENANCE & REPAIRS	384, 805	960, 926			1, 345, 731	
	00700 OPERATION OF PLANT	0	952, 412	952, 412		952, 412	
	00800 LAUNDRY & LINEN SERVICE	62, 572	43, 252	105, 824		105, 824	8.00
	00900 HOUSEKEEPI NG 01000 DI ETARY	340, 172 228, 055	261, 681 637, 033	601, 853 865, 088		601, 853 191, 731	•
	D1100 CAFETERI A	220,033	037,033	005,000		673, 357	11.00
	01300 NURSI NG ADMI NI STRATI ON	625, 936	13, 275	639, 211		639, 211	
	01400 CENTRAL SERVICES & SUPPLY	58, 298	18, 154	76, 452		76, 452	
	01500 PHARMACY	852, 949	229, 849	1, 082, 798		1,082,798	•
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	459, 846 288, 618	149, 571	609, 417 300, 888		609, 417 300, 888	
	NPATIENT ROUTINE SERVICE COST CENTERS	200,010	12, 270	300, 888	0	300, 888	17.00
30.00 0	03000 ADULTS & PEDIATRICS	3, 435, 089	171, 375	3, 606, 464	-211, 345	3, 395, 119	30.00
	04300 NURSERY	0	0	0	135, 495	135, 495	43.00
	NCI LLARY SERVICE COST CENTERS	1.015.5(0)	(00, 100)	1 0 (0 (0 0		1 0 (0 (0 0	1
	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	1, 245, 569 0	623, 123 0	1, 868, 692 0		1, 868, 692 75, 850	
	05300 ANESTHESI OLOGY	705, 476	586, 711	1, 292, 187		1, 351, 871	
	05400 RADI OLOGY-DI AGNOSTI C	1, 346, 036	1, 792, 266	3, 138, 302		2, 987, 873	
	05500 RADI OLOGY – THERAPEUTI C	0	0	0		0	55.00
	03630 ULTRA SOUND	0	52, 800	52, 800		203, 229	
	06000 LABORATORY	370, 708	3, 431, 493	3, 802, 201		3, 802, 201	60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06500 RESPI RATORY THERAPY	0 709, 625	94, 793 205, 582	94, 793 915, 207		94, 793 828, 559	
	06600 PHYSI CAL THERAPY	847, 181	15, 354	862, 535		862, 535	
67.00 C	06700 OCCUPATI ONAL THERAPY	275, 614	4, 438			280, 052	
	06800 SPEECH PATHOLOGY	146, 428	32, 675	179, 103		179, 103	
	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	144, 311	29, 962	174, 273		260, 921	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	2, 423, 314 0	2, 423, 314		1, 621, 767 741, 863	•
	07300 DRUGS CHARGED TO PATIENTS	0	7, 678, 945	7, 678, 945		7, 678, 945	
0	DUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	2, 442, 777	211, 612			2, 940, 171	
	08801 RURAL HEALTH CLINIC II 09000 CLINIC	2, 346, 513	309, 326 139, 960				88.01
	09000 CLINIC 09001 ONCOLOGY	1, 204, 607 363, 451	218, 193	1, 344, 567 581, 644		1, 344, 567 581, 644	90.00
	09002 OUTPATIENT CLINIC	140, 900	4, 379	145, 279		145, 279	
90.03 0	09003 PROVIDER BASED CLINIC - TCMP	0	0	0	0	0	
	09004 PROVIDER BASED CLINIC - DCPC	0	0	0	0	0	90.04
	09005 PROVIDER BASED CLINIC - WESTPORT	1, 876 472, 757	84 102, 715	1, 960 575, 472		1, 960 575, 472	
	09007 WOMEN'S HEALTH SERVICES	1, 218, 958	82, 663			1, 301, 621	90.00
	09008 PAIN MANAGEMENT	0	0	0		0	90.08
	09009 GERIATRI C PSYCH	35, 738	361, 758			397, 496	
	09010 PROVIDER BASED CLINIC - DCPM	572, 648	7,974	580, 622		580, 622	90.10
	09011 PROVIDER BASED CLINIC - NEPHROLOGY 09012 DIABETES CLINIC	189, 845 4, 744	101 3, 366	189, 946 8, 110		189, 946 8, 110	
	09013 NEUROLOGY	257, 297	3, 300	257, 668		257, 668	
	09014 FOOT AND ANKLE	108, 584	5, 626	114, 210		114, 210	•
91.00 0	09100 EMERGENCY	1, 744, 977	1, 163, 551	2, 908, 528	0	2, 908, 528	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS	965, 240	100, 814	1, 066, 054	0	1,066,054	95 00
	10100 HOME HEALTH AGENCY	005, 240	00,014				101.00
	SPECIAL PURPOSE COST CENTERS	-	-			-	1
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	29, 712, 460	43, 640, 299	73, 352, 759	684	73, 353, 443]118.00
	IONREI MBURSABLE COST CENTERS		2			2	100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0			190.00 192.00
	07950 MARKETING	202, 368	377, 646	-		579, 330	
194.020	07952 NRCC	0	0	0	0	0	194.02
194.050	07955 RETAIL PHARMACY	404, 958	2, 611, 696 46, 629, 641			3, 016, 654 76, 949, 427	
200.00	TOTAL (SUM OF LINES 118 through 199)	30, 319, 786			0		

CLASSIFIC	CATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider C	CN: 15-1332	Period: From 01/01/2020	Worksheet A	
					To 12/31/2020	Date/Time Prep 6/22/2021 8:27	
	Cost Center Description	Adjustments	Net Expenses			0/22/2021 0.2/	_pii
		(See A-8)	For				
	-	6.00	Allocation				
GENE	RAL SERVICE COST CENTERS	6.00	7.00				
	O CAP REL COSTS-BLDG & FIXT	-78,970	3, 855, 282				1.
	O EMPLOYEE BENEFITS DEPARTMENT	-906, 236	7, 186, 235				4.
00 0050	O ADMINI STRATI VE & GENERAL	-3, 108, 016	10, 198, 181				5
0000 0060	O MAINTENANCE & REPAIRS	0	1, 345, 731				6
00 0070	O OPERATION OF PLANT	0	952, 412				7
	O LAUNDRY & LI NEN SERVI CE	0	105, 824				8
	O HOUSEKEEPI NG	0	601, 853				9
	O DI ETARY	-142, 390	49, 341				10
		0	673, 357				11
	0 NURSING ADMINISTRATION 10 CENTRAL SERVICES & SUPPLY	-950 27, 861-	638, 261 48, 591				13 14
	0 PHARMACY	-27,801	1, 082, 798				15
	0 MEDICAL RECORDS & LIBRARY	0	609, 417				16
	0 SOCI AL SERVI CE	0	300, 888				17
	TIENT ROUTINE SERVICE COST CENTERS						
00 0300	0 ADULTS & PEDIATRICS	-636, 510	2, 758, 609				30
	0 NURSERY	0	135, 495				43
	LLARY SERVICE COST CENTERS						
	O OPERATING ROOM	-96, 928	1, 771, 764	1			50
	O DELIVERY ROOM & LABOR ROOM	0	75, 850				52
	O ANESTHESI OLOGY	-1, 201, 767	150, 104				53
	0 RADI OLOGY-DI AGNOSTI C 10 RADI OLOGY - THERAPEUTI C	-1, 122, 466 0	1, 865, 407 0				54 55
	0 ULTRA SOUND	0	203, 229				55
	0 LABORATORY	-431,075	3, 371, 126				60
	0 WHOLE BLOOD & PACKED RED BLOOD CELL	431, 075	94, 793				62
	0 RESPI RATORY THERAPY	-49, 801	778, 758				65
	0 PHYSI CAL THERAPY	-149, 281	713, 254				66
00 0670	O OCCUPATI ONAL THERAPY	-79, 274	200, 778				67
	O SPEECH PATHOLOGY	-9, 026	170, 077				68
	0 ELECTROCARDI OLOGY	-12, 600	248, 321				69
	O MEDI CAL SUPPLIES CHARGED TO PATIENT	0	1, 621, 767				71
	O IMPL. DEV. CHARGED TO PATIENTS	1 507 000	741,863				72
	0 DRUGS CHARGED TO PATIENTS	-1, 597, 898	6, 081, 047				73
	0 RURAL HEALTH CLINIC	0	2, 940, 171				88
	1 RURAL HEALTH CLINIC II	0	2, 658, 633				88
	O CLINIC	-938, 877	405, 690				90
01 0900	1 ONCOLOGY	-191, 774	389, 870				90
02 0900	2 OUTPATIENT CLINIC	-4, 923	140, 356				90
	3 PROVIDER BASED CLINIC - TCMP	0	0				90
	4 PROVIDER BASED CLINIC - DCPC	0	0				90
	5 PROVIDER BASED CLINIC - WESTPORT	0					90
	6 CLINIC 7 WOMEN'S HEALTH SERVICES	-246, 167	329, 305				90
	8 PAIN MANAGEMENT	-1, 079, 657 183, 524	221, 964 183, 524				90 90
	9 GERIATRIC PSYCH	183, 524	410, 904				90 90
	O PROVIDER BASED CLINIC - DCPM	-493, 092	87, 530				90 90
	1 PROVIDER BASED CLINIC - NEPHROLOGY	-154, 909	35, 037				90
	2 DI ABETES CLINIC	-1, 300	6, 810			1	90
	3 NEUROLOGY	-252, 792	4, 876			1	90
	4 FOOT AND ANKLE	-91, 031	23, 179				90
	O EMERGENCY	-580, 337	2, 328, 191			1	91
	0 OBSERVATION BEDS (NON-DISTINCT PART						92
	R REIMBURSABLE COST CENTERS	0.010	1 0/0 400				05
	O AMBULANCE SERVICES	2,068	1, 068, 122			1	95
	O HOME HEALTH AGENCY	0	0			1	101
3. 00	SUBTOTALS (SUM OF LINES 1 through 117)	-13, 486, 908	59, 866, 535				118
	EIMBURSABLE COST CENTERS	- 13, 400, 700	57,000,000	I			. 10
	O GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0			11	190
	0 PHYSI CI ANS' PRI VATE OFFI CES	0	0				192
1.000795	O MARKETI NG	0	579, 330				194
1. 02 0795		0	0				194
	5 RETAIL PHARMACY	0	3, 016, 654				194
0. 00		12 106 000					200

Heal th	Fi nanci al	Systems
RECLAS	SI FI CATI ON	IS

Heal th	Financial Systems	DE	CATUR CO. MEMOR	IAL HOSPITAL	-	In Lieu	ı of Form CMS	5-2552-10
RECLAS	SI FI CATI ONS			Provider (CCN: 15-1332	Period: From 01/01/2020 To 12/31/2020	Worksheet A Date/Time P 6/22/2021 8	repared:
		Increases						
	Cost Center	Line #	Sal ary	Other				
	2.00	3.00	4.00	5.00				
	A - ULTRASOUND SALARY RECLASS							
1.00	ULTRA SOUND	<u>55.</u> 01	<u> </u>	00	-			1.00
	0		150, 429	0				_
	B - L&D AND NURSERY RECLASS				1			
1.00	NURSERY	43.00	127, 776	7, 719				1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	7 <u>1,5</u> 29	4, 321	-			2.00
			199, 305	12, 040				_
	C - EKG SALARY RECLASS	(0.00	o (, , , , , , , , , , , , , , , , , ,					
1.00	ELECTROCARDI OLOGY	69.00	86, 648	00				1.00
			86, 648	0				_
1 00	D - CAFETERIA RECLASS	11.00	477 544	405 044				1 00
1.00	CAFETERI A	<u>11.00</u>	177,511	495,846				1.00
			177, 511	495, 846				_
1 00	E - ANESTHESI A GAS EXPENSE ANESTHESI OLOGY	F2 00	0	FO (04	1			1 00
1.00		<u>53.00</u>	0	<u>59, 684</u> 59, 684				1.00
	F - MARKETING EXPENSE RECLASS		U	59, 084				_
1.00	ADMINISTRATIVE & GENERAL	5.00	ol	684				1.00
1.00	O GENERAL			_ <u> </u>				1.00
	G - IMPLANTABLE DEVICES		U	004				_
1.00	IMPL. DEV. CHARGED TO	72.00	0	741,863				1.00
1.00	PATIENTS	72.00	0	741,003				1.00
		+		741,863	-			
	H - RCH CALL CENTER RECLASS		Ŋ	741,003				
1.00	RURAL HEALTH CLINIC	88.00	143, 103	1, 185				1.00
2.00	RURAL HEALTH CLINIC II	88.01	143, 103	1, 185				2.00
2.00			286, 206	<u>1, 185</u> 2, 370				2.00
	I - RHC SALARY RECLASS		200, 200	2, 370	I			-
1.00	RURAL HEALTH CLINIC	88.00	141, 494	0				1.00
1.00			141, 494	0	1			1.00
500 00	Grand Total: Increases		1, 041, 593	1, 312, 487	1			500.00
500.00		I	1, 041, 575	1, 512, 407	I			1 300.00

RECLASS	SI FI CATI ONS			Provi der	CCN: 15-1332	Period: From 01/01/2020	Worksheet A	-6
						To 12/31/2020	Date/Time F 6/22/2021 8	
		Decreases						
	Cost Center	Line #	Sal ary	Other	Wkst. A-7 Ref	F		
	6.00	7.00	8.00	9.00	10.00			
	A - ULTRASOUND SALARY RECLASS				1			
1.00	RADI OLOGY-DI AGNOSTI C	54.00	15 <u>0, 4</u> 29	0)	Q		1.00
	0		150, 429	0)			
	B - L&D AND NURSERY RECLASS				1			
1.00	ADULTS & PEDIATRICS	30. 00	199, 305	12,040)	0		1.00
2.00		0.00	0	()	Q		2.00
	0		199, 305	12, 040)			
	C – EKG SALARY RECLASS							
1.00	RESPI RATORY_THERAPY	<u> </u>	<u> </u>	()	0		1.00
	0		86, 648	C)			
	D - CAFETERIA RECLASS							
1.00	DI ETARY	10.00	177, 511	495, 846	b	0		1.00
	0		177, 511	495, 846	b			
	E - ANESTHESIA GAS EXPENSE							
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	59, 684	Ļ	0		1.00
	PATI ENT							
	0	T		59,684	ļ	7		
	F - MARKETING EXPENSE RECLASS							
1.00	MARKETING	194.00	0	684	Ļ	0		1.00
	0			684	ļ			
	G – IMPLANTABLE DEVICES							
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	741, 863	3	0		1.00
	PATIENT							
	0			741,863	3	7		
	H - RCH CALL CENTER RECLASS	· · · ·				· ·		
1.00	ADMI NI STRATI VE & GENERAL	5.00	286, 206	2, 370)	0		1.00
2.00		0.00	0	C)	0		2.00
		+	286, 206	2, 370)	7		
	I - RHC SALARY RECLASS							
1.00	RURAL HEALTH CLINIC II	88.01	141, 494	()	0		1.00
		+	141, 494	;		1		
F00 00	Grand Total: Decreases		1,041,593	1, 312, 487	7			500.00

Heal th	Financial Systems D	ECATUR CO. MEMO	ORIAL HOSPITAL			In Lie	u of Form CMS-2	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider CO		То	od: 01/01/2020 12/31/2020		pared:
				IS				
		Begi nni ng	Purchases	Donati on		Total	Disposals and	
		Bal ances					Retirements	
		1.00	2.00	3.00		4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES						
1.00	Land	1, 134, 637	0		0	0	0	1.00
2.00	Land Improvements	537, 869	0		0	0	0	2.00
3.00	Buildings and Fixtures	35, 743, 871	25, 749		0	25, 749	0	3.00
4.00	Building Improvements	8, 630, 651	0		0	0	0	4.00
5.00	Fixed Equipment	2, 557, 216	0		0	0	0	5.00
6.00	Movable Equipment	18, 098, 526	739, 398		0	739, 398	45, 927	6.00
7.00	HIT designated Assets	8, 174, 780	6, 761, 851		0	6, 761, 851	0	
8.00	Subtotal (sum of lines 1-7)	74, 877, 550	7, 526, 998		0	7, 526, 998	45, 927	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	74, 877, 550	7, 526, 998		0	7, 526, 998	45, 927	10.00
		Endi ng	Fully					
		Bal ance	Depreciated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES						
1.00	Land	1, 134, 637	0					1.00
2.00	Land Improvements	537, 869	0					2.00
3.00	Buildings and Fixtures	35, 769, 620	0					3.00
4.00	Building Improvements	8, 630, 651	0					4.00
5.00	Fixed Equipment	2, 557, 216	0					5.00
6.00	Movable Equipment	18, 791, 997	0					6.00
7.00	HIT designated Assets	14, 936, 631	0					7.00
8.00	Subtotal (sum of lines 1-7)	82, 358, 621	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	82, 358, 621	0					10.00
	· · ·	•						•

Health Financial Systems	ECATUR CO. MEMO	ORIAL HOSPITAL		In Lieu of Form CMS-2552-10					
RECONCILIATION OF CAPITAL COSTS CENTERS				Period: From 01/01/2020	Worksheet A-7 Part II				
				To 12/31/2020	Date/Time Pre				
					6/22/2021 8:2	7 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, COLUN	<u>/N 2, LINES 1 a</u>	and 2						
1.00 CAP REL COSTS-BLDG & FIXT	3, 806, 565	0	127, 68	7 0	0	1.00			
3.00 Total (sum of lines 1-2)	3, 806, 565	0	127, 68	7 0	0	3.00			
	SUMMARY O	F CAPITAL							
Cost Center Description	Other	Total (1)							
	Capital-Relat	(sum of cols.							
	ed Costs (see	9 through 14)							
	instructions)	0,							
	14.00	15.00							
PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	/N 2, LINES 1 a	and 2						
1.00 CAP REL COSTS-BLDG & FIXT	0	3, 934, 252				1.00			
3.00 Total (sum of lines 1-2)	0	3, 934, 252				3.00			

Health Financial Systems	ECATUR CO. MEMO	ORIAL HOSPITAL		In Lieu of Form CMS-2552-				
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/2020 To 12/31/2020		pared:		
	COMF	PUTATION OF RA	TI OS	ALLOCATION OF				
Cost Center Description	Gross Assets	Capi tal i zed Leases			Insurance			
	1.00	2.00	3.00	4.00	5.00			
PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS		•					
1.00 CAP REL COSTS-BLDG & FIXT	63, 566, 624	0	63, 566, 62	4 1.000000	0	1.00		
3.00 Total (sum of lines 1-2)	63, 566, 624	0	63, 566, 62			3.00		
	ALLOCA	ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL						
Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease			
		0	0	Capi tal -Rel at				
		ed Costs	through 7)					
	6.00	7.00	8.00	9.00	10.00			
PART III - RECONCILIATION OF CAPITAL COSTS C	1		1					
1.00 CAP REL COSTS-BLDG & FIXT	0			0 3, 855, 282		1.00		
3.00 Total (sum of lines 1-2)	0	•		0 3, 855, 282	0	3.00		
		SL	JMMARY OF CAPI	_				
Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)			
		(see	instructions)					
		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	ENTERS							
1.00 CAP REL COSTS-BLDG & FIXT	0	0		0 0	3, 855, 282	1.00		
3.00 Total (sum of lines 1-2)	0	0	1	0 0	3, 855, 282	3.00		

ADJUST	MENTS TO EXPENSES			Provider CCN: 15-1332	Period: From 01/01/2020 To 12/31/2020	Worksheet A-8	
					To 12/31/2020	Date/Time Pre 6/22/2021 8:2	
				Expense Classification of			
			Tc	p/From Which the Amount i	s to be Adjusted		
		Deel a (Carla	A	Cost Costor	1	WU + A 7	
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL	A	-127, 687 CA	AP REL COSTS-BLDG & FIXT	1.00	11	1.00
0.00	COSTS-BLDG & FIXT (chapter 2)		0.**				0.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0^^	** Cost Center Deleted **	* 2.00	0	2.00
3.00	Investment income - other		0		0.00	0	3.00
	(chapter 2)						
4.00	Trade, quantity, and time		0		0.00	0	4.00
5.00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5.00
5.00	expenses (chapter 8)		0		0.00	0	0.00
6.00	Rental of provider space by		0		0.00	0	6.00
7 00	suppliers (chapter 8)				0.00		7 00
7.00	Telephone services (pay stations excluded) (chapter		0		0.00	0	7.00
	21)						
8.00	Television and radio service		0		0.00	0	8.00
9.00	(chapter 21)		0		0.00	0	0.00
9.00 10.00	Parking lot (chapter 21) Provider-based physician	A-8-2	-6, 967, 972		0.00	0	
10.00	adjustment	N 0 2	0, 707, 772			Ŭ	10.00
11.00	Sale of scrap, waste, etc.		О		0.00	0	11.00
12 00	(chapter 23)	A 0 1	220,010			0	12 00
12.00	Related organization transactions (chapter 10)	A-8-1	328, 019			0	12.00
13.00	Laundry and linen service		О		0.00	0	13.00
14.00	Cafeteria-employees and guests	В	0 CA	AFETERI A	11.00	0	
15.00	Rental of quarters to employee		0		0.00	0	15.00
16.00	and others Sale of medical and surgical		0		0.00	0	16.00
101.00	supplies to other than		Ű		0.00	U	10100
	patients						
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00			О		0.00	0	18.00
	abstracts						
19.00	Nursing and allied health		0		0.00	0	19.00
	education (tuition, fees, books, etc.)						
20.00	Vending machines	В	-925 DI	ETARY	10.00	0	20.00
21.00	Income from imposition of		0		0.00	0	21.00
	interest, finance or penalty						
22 00	charges (chapter 21) Interest expense on Medicare		o		0.00	0	22.00
221 00	overpayments and borrowings to		0		0.00	Ŭ	22100
	repay Medicare overpayments						
23.00	Adjustment for respiratory	A-8-3	ORE	ESPI RATORY THERAPY	65.00		23.00
	therapy costs in excess of limitation (chapter 14)						
24.00	Adjustment for physical	A-8-3	0 PH	IYSI CAL THERAPY	66.00		24.00
	therapy costs in excess of						
25 00	limitation (chapter 14) Utilization review –		0 * *	** Cost Center Deleted **	* 114.00		25.00
25.00	physicians' compensation		0	cost center bereted	114.00		25.00
	(chapter 21)						
26.00	Depreciation - CAP REL		AD O	AP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	COSTS-BLDG & FIXT Depreciation - CAP REL		0.**	** Cost Center Deleted **	* 2.00	0	27.00
21.00	COSTS-MVBLE EQUIP		U	JUST VEHICE DELETER	2.00	0	27.00
28.00	Non-physician Anesthetist		0 * *	** Cost Center Deleted **			28.00
29.00	Physicians' assistant		0		0.00	0	
30.00	Adjustment for occupational therapy costs in excess of	A-8-3	000	CCUPATIONAL THERAPY	67.00		30.00
	limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		OAD	OULTS & PEDIATRICS	30.00		30. 99
	instructions)						I

ADJUST	MENTS TO EXPENSES				eri od:	Worksheet A-8	3
					rom 01/01/2020 o 12/31/2020	Date/Time Pre 6/22/2021 8:2	
				Expense Classification on	Worksheet A	0/22/2021 0.2	<u>27 piii</u>
				To/From Which the Amount is			
	Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	<u> </u>
		(2)				Ref.	
		1.00	2.00	3.00	4.00	5.00	
I. 00	Adjustment for speech	A-8-3	-9, 026	SPEECH PATHOLOGY	68.00		31.
	pathology costs in excess of						
	limitation (chapter 14)		_				
2.00	CAH HIT Adjustment for	A	0	CAP REL COSTS-BLDG & FIXT	1.00	9	32.
00	Depreciation and Interest	В	204 227		F 00	o	33.
3.00 3.01	PHYSICIAN MALPRACTICE COSTS ADMIN REBATES/DISCOUNTS	В		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5.00 5.00		
. 01	ADMIN REBATES/DISCOUNTS	В		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5.00		
. 02	CATERING COSTS	B	-141, 465		10.00	0	
. 03	MEDICAL RECORDS MISC REVENUE	B		CENTRAL SERVICES & SUPPLY	14.00	0	
. 04	OP CLINIC MISC REVENUE	B		OUTPATIENT CLINIC	90.02	0	
. 06	NURSING ADMIN REVENUE	B		NURSING ADMINISTRATION	13.00	0	
. 07	LAB MI SC REVENUE	B		LABORATORY	60,00	0	
. 08	PT MI SC REVENUE	В		PHYSI CAL THERAPY	66.00	0	
. 09	OT MISC REVENUE	В		OCCUPATI ONAL THERAPY	67.00	0	
. 10	PHARMACY REBATES/DI SCOUNTS	В		DRUGS CHARGED TO PATIENTS	73.00	0	
. 11	PHARMACY MISC REVENUE	В		DRUGS CHARGED TO PATIENTS	73.00	0	
. 12	RADI OLOGY REVENUE	В		RADI OLOGY-DI AGNOSTI C	54.00	0	33
. 13	WOMEN'S CLINIC MISC REVENUE	В	-90	WOMEN'S HEALTH SERVICES	90.07	0	33
. 14	PAIN MGMT MISC REVENUE	В	-95, 778	PAIN MANAGEMENT	90.08	0	33.
. 15	DIABETES MISC REVENUE	В	-1, 300	DIABETES CLINIC	90. 12	0	33.
. 16	340B COSTS	В	-1, 576, 424	DRUGS CHARGED TO PATIENTS	73.00	0	33
. 17	LEASED SPACE RENTAL INCOME	В		ADMI NI STRATI VE & GENERAL	5.00	0	
. 18	PHYSI CI AN RECRUI TMENT	A		ADMI NI STRATI VE & GENERAL	5.00	0	
. 19	PATIENT TELEPHONE EXPENSE	A		ADMI NI STRATI VE & GENERAL	5.00	0	
. 20	PATIENT TELEPHONE BENEFITS	A		EMPLOYEE BENEFITS DEPARTMENT		0	
. 21	PHYSI CI AN BENEFI TS	A		EMPLOYEE BENEFITS DEPARTMENT		0	
. 22	AHA/I HA LOBBYI NG EXPENSE	A		ADMI NI STRATI VE & GENERAL	5.00	0	
. 23	CARDI OPULM MI SC REVENUE	В		RESPI RATORY THERAPY	65.00	0	
. 24	CRNA OFFSET	A		ANESTHESI OLOGY	53.00	0	33
. 25	BILLING COSTS OFFSET BILLING COSTS OFFSET	A		ADMI NI STRATI VE & GENERAL	5.00	0	
. 26 . 27	HOSPITAL ASSESSMENT FEE	A A		EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	4.00 5.00	0	
. 27	ADMIN CONTRIBUTION/DONATION	A		ADMINISTRATIVE & GENERAL	5.00	0	
. 20	EXP	A	-23, 890	ADMINISTRATIVE & GENERAL	5.00	U	33.
. 29	GEROPSYCH START UP	А	13 408	GERI ATRI C PSYCH	90.09	C	33.
. 30	EMS REVENUE	В		AMBULANCE SERVICES	95.00	0	
. 31	MEDICAL STAFF CONTRIBUTIONS	B		ADMI NI STRATI VE & GENERAL	5.00	Ő	
. 32	CARDI OPALM MI SC REVENUE	В		RESPI RATORY THERAPY	65.00	0	
). 00	TOTAL (sum of lines 1 thru 49)	-	-13, 486, 908			Ū	50.
	(Transfer to Worksheet A,		.,,				
	column 6, line 200.)						

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

A. Costs - if cost, including applicable overhead, can be determined.
 B. Amount Received - if cost cannot be determined.

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

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

Health Financial Systems DECATUR CO. MEMORIAL HOSPITAL In Lieu of Form									
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO	ME Provider CCN: 15-1332	Period: From 01/01/2020	Worksheet A-8	3-1			
OFFICE				To 12/31/2020					
	Line No.	Cost Center	Expense Items	Amount of	Amount				
				Allowable Cost					
					Wks. A, column				
					5				
	1.00	2.00	3.00	4.00	5.00				
	A. COSTS INCURRED AND ADJUST	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED	ORGANIZATIONS OF	CLAIMED HOME				
	OFFICE COSTS:								
1.00	1.00	CAP REL COSTS-BLDG & FIXT	DEPRECI ATI ON	48, 717	0	1.00			
2.00	90.08	PAIN MANAGEMENT	OPERATING EXPENSE	279, 302	0	2.00			
3.00	0.00			0	0	3.00			
4.00	0.00			0	0	4.00			
5.00	TOTALS (sum of lines 1-4).			328,019	0	5.00			
	Transfer column 6, line 5 to				-				
	Worksheet A-8, column 2,								
	line 12.								

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

nas	s not	been posted to worksheet A,	columns I and/or 2,	the amou	nt allowable si	nould be indicated in col	umn 4 or this part					
						Rel ated Organi zati on(s)	and/or Home Office					
						5						
					_							
		Symbol (1)	Name		Percentage of	Name	Percentage of					
					Ownership		Ownershi p					
		1.00	2.00		3.00	4.00	5.00					
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:											

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

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

i oi inour c					
6.00	G	COUNTY	100. 00 COUNTY	100.00	6.00
7.00	С	PAIN MANAGEMENT	51.00 PALN MANAGEMENT	51.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
100.00 (G. Other (financial or	COUNTY			100.00
lr	non-financial) specify:				1

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
 B. Corporation, partnership, or other organization has financial interest in provider.

C. Provider has financial interest in corporation, partnership, or other organization.

D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related

organi zati on.

E. Individual is director, officer, administrator, or key person of provider and related organization. F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der.

Health Financial Systems	DECATUR CO. MEMORIAL HOSPIT	AL In Lie	In Lieu of Form CMS-2552-10			
STATEMENT OF COSTS OF SERVICES FROM REL OFFICE COSTS	ATED ORGANIZATIONS AND HOME Provider	CCN: 15-1332 Period: From 01/01/2020	Worksheet A-8-1			
			Date/Time Prepared:			

			6/2	22/2021 8:2	7 pm
	Net	Wkst. A-7 Ref.			
	Adjustments				
	(col. 4 minus				
	col. 5)*				
	6.00	7.00			
	A. COSTS INCUR	RED AND ADJUST	MENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLA	I MED HOME	
	OFFICE COSTS:				
1.00	48, 717	9			1.00
2.00	279, 302	0			2.00
3.00	0	0			3.00
4.00	0	0			4.00
5.00	328, 019				5.00

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

nas not	been posted to worksheet A,	cor unins T	anu/or	Ζ,	the amount	arrowabre	Should b	be indicated	TH COLUMN 4	1 01	this part.	
	Related Organization(s)											
	and/or Home Office											
	Turne of Ducingon											
	Type of Business											
	6.00											
	B. INTERRELATIONSHIP TO RELA	TED ORGANI	ZATI ON (S	5) A	AND/OR HOME	OFFLCE:						

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

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

rerindur	sement under title XVIII.	
6.00	COUNTY	6.00
7.00	JOINT VENTURE	7.00
8.00		8.00
9. 00 10. 00		9.00
10.00		10.00
100.00		100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership, or other organization has financial interest in provider.

 C. Provider has financial interest in corporation, partnership, or other organization.
 D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.

E. Individual is director, officer, administrator, or key person of provider and related organization.

F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der.

DECATUR CO. MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

	Financial Syste		DECATUR CO. MEI	MORIAL HOSPITAL			eu of Form CMS-	
PROVI DE	ER BASED PHYSICI	I AN ADJUSTMENT		Provider (Period:	Worksheet A-8	3-2
						From 01/01/2020) Doto/Timo Dra	norod.
						To 12/31/2020) Date/Time Pre 6/22/2021 8:2	epared:
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
	WKSL. A LINE #	I denti fi er	Remuneration	Component	Component	ROL AMOUNT	ider Component	
		rdentifier	Remuner at rom	component	component		Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		ADULTS & PEDIATRICS	636, 510					1.00
2.00		OPERATING ROOM	96, 928				-	2.00
3.00	1	ANESTHESI OLOGY	593, 406				0	3.00
4.00		RADI OLOGY-DI AGNOSTI C	1, 117, 010				0	4.00
5.00		LABORATORY	431, 094	431, 094	-	-	0	5.00
6.00		RESPIRATORY THERAPY	49, 307	49, 307	-		0	6.00
7.00		PHYSICAL THERAPY	2, 571	2, 571		-	0	7.00
8.00							0	
8.00 9.00		ELECTROCARDI OLOGY CLI NI C	12,600	12, 600 938, 877	-		0	8.00 9.00
			938, 877				0	
10.00		ONCOLOGY	191, 774	191, 774	-			10.00
11.00			246, 167	246, 167		-	0	11.00
12.00		WOMEN' S HEALTH SERVICES	1, 079, 567				0	12.00
13.00		PROVIDER BASED CLINIC - DCPM	493, 092			-	0	13.00
14.00		PROVIDER BASED CLINIC -	154, 909	154, 909	C	0	0	14.00
		NEPHROLOGY				-		
15.00		NEUROLOGY	252, 792				0	15.00
16.00		FOOT AND ANKLE	91, 031	91, 031		-	0	16.00
17.00	91.00	EMERGENCY	1, 334, 870				0	17.00
200.00			7, 722, 505				0	200.00
	Wkst. A Line #		Unadjusted RCE		Cost of	Provi der	Physician Cost	
		l denti fi er	Limit	Unadjusted RCE		1 1	of Malpractice	
				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	-		-	1.00
2.00		OPERATING ROOM	0	0			-	2.00
3.00		ANESTHESI OLOGY	0		-		0	3.00
4.00		RADI OLOGY-DI AGNOSTI C	0	0		0	0	4.00
5.00		LABORATORY	0	0	-	0	0	5.00
6.00		RESPI RATORY THERAPY	0	0	-		0	6.00
7.00	66.00	PHYSI CAL THERAPY	0	0	C	0	0	7.00
8.00	69.00	ELECTROCARDI OLOGY	0	0	C	0	0	8.00
9.00	90.00	CLINIC	0	0	C	0	0	9.00
10.00	90.01	ONCOLOGY	0	0	C	0	0	10.00
11.00	90.06	CLINIC	0	0	C	0	0	11.00
12.00	90.07	WOMEN'S HEALTH SERVICES	0	0	C	0	0	12.00
13.00	90.10	PROVIDER BASED CLINIC - DCPM	0	0	C	0	0	13.00
14.00	90. 11	PROVIDER BASED CLINIC -	0	0	C	0	0	14.00
		NEPHROLOGY						
15.00	90. 13	NEUROLOGY	0	0	C	0	0	15.00
16.00	90. 14	FOOT AND ANKLE	0	0	C	0	0	16.00
17.00	91.00	EMERGENCY	0	0	C	0	0	17.00
200.00			0	0	C	0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	C	636, 510		1.00
2.00	50.00	OPERATING ROOM	0			96, 928		2.00
3.00	53.00	ANESTHESI OLOGY	0		C			3.00
4.00	54.00	RADI OLOGY-DI AGNOSTI C	0		C			4.00
5.00		LABORATORY	0	0	C			5.00
6.00		RESPI RATORY THERAPY	0	0	C			6.00
7.00		PHYSICAL THERAPY	0	0				7.00
8.00		ELECTROCARDI OLOGY	0		-			8.00
9.00		CLINIC	0	0				9.00
10.00		ONCOLOGY	0		-			10.00
11.00		CLINIC	0					11.00
12.00		WOMEN'S HEALTH SERVICES		0	-			12.00
13.00		PROVIDER BASED CLINIC - DCPM	0					13.00
14.00		PROVIDER BASED CLINIC -		0				14.00
14.00		NEPHROLOGY				104,909		14.00
15.00		NEUROLOGY	o	0	C	252, 792		15.00
15.00 16.00		FOOT AND ANKLE	0					15.00 16.00
18.00 17.00		EMERGENCY	0					17.00
200.00			0					200.00
200.00	I		0	I 0	'I U	u, 907, 972	i l	200.00

UTSI D	ABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS			CN: 15-1332	Period: From 01/01/2020 To 12/31/2020		epared:		
					Physical Therap	y Cost			
						1.00			
	PART I - GENERAL INFORMATION					-			
. 00 . 00	Total number of weeks worked (excluding aide Line 1 multiplied by 15 hours per week	s) (see instruc	ctions)			230			
1.00 1.00	Number of unduplicated days in which supervi	sor or therapis	st was on provi	ider site (s	see instructions)				
. 00	Number of unduplicated days in which therapy					0			
	nor therapist was on provider site (see inst								
5.00 5.00	Number of unduplicated offsite visits - supe Number of unduplicated offsite visits - ther					0			
. 00	assistant and on which supervisor and/or the	15			5 15	0	0.00		
	instructions)								
. 00	Standard travel expense rate					3. 25			
8. 00	Optional travel expense rate per mile	Supervi sors	Therapi sts	Assi stant	s Ai des	Trai nees	8.00		
		1.00	2.00	3.00	4.00	5.00			
. 00	Total hours worked	0.00	47.50		. 00 0. 00				
0.00	AHSEA (see instructions) Standard travel allowance (columns 1 and 2,	0.00 43.41	86. 81 43. 41		. 00 0. 00 . 00	0.00	10.00		
1.00	one-half of column 2, line 10; column 3,	43.41	43.41	0	. 00		11.00		
	one-half of column 3, line 10)								
	Number of travel hours (provider site)	0	0		0		12.00		
2.01 3.00	Number of travel hours (offsite) Number of miles driven (provider site)	0	0		0		12.0		
3.00	Number of miles driven (provider site)	0	0		0		13.0		
					-1				
						1.00			
4.00	Part II - SALARY EQUIVALENCY COMPUTATION Supervisors (column 1, line 9 times column 1	line 10)				0	14.00		
5.00	Therapists (column 2, line 9 times column 2,					4, 123			
6.00	Assistants (column 3, line 9 times column 3,					0			
7.00	Subtotal allowance amount (sum of lines 14 a	nd 15 for respi	ratory therapy	y or lines 1	4-16 for all	4, 123	17.0		
8.00	others) Aides (column 4, line 9 times column 4, line	10)				0	18.00		
9.00	Trainees (column 5, line 9 times column 5, l					0			
0.00	Total allowance amount (sum of lines 17-19 f						20.0		
	If the sum of columns 1 and 2 for respiratory								
	occupational therapy, line 9, is greater than amount from line 20. Otherwise complete line		no entries on	Times 21 ar	id 22 and enter of	n Tine 23 the			
1. 00	Weighted average rate excluding aides and tr		7 divided by su	um of columr	ns 1 and 2, line	9 0.00	21.00		
	for respiratory therapy or columns 1 thru 3,					-	22.00		
2.00 3.00									
5.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLON	WANCE AND TRAVE	EL EXPENSE COM	PUTATION - F	PROVIDER SITE	4,123	23.00		
	Standard Travel Allowance					1			
	Therapists (line 3 times column 2, line 11)						24.00		
25.00 26.00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or	0 260							
7.00	Standard travel expense (line 7 times line 3				3 and 4 for all	20			
	others)								
8.00	Total standard travel allowance and standard 27)	travel expense	e at the provid	der site (su	im of lines 26 and	d 280	28.00		
	Optional Travel Allowance and Optional Travel	Expense					1		
9.00	Therapists (column 2, line 10 times the sum	of columns 1 ar	nd 2, line 12)		0			
0.00	Assistants (column 3, line 10 times column 3		00 and 20 f	oll otheres		0			
1.00 2.00	Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column				nov or sum of	0			
2.00	columns 1-3, line 13 for all others)			and y more	, , , , , , , , , , , , , , , , , , ,		02.00		
3.00	Standard travel allowance and standard trave					280			
4.00	Optional travel allowance and standard trave					0			
5. 00	Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW				RVICES OUTSIDE P	O ROVIDER SLTE	35.00		
	Standard Travel Expense								
6.00	Therapists (line 5 times column 2, line 11)					0			
7.00	Assistants (line 6 times column 3, line 11)					0			
8.00 9.00	Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the su	m of lines 5 ar	nd 6)			0			
	Optional Travel Allowance and Optional Travel]		
0.00	Therapists (sum of columns 1 and 2, line 12.	01 times columr	n 2, line 10)			0			
1.00	Assistants (column 3, line 12.01 times colum	n 3, line 10)				0			
2.00 3.00	Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the su	m of columns 1.	-3. line 13 01`)		0			
3.00	Total Travel Allowance and Travel Expense - (llowing three li		1 10.0		
	46, as appropriate.								
			of Linos 20 or	ad 30 = saa	instructions)	1 0	44.0		
4.00	Standard travel allowance and standard trave Optional travel allowance and standard trave						45.0		

SONABLE COST DETERMINATION FOR THERAPY SERVICES SIDE SUPPLIERS	FURNI SHED BY	Provider CC		Period: From 01/01/2020 To 12/31/2020		pared:
			F	Physical Therapy		
					1.00	
00 Optional travel allowance and optional trave					0	46.00
	Therapi sts	Assi stants	Ai des	Trai nees	Total	
	1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION	0.00					
00 Overtime hours worked during reporting	0.00	0.00	0.0	0.00	0.00	47.0
period (if column 5, line 47, is zero or						
equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each						
column of line 56)						
00 Overtime rate (see instructions)	0.00	0.00	0.0	0.00		48.0
00 Total overtime (including base and overtime	0.00	0.00	0.0			49.0
allowance) (multiply line 47 times line 48)						
CALCULATION OF LIMIT						1
00 Percentage of overtime hours by category	0.00	0.00	0.0	0.00	0.00	50.0
(divide the hours in each column on line 47						
by the total overtime worked - column 5,						
line 47)						
00 Allocation of provider's standard work year	0.00	0.00	0.0	0.00	0.00	51.0
for one full-time employee times the						
percentages on line 50) (see instructions)						
DETERMINATION OF OVERTIME ALLOWANCE 00 Adjusted hourly salary equivalency amount	86.81	0.00	0.0	0.00		52.0
(see instructions)	00.01	0.00	0.0	0.00		52.0
00 Overtime cost limitation (line 51 times line	0	0		0 0		53.0
52)	0	0		0 0		35.0
00 Maximum overtime cost (enter the lesser of	0	o		0 0		54.0
line 49 or line 53)		-		-		
00 Portion of overtime already included in	0	0		0 0		55.0
hourly computation at the AHSEA (multiply						
line 47 times line 52)						
00 Overtime allowance (line 54 minus line 55 -	0	0		0 0	0	56.0
if negative enter zero) (Enter in column 5						
the sum of columns 1, 3, and 4 for						
respiratory therapy and columns 1 through 3						
for all others.)						
					1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION A	AND EXCESS COST	ADJUSTMENT			1100	
00 Salary equivalency amount (from line 23)					4, 123	57.0
00 Travel allowance and expense - provider site	(from lines 33,	34, or 35))			280	58.0
00 Travel allowance and expense - Offsite service	ces (from lines	44, 45, or 46	b)		0	59.0
00 Overtime allowance (from column 5, line 56)					0	60.0
00 Equipment cost (see instructions)					0	61.0
00 Supplies (see instructions)					0	
00 Total allowance (sum of lines 57-62)					4,403	
00 Total cost of outside supplier services (from						64.0
00 Excess over limitation (line 64 minus line 65	3 - if negative,	enter zero)			0	65.0
LINE 33 CALCULATION						
0.00 Line 26 = line 24 for respiratory therapy or						100.0
0.01 Line 27 = line 7 times line 3 for respiratory	y therapy or sum	n of lines 3 a	and 4 for all	others		100.0
0.02 Line 33 = line 28 = sum of lines 26 and 27					280	100. C
LINE 34 CALCULATION				-	20	101 0
.00 Line 27 = line 7 times line 3 for respiratory				others		101. C 101. C
.01 Line 31 = line 29 for respiratory therapy or	sum of times 29	and 30 for a	all others			
. 02 Line 34 = sum of lines 27 and 31					20	101. C
LINE 35 CALCULATION	sum of Lines 20) and 30 for a	all others		0	102.0
(0)		ל תרד הכי החווה י			0	יייב. ע
2.00 Line 31 = line 29 for respiratory therapy or				umps 1_3 line	0	102 0
2.00 Line 31 = line 29 for respiratory therapy or 2.01 Line 32 = line 8 times columns 1 and 2, line 13 for all others				umns 1-3, line	0	102.

OUTSIE	NABLE COST DETERMINATION FOR THERAPY SERVICES DE SUPPLIERS	FURNI SHED BY	Provider CC	CN: 15-1332	Period: From 01/01/2020 To 12/31/2020 Speech Pathology	Date/Time Pre 6/22/2021 8:2	pared:
						1.00	
1 00	PART I - GENERAL INFORMATION		1			10	1 00
1.00 2.00 3.00 4.00	Total number of weeks worked (excluding aide Line 1 multiplied by 15 hours per week Number of unduplicated days in which supervi Number of unduplicated days in which therapy nor therapist was on provider site (see inst	sor or therapist assistant was d	t was on provi	•	,	18 270 36 0	1.00 2.00 3.00 4.00
5.00 6.00	Number of unduplicated offsite visits - supe Number of unduplicated offsite visits - ther assistant and on which supervisor and/or the instructions)	rvisors or thera apy assistants ((include only	visits made		0	5.00 6.00
7.00	Standard travel expense rate					3. 25	7.00
8.00	Optional travel expense rate per mile	Supervi sors	Therapi sts	Assi stants	s Ai des	0.00 Trai nees	8.00
		1.00	2.00	3.00	4.00	5.00	
9.00 10.00 11.00	Total hours worked AHSEA (see instructions) Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	0.00 0.00 39.55	250. 00 79. 10 39. 55	0.	00 0.00 00 0.00 00		9.00 10.00 11.00
	Number of travel hours (provider site) Number of travel hours (offsite)	0 0 0	0 0 0 0		0 0 0		12. 00 12. 01 13. 00 13. 01
			-1			1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00 15.00	Supervisors (column 1, line 9 times column 1 Therapists (column 2, line 9 times column 2,					0 19, 775	14.00 15.00
16. 00 17. 00	Assistants (column 3, line 9 times column 3, line10)						16.00 17.00
18.00 19.00 20.00	8.00 Aides (column 4, line 9 times column 4, line 10) 9.00 Trainees (column 5, line 9 times column 5, line 10)						18.00 19.00 20.00
21.00	amount from line 20. Otherwise complete line Weighted average rate excluding aides and tr for respiratory therapy or columns 1 thru 3,	es 21-23. ainees (line 17	divided by su				21.00
22.00	Weighted allowance excluding aides and train		21, 357	22.00			
23.00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW	VANCE AND TRAVEL	EXPENSE COMP	PUTATION - P	ROVI DER SI TE	21, 357	23.00
	Standard Travel Allowance					1 101	
	Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11)					1, 424	24.00 25.00
26.00	Subtotal (line 24 for respiratory therapy or	2 and 4 for all	1, 424	26.00			
27.00	Standard travel expense (line 7 times line 3 others)	117	27.00				
28.00	Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel	·	at the provic	ler site (su	m of lines 26 and	1, 541	28.00
29.00	Therapists (column 2, line 10 times the sum	of columns 1 and	d 2, line 12)			0	29.00
30.00	Assistants (column 3, line 10 times column 3		0	30.00 31.00			
31.00 32.00	Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column	0	31.00				
	columns 1-3, line 13 for all others) Standard travel allowance and standard trave	I expense (line	28)			1, 541	33.00
33.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)						34.00 35.00
34.00	Optional travel allowance and optional trave	· · · ·	EXPENSE COMPU	JIAIION - SE	RVICES OUTSIDE PR	ROVI DER SI TE	
34. 00 35. 00	Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense	· · · ·	EXPENSE COMPU	JIAIION - SE	RVICES OUTSIDE Pr		36 00
34.00	Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW	· · · ·	EXPENSE COMPU	ITATION - SE	RVICES OUTSIDE Pr	OVIDER SITE	36. 00 37. 00
34.00 35.00 36.00 37.00 38.00	Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW, Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37)	ANCE AND TRAVEL		ITATION - SE	KVICES OUTSIDE Pr	0	37.00
34.00 35.00 36.00 37.00 38.00 39.00	Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the su Optional Travel Allowance and Optional Travel	m of lines 5 and Expense	d 6)	ITATION - SE	RVICES OUTSIDE Pr		37.00 38.00 39.00
34.00 35.00 36.00 37.00 38.00	Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the su	m of lines 5 and Expense 01 times column	d 6)	JIAITON - SE	KVICES OUTSIDE Pr	0 0 0	37. 00 38. 00
34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00	Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the su Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12, Assistants (column 3, line 12.01 times colum Subtotal (sum of lines 40 and 41)	m of lines 5 and Expense O1 times column n 3, line 10)	1 6) 2, line 10)		RVICES OUTSIDE Pr	0 0 0 0	37.00 38.00 39.00 40.00 41.00 42.00
34.00 35.00 36.00 37.00 38.00 39.00 40.00 41.00 42.00 43.00	Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the su Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12. Assistants (column 3, line 12.01 times colum	m of lines 5 and Expense 01 times column n 3, line 10) m of columns 1-3 Dffsite Services	d 6) 2, line 10) 3, line 13.01) 5; Complete on	e of the fo	llowing three lir	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	37.00 38.00 39.00 40.00 41.00

alth Financial Systems DE ASONABLE COST DETERMINATION FOR THERAPY SERVICES ITSIDE SUPPLIERS	CATUR CO. MEMOR FURNI SHED BY	Provider CC		Period: From 01/01/2020 To 12/31/2020		pared:
			!	Speech Pathology	Cost	
					1.00	
.00 Optional travel allowance and optional travel						46.00
	Therapists 1.00	Assistants 2.00	Ai des 3.00	Trai nees 4.00	Total 5.00	
PART V - OVERTIME COMPUTATION	1.00	2.00	3.00	4.00	5.00	
7.00 Overtime hours worked during reporting	0.00	0.00	0.0	0.00	0, 00	47.00
period (if column 5, line 47, is zero or						
equal to or greater than 2,080, do not						
complete lines 48-55 and enter zero in each						
column of line 56)						
8.00 Overtime rate (see instructions)	0.00	0.00	0. C			48.00
0.00 Total overtime (including base and overtime	0.00	0.00	0. C	0.00		49.00
allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT		I				-
0.00 Percentage of overtime hours by category	0.00	0.00	0.0	0.00	0.00	50.00
(divide the hours in each column on line 47	0.00	0.00	0.0	0.00	0.00	00.00
by the total overtime worked - column 5,						
line 47)						
.00 Allocation of provider's standard work year	0.00	0.00	0. C	0.00	0.00	51.00
for one full-time employee times the						
percentages on line 50) (see instructions)						
DETERMINATION OF OVERTIME ALLOWANCE	70.10	0.00				
2.00 Adjusted hourly salary equivalency amount (see instructions)	79.10	0.00	0. C	0.00		52.00
8.00 Overtime cost limitation (line 51 times line	0	0		0 0		53.00
52)	0	0		0 0		
.00 Maximum overtime cost (enter the lesser of	0	0		0 0		54.OC
line 49 or line 53)						
5.00 Portion of overtime already included in	0	0		0 0		55.OC
hourly computation at the AHSEA (multiply						
line 47 times line 52)		-		-	_	
0.00 Overtime allowance (line 54 minus line 55 -	0	0		0 0	0	56.00
if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for						
respiratory therapy and columns 1 through 3						
for all others.)						
		1				
					1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST	ADJUSTMENT			01 057	
7.00 Salary equivalency amount (from line 23) 8.00 Travel allowance and expense - provider site	(from Linos 22	24 or 25))			21, 357	
9.00 Travel allowance and expense - offsite service					1, 541 0	
0.00 Overtime allowance (from column 5, line 56)		44, 45, 01 40)		0	
. 00 Equipment cost (see instructions)					0	
2. 00 Supplies (see instructions)					0	
00 Total allowance (sum of lines 57-62)					22, 898	
.00 Total cost of outside supplier services (from	n your records)				31, 924	
00 Excess over limitation (line 64 minus line 63		enter zero)			9, 026	65.00
LINE 33 CALCULATION						
00.00 Line 26 = line 24 for respiratory therapy or					1, 424	
00.01 Line 27 = line 7 times line 3 for respiratory	y therapy or sum	n of lines 3 a	nd 4 for all	others		100. 01
00.02 Line 33 = line 28 = sum of lines 26 and 27					1, 541	100. 02
LINE 34 CALCULATION 1.00 Line 27 = line 7 times line 3 for respiratory	thorses or our	of Linco 2 o	and 1 fee all	athana	117	101 00
/LUUILINE Z/ = LINE / TIMES LINE 3 FOR RESDIRATORY				others	117	101.00 101.01
			in others			101.02
01.01 Line 31 = line 29 for respiratory therapy or	50m 01 11105 27					1101.02
)1.01 Line 31 = line 29 for respiratory therapy or)1.02 <u>Line 34 = sum of lines 27 and 31</u>					117	1
11.01 Line 31 = line 29 for respiratory therapy or 11.02 <u>Line 34 = sum of lines 27 and 31</u> LINE 35 CALCULATION) and 30 for a	III others			102.00
)1.01 Line 31 = line 29 for respiratory therapy or)1.02 <u>Line 34 = sum of lines 27 and 31</u>	sum of lines 29			umns 1-3, line	0	102. 00 102. 0
11.01 Line 31 = line 29 for respiratory therapy or 11.02 Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION 12.00 Line 31 = line 29 for respiratory therapy or	sum of lines 29			umns 1-3, line	0	

IST A	Financial Systems D LLOCATION - GENERAL SERVICE COSTS	DECATUR CO. MEM	Provider CC		Period:	u of Form CMS-2 Worksheet B	
					From 01/01/2020 To 12/31/2020	Date/Time Pre	pare
			CAPI TAL			6/22/2021 8:2	/ pm
	Cost Center Description	Net Expenses	RELATED COSTS BLDG & FIXT	EMPLOYEE	Subtotal	ADMI NI STRATI V	
	cost center bescription	for Cost	DEDG & TTXT	BENEFITS	Subtotal	E & GENERAL	
		Allocation		DEPARTMENT			
		(from Wkst A					
		<u>col. 7)</u>	1.00	4.00	4A	5.00	
	GENERAL SERVICE COST CENTERS		1.00	1.00		0.00	
00	00100 CAP REL COSTS-BLDG & FIXT	3, 855, 282					1.
00 00	00400 EMPLOYEE BENEFITS DEPARTMENT	7, 186, 235		7, 236, 29 1, 319, 092		11 704 470	4.
00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS	10, 198, 181 1, 345, 731		1, 319, 092			
00	00700 OPERATION OF PLANT	952, 412			952, 412		
00	00800 LAUNDRY & LINEN SERVICE	105, 824	20, 519	18, 033		32, 931	
00	00900 HOUSEKEEPI NG	601, 853		98, 03			
	01000 DI ETARY 01100 CAFETERI A	49, 341		14,600			
	01300 NURSING ADMINISTRATION	673, 357 638, 261		51, 118 194, 859		183, 363 191, 076	
	01400 CENTRAL SERVICES & SUPPLY	48, 591		16, 80			
	01500 PHARMACY	1, 082, 798		245, 820		310, 101	15
	01600 MEDI CAL RECORDS & LI BRARY	609, 417		132, 520			
. 00	01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	300, 888	11, 601	83, 179	395, 668	90, 248	17
. 00	03000 ADULTS & PEDIATRICS	2, 758, 609	485,072	730, 333	3 3, 974, 014	906, 429	30
	04300 NURSERY	135, 495		48, 858			
	ANCI LLARY SERVI CE COST CENTERS	·	1				
	05000 OPERATING ROOM	1, 771, 764		357, 460		534, 632	
	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	75, 850		27, 35 ⁻ 23, 966			
	05400 RADI OLOGY-DI AGNOSTI C	1, 865, 407	1	333, 812			
	05500 RADI OLOGY - THERAPEUTI C	C	0		0 0	0	
	03630 ULTRA SOUND	203, 229		49, 99			
	06000 LABORATORY	3, 371, 126		106, 672			
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06500 RESPI RATORY THERAPY	94, 793 778, 758		162, 545	0 94, 793 5 1, 011, 417	21, 621 230, 693	
	06600 PHYSI CAL THERAPY	713, 254		243, 414			
	06700 OCCUPATI ONAL THERAPY	200, 778		79, 43			
	06800 SPEECH PATHOLOGY	170, 077		42, 200		48, 418	
	06900 ELECTROCARDI OLOGY	248, 321		69, 34			
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 621, 767			0 1, 621, 767 0 741, 863		
	07300 DRUGS CHARGED TO PATIENTS	6, 081, 047	1		6, 081, 047		
	OUTPATIENT SERVICE COST CENTERS	T			1		
	08800 RURAL HEALTH CLINIC	2, 940, 171		791, 364			
	08801 RURAL HEALTH CLINIC II 09000 CLINIC	2, 658, 633 405, 690		671, 378 100, 190			
	09001 ONCOLOGY	389, 870		100, 190		139, 610	
	09002 OUTPATIENT CLINIC	140, 356		40, 60			
	09003 PROVIDER BASED CLINIC - TCMP	C	0	(0 0	0	
	09004 PROVIDER BASED CLINIC - DCPC	C			0 0	0	
	09005 PROVIDER BASED CLINIC - WESTPORT 09006 CLINIC	1, 960 329, 305		54 ⁻ 65, 303			
	09007 WOMEN'S HEALTH SERVICES	221, 964		47,089			
	09008 PAIN MANAGEMENT	183, 524		-	192, 209		
. 09	09009 GERIATRI C PSYCH	410, 904	44, 080	10, 300		106, 126	90
	09010 PROVIDER BASED CLINIC - DCPM	87, 530		22, 928			
	09011 PROVIDER BASED CLINIC - NEPHROLOGY	35, 037		10, 068			
	09012 DI ABETES CLI NI C 09013 NEUROLOGY	6, 810 4, 876		1, 36 1, 298			
	09014 FOOT AND ANKLE	23, 179		5, 059			
	09100 EMERGENCY	2, 328, 191		353, 13		636, 711	
. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART				0		92
00	OTHER REIMBURSABLE COST CENTERS	1,068,122	76, 073	278, 179	9 1, 422, 374	324, 428	95
	10100 HOME HEALTH AGENCY	1,008,122			0 1, 422, 374		101
	SPECIAL PURPOSE COST CENTERS	1					
	SUBTOTALS (SUM OF LINES 1 through 117)	59, 866, 535	3, 209, 652	7, 061, 27	4 59, 045, 884	10, 779, 292	118
1.00							190
1.00 8.00	NONREIMBURSABLE COST CENTERS						1190
1.00 8.00 0.00	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(
1.00 8.00 0.00 2.00	NONREIMBURSABLE COST CENTERS	579, 330	0 0 22, 399	((58, 322	0 0	0	192
1.00 8.00 0.00 2.00 4.00 4.02	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CI ANS' PRI VATE OFFI CES 07950 MARKETI NG 07952 NRCC	C C 579, 330 C	0 0 22, 399 606, 368	(0 0	0 150, 550	192 194
1.00 8.00 0.00 2.00 4.00 4.02 4.02	NONREI MBURSABLE COST CENTERS 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CI ANS' PRI VATE OFFI CES 07950 MARKETI NG 07952 NRCC 07955 RETAI L PHARMACY	0 0 579, 330 0 3, 016, 654	606, 368	(0 2 660, 051 0 606, 368	0 150, 550 138, 306	192 194 194 194
1.00 8.00 0.00 2.00 4.00 4.02	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CI ANS' PRI VATE OFFICES 07950 MARKETI NG 07952 NRCC 07955 RETAIL PHARMACY Cross Foot Adjustments	C	606, 368	(58, 322 (116, 699	0 2 660, 051 0 606, 368	0 150, 550 138, 306 718, 530	192 194 194

	Financial Systems EALLOCATION - GENERAL SERVICE COSTS	DECATUR CO. MEMO	DRIAL HOSPITAL Provider C		eriod: rom 01/01/2020	u of Form CMS-: Worksheet B Part I Date/Time Pre 6/22/2021 8:2	pared:
	Cost Center Description	MAI NTENANCE & REPAI RS	PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
		6.00	7.00	8.00	9.00	10.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINI STRATI VE & GENERAL						5.00
6.00	00600 MAI NTENANCE & REPAI RS	2, 298, 711					6.00
7.00	00700 OPERATION OF PLANT	0	1, 169, 647				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	7, 691				8.00
9.00	00900 HOUSEKEEPI NG	197, 032	11, 896		1, 133, 585		9.00
10.00	01000 DI ETARY 01100 CAFETERI A	0	6, 502		0	107, 461	10.00
11.00 13.00	01300 NURSI NG ADMI NI STRATI ON	35, 365	29, 772 1, 727		1, 629	0	11.00 13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0, 305	919		1, 029	0	14.00
15.00	01500 PHARMACY	0	11, 595		0	0	15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	25, 261	12, 736	0	2,444	0	16.00
17.00	01700 SOCI AL SERVI CE	55, 573	4, 348	0	2, 601	0	17.00
~~ ~~	INPATIENT ROUTINE SERVICE COST CENTERS	101.010	404.000		(05.405	05 404	
30.00 43.00	03000 ADULTS & PEDIATRICS 04300 NURSERY	101, 042	181, 808 5, 283		605, 105 20, 699	95, 134 0	30.00 43.00
43.00	ANCI LLARY SERVICE COST CENTERS	0	5, 265	1, 952	20, 099	0	43.00
50.00	05000 OPERATING ROOM	101, 042	80, 485	22, 634	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	10, 104	14,035		38, 252	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0	-	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	30, 313	50, 959	13, 579	32, 712	0	54.00
55.00	05500 RADI OLOGY - THERAPEUTI C	0	0	0	0	0	55.00
55.01	03630 ULTRA SOUND	0	0	-	0	0	55.01
60.00 62.00	06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	10, 104	27, 594 0		24, 033 0	0	60.00 62.00
65.00	06500 RESPI RATORY THERAPY	171, 772	26, 279	-	17, 234	0	65.00
66.00	06600 PHYSI CAL THERAPY	106, 094	43, 759		10, 497	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	919		6, 329	0	67.00
68.00	06800 SPEECH PATHOLOGY	10, 104	0	0	4, 982	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0	2, 031	3, 885	0	69.00
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS	45, 469	0	-	0 37, 224	0	72.00 73.00
75.00	OUTPATIENT SERVICE COST CENTERS	43, 407	0	0	57,224	0	/3.00
88.00	08800 RURAL HEALTH CLINIC	1, 111, 465	100, 420	1, 613	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	30, 313	73, 848		0	0	88. 01
90.00	09000 CLINIC	0	39, 807		0	0	90.00
90.01	09001 ONCOLOGY	35, 365	30, 326		75, 702	3, 351	90.01
90. 02 90. 03	09002 OUTPATIENT CLINIC 09003 PROVIDER BASED CLINIC - TCMP	0	0	594	5, 264 0	0	90.02 90.03
90.03	09004 PROVIDER BASED CLINIC - DCPC	0	0	0	0	0	90.03
90.05	09005 PROVIDER BASED CLINIC - WESTPORT	10, 104	9, 504	0	0	0	
90.06	09006 CLI NI C	10, 104	12, 934	2, 210	18, 268	0	90.06
90.07	09007 WOMEN'S HEALTH SERVICES	85, 886	27, 721		0	0	90.07
90.08	09008 PALN MANAGEMENT	0	3, 255		0	0	90.08
90. 09 90. 10	09009 GERIATRIC PSYCH 09010 PROVIDER BASED CLINIC - DCPM	55, 573	16, 522 12, 332		0	7, 636 0	90.09 90.10
90.10	09011 PROVIDER BASED CLINIC - NEPHROLOGY	0	8, 324		0	0	90.10
90.12	09012 DI ABETES CLINIC	0	1, 893		0	0	90.12
90.13	09013 NEUROLOGY	0	2,004		0	0	90.13
90.14	09014 FOOT AND ANKLE	0	657	0	0	0	90.14
91.00	09100 EMERGENCY	35, 365	41, 296	28, 091	207, 517	1, 340	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
95 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	0	28, 513	1, 158	0	0	95.00
	10100 HOME HEALTH AGENCY	0	20, 313		0	-	101.00
	SPECIAL PURPOSE COST CENTERS			-	-	-	
118.00		2, 273, 450	927, 663	184, 998	1, 114, 377	107, 461	118.00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190.00
) 19200 PHYSI CLANS' PRI VATE OFFI CES) 07950 MARKETI NG	25, 261	0 8, 395	-	0		192.00 194.00
	207952 NRCC	23, 201	227, 269		19, 208		194.00
	07955 RETAIL PHARMACY	0	6, 320		0		194.05
200.00	Cross Foot Adjustments						200.00
201.00		0	0	-	0		201.00
202.00	TOTAL (sum lines 118 through 201)	2, 298, 711	1, 169, 647	184, 998	1, 133, 585	107, 461	202.00

	2	ECATUR CO. MEM	ORIAL HOSPITAL			u of Form CMS-2	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 01/01/2020	Worksheet B Part I	
					To 12/31/2020	Date/Time Pre	epared:
	Cost Center Description	CAFETERIA	NURSI NG	CENTRAL	PHARMACY	6/22/2021 8: 2 MEDI CAL	<u>27 pm</u>
		0/11 21 21 11 11	ADMI NI STRATI O	SERVICES &		RECORDS &	
		11 00	N 12.00	SUPPLY	15.00	LI BRARY	
_	GENERAL SERVICE COST CENTERS	11.00	13.00	14.00	15.00	16.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
6.00 7.00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT						6.00 7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERIA	1,017,043					11.00
13.00 14.00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	18, 707 6, 718		114, 239			13.00
	01500 PHARMACY	0, / 10 C		(15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	34, 488	0	(1, 027, 830	16.00
17.00	01700 SOCI AL SERVI CE	15, 641	54, 381	(0 0	0	17.00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	110 (07	200.040			44 576	1 20 00
30.00 43.00	03000 ADULTS & PEDI ATRI CS 04300 NURSERY	119, 697 5, 208		(44, 576 3, 742	
13.00	ANCI LLARY SERVICE COST CENTERS	5,200	10,120			5,742	1 .0.00
50.00	05000 OPERATING ROOM	67, 286		(88, 002	
52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 915		(4, 581	
53.00	05300 ANESTHESI OLOGY	10, 818			0	7, 382	
54.00 55.00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY - THERAPEUTI C	54, 410 C				148, 182 0	1
55.00	03630 ULTRA SOUND	6, 846	-			25, 062	
60.00	06000 LABORATORY	24, 427			0 0	136, 109	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	C	-		0 0	2, 713	
65.00		27, 736			0	19, 991	
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	42, 687 10, 783		(-	30, 034 11, 944	
68.00	06800 SPEECH PATHOLOGY	5, 065		(-	6, 583	
69.00	06900 ELECTROCARDI OLOGY	11, 472		(27, 216	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	C		78, 383		19, 107	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	-	35, 856		9, 754	
73.00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	35, 417	0	(1, 261, 098	166, 100	73.00
88.00	08800 RURAL HEALTH CLINIC	119, 800	0	(0 0	14, 030	88.00
88.01	08801 RURAL HEALTH CLINIC II	86, 435	0	C	0 0	13, 576	88.01
90.00	09000 CLI NI C	43, 962	1 1	(0 0	10, 613	
90.01	09001 ONCOLOGY	20, 155	1 1	(0	17, 931	
90. 02 90. 03	09002 OUTPATIENT CLINIC 09003 PROVIDER BASED CLINIC - TCMP	17, 157 C	1 1			1, 763 0	
	09004 PROVI DER BASED CLINIC - DCPC	C		(0	
90.05	09005 PROVIDER BASED CLINIC - WESTPORT	C		(0 0	46	
90.06	09006 CLI NI C	12, 955			0 0	19, 740	
90.07	09007 WOMEN'S HEALTH SERVICES 09008 PAIN MANAGEMENT	22, 808			0	1,009	
90. 08 90. 09	09008 PATN MANAGEMENT 09009 GERIATRIC PSYCH	9, 889 3, 515				16, 416 7, 689	
90.10	09010 PROVIDER BASED CLINIC - DCPM	13, 437		(1, 413	
90. 11	09011 PROVIDER BASED CLINIC - NEPHROLOGY	4, 789		(0 0	274	90.11
90.12	09012 DI ABETES CLINIC	C	0	C	0	114	
90.13	09013 NEUROLOGY	2, 584		(192	1
90.14 91.00	09014 FOOT AND ANKLE 09100 EMERGENCY	4, 272 59, 393		(536 139, 750	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	57, 575	100, 042			137,730	92.00
	OTHER REIMBURSABLE COST CENTERS		· · ·		· · ·		1
	09500 AMBULANCE SERVICES	71, 282					95.00
101.00	10100 HOME HEALTH AGENCY	C	0	(0 0	0	101.00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	992, 754	1, 086, 231	114, 239	1, 261, 098	1, 027, 830	118 00
110.00	NONREI MBURSABLE COST CENTERS	772,734	1,000,201	114, 25	1,201,070	1, 027, 030	1 10.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	0	(0 0		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	C	0	0	0		192.00
192.00				· · · · · · · · · · · · · · · · · · ·	N 0	0	194.00
192.00 194.00	07950 MARKETI NG	8, 648	0				
192.00 194.00 194.02	07950 MARKETI NG 07952 NRCC	C	0	(0	194.02
192.00 194.00 194.02 194.05	07950 MARKETI NG 07952 NRCC 07955 RETAI L_PHARMACY	8, 648 C 15, 641	0	() 0 0 0 0 420, 158	0	194. 02 194. 05
192.00 194.00 194.02	07950 MARKETING 07952 NRCC 07955 RETAIL PHARMACY Cross Foot Adjustments	C	0		0 0 0 420, 158 0 0	0 0	194.02 194.05 200.00 201.00

ST ALLOCATION -	GENERAL SERVICE COSTS		Provider CO	CN: 15-1332	Peri od:	Worksheet B
					From 01/01/2020 To 12/31/2020	Date/Time Prepa
Cost (Center Description	SOCI AL SERVI CE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments		6/22/2021 8:27
		17.00	24.00	25.00	26.00	
00 00100 CAP RE 00 00400 EMPLOY 00 00500 ADMI NI 00 00600 MAI NTE 00 00700 OPERAT 00 00800 LAUNDF 00 00900 HOUSEF .00 01100 CAFETE .00 01300 NURSI N .00 01400 CENTR/ .00 01500 PHARM/ .00 01500 MEDI CA	RY ERIA IG ADMINISTRATION AL SERVICES & SUPPLY ACY AL RECORDS & LIBRARY	(10.4/0				1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
. 00 01700 SOCIAL	DUTINE SERVICE COST CENTERS	618, 460				1
. 00 03000 ADULTS . 00 04300 NURSEF	5 & PEDIATRICS RY	552, 711 0	7, 037, 925 298, 721		0 7, 037, 925 0 298, 721	3
ANCI LLARY SI 0. 00 05000 0PERAT 0. 00 05200 DELI VE 00 05300 ANESTH	ERVICE COST CENTERS ING ROOM ERY ROOM & LABOR ROOM	0 0 0 0	3, 454, 136 252, 841 231, 973 3, 197, 963		0 3, 454, 136 0 252, 841 0 231, 973 0 3, 197, 963	5
. 01 03630 ULTRA . 00 06000 LABORA . 00 06200 WHOLE		0 0 0 0	0 342, 892 4, 592, 484 119, 127 1, 603, 317		0 0 0 342,892 0 4,592,484 0 119,127 0 1,603,317	5 5 6 6
. 00 06600 PHYSI (CAL THERAPY NTIONAL THERAPY I PATHOLOGY	0 0 0 0	1, 561, 304 377, 107 287, 429 474, 657		0 1, 561, 304 0 377, 107 0 287, 429 0 474, 657	
. 00 07200 I MPL. . 00 07300 DRUGS OUTPATI ENT	AL SUPPLIES CHARGED TO PATIENT DEV. CHARGED TO PATIENTS CHARGED TO PATIENTS SERVICE COST CENTERS	0 0 0	2, 089, 164 956, 684 9, 013, 358		0 2, 089, 164 0 956, 684 0 9, 013, 358	
	OGY	0 0 33, 958 9, 393	6, 259, 021 4, 536, 005 846, 079 920, 960 256, 410		0 6, 259, 021 0 4, 536, 005 0 846, 079 0 920, 960 0 256, 410	2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2
.03 09003 PROVI [.04 09004 PROVI [.05 09005 PROVI [.06 09006 CLI NI (DER BASED CLINIC – TCMP DER BASED CLINIC – DCPC DER BASED CLINIC – WESTPORT	0 0 0	0 0 53, 867 648, 315		0 0 0 0 0 53,867 0 648,315	ç ç ç
. 08 09008 PALN M . 09 09009 GERLAT . 10 09010 PROVID	RIC PSYCH DER BASED CLINIC – DCPM	0 0 0 0	559, 512 265, 610 662, 345 203, 241		0 559, 512 0 265, 610 0 662, 345 0 203, 241	ç
12 09011 PROVID 12 09012 DI ABET 13 09013 NEUROL 14 09014 FOOT A 00 09100 EMERGE	.OGY ND ANKLE	0 0 0 22, 398	96, 055 18, 251 18, 928 42, 298 4, 150, 204		0 96,055 0 18,251 0 18,928 0 42,298 0 4,150,204	
00 09200 OBSERV	ATION BEDS (NON-DISTINCT PART JRSABLE COST CENTERS	0	1, 879, 415		0 1, 879, 415	Ģ
1.00 10100 HOME H SPECIAL PURI		618, 460	57, 307, 598		0 57, 307, 598	10
NONREI MBURS/ D. 00 19000 GI FT,	ABLE COST CENTERS FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	19
4. 00 07950 MARKET 4. 02 07952 NRCC 4. 05 07955 RETAI L		0 0 0 0	0 852, 905 991, 151 4, 310, 865 0		0 0 0 852, 905 0 991, 151 0 4, 310, 865 0 0	19 19 19 19 20
1.00 Negati	ve Cost Centers (sum lines 118 through 201)	0 618, 460	0 0 63, 462, 519		0 0 0 63, 462, 519	20

	Financial Systems D TION OF CAPITAL RELATED COSTS	ECATUR CO. MEMO			eriod: rom 01/01/2020	Date/Time Pre	epared:
	Cost Center Description	Directly Assigned New Capital Related Costs	CAPI TAL RELATED COSTS BLDG & FI XT	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	6/22/2021 8: 2 ADMI NI STRATI V E & GENERAL	
	GENERAL SERVI CE COST CENTERS	0	1.00	2A	4.00	5.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	50, 060		50, 060		4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	0	269, 405		9, 119		
6.00 7.00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	0	415, 148	415, 148 0	767 0	10,089	
7.00 8.00	00800 LAUNDRY & LINEN SERVICE	0	j v	-	125	5, 134	
9.00	00900 HOUSEKEEPI NG	0	31, 739		678		
	01000 DI ETARY	0	17, 349		101	438	
		0	79, 433		354	4, 333	
	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	0	4, 607 2, 451		1, 348 116		
	01500 PHARMACY	0	30, 936		1, 701	7, 328	
	01600 MEDICAL RECORDS & LIBRARY	0			917	4, 182	
17.00	01700 SOCIAL SERVICE	0	11, 601	11, 601	576	2, 133	17.00
~~ ~~	INPATIENT ROUTINE SERVICE COST CENTERS		405 070	405 070		04.400	
	03000 ADULTS & PEDI ATRI CS 04300 NURSERY	0			5, 053 338	21, 420	
43.00	ANCI LLARY SERVI CE COST CENTERS	0	14, 095	14,095	330	1,070	43.00
50.00	05000 OPERATI NG ROOM	0	214, 738	214, 738	2, 473	12, 634	50.00
	05200 DELIVERY ROOM & LABOR ROOM	0	37, 445		189		
	05300 ANESTHESI OLOGY	0	0	0 0	166		
	05400 RADI OLOGY-DI AGNOSTI C	0	135, 960		2, 310		
	05500 RADI OLOGY - THERAPEUTI C 03630 ULTRA SOUND	0			0 346	0 1, 365	
	06000 LABORATORY	0	73, 622	-	738	19, 142	
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0,022	0	0	511	
	06500 RESPI RATORY THERAPY	0	70, 114	70, 114	1, 125	5, 452	65.00
	06600 PHYSI CAL THERAPY	0	116, 751		1, 684	5, 786	
	06700 OCCUPATI ONAL THERAPY	0	2, 451		550		1
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0			292 480	1, 144	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0) O	004	8, 741	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	3, 999	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	32, 766	73.00
00 00	OUTPATIENT SERVICE COST CENTERS	0	247.025	267, 925	E 47E	21 557	
	08800 RURAL HEALTH CLINIC 08801 RURAL HEALTH CLINIC II	0	267, 925 197, 029		5,475 4,645		
	09000 CLINIC	0			693		
90.01	09001 ONCOLOGY	0			706		90.01
	09002 OUTPATIENT CLINIC	0	0	0	281	975	
	09003 PROVIDER BASED CLINIC - TCMP	0		0	0	0	
	09004 PROVIDER BASED CLINIC - DCPC 09005 PROVIDER BASED CLINIC - WESTPORT	0	25, 358	25, 358	0	0	
	09006 CLINIC	0	34, 508		452	2, 313	
90.07	09007 WOMEN'S HEALTH SERVICES	0	73, 960	73, 960	326	1, 849	90.07
	09008 PALN MANAGEMENT	0	8, 685		0	1,036	
	09009 GERIATRIC PSYCH	0	44,080		71	2, 508	
	09010 PROVIDER BASED CLINIC - DCPM 09011 PROVIDER BASED CLINIC - NEPHROLOGY	0	32, 902 22, 209		159 70		
	09012 DI ABETES CLINIC	0	5, 050		, 0	71	1
	09013 NEUROLOGY	0	5, 346		9	62	
	09014 FOOT AND ANKLE	0	1, 754		35	162	
	09100 EMERGENCY	0	110, 179		2, 443	15, 046	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS			0			92.00
95.00	09500 AMBULANCE SERVICES	0	76, 073	76, 073	1, 925	7,667	95.00
	10100 HOME HEALTH AGENCY	0		0	0		101.00
	SPECIAL PURPOSE COST CENTERS		1			1	
118.00		0	3, 209, 652	3, 209, 652	48, 849	254, 718	118.00
100 00	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	~			<u>^</u>	100.00
	19200 PHYSICIANS' PRIVATE OFFICES	0			0		190.00 192.00
	07950 MARKETI NG	0	22, 399	22, 399	404		194.00
194.02	07952 NRCC	0	606, 368	606, 368	0	3, 268	194.02
	07955 RETAIL PHARMACY	0	16, 863	16, 863	807	16, 980	194.05
200.00				0	~	_	200.00
201.00 202.00		0	3, 855, 282	3, 855, 282	0 50, 060		
		. 0	, 0,000,202	0,000,202	50, 500	2,0,024	

ALLOCATION OF CAPITAL RELATED COSTS Protein Control Protein Contro	Health Financial Systems	DECATUR CO. MEM	ORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
International structure International	ALLOCATION OF CAPITAL RELATED COSTS		Provider C				
Cost Gener Description MNILENNE & PLANIEN OF BIFFAUX PLANE F PLODE BIFFAUX PLODE BIFFAUX <thplode BIFFAUX PLODE BIFFAUX</thplode 						Date/Time Pre	
BEAM IS PLANT LIER 8.580 (2)	Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG		/ pm
EREMENT SERVICE COST CENTERS		REPAI RS	PLANT	LINEN SERVICE			
1.00 DOTOD CAP REL COSTS = BLOG & LINT 4.00 5.00 DOSCOM ANNI MISTATI VI & A EMPERATION 4.70 5.00 DOSCOM ANNI MISTATI VI & A EMPERATION 4.70 5.00 DOSCOM ANNI MISTATI VI & A EMPERATION 6.70 6.00 DOSCOM ANNI MISTATI VI & A EMPERATION 5.13 6.00 DOSCOM ANNI MISTATI VI & A EMPERATION 6.56 7.00 DOSCOM ANNI MISTATI VI & A EMPERATION 6.56 7.00 DOSCOM ANNI STRATION 6.56 7.00 DISCOM CONTRAL, SERVICES A CONTRAL 7.00 DISCOM CONTRAL, SERVICES & SUPPLY 6.4 7.00 DISCOM CONTRAL, SERVICE & SUPPLY 6.4 7.00 DISCOM CONTRAL, SERVICE & SUPPLY 6.4 7.00 DISCOM ANDERS NOW MINISTATION 6.554 8.00 DISCOM ANDERS NOW MINISTATION 7.951	CENERAL SERVICE COST CENTERS	6.00	7.00	8.00	9.00	10.00	
5.00 00000 (APRATI OF 2, GINTRAL							1.00
6.00 0000000 LARREY & LINEN SERVICE 6 6 0 75,960 8 0 75,960 8 0 0 75,960 8 0<							1
7.00 00/700 DEFENT ION 0F PLANT 0 5.134 21,456 7.00 8.00 9.00 000000 ILENRY F J INER SERVICE 36,513 52 3.033 75,948 8.00 8.00 8.00 8.00 8.00 8.00 9.00 11,000 110							1
8.00 00800 LUMBOPS & LIMBN SERVICE 0 34 21, 456 8.00 9.00 00.0000 UNESKEP M 0 29 130 0 9.00 9.							1
9.00 00000 PTARY NO. 25 00 0000 PTARY NO. 00000 PTARY NO. 000000 PTARY NO. 00000 PTARY NO. 000000 PTARY NO. 00000 PTARY NO. 00							1
10. 00 01000 DETRY 0 27 130 0 18, 67 10, 70 13. 00 01300 MURSING ANDINISTRATION 6, 554 B 0 0 11, 00 14. 00 1400 01300 MURSING ANDINISTRATION 6, 554 B 0 0 14, 00 14. 00 1400 District Participant Structure 0 14, 00 1400 0 0 14, 00 1400 District Participant Structure 0, 200 14, 200 17, 00 14, 00 14, 00 14, 00 14, 00 14, 00 14, 00 14, 00		, s			75, 960		1
13.00 01300 MIRES ING. ADMINISTRATION 6.554 8 0 109 0 13.00 14.00 01400 01500 FIRTRAL SERVICE & SUBPLY 0 51 0 0 16.00 15.00 01500 FIRTRAL SERVICE COST CENTERS 10.290 17.00 17.00 17.00 0.00 00500 FIRTRAL SERVICE COST CENTERS 10.290 17.00 17.00 17.00 17.00 0.00 005000 OFSOM OPLITS & FEBRICE COST CENTERS 0 23.00 25.00 05.000 005000 00.500<						18, 047	1
14. 00 0 0 0 14. 00 0 0 14. 00 15. 00 01500 HEROMERS & LIBRARY 4, 681 56 0 16. 00 15. 00		-			-	-	
15. 00 01500 PHARIMACY 0 51 0 0 0 15. 00 17. 00 01700 SCRUICE 10. 299 19 0 174 0 1700 18.00 100000 AULTS SERVICE 10. 299 19 0 174 0 17 0 17 0 17 0 17 0 0 17 0 0 17 0 0 17 0 0 17 0 17 0 0 17 0 0 17 0 0 17 0 0 17 0 0 17 0 0 17 0				0			1
16.00 01600 DEDICAL RECORDS & LIBRARY 4, 681 56 0 16.00 INPATIENT ROUTHE SERVICE COST CENTERS 023 226 1, 387 01 0.00 04.300 MURITS & PENICE COST CENTERS 0 23 226 1, 387 04 3.00 05200 OFFRATINE SERVICE COST CENTERS 0 2.025 0 00 00000 OFFRATINE ROUT 1.6.00 0.0					0		1
17.000 01700_SOCIAL SFRVICE 10,299 19 0 17.4 01 17.00 30.00 03000_ADULTS & PEDIATRICS 18,725 778 7,951 40,649 15,977 30.00 30.00 04000_MIRSERY 0 23 224 1,387 04 43.00 40.00 0400_MIRSERY 0 23 2,622 0 0500 <		Ŭ		, o	164	-	1
30.00 3000 ADULTS & PEDIATRICS 18, 725 798 7, 951 40, 549 15, 977 30.00 ANGULLARY SERVICE COST CENTERS						0	1
43. 00 04300 23 226 1,387 0 43. 00 AMELLIARY SERVICE COST CENTERS							
MCULLARY SERVICE COST CONTERS 90.00 05:00 0PENTING ROM 18,725 3.53 2,625 0 0 50.00 52:00 05:00 0PENTING ROM 1,873 62 9 2.563 0 53.00 54:00 05:40 00 0							
50.00 05000 DELVERY ROM & LABOR ROM 18,725 353 2,625 0 50.00 53.00 05300 DELVERY ROM & LABOR ROM 1,873 62 9 2,663 0 53.00 53.00 05300 AMESTHESI OLOCY 16 0		0	23	226	1, 387	0	43.00
52.00 05200 DELLIVERY ROUM & LABOR ROUM 1, 973 62 9 2, 563 0 53.00 54.00 05400 ARSTINESIOLOGY 0 0 0 0 0 0 0 53.00 55.01 05500 ARSIDICUCY 116877 121 0 1.610 0		18, 725	353	2, 625	0	0	50.00
54.00 06400 RADIOLOGY-JI AGNOSTIC 5.618 224 1.575 2.192 54.00 05.00 0500 RADIOLOGY-JI THERAPUTIC 0 0 0 0 55.01 03030 ULTRA SOUND 0 0 0 0 0 65.01 0600 GEOD LABORATORY 1,873 121 0 1,610 66.00 0600 RESPI RATORY THERAPY 31,833 115 40.60 1,155 66.00 0600 DECOPATIONAL THERAPY 1,873 0 0 24.00 67.00 06400 DECUPATIONAL THERAPY 0 4 0 24.00 67.00 07100 MEDICAL SUPPLIES CHARED TO PATIENTS 0 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 8.420 0 0 0 73.00 86.00 88.01 88.01 88.01 88.01 88.01 88.01 88.01 88.01 88.01 88.01 88.01 88.01 88.01 88.01 88.01 88.01 90.03 90.03 90					2, 563	0	52.00
55. 00 05500 05700 05700 05700 05700 05700 05700 05700 05700 05700 07700 07700 07700 07700 07700 07700 07700 07700 07700 07700 07700 07700 07700 07700 07700 <t< td=""><td></td><td>-</td><td></td><td></td><td>0</td><td>-</td><td>1</td></t<>		-			0	-	1
55. 01 03:330 ULTRA SOUND 0 0 0 0 55. 00 00. 00 CORD (HADDRATORY 1.873 121 0 1.610 66. 00 00. 00 CORD (HADDRATORY 1.873 115 40.66 1.55 0 65. 00 00. 00 CORD (HESP) RATORY THERAPY 19. 662 192 1.157 17.03 0 66. 00 00. 00 CCUPAT TOWAL THERAPY 0 4 0 424 0 67. 00 00. 00 CCUPAT TOWAL THERAPY 0 0 0.2660 92.66 26.00 67. 00 67.00 67.00 0 0 72.00						-	1
60.00 06000 LABORATORY 1.873 121 0 1.670 0 60.00 60.00 06500 PHASDERA TRAPY 31.833 115 40.6 1.155 0 62.00 67.00 06500 PHASDEA THERAPY 19.62 1157 703 0 64.00 68.00 06500 SPECH PATHOLOGY 1.873 0 0 24.4 67.00 69.00 06900 LECIROCARDIOLOGY 1.873 0 0 23.6 26.00 67.00 77.00 71.00 OT200 IMED CAL SUPPLIES CHARGED TO PATIENTS 8.426 0 0 77.00 77.00 73.00 07200 IMEAL HEALTH CLINIC 20.6,978 44.1 187 0 88.00 88.00 88.00 88.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00					0	-	1
62.00 06200 HIGE BLODD & PACKED RED BLODD CELL 0 0 0 0 0 66.00 65.00 06560 PESPIR ATORY THERAPY 19, 662 192 1, 157 703 0 65.00 0 06700 0CPUATIONAL THERAPY 0 4 0 42.4 0 67.00 0.6700 0CPUATIONAL THERAPY 0 4 0 42.4 0 67.00 0.00 0CUPATIONAL THERAPY 0 0 22.6 26.0 69.00 0.00 0.01 0.0 22.6 26.0 0 0 72.0 0.01 0.01 0.0 0 0 0 0 72.0 72.0 0.01 0.0000 DUPATIENT SERVICE COST CENTERS 0		-		0	1, 610		1
66.00 06600 PHYSICAL THERAPY 19.662 19.2 1.57 703 0 66.00 67.00 72.00 <td< td=""><td></td><td></td><td></td><td>0</td><td></td><td></td><td>1</td></td<>				0			1
67.00 06/700 0CUPATIONAL THERAPY 0 4 0 424 0 67.00 68.00 06800 SPECH, PATHOLOY 1,873 0 0 334 0 66.00 97.00 DY200 MPL, DEV, CHARGED TO PATIENTS 0 0 0 0 0 71.00 77.00						-	1
68. 00 068.00 SPECCH PATHOLOGY 1,873 0 0 334 0 68. 00 71. 00 071.00 NEDICAL SUPPLIES CHARGED TO PATIENT 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>1</td>							1
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11.00 00 00 0 </td <td></td> <td></td> <td></td> <td>-</td> <td></td> <td>-</td> <td></td>				-		-	
73.00 OR300 DRUGS CHARGED TO PATIENTS 8, 426 O 2, 494 73.00 0017711 ENT SERVICE COST CENTERS 90000 9000 9000 90		0	0				1
OUTPATLENT SERVICE COST CENTERS OUTPATLENT SERVICE COST CENTERS OBB 00 RURAL HEALTH CLINIC 205,978 441 187 0		0			0	-	
B8: 00 D8800 RURAL HEALTH CLINIC 205,978 441 187 0 0 88: 00 08801 RURAL HEALTH CLINIC III 5,618 324 36 0 0 88: 01 00:00 09000 CLINIC 0 175 0 0 0 90: 01 00:02 09002 CUTPATIENT CLINIC 0 0 69 353 0 09: 00 0		8, 426	0	0	2, 494	0	73.00
B8.01 RURAL HEALTH CLINIC II 5,618 324 36 0 0 88.01 90.00 09000 CLINIC 0 175 0 0 0 00.00 90.01 09001 ONCOLOGY 6,554 133 71 5,073 563 90.01 90.02 0002 PROVIDER BASED CLINIC - TCMP 0<		205.978	441	187	0	0	88 00
90.01 09001 0NCOLOGY 6,554 133 71 5,073 563 90.02 90.02 09002 QUTPATI ENT CLINIC - TCMP 0<					-	-	
90.02 09002 0UTPATI ENT CLINIC 0 0 69 353 0 90.03 90.03 09003 PROVI DER BASED CLINIC - TCMP 0 0 0 0 90.04 90.04 09004 PROVI DER BASED CLINIC - TCMP 0 0 0 0 90.04 90.05 09005 PROVI DER BASED CLINIC - WESTPORT 1, 873 42 0 0 90.04 90.06 09007 09007 WOMEN'S HEALTH SERVICES 15, 917 122 97 0 0 90.07 90.08 09009 GRIATRIC PSYCH 0 14 0 0 1, 282 90.09 90.09 09009 (GRIATIC PSYCH 10, 299 73 0 0 0 90.010 90.11 09011 PROVI DER BASED CLINIC - NEPHROLOGY 0 37 0 0 0 90.12 90.13 09013 NEUROLOGY 0 3 0 0 90.13 90.14 09014 F		0			0	0	90.00
90.03 09003 PROVI DER BASED CLINIC - TCMP 0							1
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90.06 09006 CLINIC 1,873 57 256 1,224 0 90.06 90.07 09007 WOMEN'S HEALTH SERVICES 15,917 122 97 0 0 90.07 90.08 PAIN MANAGEMENT 0 14 0 0 0 90.09 90.09 09009 GERIATRIC PSYCH 10,299 73 0 0 90.09 90.10 09010 PROVI DER BASED CLINIC - DCPM 0 54 0 0 90.10 90.11 09012 PROVI DER BASED CLINIC - NEPHROLOGY 0 37 0 0 90.12 90.12 09013 NEUROLOGY 0 8 0 0 90.12 90.13 09104 FOOT AND ANKLE 0 3 0 0 90.13 92.00 09200 OBSERVATION BEDS (NON-DI STINCT PART 0 0 0 0 95.00 90.00 09500 MABULANCE SERVICES 0 125 134 0 0 95.00 101.00 IOMER RELIMBURSABLE COST CENTERS 91 <td></td> <td></td> <td></td> <td></td> <td>0</td> <td>-</td> <td></td>					0	-	
90.08 09008 PAI N MANAGEMENT 0 14 0 0 0 90.09 90.00 GERIATRIC PSYCH 10,299 73 0 0 1,282 90.09 90.10 90.010 PROVIDER BASED CLINIC - DCPM 0 54 0 0 90.10 90.11 90.11 90.11 PROVIDER BASED CLINIC - NEPHROLOGY 0 37 0 0 90.10 90.11 90.12 09012 DI ABETES CLINIC NEHROLOGY 0 37 0 0 90.11 90.13 09013 NEUROLOGY 0 9 0 0 90.12 90.13 09014 FOOT AND ANKLE 0 3 0 0 90.14 90.14 0910 EMERGENCY 0 0 90.14	90. 06 09006 CLINIC	1, 873	57		1, 224		
90.09 09009 GERIATRIC PSYCH 10,299 73 0 0 1,282 90.09 90.10 09010 PROVI DER BASED CLINIC - DCPM 0 54 0 0 90.11 90.11 09011 PROVI DER BASED CLINIC - NEPHROLOGY 0 37 0 0 90.11 90.12 DIABETES CLINIC 0 8 0 0 90.12 90.13 09013 NEUROLOGY 0 8 0 0 90.13 90.14 FOOT AND ANKLE 0 3 0 0 90.13 90.14 FOOT AND ANKLE 0 3 0 0 90.14 90.00 DERRGENCY 6,554 181 3,258 13,905 2255 91.00 92.00 OBSERVATION BEDS (NON-DISTINCT PART - - 92.00 95.00 101.00 HOME HEALTH AGENCY 0 0 0 0 95.00 101.00 HOME HEALTH AGENCY 0 0		15, 917			0	-	
90.10 OPOVI DER BASED CLINIC - DCPM 0 54 0 0 90.10 90.11 OPOTI2 DROVI DER BASED CLINIC - NEPHROLOGY 0 37 0 0 90.11 90.12 DI ABETES CLINIC NEROLOGY 0 8 0 0 90.12 90.13 DEUROLOGY 0 9 0 0 90.12 90.14 OPOTA AND ANKLE 0 3 0 0 90.14 91.00 OP100 EMERGENCY 6,554 181 3,258 13,905 225 91.00 92.00 OBSERVATI ON BEDS (NON-DI STINCT PART 6,554 181 3,258 13,905 225 91.00 95.00 OPSOO AMBULANCE SERVICES 0 125 134 0 0 95.00 101.00 Inter Reit MBURSABLE COST CENTERS 0 0 0 0 101.00 SPECI AL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 421,323 4,074 21,456		10 299			0	-	1
90.11 09011 PROVI DER BASED CLINIC - NEPHROLOGY 0 37 0 0 90.11 90.12 09012 DI ABETES CLINIC 0 8 0 0 90.12 90.13 09013 NEUROLOGY 0 9 0 0 90.12 90.14 69014 FOOT AND ANKLE 0 3 0 0 90.14 90.14 FOOT AND ANKLE 0 3 0 0 90.14 90.10 EMERGENCY 66,554 181 3,258 13,905 225 91.00 92.00 O9500 AMBULANCE SERVICES 0 125 134 0 0 92.00 95.00 09500 AMBULANCE SERVICES 0 125 134 0 0 95.00 101.00 HOME HEALTH AGENCY 0 0 0 0 0 10 0 101.00 190.00 I9000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190.00					0		
90.13 09013 NEUROLOGY 0 0 0 0 0 0 0 0 13 90.14 09014 FOOT AND ANKLE 0 3 0 0 0 0 90.14 91.00 09100 EMERGENCY 6,554 181 3,258 13,905 225 91.00 92.00 OBSERVATION BEDS (NON-DISTINCT PART 6,554 181 3,258 13,905 225 91.00 92.00 OBSERVATION BEDS (NON-DISTINCT PART 6,554 181 3,258 13,905 225 91.00 95.00 09500 AMBULANCE SERVICES 0 125 134 0 0 95.00 101.00 HOME HEALTH AGENCY 0 0 0 0 0 0 101.00 SPECI AL PURPOSE COST CENTERS ***********************************		0			0	0	
90. 14 09014 FOOT AND ANKLE 0 3 0 0 0 0 90. 14 91. 00 09100 EMERGENCY 6, 554 181 3, 258 13, 905 225 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 6, 554 181 3, 258 13, 905 225 91. 00 92. 00 OBSERVATI ON BEDS (CONT CENTERS 0 125 134 0 0 95. 00 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101. 00 SPECI AL PURPOSE COST CENTERS THE INBURSABLE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 421, 323 4, 074 21, 456 74, 673 18, 047 118. 00 NONRET IMBURSABLE COST CENTERS 190. 00 GI FT, FLOWER, COFFE SHOP & CANTEEN 0 0 0 190. 00 192.00 192.00 192.00 194. 00 194. 00 194. 00 194. 00 194. 00		0			0		
91.00 09100 EMERGENCY 6,554 181 3,258 13,905 225 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 92.00 92.00 92.00 92.00 0THER REI MBURSABLE COST CENTERS 0 125 134 0 0 95.00 95.00 09500 AMBULANCE SERVI CES 0 125 134 0 0 95.00 101.00 HOME HEALTH AGENCY 0 0 0 0 0 0 0 10.00 SPECIAL PURPOSE COST CENTERS 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 0 0 192.00 192.00 192.00 192.00 192.00 192.00 192.00		0		-	0		
92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART 92.00 0THER REIMBURSABLE COST CENTERS 95.00 0125 134 0 0 95.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 421,323 4,074 21,456 74,673 18,047 118.00 NONREL MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 0 0 0 192.00 192.00 192.00 192.00 192.00 0 0 192.00 0 192.00 192.00 192.00 192.00 0 192.00 192.00 0 192.00 192.00		-	-	, o	12 005	-	
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101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 421,323 4,074 21,456 74,673 18,047 118.00 NONREI MBURSABLE COST CENTERS 190.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 190.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 0 0 0 192.00 192.00 192.00 192.00 0 0 192.00 192.00 192.00 192.00 0 0 192.00 192.00 192.00 192.00 0 0 0 192.00 192.00 192.00 192.00 192.00 192.00 192.00 194.00 194.00 194.00 194.00 194.00 194.00 194.02 194.02 194.02 194.02 194.02 194.02 194.02 194.02 194.02							
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 421,323 4,074 21,456 74,673 18,047 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0 192.00 194.00 07950 MARKETI NG 4,681 37 0 0 194.02 194.02 07952 NRCC 0 28 0 0 194.02 194.05 07955 RETAIL PHARMACY 0 28 0 0 194.02 200.00 Cross Foot Adjustments 0 0 0 0 194.02 200.00 0 0 0 194.02 194.05 07955 RETAIL PHARMACY 0 28 0 0 194.02 200.00 Cross Foot Adjustments 0 0 0 0 0 0 0 20						-	
I18.00 SUBTOTALS (SUM OF LINES 1 through 117) 421,323 4,074 21,456 74,673 18,047 118.00 NONREI MBURSABLE COST CENTERS NONREI MBURSABLE COST CENTERS 0 0 0 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190.00 192.00 192.00 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 192.00 192.00 192.00 192.00 192.00 192.00 0 192.00 192.00 0 0 0 192.00 192.00 194.00 192.00 0 194.00 194.00 194.02 0 0 0 194.02 194.02 0 194.02 0 194.02 194.02 0 194.02 0 194.02 194.02 194.02 194.02 0 194.02 0 194.02 0 194.02 194.02 194.02 0 194.02 194.02 0 194.02 0 194.02 0 194.02 0 194.02 0 0 0		0	0	0	0	0	101.00
NONREI MBURSABLE COST CENTERS 190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0 192.00 194.00 07950 MARKETI NG 4, 681 37 0 0 194.00 194.02 07952 NRCC 0 995 0 1, 287 0 194.02 194.05 07955 RETAIL PHARMACY 0 28 0 0 194.02 200.00 Cross Foot Adjustments 200.00 200.00 0 0 0 200.00		7) 421 222	4 074	21 456	74 673	18 047	118 00
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190.00 192.00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 0 0 192.00 194.00 07950 MARKETI NG 4, 681 37 0 0 194.00 194.02 07952 NRCC 0 995 0 1, 287 0 194.02 194.05 07955 RETAI L PHARMACY 0 28 0 0 194.05 200.00 Cross Foot Adjustments 0 0 0 0 0 200.00 201.00 Negati ve Cost Centers 0 0 0 0 0 0 201.00		.,	4,074	21,400	,4,075	10, 047	1.13.00
192.00 19200 PHYSI CLANS' PRI VATE OFFICES 0 0 0 192.00 194.00 07950 MARKETI NG 4, 681 37 0 0 194.00 194.02 07952 NRC 0 995 0 1, 287 194.02 194.05 07955 RETAIL PHARMACY 0 28 0 0 194.05 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0	190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.02 07952 NRCC 0 995 0 1,287 0 194.02 194.05 07955 RETAIL PHARMACY 0 28 0 0 0 194.05 200.00 Cross Foot Adjustments 0 0 0 0 201.00 201.00 Negative Cost Centers 0 0 0 0 0 0		-			0		
194.05 07955 RETAIL PHARMACY 0 28 0 0 194.05 200.00 Cross Foot Adjustments 200.00 200.00 200.00 200.00 200.00 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0 201.00					0		
200.00 Cross Foot Adjustments 200.00					1, 287		
201.00 Negative Cost Centers 0 </td <td></td> <td></td> <td>20</td> <td>Í</td> <td></td> <td>0</td> <td></td>			20	Í		0	
202.00 TOTAL (sum lines 118 through 201) 426,004 5,134 21,456 75,960 18,047 202.00	201.00 Negative Cost Centers	0	0	0	0		201.00
	202.00 TOTAL (sum lines 118 through 201)	426, 004	5, 134	21, 456	75, 960	18, 047	202.00

	Financial Systems DE	CATUR CO. MEM	ORIAL HOSPITAL Provider CC	N· 15-1332 □	eriod:	u of Form CMS-: Worksheet B	2552-10
ALLUCA	ATTON OF CALLER RELATED COSTS			F	rom 01/01/2020 o 12/31/2020	Part II Date/Time Pre	epared:
	Cost Center Description	CAFETERI A	NURSING	CENTRAL	PHARMACY	6/22/2021 8: 2 MEDI CAL	27 pm
			ADMI NI STRATI O N	SERVICES & SUPPLY		RECORDS & LI BRARY	
		11.00	13.00	14.00	15.00	16.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
6.00	00600 MAINTENANCE & REPAIRS						6.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11.00		84, 251					11.00
13.00 14.00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	1, 550 557		3, 895			13.00
14.00	01500 PHARMACY	557 C		3, 895 C			14.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	2, 857		0		46, 836	
17.00	01700 SOCI AL SERVI CE	1, 296	936	0	0	0	17.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	0.01/	((01			2,020	1 20 00
30.00 43.00	03000 ADULTS & PEDI ATRI CS 04300 NURSERY	9, 916 431		C		2, 028 170	
10.00	ANCI LLARY SERVICE COST CENTERS	431	1 512		<u> </u>	170	3.00
50.00	05000 OPERATING ROOM	5, 574		C		4,005	
52.00	05200 DELIVERY ROOM & LABOR ROOM	241		0		208	
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	896		C		336 6, 743	
55.00	05500 RADI OLOGY - THERAPEUTI C	4, 507 C		0	0	0,743	54.00 55.00
55.01	03630 ULTRA SOUND	567	-	0	Ű	1, 140	1
60.00	06000 LABORATORY	2, 023	151	C		6, 194	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0		0		123	
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	2, 298 3, 536		C		910 1, 367	65.00 66.00
67.00	06700 OCCUPATI ONAL THERAPY	893		C		544	67.00
68.00	06800 SPEECH PATHOLOGY	420		C		300	68.00
69.00	06900 ELECTROCARDI OLOGY	950		0	-	1, 238	
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	C	-	2, 672 1, 223		869 444	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 934		1, 223	-	7, 625	
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	9, 925		0		638	
88.01 90.00	08801 RURAL HEALTH CLINIC II 09000 CLINIC	7, 160 3, 642		C		618 483	
90.00 90.01	09001 ONCOLOGY	1, 670		C	0	816	
90.02	09002 OUTPATIENT CLINIC	1, 421		0	0	80	
90.03	09003 PROVIDER BASED CLINIC - TCMP	C		C	0	0	
90.04 90.05	09004 PROVIDER BASED CLINIC - DCPC	C	-	C	0	0	
90.05	09005 PROVIDER BASED CLINIC - WESTPORT 09006 CLINIC	1, 073		0		2 898	90.05
90.07	09007 WOMEN' S HEALTH SERVICES	1, 889		0	0	46	
90.08	09008 PAIN MANAGEMENT	819		C	0	747	
90.09	09009 GERIATRIC PSYCH	291		0		350	
90. 10 90. 11	09010 PROVIDER BASED CLINIC - DCPM 09011 PROVIDER BASED CLINIC - NEPHROLOGY	1, 113 397		C	-	64 12	90.10
90.12	09012 DI ABETES CLINIC	C		C	0	5	90.12
90.13	09013 NEUROLOGY	214	0	C	0	9	90.13
90.14	09014 FOOT AND ANKLE	354		0	0	24	90.14
91.00 92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	4, 920	3, 215	C	0	6, 359	91.00 92.00
72.00	OTHER REIMBURSABLE COST CENTERS		1				92.00
95.00	09500 AMBULANCE SERVICES	5, 905	0	0	0	1, 441	95.00
101.00	10100 HOME HEALTH AGENCY	C	0	0	0	0	101.00
110 00	SPECIAL PURPOSE COST CENTERS	00.000	10 (01	2.005	20.015	44 024	110 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	82, 239	18, 691	3, 895	30, 015	40, 836	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	0	C	0	0	190.00
192.00	19200 PHYSI CI ANS' PRI VATE OFFI CES	C		C			192.00
	07950 MARKETI NG	716	1	0	0		194.00
		C 1 204	-	0	0		194.02
200.00	07955 RETALL PHARMACY Cross Foot Adjustments	1, 296		U	10, 001	0	194.05 200.00
201.00		C	0	C	0	0	201.00
201.00							

<u>Heal th</u>	Financial Systems Di	ECATUR CO. MEMO	RIAL HOSPITAL		In Lieu	u of Form CMS-	2552-10
ALLOCA	ATION OF CAPITAL RELATED COSTS		Provider CC		eriod: com 01/01/2020 0 12/31/2020	Worksheet B Part II Date (Time Pro	parod
						Date/Time Pre 6/22/2021 8:2	27 pm
	Cost Center Description	SOCI AL SERVI CE	Subtotal	Intern & Residents	Total		
		SERVICE		Cost & Post			
				Stepdown			
		17.00	24.00	Adjustments 25.00	26.00		
	GENERAL SERVICE COST CENTERS				1		
1.00 4.00	00100 CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT						1.00 4.00
4.00 5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
6.00	00600 MAI NTENANCE & REPAI RS						6.00
7.00 8.00	00700 OPERATION OF PLANT						7.00
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG						8.00 9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A						11.00
13.00 14.00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY						13.00 14.00
15.00	01500 PHARMACY						15.00
16.00	01600 MEDICAL RECORDS & LIBRARY						16.00
17.00	01700 SOCIAL SERVICE	27, 034					17.00
30.00	03000 ADULTS & PEDIATRICS	24, 160	638, 340	0	638, 340		30.00
43.00	04300 NURSERY	0	18, 052	0	18, 052		43.00
50.00	ANCI LLARY SERVICE COST CENTERS		0(4.045		0(4.045		1 50 00
50.00 52.00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	264, 845 43, 523	0	264, 845 43, 523		50.00 52.00
53.00	05300 ANESTHESI OLOGY	0	2, 336	0	2, 336		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	171, 716	0	171, 716		54.00
55.00 55.01	05500 RADI OLOGY - THERAPEUTI C 03630 ULTRA SOUND	0	0 3, 418	0	0 3, 418		55.00 55.01
60.00	06000 LABORATORY	0	105, 474	0	105, 474		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	634	0	634		62.00
65.00	06500 RESPIRATORY THERAPY	0	115,037	0	115, 037		65.00
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	150, 838 6, 390	0	150, 838 6, 390		66.00 67.00
68.00	06800 SPEECH PATHOLOGY	0	4, 363	0	4, 363		68.00
69.00	06900 ELECTROCARDI OLOGY	0	5, 563	0	5, 563		69.00
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	12, 282 5, 666	0	12, 282 5, 666		71.00
72.00	07300 DRUGS CHARGED TO PATIENTS	0	84, 260	0	84, 260		73.00
	OUTPATIENT SERVICE COST CENTERS						
88. 00 88. 01	08800 RURAL HEALTH CLINIC 08801 RURAL HEALTH CLINIC II	0	512, 126 234, 441	0	512, 126 234, 441		88.00 88.01
90.00	09000 CLINIC	0	114, 499	0	114, 499		90.00
90.01	09001 ONCOLOGY	1, 484	101, 070	0	101, 070		90.01
	09002 OUTPATIENT CLINIC	411	3, 590	0	3, 590		90.02
		0	0	0	0		90.03 90.04
90.04 90.05	09005 PROVIDER BASED CLINIC - WESTPORT	0	27, 429	0	27, 429		90.05
90.06	09006 CLI NI C	О	43, 430	0	43, 430		90.06
90.07	09007 WOMEN' S HEALTH SERVICES 09008 PAIN MANAGEMENT	0	94, 206	0	94, 206		90.07
90. 08 90. 09		0	11, 301 58, 954	0	11, 301 58, 954		90.08 90.09
90.10		0	35, 065	0	35, 065		90.10
		0	23, 088	0	23, 088		90.11
	09012 DI ABETES CLINIC 09013 NEUROLOGY	0	5, 143 5, 649	0	5, 143 5, 649		90.12 90.13
		0	2, 332	0	2, 332		90.14
	09100 EMERGENCY	979	167, 264	0	167, 264		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
95.00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	0	93, 270	0	93, 270		95.00
	10100 HOME HEALTH AGENCY	0	0	0	0		101.00
	SPECIAL PURPOSE COST CENTERS	07.004	0.4/5.504		0.4/5.50/		
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	27,034	3, 165, 594	0	3, 165, 594		118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	О		192.00
	07950 MARKETI NG 207952 NRCC	0	31, 795	0	31, 795		194.00 194.02
	07952 NRCC 07955 RETAIL PHARMACY	0	611, 918 45, 975	0	611, 918 45, 975		194.02 194.05
200.00	Cross Foot Adjustments	Ŭ	0	0	0		200.00
201.00	5	0	2 055 202	0	2 055 202		201.00
202.00) TOTAL (sum lines 118 through 201)	27, 034	3, 855, 282	0	3, 855, 282		202.00

ST AL		ial Systems D ON - STATISTICAL BASIS	ECATUR CO. MEMC	Provi der C		eriod:	u of Form CMS-2 Worksheet B-1	
					F	rom 01/01/2020 o 12/31/2020		
			CAPI TAL				6/22/2021 8:2	<u>27 pm</u>
			RELATED COSTS					
	C	Cost Center Description	BLDG & FIXT	EMPLOYEE		ADMI NI STRATI V		
			(SQUARE FEET)	BENEFITS	n	E & GENERAL	REPAI RS	
				DEPARTMENT		(ACCUM. COST)	(TIME SPENT)	
			1.00	(SALARI ES) 4.00	5A	5.00	6.00	+
		L SERVICE COST CENTERS						
		CAP REL COSTS-BLDG & FIXT	182, 443	05 400 040				1
		EMPLOYEE BENEFITS DEPARTMENT	2, 369	25, 108, 810		F1 (7F 041		4
		ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS	12, 749 19, 646	4, 577, 011 384, 805			455	5
		OPERATION OF PLANT	19,040	384, 803			433	
		LAUNDRY & LINEN SERVICE	971	62, 572	-		0	
		HOUSEKEEPING	1, 502	340, 172		731, 629	39	
00	01000	DI ETARY	821	50, 682	0	81, 296	0	10
		CAFETERI A	3, 759	177, 373			0	
		NURSING ADMINISTRATION	218	676, 130		1	7	
		CENTRAL SERVICES & SUPPLY	116	58, 298			0	
		PHARMACY MEDICAL RECORDS & LIBRARY	1, 464 1, 608	852, 978 459, 846			0	
		SOCIAL SERVICE	549	459, 846 288, 618			5 11	
		ENT ROUTINE SERVICE COST CENTERS	547	200, 010	. 0	0,0,000		1''
		ADULTS & PEDIATRICS	22, 955	2, 534, 145	0	3, 974, 014	20	30
		NURSERY	667	169, 531	0	198, 448	0	43
		ARY SERVICE COST CENTERS	40.41-	1 040 05	-	0.040.015		
		DPERATING ROOM DELIVERY ROOM & LABOR ROOM	10, 162	1, 240, 331	0		20	
		ANESTHESI OLOGY	1, 772	94, 903 83, 159			2	
		RADI OLOGY-DI AGNOSTI C	6, 434	1, 158, 278			6	
		RADIOLOGY - THERAPEUTIC	0, 101	1, 100, 2,0			0	
		JLTRA SOUND	0	173, 483	0	253, 226	0	55
00	06000 L	ABORATORY	3, 484	370, 134	0	3, 551, 420	2	60
		WHOLE BLOOD & PACKED RED BLOOD CELL	0	0			0	
		RESPI RATORY THERAPY	3, 318	564,006			34	
		PHYSICAL THERAPY	5, 525	844, 610			21	
		DCCUPATIONAL THERAPY SPEECH PATHOLOGY	116 0	275, 614 146, 428		282, 660 212, 277	0	
		ELECTROCARDI OLOGY	0	240, 623			0	
		MEDICAL SUPPLIES CHARGED TO PATIENT	0	0			0	
. 00	07200	MPL. DEV. CHARGED TO PATIENTS	0	0	0	741, 863	0	72
		DRUGS CHARGED TO PATIENTS	0	0	0	6, 081, 047	9	73
		I ENT_SERVI CE_COST_CENTERS	10 (70	0 745 015		2 000 4/0	220	
		RURAL HEALTH CLINIC RURAL HEALTH CLINIC II	12, 679 9, 324	2, 745, 915 2, 329, 581	0		220	
	09000		9, 324 5, 026	2, 329, 381			0	
		DNCOLOGY	3, 829	354, 302		572, 891	7	
		DUTPATIENT CLINIC	0	140, 900			0	
03	09003 F	PROVIDER BASED CLINIC - TCMP	0	0	0	0	0	90
		PROVIDER BASED CLINIC - DCPC	0	0	0	0	0	
		PROVIDER BASED CLINIC - WESTPORT	1,200	1, 876		27, 859	2	90
	09006		1,633	226, 590	0	429, 116	2	
		NOMEN'S HEALTH SERVICES PAIN MANAGEMENT	3, 500 411	163, 391 0		343, 013 192, 209	17 0	
		GERIATRIC PSYCH	2,086	35, 738		465, 284	11	90
		PROVIDER BASED CLINIC - DCPM	1, 557	79, 556		143, 360	0	
		PROVIDER BASED CLINIC - NEPHROLOGY	1, 051	34, 936		67, 314	0	
12	09012	DIABETES CLINIC	239	4, 744	0	13, 227	0	90
		NEUROLOGY	253	4, 505		11, 520	0	
		FOOT AND ANKLE	83	17, 553		29, 992	0	
		EMERGENCY	5, 214	1, 225, 312	0	2, 791, 501	7	91
		DBSERVATION BEDS (NON-DISTINCT PART REIMBURSABLE COST CENTERS			1	l		92
		AMBULANCE SERVICES	3, 600	965, 240	0	1, 422, 374	0	95
1.00	10100 H	HOME HEALTH AGENCY	0	0				101
		L PURPOSE COST CENTERS	· · · · · ·					1
3. 00		SUBTOTALS (SUM OF LINES 1 through 117)	151, 890	24, 501, 513	-11, 786, 678	47, 259, 206	450	1118
		MBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN		0	0	0	0	190
		PHYSICIANS' PRIVATE OFFICES	0	0		0		190
		MARKETING	1,060	202, 368	-	660, 051		194
	07952		28, 695	202, 300	0	606, 368		194
		RETALL PHARMACY	798	404, 929	0	3, 150, 216		194
		Cross Foot Adjustments						200
		Negative Cost Centers	1					201
0.00 1.00 2.00		Cost to be allocated (per Wkst. B,	3, 855, 282	7, 236, 295		11, 786, 678	2, 298, 711	

Heal th	Financial Systems Di	ECATUR CO. MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-	2552-10
COST AL	LOCATION - STATISTICAL BASIS		Provider C		Period: From 01/01/2020	Worksheet B-1	
					To 12/31/2020		
		CAPI TAL					
		RELATED COSTS					
	Cost Center Description	BLDG & FIXT	EMPLOYEE	Reconciliati	D ADMI NI STRATI V		
		(SQUARE FEET)	BENEFI TS	n	E & GENERAL	REPAI RS	
			DEPARTMENT		(ACCUM. COST)	(TIME SPENT)	
			(SALARI ES)				
		1.00	4.00	5A	5.00	6.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	21. 131433	0. 288197		0. 228089	5, 052. 112088	203.00
204.00	Cost to be allocated (per Wkst. B,		50, 060		278, 524	426, 004	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part		0. 001994		0.005390	936. 272527	205.00
	11)						
206.00	NAHE adjustment amount to be allocated						206.00
	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D,						207.00
	Parts III and IV)						

OST ALLO	nancial Systems D DCATION - STATISTICAL BASIS	ECATUR CO. MEM	Provider C		eriod: rom 01/01/2020	u of Form CMS-2 Worksheet B-1	
					0 12/31/2020	Date/Time Pre 6/22/2021 8:2	
	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (HOURS OF S ERVI CE)	DI ETARY (MEALS SERV ED)	CAFETERI A (HOURS)	
		7.00	8.00	9.00	10.00	11.00	
00 00 00 00 00 00 00 00 00 00	NERAL SERVICE COST CENTERS 100 CAP REL COSTS-BLDG & FIXT 400 EMPLOYEE BENEFITS DEPARTMENT 500 ADMINISTRATIVE & GENERAL 600 MAINTENANCE & REPAIRS 700 OPERATION OF PLANT	147 (70					1. 4. 5. 6.
00 00 00 00 00 01 00 01 00 01 00 01	800 LAUNDRY & LI NEN SERVI CE 900 HOUSEKEEPI NG 000 DI ETARY 100 CAFETERI A 300 NURSI NG ADMI NI STRATI ON	147, 679 971 1, 502 821 3, 759 218	258, 695 36, 569 1, 566 0 0	180, 889 0 0 260	11, 385 0 0	614, 015 11, 294	13
. 00 01 . 00 01 . 00 01	400 CENTRAL SERVICES & SUPPLY 500 PHARMACY 600 MEDICAL RECORDS & LIBRARY 700 SOCIAL SERVICE PATIENT ROUTINE SERVICE COST CENTERS	116 1, 464 1, 608 549	0	0 0 390 415	0	4, 056 0 20, 821 9, 443	15 16
. 00 04	000 ADULTS & PEDI ATRI CS 300 NURSERY CI LLARY SERVI CE COST CENTERS	22, 955 667		96, 558 3, 303		72, 264 3, 144	30 43
0.00 050 2.00 053 3.00 053 4.00 053 5.00 053	000 OPERATI NG ROOM 200 DELI VERY ROOM & LABOR ROOM 300 ANESTHESI OLOGY 400 RADI OLOGY-DI AGNOSTI C 500 RADI OLOGY - THERAPEUTI C	10, 162 1, 772 0 6, 434 0	114 0 18, 989 0	0 6, 104 0 5, 220 0	0 0 0	40, 622 1, 760 6, 531 32, 849 0	52 53 54 55
. 00 06 . 00 06 . 00 06 . 00 06	630 ULTRA SOUND 000 LABORATORY 200 WHOLE BLOOD & PACKED RED BLOOD CELL 500 RESPI RATORY THERAPY 600 PHYSI CAL THERAPY	0 3, 484 0 3, 318 5, 525	0 0 4, 894 13, 955	0 3, 835 0 2, 750 1, 675	0 0 0 0	4, 133 14, 747 0 16, 745 25, 771	60 62 65 66
. 00 06 . 00 06 . 00 07 . 00 07	700 OCCUPATIONAL THERAPY 800 SPEECH PATHOLOGY 900 ELECTROCARDIOLOGY 100 MEDICAL SUPPLIES CHARGED TO PATIENT 200 IMPL. DEV. CHARGED TO PATIENTS 300 DRUGS CHARGED TO PATIENTS	116 0 0 0 0 0 0 0	0 2, 840 0	1, 010 795 620 0 0 5, 940	0 0 0	6, 510 3, 058 6, 926 0 0 21, 382	68 69 71 72
	TPATIENT SERVICE COST CENTERS 800 RURAL HEALTH CLINIC	12, 679	2, 256	0	0	72, 328	88
. 01 08	801 RURAL HEALTH CLINIC II	9, 324	439	0		52, 183	88
	000 CLINIC 001 ONCOLOGY	5, 026 3, 829		0 12, 080	0 355	26, 541 12, 168	
	002 OUTPATIENT CLINIC	0		840		10, 358	
	003 PROVIDER BASED CLINIC - TCMP	0	-	-	0	0	
	004 PROVIDER BASED CLINIC - DCPC 005 PROVIDER BASED CLINIC - WESTPORT	0 1, 200	-	0	0	0	90
. 06 09	006 CLINIC	1, 633	3, 091	2, 915	0	7, 821	90
	007 WOMEN'S HEALTH SERVICES 008 PAIN MANAGEMENT	3, 500 411		0	0	13, 770 5, 970	90
	009 GERIATRI C PSYCH	2, 086		0	809	2, 122	
	010 PROVIDER BASED CLINIC - DCPM	1, 557		0	0	8, 112	
	011 PROVIDER BASED CLINIC - NEPHROLOGY 012 DIABETES CLINIC	1, 051 239		0	0	2, 891 0	90
. 13 09	013 NEUROLOGY	253	0	0	0	1, 560	90
	014 FOOT AND ANKLE 100 EMERGENCY	83 5, 214		0 33, 114	0 142	2, 579 35, 857	90
. 00 09: 0TI	200 OBSERVATION BEDS (NON-DISTINCT PART HER REIMBURSABLE COST CENTERS						92
1. 00 <u>10</u>	500 AMBULANCE SERVICES 100 HOME HEALTH AGENCY ECIAL PURPOSE COST CENTERS	3, 600				43, 035 0	95 101
8.00	SUBTOTALS (SUM OF LINES 1 through 117)	117, 126	258, 695	177, 824	11, 385	599, 351	118
	NREIMBURSABLE COST CENTERS 000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	ol	0	190
2.00 19:	200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192
	950 MARKETI NG	1,060			0	5, 221	
	952 NRCC 955 RETAIL PHARMACY	28, 695 798		3, 065	0	0 9, 443	194
0.00	Cross Foot Adjustments	, , , ,				7, 40	200
1.00	Negative Cost Centers						201
2.00	Cost to be allocated (per Wkst. B, Part I)	1, 169, 647	184, 998	1, 133, 585	107, 461	1, 017, 043	202
	Unit cost multiplier (Wkst. B, Part I)	7. 920199	0. 715120	6. 266744	9. 438823	1.656381	200

Health Fir	nancial Systems	DECATUR CO. MEM	ORIAL HOSPITAL		In Lie	u of Form CMS-:	2552-10
COST ALLO	CATION - STATISTICAL BASIS		Provider C	Provider CCN: 15-1332		Worksheet B-1	
			_		From 01/01/2020 To 12/31/2020		
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NO	G DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE	(HOURS OF S	(MEALS SERV	(HOURS)	
		(SQUARE FEET)	(POUNDS OF	ERVICE)	ED)		
			LAUNDRY)				
		7.00	8.00	9.00	10.00	11.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	5, 134	21, 456	75, 96	18, 047	84, 251	204.00
205.00	Unit cost multiplier (Wkst. B, Part	0. 034765	0. 082939	0. 41992	1. 585156	0. 137213	205.00
206.00	NAHE adjustment amount to be allocated						206.00
007 00	(per Wkst. B-2)						0.07 0.0
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

	DECATUR CO. MEMO		N 45 4000		u of Form CMS-	
COST ALLOCATION - STATISTICAL BASIS		Provider CC		Period: From 01/01/2020	Worksheet B-1	
				To 12/31/2020	Date/Time Pre 6/22/2021 8:2	
Cost Center Description	NURSI NG ADMI NI STRATI O N (NURSI NG HO	CENTRAL SERVI CES & SUPPLY (COSTED	PHARMACY (COSTED REQUI S.)	MEDI CAL RECORDS & LI BRARY (GROSS	SOCI AL SERVI CE (TI ME SPENT)	
	URS)	REQUIS.)	15.00	CHARGES)	17.00	
GENERAL SERVICE COST CENTERS	13.00	14.00	15.00	16.00	17.00	
1.00 00100 CAP_REL_COSTS-BLDG & FIXT 4.00 00400 EMPLOYEE_BENEFITS_DEPARTMENT 5.00 00500 ADMI NI STRATI VE & GENERAL 6.00 00600 MAI NTENANCE & REPAIRS 7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING 10.00 D1000 DI ETARY						1.00 4.00 5.00 6.00 7.00 8.00 9.00
11.00 01100 CAFETERI A 13.00 01300 NURSI NG ADMI NI STRATI ON 14.00 01400 CENTRAL SERVI CES & SUPPLY 15.00 01500 PHARMACY 16.00 01600 MEDI CAL RECORDS & LI BRARY 17.00 01700 SOCI AL SERVI CE	188, 420 4, 039 0 0 9, 433	2, 363, 630 0 0 0		7 0 130, 292, 695 0 0	856	10.00 11.00 13.00 14.00 15.00 16.00 17.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	67, 454	0		0 5, 650, 388	765	30.00
43. 00 04300 NURSERY	3, 144	0		0 5, 850, 388 0 474, 351	/65 0	
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	37, 484	0		0 11, 155, 054	0	50.00
52.00 05200 DELI VERY ROOM & LABOR ROOM 53.00 05300 ANESTHESI OLOGY 54.00 05400 RADI OLOGY-DI AGNOSTI C 55.00 05500 RADI OLOGY - THERAPEUTI C	1, 760 0 0 0	0 0 0		0 580, 626 0 935, 697 0 18, 783, 347 0 0	0 0 0 0	52.00 53.00 54.00 55.00
55. 01 03630 ULTRA SOUND 60. 00 06000 LABORATORY 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0 1, 519 0 16, 426 0	0 0 0 0		0 3, 176, 778 0 17, 252, 964 0 343, 876 0 2, 534, 055 0 3, 807, 030		60.00 62.00 65.00
 67. 00 67. 00 667.00 668.00 66800 692.00 692.00 6900 692.00 692.00 692.00 692.00 692.00 692.00 692.00 692.00 692.00 71.00 <l< td=""><td>0 0 6, 926 0 0</td><td>0 0 1, 621, 767 741, 863</td><td></td><td>0 1, 513, 970 834, 510 0 3, 449, 851 0 2, 421, 970 0 1, 236, 438</td><td>0 0 0 0 0</td><td>68.00 69.00 71.00</td></l<>	0 0 6, 926 0 0	0 0 1, 621, 767 741, 863		0 1, 513, 970 834, 510 0 3, 449, 851 0 2, 421, 970 0 1, 236, 438	0 0 0 0 0	68.00 69.00 71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	7, 678, 94	5 21, 061, 239	0	73.00
OUTPATI ENT SERVI CE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.01 08801 RURAL HEALTH CLINIC	0	0		0 1, 778, 372 0 1, 720, 897	0	88.01
90.00 09000 CLINIC 90.01 09001 ONCOLOGY 90.02 09002 OUTPATIENT CLINIC 90.03 09003 PROVIDER BASED CLINIC - TCMP 90.04 09004 PROVIDER BASED CLINIC - DCPC	000000000000000000000000000000000000000	0 0 0 0		0 1, 345, 324 0 2, 272, 873 0 223, 472 0 0 0	0 47 13 0 0	90. 01 90. 02 90. 03
90.05 09005 PROVI DER BASED CLINIC - WESTPORT 90.06 09006 CLINIC - 90.07 09007 WOMEN'S HEALTH SERVICES - 90.08 09008 PAIN MANAGEMENT -	0 7, 825 0 0	0 0 0		0 5, 819 0 2, 502, 234 0 127, 871 0 2, 080, 912	0 0 0	90.06 90.07 90.08
90. 09 09009 GERIATRIC PSYCH 90. 10 09010 PROVIDER BASED CLINIC - DCPM 90. 11 09011 PROVIDER BASED CLINIC - NEPHROLOGY 90. 12 09012 DIABETES CLINIC 90. 13 09013 NEUROLOGY 90. 14 09014 FOOT AND ANKLE		000000000000000000000000000000000000000		0 974, 674 0 179, 050 0 34, 707 0 14, 415 0 24, 311 0 67, 995	0 0 0 0 0 0 0	90. 10 90. 11 90. 12 90. 13
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	32, 410	0		0 17, 714, 484	31	91.00 92.00
95. 00 09500 AMBULANCE SERVICES 101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	00	0		0 4, 013, 141 0 0		101.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117 NONREI MBURSABLE COST CENTERS 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN) 188, 420	2, 363, 630		5 130, 292, 695 0 0		118.00 190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES 194.00 07950 MARKETING 194.02 07952 NRCC 194.05 07955 RETAIL PHARMACY 200.00 Cross Foot Adjustments	0 0 0	0 0 0 0	2, 558, 38	0 0 0 0 0 0	0 0 0	192.00 194.00 194.02 194.05 200.00
201.00Negative Cost Centers202.00Cost to be allocated (per Wkst. B, Part I)203.00Unit cost multiplier (Wkst. B, Part I)	1, 086, 231) 5. 764945	114, 239 0. 048332				
200.00 junit cost multipiter (wkst. b, Part I	7 5.704945	0. 040332	0. 10422	0.007689	1 122.300000	1203.00

Health Fin	ancial Systems	DECATUR CO. MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-:	2552-10
COST ALLO	CATION - STATISTICAL BASIS		Provider C	CN: 15-1332	Period:	Worksheet B-1	
					From 01/01/2020 To 12/31/2020		
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	
		ADMI NI STRATI O	SERVICES &	(COSTED	RECORDS &	SERVI CE	
		N	SUPPLY	REQUIS.)	LI BRARY	(TIME SPENT)	
		(NURSING HO	(COSTED		(GROSS		
		URS)	REQUIS.)		CHARGES)		
		13.00	14.00	15.00	16.00	17.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	18, 691	3, 895	40, 01	6 46, 836	27, 034	204.00
205.00	Unit cost multiplier (Wkst. B, Part	0. 099199	0. 001648	0. 00390	0.000359	31. 581776	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

MPUTATI ON	OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-1332	Period: From 01/01/2020	Worksheet C Part I	
					To 12/31/2020		
			Title	XVIII	Hospi tal	Cost	
					Costs	·	
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst.	Adj.		Di sal I owance		
		B, Part I,					
		col. 26)					
	· · · · · · · · · · · · · · · · · · ·	1.00	2.00	3.00	4.00	5.00	
	IENT ROUTINE SERVICE COST CENTERS	-					
	ADULTS & PEDIATRICS	7, 037, 925		7, 037, 92		0	
	NURSERY	298, 721		298, 72	21 0	0	43.
	LARY SERVICE COST CENTERS						
	OPERATING ROOM	3, 454, 136		3, 454, 13		0	50.
	DELIVERY ROOM & LABOR ROOM	252, 841		252, 84		0	52.
3.00 05300	ANESTHESI OLOGY	231, 973		231, 97	73 0	0	53
	RADI OLOGY-DI AGNOSTI C	3, 197, 963		3, 197, 96	53 0	0	54
6.00 05500	RADIOLOGY - THERAPEUTIC	0			0 0	0	55
5.01 03630	ULTRA SOUND	342, 892		342, 89	92 0	0	55
06000	LABORATORY	4, 592, 484		4, 592, 48	34 0	0	60
	WHOLE BLOOD & PACKED RED BLOOD CELL	119, 127		119, 12		0	62
	RESPI RATORY THERAPY	1, 603, 317	0			0	65
	PHYSI CAL THERAPY	1, 561, 304	0			0	
	OCCUPATI ONAL THERAPY	377, 107	0	377, 10		0	
	SPEECH PATHOLOGY	287, 429	0	287, 42		0	
	ELECTROCARDI OLOGY	474, 657	0	474,65		0	
	MEDICAL SUPPLIES CHARGED TO PATIENT	2, 089, 164		2, 089, 16		0	
	IMPL. DEV. CHARGED TO PATIENTS	956, 684		956, 68		0	
	DRUGS CHARGED TO PATIENTS	9, 013, 358		9, 013, 35		0	
	TI ENT SERVICE COST CENTERS	7,013,330		7,013,30		0	/ / 3
3. 00 08800	RURAL HEALTH CLINIC	6, 259, 021		6, 259, 02	21 0	0	88
	RURAL HEALTH CLINIC II	4, 536, 005		4, 536, 00		0	
		4, 536, 005		4, 550, 00		0	
	ONCOLOGY	920, 960		920, 96		0	
	OUTPATIENT CLINIC						
		256, 410		256, 41		0	
	PROVIDER BASED CLINIC - TCMP	0			0 0	0	
	PROVIDER BASED CLINIC - DCPC	0		50.00	0 0	0	
	PROVIDER BASED CLINIC - WESTPORT	53, 867		53, 86		0	
		648, 315		648, 31		0	
	WOMEN' S HEALTH SERVICES	559, 512		559, 51		0	
	PAIN MANAGEMENT	265, 610		265, 61		0	
	GERIATRIC PSYCH	662, 345		662, 34		0	
	PROVIDER BASED CLINIC - DCPM	203, 241		203, 24		0	
	PROVIDER BASED CLINIC - NEPHROLOGY	96, 055		96, 05		0	1
	DIABETES CLINIC	18, 251		18, 25		0	
	NEUROLOGY	18, 928		18, 92		0	
	FOOT AND ANKLE	42, 298		42, 29		0	
	EMERGENCY	4, 150, 204		4, 150, 20		0	
	OBSERVATION BEDS (NON-DISTINCT PART	1, 150, 682		1, 150, 68	32	0	92
	REIMBURSABLE COST CENTERS	1					
	AMBULANCE SERVICES	1, 879, 415		1, 879, 41		0	
	HOME HEALTH AGENCY	0			0		101
0.00	Subtotal (see instructions)	58, 458, 280	0				200
01.00	Less Observation Beds	1, 150, 682		1, 150, 68	32	0	201
			0		98 0		202

	ATION OF RATIO OF COSTS TO CHARGES		Provider C	UN: 15-1332	Period: From 01/01/2020 To 12/31/2020		epared: 27 pm
		1		XVIII	Hospi tal	Cost	
	Cost Center Description	I npati ent	Charges Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1					
	03000 ADULTS & PEDIATRICS	4, 731, 374		4, 731, 37			30.00
43.00	04300 NURSERY	474, 351		474, 35	51	L	43.00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	1, 742, 953	9, 412, 101	11, 155, 05			
	05200 DELIVERY ROOM & LABOR ROOM	465, 564	115, 062			0.000000	
	05300 ANESTHESI OLOGY	122, 666	813, 031	935, 69		0.000000	
	05400 RADI OLOGY-DI AGNOSTI C	841, 988	17, 941, 359	18, 783, 34		0.000000	
55.00	05500 RADI OLOGY - THERAPEUTI C 03630 ULTRA SOUND	07 105	2 070 472	2 174 7	0 0.00000	0.000000	
55.01 60.00	06000 LABORATORY	97, 105	3, 079, 673			0.000000	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	944, 312 129, 786	16, 308, 652 214, 090	17, 252, 96		0.000000	
	06500 RESPI RATORY THERAPY	1, 373, 059	1, 160, 996	343, 87 2, 534, 05		0.000000	
66.00	06600 PHYSI CAL THERAPY	475, 327	3, 331, 703			0.000000	
67.00	06700 OCCUPATI ONAL THERAPY	475, 327 468, 719	1, 045, 251	1, 513, 97		0.000000	
	06800 SPEECH PATHOLOGY	100, 458	734, 052	834, 5		0.000000	
	06900 ELECTROCARDI OLOGY	347, 013	3, 102, 838			0.000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	880, 911	1, 541, 059			0.000000	
	07200 I MPL. DEV. CHARGED TO PATIENTS	417, 726	818, 712	1, 236, 43		0.000000	
	07300 DRUGS CHARGED TO PATIENTS	3, 665, 850	17, 395, 389			0.000000	
. 0. 00	OUTPATIENT SERVICE COST CENTERS	0,000,000	11/0/0/00/	21,001,20	01127700	01000000	1 101 00
88.00	08800 RURAL HEALTH CLINIC	0	1, 778, 372	1, 778, 37	72		88.00
	08801 RURAL HEALTH CLINIC II	0	1, 720, 897	1, 720, 89			88.01
	09000 CLINIC	0	1, 345, 324			0. 000000	90.00
90. 01	09001 ONCOLOGY	1, 118	2, 271, 755	2, 272, 87	0. 405196	0. 000000	90.01
90. 02	09002 OUTPATIENT CLINIC	48, 141	175, 331	223, 47	1. 147392	0. 000000	90.02
90.03	09003 PROVIDER BASED CLINIC - TCMP	0	0		0 0.000000	0.000000	90.03
90.04	09004 PROVIDER BASED CLINIC - DCPC	0	0		0 0.000000	0.000000	90.04
	09005 PROVIDER BASED CLINIC - WESTPORT	0	5, 819	5, 81		0.00000	
	09006 CLINIC	9, 769	2, 492, 465	2, 502, 23	0. 259094	0.000000	90.06
	09007 WOMEN'S HEALTH SERVICES	798	127, 073			0. 000000	
	09008 PAIN MANAGEMENT	0	2, 080, 912	2, 080, 91		0. 000000	
90.09	09009 GERI ATRI C PSYCH	0	974, 674	974, 67		0. 000000	
	09010 PROVIDER BASED CLINIC - DCPM	0	179, 050			0.000000	
	09011 PROVIDER BASED CLINIC - NEPHROLOGY	0	34, 707	34, 70		0.000000	
	09012 DI ABETES CLINIC	0	14, 415			0.000000	
	09013 NEUROLOGY	0	24, 311	24, 31		0.000000	
	09014 FOOT AND ANKLE	0	67, 995			0.000000	
	09100 EMERGENCY	19, 590	17, 694, 894			0.000000	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 475	916, 539	919, 01	14 1. 252083	0.000000	92.00
05 00	OTHER REIMBURSABLE COST CENTERS		4 040 411	4 010 1	0 4/0015	0.000000	05 00
	09500 AMBULANCE SERVICES	0	4, 013, 141	4, 013, 14	0. 468315	0. 000000	
101.00 200.00	10100 HOME HEALTH AGENCY	17 341 053	112 021 442	120 202 //		ł	101.00
ZUU. UU	Subtotal (see instructions)	17, 361, 053	112, 931, 642	130, 292, 69	70	1	
201.00	Less Observation Beds					Į.	201.00

Heal th	Fi nar	nci al	Syst	ems		
COMPLIE	ATLON				COCTC	TO

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1332	Peri od:	Worksheet C	
			From 01/01/2020	Part I	
			To 12/31/2020	Date/Time Pre 6/22/2021 8:2	epared:
		Title XVIII	Hospi tal	Cost	<u>z / pili</u>
Cost Center Description	PPS Inpatient		10301 tui	0031	
cost center bescription	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS	11.00				-
30. 00 03000 ADULTS & PEDIATRICS					30.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVICE COST CENTERS	I				- 10.00
50. 00 05000 OPERATING ROOM	0. 000000				50.00
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
55. 00 05500 RADI OLOGY - THERAPEUTI C	0. 000000				55.00
55. 01 03630 ULTRA SOUND	0. 000000				55.01
60. 00 06000 LABORATORY	0. 000000				60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000				62.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000				67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000				68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				69.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT	0. 000000				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
88. 00 08800 RURAL HEALTH CLINIC					88.00
88. 01 08801 RURAL HEALTH CLINIC II	0.000000				88.01
90. 00 09000 CLINIC	0. 000000				90.00
90. 01 09001 ONCOLOGY	0. 000000				90.01
90. 02 09002 OUTPATIENT CLINIC	0. 000000				90.02
90. 03 09003 PROVIDER BASED CLINIC - TCMP	0. 000000				90.03
90. 04 09004 PROVIDER BASED CLINIC - DCPC	0. 000000				90.04
90. 05 09005 PROVIDER BASED CLINIC - WESTPORT	0. 000000				90.05
90. 06 09006 CLINIC	0. 000000				90.06
90. 07 09007 WOMEN' S HEALTH SERVICES	0. 000000				90.07
90. 08 09008 PAIN MANAGEMENT	0. 000000				90.08
90. 09 09009 GERIATRIC PSYCH	0. 000000				90.09
90.10 09010 PROVIDER BASED CLINIC - DCPM	0. 000000				90.10
90. 11 09011 PROVIDER BASED CLINIC - NEPHROLOGY	0.000000				90.11
90. 12 09012 DI ABETES CLINIC	0.000000				90.12
90. 13 09013 NEUROLOGY	0. 000000				90.13
90.14 09014 FOOT AND ANKLE	0. 000000				90.14
91. 00 09100 EMERGENCY	0. 000000				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000				92.00
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVI CES	0. 000000				95.00
101.00 10100 HOME HEALTH AGENCY					101.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00

MPUTATI O'	ON OF RATIO OF COSTS TO CHARGES		Provi der C	CCN: 15-1332	Period: From 01/01/2020		
				,	To 12/31/2020	Date/Time Prep 6/22/2021 8:2	pared 27 pm
				le XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost (from Wkst. B, Part I,	Therapy Limit Adj.	Total Costs	s RCE Di sal I owance	Total Costs	
		col . 26)	2.00	2.00	1.00	5.00	
	ATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	-
	ATTENT ROUTINE SERVICE COST CENTERS	7,037,925		7,037,92	25 0	7,037,925	30.0
	BOO NURSERY	298, 721	i	298, 72			
	ILLARY SERVICE COST CENTERS	270, 721		270,12		270, 721	43.0
	DOO OPERATING ROOM	3, 454, 136	1	3, 454, 13	36 0	3, 454, 136	50.0
	200 DELIVERY ROOM & LABOR ROOM	252, 841	i	252, 84			
	300 ANESTHESI OLOGY	232, 841	1	231, 97			
			i				
		3, 197, 963	i	3, 197, 96		0,,	
	00 RADI OLOGY - THERAPEUTI C	242 902	i	242.0	0 0		
	30 ULTRA SOUND	342, 892	i	342, 89		342, 892	
		4, 592, 484	i	4, 592, 48		4, 592, 484	
	200 WHOLE BLOOD & PACKED RED BLOOD CELL	119, 127	1 ,	119, 12		119, 127	
	500 RESPI RATORY THERAPY	1, 603, 317	0			1, 603, 317	
	00 PHYSI CAL THERAPY	1, 561, 304	0			1, 561, 304	
	OO OCCUPATIONAL THERAPY	377, 107	0	0////		377, 107	
	300 SPEECH PATHOLOGY	287, 429	9, 026			296, 455	
	200 ELECTROCARDI OLOGY	474, 657	i	474, 65		474, 657	
	00 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 089, 164	i	2, 089, 16	64 0	2, 089, 164	71.0
2.00 0720	200 IMPL. DEV. CHARGED TO PATIENTS	956, 684	i	956, 68	084 0		
	OO DRUGS CHARGED TO PATIENTS	9, 013, 358	ı	9, 013, 35	358 0	9, 013, 358	73. C
	PATIENT SERVICE COST CENTERS						
	BOO RURAL HEALTH CLINIC	6, 259, 021	·	6, 259, 02		-, ,	
	301 RURAL HEALTH CLINIC II	4, 536, 005	i	4, 536, 00		.,,	
	DOO CLINIC	846, 079	i	846, 07		,	
	001 ONCOLOGY	920, 960	i	920, 96	060 0	920, 960	90.0
. 02 0900	002 OUTPATIENT CLINIC	256, 410	i	256, 41	10 0		
	003 PROVIDER BASED CLINIC - TCMP	0	i		0 0		
	004 PROVIDER BASED CLINIC - DCPC	0	i		0 0		
	005 PROVIDER BASED CLINIC - WESTPORT	53, 867	i	53, 86			
	006 CLINIC	648, 315	i	648, 3			
	007 WOMEN'S HEALTH SERVICES	559, 512	i	559, 5		0.0,0.0	
	008 PALN MANAGEMENT	265, 610	i	265, 6			
	009 GERIATRIC PSYCH	662, 345	i	662, 34			
	10 PROVIDER BASED CLINIC - DCPM	203, 241	i	203, 24			
	11 PROVIDER BASED CLINIC - DCPM	96, 055	i	96, 05			
	12 DIABETES CLINIC	98, 055 18, 251	i	18, 25		18, 251	
)12 DIABETES CLINIC)13 NEUROLOGY	18, 251	i	18, 25			
			i				
	114 FOOT AND ANKLE	42, 298	i	42, 29			
	00 EMERGENCY	4, 150, 204	1	4, 150, 20		.,,	
	200 OBSERVATION BEDS (NON-DISTINCT PART	1, 150, 682		1, 150, 68	32	1, 150, 682	92.0
	IER REI MBURSABLE COST CENTERS	1 070 415		1 070 4		1 070 415	1
	OO AMBULANCE SERVICES	1, 879, 415	i	1, 879, 47			
	00 HOME HEALTH AGENCY				0		101.0
0.00	Subtotal (see instructions)	58, 458, 280	0				
01.00	Less Observation Beds	1, 150, 682	1 ,	1, 150, 68		1, 150, 682	
2.00	Total (see instructions)	57, 307, 598	0	0 57, 316, 62	24 0	57, 316, 624	1202.1

Cost Center Description Title VIX Hospital PPE Inpatient Outpatient Total (col. 6) Cost or Other Ratio TEFRA 0.00 0300 AULTS & FOLTRICS 6.00 7.00 8.00 9.00 10.00 0.01 0300 AULTS & FOLTRICS 4.731.374 4.731.374 4.731.374 4.743.351	COMPUTA	TION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-1332	Period: From 01/01/2020 To 12/31/2020		epared: 27 pm
Cost Center Description Inpatient Outpatient Total (col., 6) (sol. 7) Cost or Other Ratio TEFRA Inpatient Ratio INPATIENT ROUTINE SERVICE COST CENTERS - - 0.00 0.00 9.00 10.00 0.00 0.0000000 0.00000 47.31, 37.4 - 4.731, 37.4 - - 43.00 0.000000 0.00000 4.743, 351 - <th></th> <th></th> <th></th> <th>Ti tl</th> <th>e XIX</th> <th>Hospi tal</th> <th>PPS</th> <th></th>				Ti tl	e XIX	Hospi tal	PPS	
INPATI ENT ROUTINE SERVICE COST CENTERS 6.00 7.00 8.00 9.00 10.00 30.00 03000 ADULTS & PEDIATRICS 4,731,374 4,731,374 4,731,374 4,731,374 30.00 05200 ADULTS & PEDIATRICS 4,741,351 474,351 474,351 30.00 05200 DELIVERY ROOM LABOR ROOM 1,742,953 9,412,101 11,155,054 0.309648 0.0000 51.00 05500 RADIOLOGY 122,666 813,031 955,697 0.247915 0.00000 55.00 05500 RADIOLOGY 112,797 3,079,673 3,176,778 0.00000 0.0000 60.00 06000 LABORATORY 97,105 3,079,673 3,176,778 0.261655 0.0000 0.0000 OCCUMHOLE BLOOD & PACKED RED BLOOD CELL 129,786 214,090 334,876 0.364424 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000		Cost Center Description	I npati ent				I npati ent	
30: 00 03000 ADULTS & PEDIATRICS 4, 731, 374 4, 731, 374 4, 731, 374 A0: 00 04300 NURSERY 474, 351 474, 351 9, 474, 351 ANCILLARY SERVICE COST CENTERS 0 05000 DECLATINE ROOM 1, 742, 953 9, 412, 101 11, 155, 054 0.00000 52, 00 05200 DELIVERY ROM & LABOR ROOM 122, 666 913, 031 935, 697 0.247915 0.0000 54, 00 05500 ANSTHESI OLOGY 122, 666 913, 031 935, 697 0.47915 0.0000 55, 00 05500 RADIOLOGY - I TERAPEUTIC 0 0 0.00000 0.00000 0.0000 55, 01 03630 ULTRA SOND 97, 105 3, 079, 673 3, 176, 778 0.107937 0.0000 60, 00 06000 WHOLE BLOOD & PACKED RED BLOOD CELL 129, 786 214, 090 343, 876 0.346424 0.0000 60, 00 06000 OCUPATI NAL THERAPY 1, 373, 693 3, 102, 838 3, 479, 851 0.331788 0.0000 60, 00 06000 SPECEH PATHOLOGY 100, 458 73, 4052 834, 510 0.344242			6.00	7.00	8.00	9.00		
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52:00 052:00 PELI VERY ROOM & LABOR ROOM 445,564 115,062 580,626 0.435463 0.0000 54:00 05400 RADI OLOGY - DI AGNOSTI C 841,988 17,941,359 18,783,347 0.170255 0.0000 55:00 05500 RADI OLOGY - THERAPEUTI C 0 0 0 0.00000 0.00000 55:00 06300 LTRA SOUND 97,105 3,079,673 3,176,778 0.1207937 0.00000 60:00 06000 HADRATORY 944,312 16,308,652 17,252,964 0.266185 0.00000 06:00 06600 PHYSI CAL THERAPY 1475,327 3,317,03 3,807,033 0.6111 0.00000 06:00 06600 PHYSI CAL THERAPY 4468,719 1.045,251 1,513,970 0.249085 0.0000 01:00 OTO MEIC CAL SUPLIES CHARGED TO PATI ENT 480,911 1.541,059 0.38767 0.38767 0.385,851 0.37742 0.0000 00 07300 RUBALHEAL HEALTH CLIN C 1 778,872 1.785,838			1 740 050	0 410 101	11 155 0	- 4 0 200(40	0.00000	50.00
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90.02 09002 0UTPATIENT CLINIC 48,141 175,331 223,472 1.147392 0.0000 90.03 09003 PROVI DER BASED CLINIC - TCMP 0 0 0.000000 0.00000 90.04 09004 PROVI DER BASED CLINIC - DCPC 0 0 0.000000 0.00000 90.05 09005 PROVI DER BASED CLINIC - WESTPORT 0 5,819 5,819 9.257089 0.0000 90.06 09006 CLINIC WESTPORT 0 5,819 5,252,234 0.259094 0.0000 90.07 09007 WOMEN'S HEALTH SERVICES 798 127,073 127,871 4.375597 0.0000 90.08 09008 PAIN MANAGEMENT 0 2,080,912 2,080,912 0.127641 0.0000 90.10 09010 PROVI DER BASED CLINIC - DCPM 0 179,050 1.135108 0.0000 90.11 09011 PROVI DER BASED CLINIC - NEPHROLOGY 0 14,415 1.266112 0.0000 90.12 01ABETES CLINIC NEUROLOGY 0 24,311 24,311 0.778578 0.0000 0.0000			0				0. 000000	
90.02 04000 040000 040000 000000 0.00000 0.00000 <td>90. 01 C</td> <td>D9001 ONCOLOGY</td> <td>1, 118</td> <td>2, 271, 755</td> <td>2, 272, 8</td> <td>0. 405196</td> <td>0. 000000</td> <td>90.01</td>	90. 01 C	D9001 ONCOLOGY	1, 118	2, 271, 755	2, 272, 8	0. 405196	0. 000000	90.01
90.04 09004 PROVI DER BASED CLINIC - DCPC 0 0 0.00000 0.00000 90.05 09005 PROVI DER BASED CLINIC - WESTPORT 0 5,819 5,819 9.257089 0.00000 90.06 09006 CLINIC 9,769 2,492,465 2,502,234 0.259094 0.00000 90.07 09007 WOMEN'S HEALTH SERVICES 798 127,073 127,871 4.375597 0.0000 90.08 09008 PAI NMANAGEMENT 0 2,080,912 2,080,912 0.127641 0.0000 90.09 GERIATRIC PSYCH 0 179,050 179,050 1.135108 0.0000 90.10 09010 PROVI DER BASED CLINIC - NEPHROLOGY 0 34,707 34,707 2.767597 0.0000 90.12 09012 DI ABETES CLINIC NEPHROLOGY 0 34,707 34,707 34,707 2.767597 0.0000 90.12 09012 DI ABETES CLINIC NEPHROLOGY 0 24,311 24,311 0.778578 0.00000 <	90. 02 C	09002 OUTPATIENT CLINIC	48, 141			72 1. 147392	0. 000000	90.02
90.05 09005 PROVI DER BASED CLINIC - WESTPORT 0 5,819 5,819 9,257089 0.0000 90.06 09006 CLINIC 9,769 2,492,465 2,502,234 0.259094 0.0000 90.07 09007 WOMEN'S HEALTH SERVICES 798 127,073 127,871 4.375597 0.0000 90.08 09008 PAIN MANAGEMENT 0 2,080,912 2,080,912 0.127641 0.0000 90.09 GERIATRIC PSYCH 0 974,674 974,674 0.679555 0.0000 90.10 PROVI DER BASED CLINIC - DCPM 0 179,050 1.135108 0.0000 90.11 09011 PROVI DER BASED CLINIC - NEPHROLOGY 0 34,707 34,707 2.767597 0.0000 90.12 09012 DI ABETES CLINIC 0 14,415 14,415 1.266112 0.0000 90.13 09013 NEUROLOGY 0 24,311 24,311 0.778578 0.0000 90.14 09014 FOOT AND ANKLE 0	90. 03 C	09003 PROVIDER BASED CLINIC - TCMP	0	0	1	0 0. 000000	0. 000000	90.03
90.06 09006 CLINIC 9,769 2,492,465 2,502,234 0.259094 0.0000 90.07 09007 WOMEN'S HEALTH SERVICES 798 127,073 127,871 4.375597 0.0000 90.08 09008 PAIN MANAGEMENT 0 2,080,912 2,080,912 0.127641 0.0000 90.09 GERIATRIC PSYCH 0 974,674 974,674 0.679555 0.0000 90.10 PROVIDER BASED CLINIC - DCPM 0 179,050 179,050 1.135108 0.0000 90.11 09011 PROVIDER BASED CLINIC - NEPHROLOGY 0 34,707 34,707 2.76757 0.0000 90.12 0912 DIABETES CLINIC NEPHROLOGY 0 14,415 14,415 1.266112 0.0000 90.14 09014 FOOT AND ANKLE 0 67,995 67,995 0.622075 0.0000 91.0 09100 EMERGENCY 19,590 17,694,894 17,714,484 0.234283 0.0000 92.00 OBSERVATION BEDS (NON-DIS	90.04 C	09004 PROVIDER BASED CLINIC - DCPC	0	0		0 0.000000	0. 000000	90.04
90.07 09007 WOMEN'S HEALTH SERVICES 798 127,073 127,871 4.375597 0.0000 90.08 09008 PALN MANAGEMENT 0 2,080,912 2,080,912 0.127641 0.0000 90.09 09009 GERIATRIC PSYCH 0 974,674 974,674 0.679555 0.0000 90.10 POVIDER BASED CLINIC - DCPM 0 179,050 179,050 1.135108 0.0000 90.11 PROVIDER BASED CLINIC - NEPHROLOGY 0 34,707 34,707 2.76757 0.0000 90.12 O9112 DIABETES CLINIC NEPHROLOGY 0 144,415 14,415 1.266112 0.0000 90.14 09014 FOOT AND ANKLE 0 67,995 67,995 0.622075 0.0000 90.10 O9100 EMERGENCY 19,590 17,694,894 17,714,484 0.234283 0.0000 91.00 O9200 OBSERVATION BEDS (NON-DI STINCT PART 2,475 916,539 919,014 1.252083 0.0000 09200 <	90. 05 C	09005 PROVIDER BASED CLINIC - WESTPORT	0	5, 819	5, 8	9. 257089	0. 000000	90.05
90.08 09008 PAIN MANAGEMENT 0 2,080,912 2,080,912 0.127641 0.0000 90.09 09009 GERIATRIC PSYCH 0 974,674 974,674 0.679555 0.0000 90.10 09010 PROVI DER BASED CLINIC - DCPM 0 179,050 1.135108 0.0000 90.11 09011 PROVI DER BASED CLINIC - NEPHROLOGY 0 34,707 34,707 2.767597 0.0000 90.12 09012 DI ABETES CLINIC NEPHROLOGY 0 14,415 1.4,415 1.266112 0.0000 90.13 09013 NEUROLOGY 0 24,311 0.778578 0.0000 90.14 09014 FOOT AND ANKLE 0 67,995 67,995 0.622075 0.0000 91.00 09100 EMERGENCY 19,590 17,694,894 17,714,484 0.234283 0.0000 92.00 0BSERVATION BEDS (NON-DISTINCT PART 2,475 916,539 919,014 1.252083 0.0000 011.00 09500 AMBULANCE SER	90.06 C	09006 CLINIC	9, 769	2, 492, 465	2, 502, 2	0. 259094	0. 000000	90.06
90.09 09009 GERIATRIC PSYCH 0 974,674 974,674 0.679555 0.0000 90.10 09010 PROVIDER BASED CLINIC - DCPM 0 179,050 179,050 1.135108 0.0000 90.11 09011 PROVIDER BASED CLINIC - NEPHROLOGY 0 34,707 34,707 2.767597 0.0000 90.12 09012 DIABETES CLINIC NEUROLOGY 0 14,415 1.44,415 1.266112 0.0000 90.13 09013 NEUROLOGY 0 24,311 24,311 0.778578 0.0000 90.14 09014 FOOT AND ANKLE 0 67,995 67,995 0.622075 0.0000 91.00 09100 EMERGENCY 19,590 17,694,894 17,714,484 0.234283 0.0000 92.00 OBSERVATION BEDS (NON-DISTINCT PART 2,475 916,539 919,014 1.252083 0.0000 0THER REI MBURSABLE COST CENTERS 0 4,013,141 4,013,141 0.468315 0.00000 010.00 H			798	127, 073	127, 8	4. 375597	0. 000000	90.07
90.10 09010 PROVI DER BASED CLINIC - DCPM 0 179,050 179,050 1.135108 0.0000 90.11 09011 PROVI DER BASED CLINIC - NEPHROLOGY 0 34,707 34,707 2.767597 0.0000 90.12 09012 DI ABETES CLINIC NEPHROLOGY 0 14,415 14,415 1.266112 0.0000 90.13 09013 NEUROLOGY 0 24,311 24,311 0.778578 0.0000 90.14 FOOT AND ANKLE 0 67,995 67,995 0.622075 0.0000 91.00 09100 EMERGENCY 19,590 17,694,894 17,714,484 0.234283 0.0000 92.00 OBSERVATION BEDS (NON-DI STINCT PART 2,475 916,539 919,014 1.252083 0.0000 0THER REI MBURSABLE COST CENTERS 0 4,013,141 4,013,141 0.468315 0.0000 101.00 HOME HEALTH AGENCY 0 0 0 0 0			0	2, 080, 912	2, 080, 9	0. 127641	0. 000000	90.08
90.11 09011 PROVI DER BASED CLINIC - NEPHROLOGY 0 34,707 34,707 2.767597 0.0000 90.12 09012 DI ABETES CLINIC 0 14,415 14,415 1.266112 0.0000 90.13 09013 NEUROLOGY 0 24,311 24,311 0.778578 0.0000 90.14 09014 FOOT AND ANKLE 0 67,995 67,995 0.622075 0.0000 91.00 09100 EMERGENCY 19,590 17,694,894 17,714,484 0.234283 0.0000 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 2,475 916,539 919,014 1.252083 0.0000 0THER REI MBURSABLE COST CENTERS 0 4,013,141 4,013,141 0.468315 0.0000 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0			0				0. 000000	
90. 12 09012 DLABETES CLINIC 0 14,415 14,415 1.266112 0.0000 90. 13 09013 NEUROLOGY 0 24,311 24,311 0.778578 0.0000 90. 14 09014 FOOT AND ANKLE 0 67,995 67,995 0.622075 0.0000 91. 00 09100 EMERGENCY 19,590 17,694,894 17,714,484 0.234283 0.0000 92.00 OBSERVATION BEDS (NON-DISTINCT PART 2,475 916,539 919,014 1.252083 0.0000 07HER REI MBURSABLE COST CENTERS 0 4,013,141 4,013,141 0.468315 0.0000 101.00 HOME HEALTH AGENCY 0 0 0 0 0 0			-					
90.13 09013 NEUROLOGY 0 24,311 24,311 0.778578 0.0000 90.14 09014 FOOT AND ANKLE 0 67,995 67,995 0.622075 0.0000 91.00 09100 EMERGENCY 19,590 17,694,894 17,714,484 0.234283 0.0000 92.00 OBSERVATI ON BEDS (NON-DI STINCT PART 2,475 916,539 919,014 1.252083 0.0000 0THER REI MBURSABLE COST CENTERS 0 4,013,141 0.468315 0.0000 95.00 09500 AMBULANCE SERVICES 0 4,013,141 0.468315 0.0000 101.00 HOME HEALTH AGENCY 0 0 0 0 0							0. 000000	
90. 14 09014 FOOT AND ANKLE 0 67,995 67,995 0.622075 0.0000 91. 00 09100 EMERGENCY 19,590 17,694,894 17,714,484 0.234283 0.0000 92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART 2,475 916,539 919,014 1.252083 0.0000 0THER REI MBURSABLE COST CENTERS 0 4,013,141 0.468315 0.0000 95. 00 09500 AMBULANCE SERVICES 0 4,013,141 0.468315 0.0000 101.00 HOME HEALTH AGENCY 0 0 0 0 0							0. 000000	
91.00 09100 EMERGENCY 19,590 17,694,894 17,714,484 0.234283 0.0000 92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART 2,475 916,539 919,014 1.252083 0.0000 0THER REI MBURSABLE COST CENTERS 0 4,013,141 0.468315 0.0000 95.00 09500 AMBULANCE SERVICES 0 4,013,141 0.468315 0.0000 101.00 HOME HEALTH AGENCY 0 0 0 0								
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 2, 475 916, 539 919, 014 1. 252083 0.0000 0THER REI MBURSABLE COST CENTERS 0 4, 013, 141 4, 013, 141 0. 468315 0.0000 95. 00 09500 AMBULANCE SERVICES 0 4, 013, 141 0. 468315 0.0000 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0								
OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 0 4, 013, 141 0. 468315 0. 0000 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0								
95. 00 09500 AMBULANCE SERVICES 0 4, 013, 141 4, 013, 141 0. 468315 0. 0000 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0	_		2, 475	916, 539	919, 0	14 1. 252083	0.00000	92.00
101.00 10100 HOME HEALTH AGENCY 0 0 0			1				0	0.5.5
				4,013,141	4, 013, 14	0. 468315	0.000000	
200,001 (Suptotal (See Instructions) [17,361.053] 112,931.642[130.292.695]			-	0	100 000 /			101.00
			17, 361, 053	112, 931, 642	130, 292, 6	75		200.00
201.00 Less Observation Beds 202.00 Total (see instructions) 17, 361, 053 112, 931, 642 130, 292, 695			17 3/1 053	110 001 440	120 202 (25		201.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1332	Period: From 01/01/2020	Worksheet C	
			Erom 01/01/2020		
				Part I	
			To 12/31/2020	Date/Time Pre 6/22/2021 8:2	
		Title XIX	Hospi tal	PPS	<u>. 7 pili</u>
Cost Center Description	PPS Inpatient		nospi tui	115	
obst benter beschiption	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
13. 00 04300 NURSERY					43.00
ANCI LLARY SERVICE COST CENTERS	I				-
50. 00 05000 OPERATI NG ROOM	0. 309648				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 435463				52.00
53. 00 05300 ANESTHESI OLOGY	0. 247915				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 170255				54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	0. 000000				55.00
55. 01 03630 ULTRA SOUND	0. 107937				55.0
50. 00 06000 LABORATORY	0. 266185				60.0
52.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	1				62.0
55. 00 06500 RESPIRATORY THERAPY	0. 632708				65.0
56. 00 06600 PHYSI CAL THERAPY	0. 410111				66.0
57.00 06700 OCCUPATIONAL THERAPY	0. 249085				67.0
58. 00 06800 SPEECH PATHOLOGY	0. 355244				68.0
					69.0
	0. 137588				
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	1				71.0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 773742				72.0
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 427960				73.00
	2 510522				
38. 00 08800 RURAL HEALTH CLINIC	3. 519523				88.0
38.01 08801 RURAL HEALTH CLINIC II	2. 635838				88.0
20. 00 09000 CLINIC	0. 628904				90.0
20. 01 09001 ONCOLOGY	0. 405196				90.0
20. 02 09002 OUTPATIENT CLINIC	1. 147392				90.0
20. 03 09003 PROVIDER BASED CLINIC - TCMP	0. 000000				90.0
20. 04 09004 PROVIDER BASED CLINIC - DCPC	0. 000000				90.0
20. 05 09005 PROVIDER BASED CLINIC - WESTPORT	9. 257089				90.0
20. 06 09006 CLINIC	0. 259094				90.0
20. 07 09007 WOMEN' S HEALTH SERVICES	4. 375597				90.0
20. 08 09008 PAIN MANAGEMENT	0. 127641				90.0
0. 09 09009 GERI ATRI C PSYCH	0. 679555				90.0
20. 10 09010 PROVIDER BASED CLINIC - DCPM	1. 135108				90.1
20. 11 09011 PROVIDER BASED CLINIC - NEPHROLOGY	2. 767597				90.1
PO. 12 09012 DI ABETES CLINIC	1. 266112				90.1
20. 13 09013 NEUROLOGY	0. 778578				90.1
PO. 14 09014 FOOT AND ANKLE	0. 622075				90.1
91.00 09100 EMERGENCY	0. 234283				91.0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1. 252083				92.0
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVICES	0. 468315				95.00
101.00 10100 HOME HEALTH AGENCY					101.00
200.00 Subtotal (see instructions)					200.0
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00

CALCULATION OF OUTPATIENT SERVICE COS REDUCTIONS FOR MEDICAID ONLY	T TO CHARGE RA	ATIOS NET OF	Provider C	CN: 15-1332	Period: From 01/01/2020 To 12/31/2020	Worksheet C Part II Date/Time Pre 6/22/2021 8:2	
			Titl	e XIX	Hospi tal	PPS	
Cost Center Description		Total Cost	Capital Cost	Operating	Capi tal	Operati ng	
		(Wkst. B,	(Wkst. B,	Cost Net of		Cost	
		Part I, col.	Part II col.	Capital Cos	t	Reduction	
		26)	26)	(col. 1 -		Amount	
				col. 2)			
		1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS		1					
50.00 05000 OPERATING ROOM		3, 454, 136	264, 845			0	
52.00 05200 DELIVERY ROOM & LABOR ROO	M	252, 841	43, 523			0	
53. 00 05300 ANESTHESI OLOGY		231, 973	2, 336			0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		3, 197, 963	171, 716	3, 026, 24	47 0	0	54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C		0	0		0 0	0	55.00
55.01 03630 ULTRA SOUND		342, 892	3, 418	339, 4	74 0	0	55.01
60. 00 06000 LABORATORY		4, 592, 484	105, 474	4, 487, 0	10 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED	BLOOD CELL	119, 127	634	118, 49	93 0	0	62.00
65. 00 06500 RESPI RATORY THERAPY		1, 603, 317	115, 037	1, 488, 2	80 0	0	65.00
66.00 06600 PHYSI CAL THERAPY		1, 561, 304	150, 838			0	66.00
67.00 06700 OCCUPATI ONAL THERAPY		377, 107	6, 390			0	67.00
68.00 06800 SPEECH PATHOLOGY		287, 429	4, 363			0	68.00
69. 00 06900 ELECTROCARDI OLOGY		474, 657	5, 563			0	
71.00 07100 MEDICAL SUPPLIES CHARGED	το ρατι έντ	2,089,164	12, 282			0	
72.00 07200 IMPL. DEV. CHARGED TO PAT		956, 684	5, 666			0	
73.00 07300 DRUGS CHARGED TO PATIENTS	LINIS	9, 013, 358	84, 260			0	
OUTPATIENT SERVICE COST CENTERS		7,013,330	04,200	0, 727, 0	70 U	0	1 75.00
88. 00 08800 RURAL HEALTH CLINIC		6, 259, 021	512, 126	5, 746, 8	95 0	0	88.00
88. 01 08801 RURAL HEALTH CLINIC II		4, 536, 005	234, 441			0	
90. 00 09000 CLINIC		846, 079	114, 499			0	
90. 01 09001 ONCOLOGY		920, 960	101, 070			0	
90. 02 09002 0UTPATIENT CLINIC		256, 410	3, 590			0	
90. 03 09003 PROVIDER BASED CLINIC - T	CMD	230, 410	3, 570		0 0	0	
90. 03 09003 PROVIDER BASED CLINIC - T			0		0 0	0	
			-		-	0	
	ESTPORT	53, 867	27, 429				
90. 06 09006 CLINIC		648, 315	43, 430			0	
90. 07 09007 WOMEN' S HEALTH SERVICES		559, 512	94, 206			0	
90. 08 09008 PALN MANAGEMENT		265, 610	11, 301			0	
90. 09 09009 GERIATRI C PSYCH		662, 345	58, 954			0	
90. 10 09010 PROVIDER BASED CLINIC - D		203, 241	35, 065			0	
90.11 09011 PROVIDER BASED CLINIC - N	EPHROLOGY	96, 055	23, 088			0	1
90. 12 09012 DI ABETES CLINIC		18, 251	5, 143			0	1
90. 13 09013 NEUROLOGY		18, 928	5, 649			0	
90.14 09014 FOOT AND ANKLE		42, 298	2, 332			0	
91.00 09100 EMERGENCY		4, 150, 204	167, 264			0	1
92.00 09200 OBSERVATION BEDS (NON-DIS		1, 150, 682	104, 367	1, 046, 3	15 0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00 09500 AMBULANCE SERVICES		1, 879, 415	93, 270				95.00
101.00 10100 HOME HEALTH AGENCY		0	0		0 0		101.00
200.00 Subtotal (sum of lines 50	thru 199)	51, 121, 634	2, 613, 569				200.00
201.00 Less Observation Beds		1, 150, 682	104, 367				201.00
202.00 Total (line 200 minus lin		49, 970, 952	2, 509, 202	47, 461, 7	50 0		202.00

LCULATION OF OUTPATIENT SERVICE COST TO CHARGE R DUCTIONS FOR MEDICAID ONLY	ATIOS NET OF	Provider C	CN: 15-1332	Period: From 01/01/2020	Worksheet C Part II	
JUCTIONS FOR MEDICALD UNLY				To 12/31/2020	Date/Time Prej 6/22/2021 8:2	
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost Net of	Total Charges	Outpati ent			
	Capital and	(Worksheet C,	Cost to			
	Operati ng	Part I,	Charge Rati	D		
	Cost	column 8)	(col. 6 /			
	Reducti on		col. 7)			
	6.00	7.00	8.00			
ANCILLARY SERVICE COST CENTERS						
00 05000 OPERATING ROOM	3, 454, 136					50
00 05200 DELIVERY ROOM & LABOR ROOM	252, 841					52
00 05300 ANESTHESI OLOGY	231, 973	935, 697	0. 2479	15		53
00 05400 RADI OLOGY-DI AGNOSTI C	3, 197, 963	18, 783, 347	0. 1702	55		54
00 05500 RADI OLOGY - THERAPEUTI C	0	0	0.0000	00		55
01 03630 ULTRA SOUND	342, 892	3, 176, 778	0. 1079:	37		55
00 06000 LABORATORY	4, 592, 484	17, 252, 964	0. 2661	85		60
00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	119, 127	343, 876	0. 34642	24		62
00 06500 RESPI RATORY THERAPY	1, 603, 317	2, 534, 055	0.63270	28		65
00 06600 PHYSI CAL THERAPY	1, 561, 304	3, 807, 030		11		66
00 06700 OCCUPATI ONAL THERAPY	377, 107	1, 513, 970				67
00 06800 SPEECH PATHOLOGY	287, 429					68
00 06900 ELECTROCARDI OLOGY	474,657	3, 449, 851				69
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 089, 164					7
00 07200 IMPL. DEV. CHARGED TO PATIENTS	956, 684					72
00 07300 DRUGS CHARGED TO PATIENTS	9, 013, 358					73
OUTPATIENT SERVICE COST CENTERS	7,013,330	21,001,237	0.4277	50		1
00 08800 RURAL HEALTH CLINIC	6, 259, 021	1, 778, 372	3. 5195	23		88
01 08801 RURAL HEALTH CLINIC II	4, 536, 005					88
00 09000 CLINIC	846, 079					90
01 09001 0NC0L0GY	920, 960					90
02 09002 OUTPATIENT CLINIC	256, 410					90
03 09003 PROVIDER BASED CLINIC - TCMP						
	0					90
	0					90
05 09005 PROVIDER BASED CLINIC - WESTPORT	53, 867	5, 819				90
	648, 315					90
07 09007 WOMEN' S HEALTH SERVICES	559, 512	127, 871	4. 3755			90
08 09008 PAIN MANAGEMENT	265, 610					90
09 09009 GERIATRI C PSYCH	662, 345					90
10 09010 PROVIDER BASED CLINIC - DCPM	203, 241	179, 050				90
11 09011 PROVIDER BASED CLINIC - NEPHROLOGY	96, 055					90
12 09012 DI ABETES CLINIC	18, 251	14, 415				90
13 09013 NEUROLOGY	18, 928					90
14 09014 FOOT AND ANKLE	42, 298	67, 995	0. 6220	75		90
00 09100 EMERGENCY	4, 150, 204	17, 714, 484	0. 2342	83		91
00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 150, 682	919, 014	1. 2520	83		92
OTHER REIMBURSABLE COST CENTERS						
00 09500 AMBULANCE SERVICES	1, 879, 415	4, 013, 141	0. 4683	15		95
1.00 10100 HOME HEALTH AGENCY	0	0	0.0000	00		101
D.00 Subtotal (sum of lines 50 thru 199)	51, 121, 634	125, 086, 970				200
1.00 Less Observation Beds	1, 150, 682					201
2.00 Total (line 200 minus line 201)	49, 970, 952		1			202

PORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider C	CN 15-1332	Peri od:	Worksheet D	
TORTONWENT OF THEATENT ANGLEART SERVICE CALLER	L 00313	i i ovi dei c	GN. 13-1332	From 01/01/2020	Part II	
				To 12/31/2020	Date/Time Pre	
					6/22/2021 8:2	Żpm
			XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges			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)			
	<u>col. 26)</u> 1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
0. 00 05000 OPERATING ROOM	264, 845	11, 155, 054	0. 02374	431, 639	10, 248	50.0
2. 00 05200 DELIVERY ROOM & LABOR ROOM	43, 523				0, 240	
3. 00 05300 ANESTHESI OLOGY	2, 336				115	
1. 00 05400 RADI OLOGY-DI AGNOSTI C	171, 716				3, 971	54.0
5. 00 05500 RADI OLOGY - THERAPEUTI C	0				0,,,,	
5. 01 03630 ULTRA SOUND	3, 418	-			51	55.0
0. 00 06000 LABORATORY	105, 474				2, 308	
2. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	634	343, 876			73	
5. 00 06500 RESPI RATORY THERAPY	115,037	2, 534, 055			31, 218	
5. 00 06600 PHYSI CAL THERAPY	150, 838				7,555	
7. 00 06700 OCCUPATI ONAL THERAPY	6, 390					
3. 00 06800 SPEECH PATHOLOGY	4, 363				154	
2. 00 06900 ELECTROCARDI OLOGY	5, 563		0.00161		275	
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	12, 282				1, 948	
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	5, 666					
3. 00 07300 DRUGS CHARGED TO PATIENTS	84, 260					
OUTPATIENT SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·	i			· · · · · · · · · · · · · · · · · · ·	
3. 00 08800 RURAL HEALTH CLINIC	512, 126	1, 778, 372	0. 28797	75 0	0	88.0
3. 01 08801 RURAL HEALTH CLINIC II	234, 441	1, 720, 897	0. 13623	32 0	0	88.0
). 00 09000 CLINIC	114, 499	1, 345, 324	0. 08510	09 0	0	90.0
). 01 09001 0NC0L0GY	101, 070	2, 272, 873			3	
0. 02 09002 OUTPATIENT CLINIC	3, 590					
0. 03 09003 PROVIDER BASED CLINIC - TCMP	0	-			0	1
0. 04 09004 PROVIDER BASED CLINIC - DCPC	0	-	0.00000		0	
0.05 09005 PROVIDER BASED CLINIC - WESTPORT	27, 429	5, 819			0	
0. 06 09006 CLINIC	43, 430				0	
0. 07 09007 WOMEN' S HEALTH SERVICES	94, 206		0. 73672		588	
0. 08 09008 PAIN MANAGEMENT	11, 301	2,080,912			0	
0. 09 09009 GERIATRI C PSYCH	58, 954	974, 674			0	
0. 10 09010 PROVIDER BASED CLINIC - DCPM	35,065				0	
0. 11 09011 PROVIDER BASED CLINIC - NEPHROLOGY	23, 088				0	
0. 12 09012 DI ABETES CLI NI C	5, 143				0	
0. 13 09013 NEUROLOGY	5, 649		0. 23236		0	
0. 14 09014 FOOT AND ANKLE	2, 332				0	
00 09100 EMERGENCY	167, 264				77	91.0
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	104, 367	919, 014	0. 11356	54 741	84	92.(
						1
5. 00 09500 AMBULANCE SERVICES						95.0

Heal th	Financial Systems D	ECATUR CO. MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PAS			Period: From 01/01/2020 To 12/31/2020	Date/Time Pre 6/22/2021 8:2	
			Title	XVIII	Hospi tal	Cost	
	Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursi ng School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0		0 0	0	50.00
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
55.00	05500 RADI OLOGY - THERAPEUTI C	0	0		0 0	0	55.00
55.01	03630 ULTRA SOUND	0	0		0 0	0	55.01
60.00	06000 LABORATORY	0	0		0 0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0	0		0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0		73.00
/0/00	OUTPATIENT SERVICE COST CENTERS				0		10100
88.00	08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	0		0 0	0	88.01
90.00	09000 CLINIC	0	0		0 0	0	90.00
90.01	09001 ONCOLOGY	0	0		0 0	0	90.01
90.02	09002 OUTPATIENT CLINIC	0	0		0 0	0	90.02
90.03	09003 PROVIDER BASED CLINIC - TCMP	0	0		0 0	0	90.03
90.04	09004 PROVIDER BASED CLINIC - DCPC	0	0		0 0	0	90.04
90.05	09005 PROVIDER BASED CLINIC - WESTPORT	0	0		0 0	0	90.05
90.06	09006 CLINIC	0	0		0 0	0	90.06
90.07	09007 WOMEN' S HEALTH SERVICES	0	0		0 0	0	90.07
90.08	09008 PALN MANAGEMENT	0	0		0 0	0	90.08
90.09	09009 GERIATRI C PSYCH	0	0		0 0	0	90.09
90.10	09010 PROVIDER BASED CLINIC - DCPM	0	0		0 0	0	90.10
90.11	09011 PROVIDER BASED CLINIC - NEPHROLOGY	0	0		0 0	0	90.11
90.12	09012 DI ABETES CLI NI C	0	0		0 0	0	90.12
90.12	09013 NEUROLOGY	0	0		0 0	0	90.12
90.14	09014 FOOT AND ANKLE	0	0		0 0	0	90.14
91.00	09100 EMERGENCY	0	0		0 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0	0	92.00
,2.00	OTHER REIMBURSABLE COST CENTERS	ц – О			~	U	/2.00
95.00	09500 AMBULANCE SERVICES						95.00
200.00		0	0		0 0	0	200.00
			c	1			

VDDUD.	n Financial Systems E TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE		ORIAL HOSPITAL	CN- 15_1332	Peri od:	u of Form CMS-: Worksheet D	2002 10
	GH COSTS	NUCL OTHER TAS		GN. 15-1552	From 01/01/2020		
THROO	311 00313				To 12/31/2020	Date/Time Pre	pared:
						6/22/2021 8:2	7 pm
				XVIII	Hospi tal	Cost	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of cols.	Outpatient	(from Wkst.	to Charges	
		Educati on	1, 2, 3, and	Cost (sum of		(col. 5 ÷	
		Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
				and 4)		(see	
		4.00	F 00	(00	7.00	instructions)	
		4.00	5.00	6.00	7.00	8.00	
	ANCI LLARY SERVICE COST CENTERS	0		1	0 11 155 054	0,00000	
50.00 52.00		0			0 11, 155, 054 0 580, 626		
			-				
53.00		0			0 935, 697	0.000000	
54.00		0	0		0 18, 783, 347	0.000000	
55.00		0	0		0 0	0.000000	
55.01	03630 ULTRA SOUND	0			0 3, 176, 778		•
60.00		0	0		0 17, 252, 964		•
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0			0 343, 876		•
65.00	06500 RESPI RATORY THERAPY	0			0 2, 534, 055		•
66.00		0	0		0 3, 807, 030		•
67.00	06700 OCCUPATI ONAL THERAPY	0			0 1, 513, 970		•
68.00		0	0		0 834, 510		
69.00		0	0		0 3, 449, 851	0.000000	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0			0 2, 421, 970		
72.00		0			0 1, 236, 438		
73.00		0	0		0 21, 061, 239	0.000000	73.00
~~ ~~	OUTPATIENT SERVICE COST CENTERS			1	0 1 770 070	0.00000	
88.00		0			0 1, 778, 372		•
88.01	08801 RURAL HEALTH CLINIC II	0			0 1, 720, 897	0.000000	•
90.00		0			0 1, 345, 324		•
90.01	09001 ONCOLOGY	0			0 2, 272, 873		•
90.02		0			0 223, 472		•
90.03		0			0 0	0.000000	
90.04	09004 PROVIDER BASED CLINIC - DCPC	0			0 0	0.000000	•
90.05	09005 PROVIDER BASED CLINIC - WESTPORT	0	-		0 5, 819	0.000000	
90.06		0	0		0 2, 502, 234	0.000000	•
90.07	09007 WOMEN'S HEALTH SERVICES	0	-		0 127, 871	0.000000	
90.08		0	0		0 2, 080, 912	0.000000	
90.09	09009 GERIATRIC PSYCH	0			0 974, 674		
90.10		0	-		0 179, 050	0.000000	
90.11	09011 PROVIDER BASED CLINIC - NEPHROLOGY	0	0		0 34, 707	0.000000	
90.12		0	-		0 14, 415		•
90.13		0	0		0 24, 311	0.000000	•
90.14		0			0 67, 995		•
91.00		0			0 17, 714, 484		•
92.00		0	0		0 919, 014	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS	T	T	1		Γ	
95.00							95.00
200.00) Total (lines 50 through 199)	0	0		0 121, 073, 829		200.00

Health Financial Systems	DECATUR CO. MEMORI	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provider C	CN: 15-1332	Period: From 01/01/2020	Worksheet D Part IV	
THROUGH COSTS				To 12/31/2020	Date/Time Pre 6/22/2021 8:2	
		Title	XVIII	Hospi tal	Cost	
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-Throug	h Charges	Pass-Through	
	(col. 6 ÷	Ũ	Costs (col.		Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.000000	431, 639		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	46, 213		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	434, 328		0 0	0	54.00
55. 00 05500 RADI OLOGY – THERAPEUTI C	0. 000000	0		0 0	0	55.00
55.01 03630 ULTRA SOUND	0. 000000	47, 453		0 0	0	55.01
60. 00 06000 LABORATORY	0. 000000	377, 628		0 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	39, 404		0 0	0	62.00
65. 00 06500 RESPI RATORY THERAPY	0.000000	687, 690		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0.000000	190, 694		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0.000000	185, 453		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0, 000000	29, 483		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	170, 481		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	384, 088		0 0	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	269, 133		0 0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 564, 455		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS	0.000000	1,001,100		<u> </u>		/ 01 00
88.00 08800 RURAL HEALTH CLINIC	0.000000	0		0 0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	0,000000	0		0 0	0	88.01
90. 00 09000 CLINIC	0.000000	0		0 0	0	90.00
90. 01 09001 0NC0L0GY	0, 000000	68		0 0	0	90.01
90. 02 09002 OUTPATIENT CLINIC	0. 000000	0		0 0	0	90.02
90. 03 09003 PROVIDER BASED CLINIC - TCMP	0. 000000	0		0 0	0	90.03
90. 04 09004 PROVIDER BASED CLINIC - DCPC	0. 000000	0		0 0	0	90.04
90. 05 09005 PROVIDER BASED CLINIC - WESTPORT	0. 000000	0		0 0	0	90.05
90. 06 09006 CLINIC	0, 000000	0		0 0	0	90.06
90. 07 09007 WOMEN'S HEALTH SERVICES	0. 000000	798		0 0	0	90.07
90. 08 09008 PALN MANAGEMENT	0. 000000	0		0 0	0	90.08
90. 09 09009 GERIATRI C PSYCH	0. 000000	0		0 0	0	90.09
90. 10 09010 PROVIDER BASED CLINIC - DCPM	0.000000	0		0 0	0	90.10
90. 11 09011 PROVIDER BASED CLINIC - NEPHROLOGY	0. 000000	0		0 0	0	90.11
90. 12 09012 DI ABETES CLINIC	0. 000000	0		0 0	0	90.12
90. 13 09013 NEUROLOGY	0.000000	0		0 0	0	90.12
90. 14 09014 FOOT AND ANKLE	0.000000	0		0 0	0	90.13
91. 00 09100 EMERGENCY	0.000000	8, 189		0 0	0	90.14
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0, 189 741		0 0	0	91.00
072.00 07200 003ERVATION BEDS (NON-DISTINCT PART	0.000000	741	<u> </u>	0	0	12.00
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)		4, 867, 938		0 0	0	200.00
	1 1	., 20., 700	I	· 1	Ŭ	

PORTI ON	MENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider C	CN: 15-1332	Period: From 01/01/2020 To 12/31/2020		epared:
			Title	XVIII	Hospi tal	Cost	., bu
				Charges		Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	•	Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
		From	Services (see	Servi ces	Services Not	. , ,	
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.		Ded. & Coins			
		9		(see inst.)			
		1.00	2.00	3.00	4.00	5.00	
ANC	ILLARY SERVICE COST CENTERS						
	DOO OPERATING ROOM	0. 309648	0	1, 903, 93	26 0	0	1 50. O
	200 DELIVERY ROOM & LABOR ROOM	0. 435463	0		0 0	0	52.0
	BOO ANESTHESI OLOGY	0. 247915	0			0	
	00 RADI OLOGY-DI AGNOSTI C	0. 170255	0			0	
	00 RADIOLOGY - THERAPEUTIC	0. 000000	0		0 0	0	
	30 ULTRA SOUND	0. 107937				0	
	000 LABORATORY					0	
		0. 266185					
	200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 346424	-			0	
	500 RESPI RATORY THERAPY	0. 632708	0			0	
	00 PHYSI CAL THERAPY	0. 410111	0			0	
	OO OCCUPATIONAL THERAPY	0. 249085	0			0	
	300 SPEECH PATHOLOGY	0. 344428	0			0	
	200 ELECTROCARDI OLOGY	0. 137588	0			0	
	00 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 862589				0	
	200 IMPL. DEV. CHARGED TO PATIENTS	0. 773742	0			0	
	BOO DRUGS CHARGED TO PATIENTS	0. 427960	0	6, 404, 9	83 0	0	73.0
	PATIENT SERVICE COST CENTERS	1					ł
	BOO RURAL HEALTH CLINIC						88.0
	301 RURAL HEALTH CLINIC II						88.0
	DOO CLINIC	0. 628904	0			0	
	001 ONCOLOGY	0. 405196				0	
	002 OUTPATIENT CLINIC	1. 147392	0	42, 6		0	
	003 PROVIDER BASED CLINIC - TCMP	0. 000000	0		0 0	0	
	004 PROVIDER BASED CLINIC - DCPC	0. 000000	0		0 0	0	
	005 PROVIDER BASED CLINIC - WESTPORT	9. 257089	0	-	54 0	0	
	006 CLINIC	0. 259094	0			0	
	007 WOMEN'S HEALTH SERVICES	4. 375597	0	4,8		0	90.0
090 0.08	DO8 PAIN MANAGEMENT	0. 127641	0		0 0	0	90.0
090 090 090	009 GERIATRIC PSYCH	0. 679555	0	871, 5	60 0	0	90.0
). 10 090	010 PROVIDER BASED CLINIC - DCPM	1. 135108	0	22, 9	59 0	0	90.1
). 11 090	11 PROVIDER BASED CLINIC - NEPHROLOGY	2. 767597	0	4, 8	17 0	0	90. ⁻
). 12 090	D12 DIABETES CLINIC	1. 266112	0	30	0 0	0	90. ⁻
). 13 090	013 NEUROLOGY	0. 778578	0	2,00	03 0	0	90
	14 FOOT AND ANKLE	0. 622075	0			0	
	OO EMERGENCY	0. 234283	0			0	
	OO OBSERVATION BEDS (NON-DISTINCT PART	1. 252083	0			0	
	IER REIMBURSABLE COST CENTERS						1
	500 AMBULANCE SERVICES	0. 468315			0		95.0
0.00	Subtotal (see instructions)		0	27, 679, 0		0	200.0
1.00	Less PBP Clinic Lab. Services-Program		Ĭ	, ., ., .	0 0	Ū	201.0
	Only Charges				- 0		[
	10, 0						

PORTIONMENT OF MEDICAL, OTHER HEALTH SERV	ICES AND VACCINE COST	Provider C	CN: 15-1332	Period: Workshee From 01/01/2020 Part V To 12/31/2020 Date/Time 6/22/202 6/22/202 6/22/202		epared 27 pm
		Title	× XVIII	Hospi tal	Cost	
	Cos	sts				
Cost Center Description	Cost	Cost]			
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCILLARY SERVICE COST CENTERS						
. 00 05000 OPERATING ROOM	589, 547	0	1			50.0
. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0	1			52.0
. 00 05300 ANESTHESI OLOGY	42, 799					53.0
. 00 05400 RADI OLOGY-DI AGNOSTI C	785, 664	0				54.C
. 00 05500 RADI OLOGY - THERAPEUTI C	0	0				55.0
. 01 03630 ULTRA SOUND	104, 213					55.0
. 00 06000 LABORATORY	1, 096, 733	0				60.0
. 00 06200 WHOLE BLOOD & PACKED RED BLOOD		0				62.0
. 00 06500 RESPI RATORY THERAPY	233, 532	0				65.0
. 00 06600 PHYSI CAL THERAPY	359, 833	0				66.0
. 00 06700 OCCUPATI ONAL THERAPY	39, 717	0				67.0
. 00 06800 SPEECH PATHOLOGY	26, 479	0				68.
. 00 06900 ELECTROCARDI OLOGY	125, 164	0				69.0
. 00 07100 MEDICAL SUPPLIES CHARGED TO PAT	I ENT 302, 382	0				71. (
. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	132, 696					72.0
. 00 07300 DRUGS CHARGED TO PATIENTS	2, 741, 077	0				73.0
OUTPATIENT SERVICE COST CENTERS	-	-				
. 00 08800 RURAL HEALTH CLINIC						88.0
. 01 08801 RURAL HEALTH CLINIC II						88.0
. 00 09000 CLINIC	47,636					90.
. 01 09001 ONCOLOGY	344, 098					90.
02 09002 OUTPATIENT CLINIC	48, 953	0	1			90.0
. 03 09003 PROVIDER BASED CLINIC - TCMP	0	0				90.
. 04 09004 PROVIDER BASED CLINIC - DCPC	0	0				90.
0.05 09005 PROVIDER BASED CLINIC - WESTPOR		0				90.
. 06 09006 CLINIC	197, 957	0	1			90.
. 07 09007 WOMEN'S HEALTH SERVICES	21, 370	0				90.
0.08 09008 PAIN MANAGEMENT	0	0				90.
09 09009 GERI ATRI C PSYCH	592, 273	0				90.
. 10 09010 PROVIDER BASED CLINIC - DCPM	26, 061	0				90.
11 09011 PROVIDER BASED CLINIC - NEPHROL		0				90.
12 09012 DI ABETES CLINIC	391	0	1			90.
. 13 09013 NEUROLOGY	1, 559	0				90.
14 09014 FOOT AND ANKLE	1, 683		1			90.
. 00 09100 EMERGENCY	851, 211	0				91.0
. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT	PART 320, 620	0				92.0
OTHER REIMBURSABLE COST CENTERS			1			
. 00 09500 AMBULANCE SERVICES	0					95.
0.00 Subtotal (see instructions)	9, 068, 295	0				200. (
1.00 Less PBP Clinic Lab. Services-P	rogram 0					201. (
Only Charges						
2.00 Net Charges (line 200 - line 20	1) 9,068,295	0				202.

Health Financial Systems D	ECATUR CO. MEMO	ORIAL HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C	CN: 15-1332	Peri od:	Worksheet D	
				From 01/01/2020 To 12/31/2020		narod
				10 12/31/2020	6/22/2021 8:2	
		Ti tl	e XIX	Hospi tal	PPS	., bu
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	r		1	- 1		
30.00 ADULTS & PEDIATRICS	638, 340				157.65	•
43.00 NURSERY	18, 052		18, 05			•
200.00 Total (lines 30 through 199)	656, 392		611, 46	4, 157		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	135					30.00
43.00 NURSERY	239					43.00
200.00 Total (lines 30 through 199)	374	32, 260				200.00

	DECATUR CO. MEM			In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provider C	CN: 15-1332	Period: From 01/01/2020 To 12/31/2020		
		Ti tl	e XIX	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	T	1	1	T	1	
50.00 05000 OPERATING ROOM	264, 845					•
52.00 05200 DELIVERY ROOM & LABOR ROOM	43, 523					•
53. 00 05300 ANESTHESI OLOGY	2, 336					•
54.00 05400 RADI OLOGY-DI AGNOSTI C	171, 716					
55. 00 05500 RADI OLOGY - THERAPEUTI C	0	-			-	55.00
55.01 03630 ULTRA SOUND	3, 418					55.01
60. 00 06000 LABORATORY	105, 474					60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	634				10	
65.00 06500 RESPI RATORY THERAPY	115, 037					
66.00 06600 PHYSI CAL THERAPY	150, 838					66.00
67.00 06700 OCCUPATI ONAL THERAPY	6, 390					67.00
68.00 06800 SPEECH PATHOLOGY	4, 363				21	68.00
69.00 06900 ELECTROCARDI OLOGY	5, 563					•
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	12, 282					•
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	5, 666					•
73.00 07300 DRUGS CHARGED TO PATIENTS	84, 260	21,061,239	0.00400	149, 999	600	73.00
0UTPATI ENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC	512, 126	1, 778, 372	0. 2879	75 0	0	88.00
88. 00 08800 RURAL HEALTH CLINIC 88. 01 08801 RURAL HEALTH CLINIC II	234, 441					88.00
90. 00 09000 CLINIC	114, 499					90.00
90. 01 09000 CET NIC 90. 01 09001 ONCOLOGY	101,070					90.00
90. 02 09002 0UTPATIENT CLINIC	3, 590					90.01
90. 03 09003 PROVIDER BASED CLINIC - TCMP	3, 570		1			90.02
90. 04 09004 PROVIDER BASED CLINIC - DCPC		-				90.03
90. 05 09005 PROVIDER BASED CLINIC - WESTPORT	27, 429	-				90.05
90. 06 09006 CLINIC	43, 430					90.06
90. 07 09007 WOMEN'S HEALTH SERVICES	94, 206					90.07
90. 08 09008 PALN MANAGEMENT	11, 301					90.08
90. 09 09009 GERIATRI C PSYCH	58, 954					90.09
90. 10 09010 PROVIDER BASED CLINIC - DCPM	35, 065					90.10
90. 11 09011 PROVIDER BASED CLINIC - NEPHROLOGY	23, 088					90.11
90. 12 09012 DI ABETES CLI NI C	5, 143					90.12
90. 13 09013 NEUROLOGY	5, 649					90.13
90. 14 09014 FOOT AND ANKLE	2, 332					90.14
91. 00 09100 EMERGENCY	167, 264					91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	104, 367				11	92.00
OTHER REIMBURSABLE COST CENTERS						1
95.00 09500 AMBULANCE SERVI CES						95.00
200.00 Total (lines 50 through 199)	2, 520, 299	121, 073, 829		497, 339	8, 066	200.00
					•	

Health Financial Systems	DECATUR CO. MEMO	ORIAL HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P	ASS THROUGH COS			Period: From 01/01/2020 To 12/31/2020	Date/Time Pre 6/22/2021 8:2	
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng School	Nursi ng School	Allied Health Post-Stepdowr	Allied Health Cost	All Other Medical	
	Post-Stepdown Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2/1	2.00	0.00	
30. 00 03000 ADULTS & PEDIATRICS 43. 00 04300 NURSERY	0	0		0 0	0	00.00
200.00 Total (lines 30 through 199)	0				°	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patient	Per Diem	Inpatient	200.00
	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,		col. 6)		
		minus col. 4)				
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	3, 76	4 0.00	135	30.00
43. 00 04300 NURSERY		0	39	3 0.00	239	43.00
200.00 Total (lines 30 through 199)		0	4, 15	7	374	200.00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 <u>x col. 8</u>) 9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS 43. 00 04300 NURSERY	0					30.00 43.00
200.00 Total (lines 30 through 199)	0					200.00

Health Financial Systems	DECATUR CO. MEMO	ORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SI THROUGH COSTS	ERVICE OTHER PAS			Period: From 01/01/2020 To 12/31/2020	Date/Time Pre 6/22/2021 8:2	
			e XIX	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	
ANCILLARY SERVICE COST CENTERS	_					
50.00 05000 OPERATING ROOM	0	0		0 0	0	50.00
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
55. 00 05500 RADI OLOGY - THERAPEUTI C	0	0		0 0	0	55.00
55.01 03630 ULTRA SOUND	0	0		0 0	0	55.01
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	l o		0 0	0	62.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0			0 0	0	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	•
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	-		0 0		73.00
OUTPATIENT SERVICE COST CENTERS	0	0		0 0	0	/ 5.00
88. 00 08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
88. 01 08801 RURAL HEALTH CLINIC II	0			0 0		88.01
90. 00 09000 CLINIC	0	0		0 0	0	90.00
90. 01 09001 0NC0L0GY	0	0		0 0	0	90.01
90. 02 09002 0UTPATIENT CLINIC	0	0		0 0	0	90.02
90. 03 09003 PROVIDER BASED CLINIC - TCMP	0	0		0 0	0	90.03
90. 04 09004 PROVIDER BASED CLINIC - DCPC	0	0		0 0	0	90.04
90. 05 09005 PROVIDER BASED CLINIC - WESTPORT	0	0		0 0	0	90.05
90. 06 09006 CLINIC	0	0		0 0	0	90.06
90. 07 09007 WOMEN'S HEALTH SERVICES	0	0		0 0	0	90.07
90. 08 09008 PALN MANAGEMENT	0			0 0	0	90.07
90. 09 09009 GERI ATRI C PSYCH	0			0 0	0	90.08
90. 10 09010 PROVIDER BASED CLINIC - DCPM	0			0 0	0	90.09
90. 10 09010 PROVIDER BASED CLINIC - DCPM 90. 11 09011 PROVIDER BASED CLINIC - NEPHROLOGY	0				0	90.10
	0			0 0	0	90.11
90. 12 09012 DI ABETES CLI NI C 90. 13 09013 NEUROLOGY	0				0	90.12
90. 13 09013 NEUROLOGY 90. 14 09014 FOOT AND ANKLE	0			0 0	-	90.13
90. 14 09014 FOOT AND ANKLE 91. 00 09100 EMERGENCY	0				0	90.14
	0	0				
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES						95.00
200.00 Total (lines 50 through 199)	0	0		0 0	_	200.00
200.00 Total (Thes by through 199)	1 0	1 0	I	0	0	l≥00.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANC	LLARY SERVICE OTHER PAS	SS Provider C	CN· 15-1332	Peri od:	u of Form CMS-: Worksheet D	
THROUGH COSTS	EEART SERVICE OTHER TAG		CN. 15 1552	From 01/01/2020		
				To 12/31/2020	Date/Time Pre	
					6/22/2021 8:2	27 pm
			e XIX	Hospi tal	PPS	-
Cost Center Description	All Other	Total Cost	Total	Total Charges		
	Medical	(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	
	4.00	F 00	(00	7.00	instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	C		1	0 11, 155, 054	0. 000000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM				0 11, 155, 054 0 580, 626		
	-					
53. 00 05300 ANESTHESI OLOGY				0 935, 697 0 18, 783, 347	0.000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	-	-			0.000000	
55. 00 05500 RADI OLOGY - THERAPEUTI C	C	-		0 0	0.000000	
55. 01 03630 ULTRA SOUND	C			0 3, 176, 778		
60. 00 06000 LABORATORY	0			0 17, 252, 964		
62.00 06200 WHOLE BLOOD & PACKED RED BLOO				0 343, 876		
65. 00 06500 RESPI RATORY THERAPY	C	۰ ۱		0 2, 534, 055		
66. 00 06600 PHYSI CAL THERAPY	C	0		0 3, 807, 030		
67.00 06700 OCCUPATI ONAL THERAPY	C			0 1, 513, 970		
68.00 06800 SPEECH PATHOLOGY	C	· ·		0 834, 510		
69.00 06900 ELECTROCARDI OLOGY	C			0 3, 449, 851	0.000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO P				0 2, 421, 970		
72.00 07200 I MPL. DEV. CHARGED TO PATIENT				0 1, 236, 438		
73.00 07300 DRUGS CHARGED TO PATIENTS	C	0 0		0 21,061,239	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS				0 4 770 070	0.000000	
88.00 08800 RURAL HEALTH CLINIC	C			0 1, 778, 372		
88. 01 08801 RURAL HEALTH CLINIC II	C			0 1, 720, 897	0.000000	
90. 00 09000 CLINIC	C			0 1, 345, 324		
90. 01 09001 ONCOLOGY	C	· · · · · · · · · · · · · · · · · · ·		0 2, 272, 873		
90. 02 09002 OUTPATIENT CLINIC	C	-		0 223, 472	0.000000	
90. 03 09003 PROVIDER BASED CLINIC - TCMP		0		0 0	0.000000	
90. 04 09004 PROVIDER BASED CLINIC - DCPC				0 0	0.000000	
90. 05 09005 PROVIDER BASED CLINIC - WESTP	DRT C	· ·		0 5, 819	0.000000	
90. 06 09006 CLINIC		0		0 2, 502, 234		
90. 07 09007 WOMEN' S HEALTH SERVICES	C			0 127, 871	0.000000	
90. 08 09008 PALN MANAGEMENT	C	0		0 2,080,912	0.000000	
90. 09 09009 GERIATRI C PSYCH	C			0 974, 674	0.000000	
90. 10 09010 PROVIDER BASED CLINIC - DCPM	C	· ·		0 179,050	0.000000	
90. 11 09011 PROVIDER BASED CLINIC - NEPHR	1	-		0 34,707	0.000000	
90. 12 09012 DI ABETES CLINIC	C	-		0 14, 415		
90. 13 09013 NEUROLOGY	C			0 24, 311	0.000000	
90. 14 09014 FOOT AND ANKLE	C			0 67, 995		
91.00 09100 EMERGENCY	C			0 17, 714, 484		
92.00 09200 OBSERVATION BEDS (NON-DISTINC	r PART C	0 0		0 919, 014	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS		T	1	T	L	
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	C	0		0 121, 073, 829		200.00

J	ECATUR CO. MEMORI				u of Form CMS-2	2552-10
NPPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF HROUGH COSTS	RVICE OTHER PASS	Provider CC	CN: 15-1332	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part IV Date/Time Pre 6/22/2021 8:2	
			e XIX	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpatient	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug		Pass-Through	
	(col. 6 ÷		Costs (col.	8	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS	0.000000	74 040			0	-
50.00 05000 OPERATING ROOM	0. 000000	71, 318		0 0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	19, 050		0 0	0	
33.00 05300 ANESTHESI OLOGY	0. 000000	5, 019		0 0	0	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	34, 452		0 0	0	
5. 00 05500 RADI OLOGY - THERAPEUTI C	0. 000000	0		0 0	0	
5.01 03630 ULTRA SOUND	0. 000000	3, 973		0 0	0	55.01
0. 00 06000 LABORATORY	0. 000000	38, 639		0 0	0	
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	5, 311		0 0	0	
5.00 06500 RESPI RATORY THERAPY	0. 000000	56, 183		0 0	0	
6. 00 06600 PHYSI CAL THERAPY	0. 000000	19, 449		0 0	0	
57.00 06700 OCCUPATI ONAL THERAPY	0. 000000	19, 179		0 0	0	67.00
06800 SPEECH PATHOLOGY	0. 000000	4, 111		0 0	0	
9.00 06900 ELECTROCARDI OLOGY	0. 000000	14, 199		0 0	0	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	36, 045		0 0	0	
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	17, 093		0 0	0	
73.00 07300 DRUGS CHARGED TO PATI ENTS	0. 000000	149, 999		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS		-		-	-	
38.00 08800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	
38.01 08801 RURAL HEALTH CLINIC II	0. 000000	0		0 0	0	
20. 00 09000 CLINIC	0. 000000	0		0 0	0	
0. 01 09001 ONCOLOGY	0. 000000	46		0 0	0	
20. 02 09002 OUTPATIENT CLINIC	0. 000000	1, 970		0 0	0	
20. 03 09003 PROVIDER BASED CLINIC - TCMP	0. 000000	0		0 0	0	
20. 04 09004 PROVIDER BASED CLINIC - DCPC	0. 000000	0		0 0	0	
20. 05 09005 PROVIDER BASED CLINIC - WESTPORT	0. 000000	0		0 0	0	
20. 06 09006 CLINIC	0. 000000	400		0 0	0	
20. 07 09007 WOMEN' S HEALTH SERVICES	0. 000000	0		0 0	0	
20. 08 09008 PAIN MANAGEMENT	0. 000000	0		0 0	0	
20. 09 09009 GERIATRI C PSYCH	0. 000000	0		0 0	0	
20. 10 09010 PROVIDER BASED CLINIC - DCPM	0. 000000	0		0 0	0	
20. 11 09011 PROVIDER BASED CLINIC - NEPHROLOGY	0. 000000	0		0 0	0	
20. 12 09012 DI ABETES CLINIC	0. 000000	0		0 0	0	
20. 13 09013 NEUROLOGY	0. 000000	0		0 0	0	
20. 14 09014 FOOT AND ANKLE	0. 000000	0		0 0	0	
21.00 09100 EMERGENCY	0. 000000	802		0 0	0	
22.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	101		0 0	0	92.00
ATUER RELINDURATE AGAT AFUTERA						
OTHER REI MBURSABLE COST CENTERS	· · · ·					0.5 0.5
OTHER REIMBURSABLE COST CENTERS 25.00 09500 AMBULANCE SERVICES 200.00 Total (lines 50 through 199)		497, 339		0 0	-	95.00 200.00

PPORTI ON	IMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider C		Period: From 01/01/2020 To 12/31/2020	6/22/2021 8:2	epared: 27 pm
	,		Titl	e XIX	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
		Charge Ratio	Reimbursed	Reimbursed	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.)			
		1.00	2.00	3.00	4.00	5.00	
	CILLARY SERVICE COST CENTERS						
0.00 050	DOO OPERATING ROOM	0. 309648	0	198, 20	0 80	0	50.00
2.00 052	200 DELIVERY ROOM & LABOR ROOM	0. 435463	0	2, 42	23 0	0	52.00
3.00 053	300 ANESTHESI OLOGY	0. 247915	0	17, 12	21 0	0	53.00
4.00 054	400 RADI OLOGY-DI AGNOSTI C	0. 170255	0			0	54.0
	500 RADI OLOGY - THERAPEUTI C	0. 000000	0		0 0	0	55.0
	630 ULTRA SOUND	0. 107937	0	64, 85		0	
	DOO LABORATORY	0. 266185	o o			0	
	200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 346424	0			0	
	500 RESPI RATORY THERAPY	0. 632708	0	.,		0	
	600 PHYSI CAL THERAPY	0. 410111	0			0	
	700 OCCUPATI ONAL THERAPY	0. 249085	0			0	
	BOO SPEECH PATHOLOGY	0. 344428			-	0	
	900 ELECTROCARDI OLOGY		-			0	
		0. 137588	0				
	100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0.862589				0	
	200 IMPL. DEV. CHARGED TO PATIENTS	0. 773742	0			0	
	300 DRUGS CHARGED TO PATIENTS	0. 427960	0	366, 32	26 0	0	73.0
	TPATIENT SERVICE COST CENTERS			1			
	BOO RURAL HEALTH CLINIC						88.0
	BO1 RURAL HEALTH CLINIC II	0 (00004					88.0
		0. 628904	0			0	
	001 ONCOLOGY	0. 405196				0	
	002 OUTPATIENT CLINIC	1. 147392	0			0	
	003 PROVIDER BASED CLINIC - TCMP	0. 000000	0		0 0	0	
	004 PROVIDER BASED CLINIC - DCPC	0. 000000	0		0 0	0	
	005 PROVIDER BASED CLINIC - WESTPORT	9. 257089	0			0	
	DO6 CLINIC	0. 259094	0			0	
	007 WOMEN'S HEALTH SERVICES	4. 375597	0	2,69		0	90.0
0.08 090	DO8 PAIN MANAGEMENT	0. 127641	0	43, 82	22 0	0	90.0
0.09 090	009 GERIATRIC PSYCH	0. 679555	0	20, 52	25 0	0	90.0
0. 10 090	010 PROVIDER BASED CLINIC - DCPM	1. 135108	0	3, 7	71 0	0	90.1
0. 11 090	011 PROVIDER BASED CLINIC - NEPHROLOGY	2. 767597	0	73	31 0	0	90.1
	D12 DIABETES CLINIC	1. 266112	0	30	04 0	0	90.1
	013 NEUROLOGY	0. 778578	0			0	
	014 FOOT AND ANKLE	0. 622075	0			0	
	100 EMERGENCY	0. 234283	o o			0	
	200 OBSERVATION BEDS (NON-DISTINCT PART	1. 252083	0			0	
	HER REIMBURSABLE COST CENTERS		. 0	17,00			1
	500 AMBULANCE SERVICES	0. 468315	0	84, 51	12		95.0
00.00	Subtotal (see instructions)	0.100010	0			0	200.0
01.00	Less PBP Clinic Lab. Services-Program		Ĭ	2,007,00	0 0	l U	200.0
		1	1	1			1-01.0
01.00	Only Charges					1	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND		D VACCINE COST	Provider C	CN: 15-1332	Period: From 01/01/2020 To 12/31/2020	Date/Time Pr		
				e XIX	Hospi tal	PPS		
			sts					
	Cost Center Description	Cost	Cost					
		Reimbursed	Reimbursed					
		Servi ces	Services Not					
		Subject To	Subject To					
		Ded. & Coins.						
		(see inst.)	(see inst.)	-				
•	NOLLI ADV. CEDVICE COCT. CENTERC	6.00	7.00				-	
	NCILLARY SERVICE COST CENTERS	(1.)75					- FO 00	
	05000 OPERATING ROOM	61, 375					50.00	
	D5200 DELIVERY ROOM & LABOR ROOM	1,055					52.00	
	05300 ANESTHESI OLOGY	4, 245					53.00	
	05400 RADI OLOGY-DI AGNOSTI C	64, 326					54.00	
	05500 RADI OLOGY - THERAPEUTI C	7 000	0				55.00	
	03630 ULTRA SOUND	7,000					55.01	
	06000 LABORATORY	91, 419					60.00	
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	1, 562					62.00	
	06500 RESPI RATORY THERAPY	15, 469	, s				65.00	
	06600 PHYSI CAL THERAPY	28, 774					66.00	
	06700 OCCUPATI ONAL THERAPY	5, 483					67.00	
	06800 SPEECH PATHOLOGY	5, 324					68.00	
	06900 ELECTROCARDI OLOGY	8, 990					69.00	
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	27, 994					71.00	
	07200 IMPL. DEV. CHARGED TO PATIENTS	13, 340					72.00	
	07300 DRUGS CHARGED TO PATIENTS DUTPATIENT SERVICE COST CENTERS	156, 773	0	1			73.00	
	08800 RURAL HEALTH CLINIC						88.00	
	08801 RURAL HEALTH CLINIC II						88.01	
	09000 CLINIC	17, 817	l o				90.00	
	09001 ONCOLOGY	19, 385					90.01	
	09002 OUTPATIENT CLINIC	4, 236		1			90.02	
	09003 PROVIDER BASED CLINIC - TCMP	4, 230	-				90.03	
	99004 PROVIDER BASED CLINIC - DCPC	0					90.04	
	09005 PROVIDER BASED CLINIC - WESTPORT	1, 139					90.05	
	09006 CLINIC	13, 599					90.06	
	09007 WOMEN'S HEALTH SERVICES	11, 783	-				90.07	
	09008 PALN MANAGEMENT	5, 593					90.08	
	99009 GERIATRI C PSYCH	13, 948					90.09	
	09010 PROVIDER BASED CLINIC - DCPM	4, 280	-				90.10	
	09011 PROVIDER BASED CLINIC - NEPHROLOGY	2, 023	-				90.11	
	09012 DI ABETES CLINIC	385	-				90.12	
	09013 NEUROLOGY	399					90.13	
	09014 FOOT AND ANKLE	891		1			90.14	
	09100 EMERGENCY	87, 302		1			91.00	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	24, 166	-				92.00	
	THER REIMBURSABLE COST CENTERS	2.,100		1				
	09500 AMBULANCE SERVICES	39, 578					95.00	
200.00	Subtotal (see instructions)	739, 653					200.00	
201.00	Less PBP Clinic Lab. Services-Program	0					201.00	
	Only Charges							
	Net Charges (line 200 - line 201)	739, 653	1)			202.00	

DECATUR CO. MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

COMPUT	FINANCIAL SYSTEMS DECATOR CO. MEMORI	TAL HOSPITAL		J OF FORM CMS-2	
	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1332	Period: From 01/01/2020	Worksheet D-1	
			To 12/31/2020	Date/Time Pre	pared:
				6/22/2021 8:2	7 pm
	Cost Center Description	Title XVIII	Hospi tal	Cost	
	cost center bescription		-	1.00	
	PART I – ALL PROVIDER COMPONENTS		I	1.00	
	INPATIENT DAYS				1
	Inpatient days (including private room days and swing-bed day			4, 085	1.00
	Inpatient days (including private room days, excluding swing			3, 764	2.00
3.00	Private room days (excluding swing-bed and observation bed d	ays). If you have only p	rivate room days,	0	3.00
4.00	do not complete this line. Semi-private room days (excluding swing-bed and observation	bod days)		3, 102	4.00
5.00	Total swing-bed SNF type inpatient days (including private r		er 31 of the cost	285	
0.00	reporting period			200	0.00
6.00	Total swing-bed SNF type inpatient days (including private r	oom days) after December	31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line)				
7.00	Total swing-bed NF type inpatient days (including private ro	om days) through Decembe	r 31 of the cost	36	7.00
8.00	reporting period Total swing-bed NF type inpatient days (including private ro	om dave) after Decomber	21 of the cost	0	8.00
0.00	reporting period (if calendar year, enter 0 on this line)	olli days) ai ter becenber	ST OF THE COST	0	0.00
9.00	Total inpatient days including private room days applicable	to the Program (excludin	a swina-bed and	1, 513	9.00
	newborn days) (see instructions)	0	0 0		
10.00	Swing-bed SNF type inpatient days applicable to title XVIII		room days)	246	10.00
11 00	through December 31 of the cost reporting period (see instru				11 00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII pecember 31 of the cost reporting period (if calendar year, o		room days) after	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or X		te room days)	0	12.00
12.00	through December 31 of the cost reporting period	in only (the daring prive	te room days)	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or X	IX only (including priva	te room days)	0	13.00
	after December 31 of the cost reporting period (if calendar y				
	Medically necessary private room days applicable to the Prog	ram (excluding swing-bed	days)	0	
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT			0	10.00
	Medicare rate for swing-bed SNF services applicable to servi	ces through December 31	of the cost		17.00
	reporting period	0			
18.00	Medicare rate for swing-bed SNF services applicable to servi	ces after December 31 of	the cost		18.00
10.00	reporting period	through December 21 -	6 the cost	0.00	10.00
19.00	Medicaid rate for swing-bed NF services applicable to servic reporting period	es inrough December 31 o	r the cost	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to servic	es after December 31 of	the cost	0, 00	20.00
	reporting period				
	Total general inpatient routine service cost (see instruction			7, 037, 925	
22.00	Swing-bed cost applicable to SNF type services through Decem	ber 31 of the cost repor	ting period (line	0	22.00
22 00	5 x line 17) Swing had cast applicable to SNE type carvices after Decembe	r 21 of the cost reporti	na pariod (line 4	0	23.00
23.00	Swing-bed cost applicable to SNF type services after Decembe x line 18)	1 31 01 the cost report	ng period (inne o	0	23.00
24.00	Swing-bed cost applicable to NF type services through Decemb	er 31 of the cost report	ing period (line	0	24.00
	7 x line 19)		5 P		
	Swing-bed cost applicable to NF type services after December	31 of the cost reportin	g period (line 8	0	25.00
	x line 20) Tatal and and cast (and instructions)			405 204	
	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		495, 384 6, 542, 541	
+	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		I	0, 342, 341	27.00
	General inpatient routine service charges (excluding swing-b	ed and observation bed c	harges)	0	28.00
	Private room charges (excluding swing-bed charges)		-	0	
	Semi-private room charges (excluding swing-bed charges)			0	
	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0.000000	
	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	32.00 33.00
	Average per diem private room charge differential (line 32 m	inus line 33)(see instru	ctions)		34.00
	Average per diem private room cost differential (line 34 x l		,	0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37.00	General inpatient routine service cost net of swing-bed cost	and private room cost d	ifferential (line	6, 542, 541	37.00
	27 minus line 36)				-
ł	PART II – HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.	ILISTMENTS			-
		JUSTIVILIVIS			4
		e instructions)	I	1 738 10	38 00
38.00	Adjusted general inpatient routine service cost per diem (se Program general inpatient routine service cost (line 9 x lin			1, 738. 19 2, 629, 881	
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (se	e 38)			39.00 40.00

alth Financial Systems MPUTATION OF INPATIENT OPERATING COST		Provider (CN: 15-1332	Peri od:	u of Form CMS- Worksheet D-1	
				From 01/01/2020		
				To 12/31/2020	Date/Time Pre 6/22/2021 8:2	
			e XVIII	Hospi tal	Cost	
Cost Center Description	Total	Total	Average Per		Program Cost	
	Inpatient Cost	Inpatient Days	Diem (col. ÷ col. 2)		(col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
.00 NURSERY (title V & XIX only)	0	(0. (0 00) 42
Intensive Care Type Inpatient Hospita	al Units		1			1 4 2
. OO INTENSIVE CARE UNIT . OO CORONARY CARE UNIT						43
. 00 BURN INTENSIVE CARE UNIT						44
. 00 SURGI CAL I NTENSI VE CARE UNI T						46
. 00 OTHER SPECIAL CARE (SPECIFY)						47
Cost Center Description					1 00	_
.00 Program inpatient ancillary service	cost (Wkst D_3 col 3	Line 200)			1.00 2,146,910) 48
9.00 Total Program inpatient costs (sum o	-		ons)		4, 776, 791	
PASS THROUGH COST ADJUSTMENTS	· · · · · · · · · · · · · · · · · · ·				.,	
0.00 Pass through costs applicable to Pro	gram inpatient routine	services (fro	om Wkst. D, su	m of Parts I and	L C	50
.00 Pass through costs applicable to Pro and IV)	gram inpatient ancillar	y services (f	rom wkst. D,	sum of Parts II	C) 51
2.00 Total Program excludable cost (sum o	flines 50 and 51)				C	52
8.00 Total Program inpatient operating co		lated, non-ph	iysi ci an anest	hetist, and	C	
medical education costs (line 49 min	us line 52)					
A COMPUTATION TARGET AMOUNT AND LIMIT COMPUTATION					C	
5.00 Target amount per discharge					0.00	
0.00 Target amount (line 54 x line 55)					0.00 C	
.00 Difference between adjusted inpatien	t operating cost and ta	rget amount (line 56 minus	line 53)	C	
8.00 Bonus payment (see instructions)					C	
.00 Lesser of lines 53/54 or 55 from the	cost reporting period	endi ng 1996,	updated and c	ompounded by the	0.00	59
market basket 0.00 Lesser of lines 53/54 or 55 from pri	or year cost report up	dated by the	markat baskat		0.00	60
1.00 If line 53/54 is less than the lower					0.00	
which operating costs (line 53) are						
amount (line 56), otherwise enter ze	ro (see instructions)			-		
2.00 Relief payment (see instructions)					C	
8.00 Allowable Inpatient cost plus incent PROGRAM INPATIENT ROUTINE SWING BED (ctions)			C) 63
.00 Medicare swing-bed SNF inpatient rou		mber 31 of th	e cost report	ing period (See	427, 595	5 64
instructions)(title XVIII only)	tine coole through boos			ing poired (eee	1277070	
5.00 Medicare swing-bed SNF inpatient rou	tine costs after Decemb	er 31 of the	cost reportir	g period (See	C) 65
instructions)(title XVIII only)		(407 505	
 00 Total Medicare swing-bed SNF inpatie CAH (see instructions) 	nt routine costs (line	64 plus line	65)(title XVI	II only). For	427, 595	66
7.00 Title V or XIX swing-bed NF inpatien	t routine costs through	December 31	of the cost r	eporting period	C	67
(line 12 x line 19)		000000000000000000000000000000000000000	01 110 0001 1	opor tring porrou		
3.00 Title V or XIX swing-bed NF inpatien	t routine costs after D	ecember 31 of	the cost rep	orting period	C	68
(line 13 x line 20)			- (0)			
D. 00 Total title V or XIX swing-bed NF in PART III - SKILLED NURSING FACILITY,	•				C) 69
0.00 Skilled nursing facility/other nursi)		70
00 Adjusted general inpatient routine s				,		71
2.00 Program routine service cost (line 9						72
8.00 Medically necessary private room cos		•				73
1.00 Total Program general inpatient rout 5.00 Capital-related cost allocated to in	•		,	Part II column		74
26, line 45)						
.00 Per diem capital-related costs (line						76
. 00 Program capital -related costs (line	-					77
.00 Inpatient routine service cost (line .00 Aggregate charges to beneficiaries f	-	rovi dor rocar	de)			78
. 00 Total Program routine service costs				nus line 79)		80
. 00 Inpatient routine service cost per d	•					81
.00 Inpatient routine service cost limit)				82
.00 Reasonable inpatient routine service	-	s)				83
. 00 Program inpatient ancillary services		>				84
 00 Utilization review - physician compe 00 Total Program inpatient operating co 						85
PART IV - COMPUTATION OF OBSERVATION						- 00
7.00 Total observation bed days (see inst					662	2 87
8.00 Adjusted general inpatient routine c		line 2)			1, 738. 19	
0.00 Observation bed cost (line 87 x line					1, 150, 682	

Health Financial Systems D	ECATUR CO. MEMO	ORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 01/01/2020 To 12/31/2020		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observation	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	638, 340	7,037,925	0. 09070	0 1, 150, 682	104, 367	90.00
91.00 Nursing School cost	0	7,037,925	0.00000	0 1, 150, 682	0	91.00
92.00 Allied health cost	0	7,037,925	0.00000	0 1, 150, 682	0	92.00
93.00 All other Medical Education	0	7, 037, 925	0.00000	0 1, 150, 682	0	93.00

DECATUR CO. MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

	FINANCIAL SYSTEMS DECATOR CO. MEMOR	Provider CCN: 15-1332	Peri od:	Worksheet D-1	
			From 01/01/2020 To 12/31/2020	Date/Time Pre	nare
		T I II 1/1//		6/22/2021 8:2	
	Cost Center Description	Title XIX	Hospi tal	PPS	
				1.00	
	PART I - ALL PROVIDER COMPONENTS				-
	INPATIENT DAYS Inpatient days (including private room days and swing-bed da	avs. excluding newborn)		4, 085	1.
2.00	Inpatient days (including private room days, excluding swing	j-bed and newborn days)		3, 764	
3.00	Private room days (excluding swing-bed and observation bed d	lays). If you have only p	rivate room days,	0	3.
4.00	do not complete this line. Semi-private room days (excluding swing-bed and observation	hed days)		3, 102	4.
	Total swing-bed SNF type inpatient days (including private r		er 31 of the cost	285	
	reporting period				
b. 00	Total swing-bed SNF type inpatient days (including private r reporting period (if calendar year, enter 0 on this line)	room days) after December	31 of the cost	0	6.
7.00	Total swing-bed NF type inpatient days (including private ro	oom days) through Decembe	r 31 of the cost	36	7.
	reporting period		01 -6	0	
3. 00	Total swing-bed NF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	oom days) after December	31 of the cost	0	8.
9.00	Total inpatient days including private room days applicable	to the Program (excludin	g swing-bed and	135	9.
	newborn days) (see instructions)			0	10
10.00	Swing-bed SNF type inpatient days applicable to title XVIII through December 31 of the cost reporting period (see instru		room days)	0	10.
11.00	Swing-bed SNF type inpatient days applicable to title XVIII		room days) after	0	11.
2 00	December 31 of the cost reporting period (if calendar year,		to noom dowo)	0	12
2.00	Swing-bed NF type inpatient days applicable to titles V or X through December 31 of the cost reporting period	a k only (including priva	te room days)	0	12.
	Swing-bed NF type inpatient days applicable to titles V or X			0	13.
	after December 31 of the cost reporting period (if calendar			0	14
	Medically necessary private room days applicable to the Prog Total nursery days (title V or XIX only)	gram (excruding swing-bed	uays)	0 393	
	Nursery days (title V or XIX only)			239	
ĺ	SWING BED ADJUSTMENT				
7.00	Medicare rate for swing-bed SNF services applicable to servi reporting period	ces through December 31	of the cost		17.
8.00	Medicare rate for swing-bed SNF services applicable to servi	ces after December 31 of	the cost		18.
	reporting period				
9.00	Medicaid rate for swing-bed NF services applicable to servic reporting period	es through December 31 o	r the cost	0.00	19.
0. 00	Medicaid rate for swing-bed NF services applicable to servic	es after December 31 of	the cost	0.00	20.
1 00	reporting period	>		7 007 005	01
	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decem		ting period (line	7, 037, 925 0	
2.00	5 x line 17)		ting poir ou (i i io	C .	
23.00	Swing-bed cost applicable to SNF type services after Decembe	er 31 of the cost reporti	ng period (line 6	0	23.
24.00	x line 18) Swing-bed cost applicable to NF type services through Decemb	per 31 of the cost report	ing period (line	0	24.
	7 x line 19)	··· ·· ·· ··· ··· ··· ···			
	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reportin	g period (line 8	0	25.
	Total swing-bed cost (see instructions)			495, 384	26.
27.00	General inpatient routine service cost net of swing-bed cost	: (line 21 minus line 26)		6, 542, 541	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	ad and abcomuction had a	hangaa	0	1 20
	General inpatient routine service charges (excluding swing-b Private room charges (excluding swing-bed charges)	bed and observation bed c	narges)	0	
	Semi -private room charges (excluding swing-bed charges)			0	
	General inpatient routine service cost/charge ratio (line 27	′÷line 28)		0.00000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4)		ati ana)	0.00	
	Average per diem private room charge differential (line 32 m Average per diem private room cost differential (line 34 x l			0.00 0.00	
	Private room cost differential adjustment (line 3 x line 35)	-		0.00	
	General inpatient routine service cost net of swing-bed cost		ifferential (line	6, 542, 541	
	27 minus line 36)				-
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD	JUSTMENTS			1
	Adjusted general inpatient routine service cost per diem (se			1, 738. 19	38.
9.00	Program general inpatient routine service cost (line 9 x lin	ne 38)		234, 656	39.
10 00	Medically necessary private room cost applicable to the Prog	gram (line 14 x line 35)		0	40.
	Total Program general inpatient routine service cost (line 3	0 . Line 10	1	234, 656	44

	Financial Systems	DECATUR CO. MEMO		N. 15 1222		Workshoot D	
JUMPUTA	ATION OF INPATIENT OPERATING COST		Provider C	JN: 15-1332	Period: From 01/01/2020		
					To 12/31/2020	Date/Time Pr 6/22/2021 8:	
			Titl	e XIX	Hospi tal	PPS	27 pm
	Cost Center Description	Total	Total	Average Per		Program Cost	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)		(col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	-
	NURSERY (title V & XIX only)	298, 721	393	760. 1	0 239	181, 664	4 42.0
	Intensive Care Type Inpatient Hospital Uni	ts					1 42 6
	INTENSIVE CARE UNIT CORONARY CARE UNIT						43.C
	BURN INTENSIVE CARE UNIT						44.0
	SURGI CAL I NTENSI VE CARE UNI T						46.0
7.00	OTHER SPECIAL CARE (SPECIFY)						47.0
	Cost Center Description					1.00	
8.00	Program inpatient ancillary service cost	(Wkst D-3 col 3	Line 200)			212, 966	5 48.0
	Total Program inpatient costs (sum of line	•		ons)		629, 286	
	PASS THROUGH COST ADJUSTMENTS	· · · ·					
	Pass through costs applicable to Program i	npatient routine	services (fro	n Wkst. D, su	m of Parts I and	32, 260	50.0
	III) Pass through costs applicable to Program i	nnationt ancillar	v services (fi	com Wkst D	sum of Parts II	8,066	5 51.0
	and IV)	inputront anorridi	J SCIVICES (II	UII WKSL. D,		3,000	
52.00	Total Program excludable cost (sum of line					40, 326	
	Total Program inpatient operating cost exc		lated, non-phy	ysician anest	hetist, and	588, 960	53.0
	medical education costs (line 49 minus lin TARGET AMOUNT AND LIMIT COMPUTATION	ne 52)				I	-
	Program di scharges						54.0
	Target amount per discharge					0.00	
	Target amount (line 54 x line 55)						56.0
	Difference between adjusted inpatient oper	rating cost and ta	rget amount (ine 56 minus	line 53)		57.0
	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost	reporting period	ending 1996	indated and c	omnounded by the) 58.0) 59.0
	market basket	reporting period	churng 1770, 1		ompounded by the	0.00	5 57.0
	Lesser of lines 53/54 or 55 from prior yea		2			0.00	
	If line 53/54 is less than the lower of li					(0 61.0
	which operating costs (line 53) are less a amount (line 56), otherwise enter zero (se		s (lines 54 x	60), or 1% o	r the target		
	Relief payment (see instructions)					0	62.0
3.00	Allowable Inpatient cost plus incentive pa	ayment (see instru	ctions)			(63.0
	PROGRAM INPATIENT ROUTINE SWING BED COST		1				
	Medicare swing-bed SNF inpatient routine (instructions)(title XVIII only)	costs through Dece	mber 31 of the	e cost report	ing period (See		64.0
	Medicare swing-bed SNF inpatient routine (costs after Decemb	er 31 of the (cost reportin	g period (See	0	65.0
	instructions)(title XVIII only)						
	Total Medicare swing-bed SNF inpatient rou	utine costs (line	64 plus line	65)(title XVI	II only). For	() 66. C
	CAH (see instructions) Title V or XIX swing-bed NF inpatient rou [.]	tine costs through	December 31	of the cost r	eporting period		67.0
	(line 12 x line 19)		December of v		eporting period		07.0
	Title V or XIX swing-bed NF inpatient rou	tine costs after D	ecember 31 of	the cost rep	orting period	0) 68. C
59.00	(line 13 x line 20) Tatal title V as XIX swing had NE inpation	at routino costo (ling (7 . lin	- (0)			69.0
	Total title V or XIX swing-bed NF inpatien PART III - SKILLED NURSING FACILITY, OTHEF						<u>)</u> 69. 0
	Skilled nursing facility/other nursing fac)		70.0
1.00	Adjusted general inpatient routine service	e cost per diem (l					71.0
	Program routine service cost (line 9 x lin		(1100 14	DO 25)			72.0
	Medically necessary private room cost appl Total Program general inpatient routine se	0	•				73.0
1	Capital-related cost allocated to inpatien	•			Part II, column		75.0
	26, line 45)		-				
	Per diem capital-related costs (line 75 ÷						76.0
	Program capital-related costs (line 9 x li Inpatient routine service cost (line 74 mi						77.0
	Aggregate charges to beneficiaries for exc		rovider recor	ds)			79.0
0. 00	Total Program routine service costs for co	omparison to the c			nus line 79)		80.
	Inpatient routine service cost per diem li		`				81.
	Inpatient routine service cost limitation Reasonable inpatient routine service costs	•					82.0
	Program inpatient ancillary services (see	•					84.0
	Utilization review - physician compensation		ns)				85.0
6.00	Total Program inpatient operating costs (s	sum of lines 83 th				l	86.0
	PART IV - COMPUTATION OF OBSERVATION BED F						
37.00	Total observation bed days (see instruction Adjusted general inpatient routine cost pe	,	line 2)			662 1, 738. 19	
	ADFUSTED DEDECAL TODALLEDT FOULTINE COST OF						

Health Financial Systems D	ECATUR CO. MEMO	ORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 01/01/2020 To 12/31/2020		
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observation	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	638, 340	7,037,925	0. 09070	0 1, 150, 682	104, 367	90.00
91.00 Nursing School cost	0	7,037,925	0.00000	0 1, 150, 682	0	91.00
92.00 Allied health cost	0	7,037,925	0.00000	0 1, 150, 682	0	92.00
93.00 All other Medical Education	0	7, 037, 925	0.00000	0 1, 150, 682	0	93.00

PATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1332	Peri od:	Worksheet D-3	3
			From 01/01/2020		
			To 12/31/2020	Date/Time Pre 6/22/2021 8:2	epare 27 pr
	Title	XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
		1.00	2.00	<u>col. 2)</u> 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
. 00 03000 ADULTS & PEDIATRICS			2, 155, 123		30
. 00 04300 NURSERY					43
ANCILLARY SERVICE COST CENTERS					
. OO 05000 OPERATING ROOM		0. 30964		133, 656	
. OO 05200 DELIVERY ROOM & LABOR ROOM		0. 43546		0	
00 05300 ANESTHESI OLOGY		0. 24791		11, 457	
00 05400 RADI OLOGY-DI AGNOSTI C		0. 17025		73, 947	
00 05500 RADI OLOGY - THERAPEUTI C		0.0000		0	
01 03630 ULTRA SOUND		0. 10793		5, 122	
		0. 26618		100, 519	
00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 34642		13,650	
		0. 63270		435, 107	
00 06600 PHYSI CAL THERAPY 00 06700 0CCUPATI ONAL THERAPY		0. 41011 0. 24908		78, 206 46, 194	
00 06800 SPEECH PATHOLOGY		0. 34442		46, 194 10, 155	
00 06900 ELECTROCARDI OLOGY		0. 34442		23, 456	
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 86258		331, 310	
. 00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 77374		208, 240	
00 07300 DRUGS CHARGED TO PATI ENTS		0. 42796		669, 524	
OUTPATIENT SERVICE COST CENTERS					
. 00 08800 RURAL HEALTH CLINIC		0.00000	00	0	88
.01 08801 RURAL HEALTH CLINIC II		0. 00000		0	
. 00 09000 CLI NI C		0. 62890		0	
01 09001 ONCOLOGY		0. 40519		28	
02 09002 OUTPATIENT CLINIC		1. 14739		0	
03 09003 PROVIDER BASED CLINIC - TCMP		0.0000		0	
04 09004 PROVIDER BASED CLINIC - DCPC		0.00000		0	
. 05 09005 PROVI DER BASED CLI NI C - WESTPORT . 06 09006 CLI NI C		9. 25708 0. 25909		0	
07 09007 WOMEN'S HEALTH SERVICES		4. 37559		3, 492	
08 09008 PALN MANAGEMENT		0. 12764		3, 492 0	
09 09009 GERIATRI C PSYCH		0. 67955		0	
10 09010 PROVIDER BASED CLINIC - DCPM		1. 13510		0	
. 11 09011 PROVIDER BASED CLINIC - NEPHROLOGY		2. 76759		0	
12 09012 DI ABETES CLINIC		1. 26611		0	
13 09013 NEUROLOGY		0. 77857		0	
. 14 09014 FOOT AND ANKLE		0. 62207		0	90
00 09100 EMERGENCY		0. 23428	33 8, 189	1, 919	91
00 09200 OBSERVATION BEDS (NON-DISTINCT PART		1. 25208	33 741	928	92
.00 09500 AMBULANCE SERVICES D.00 Total (sum of lines 50 through 94 and 96 through 98)			4, 867, 938	2, 146, 910	95
	(1) (1)			2, 140, 910	200
1.00 Less PBP Clinic Laboratory Services-Program only charc	$1 \Delta S (n \Delta S)$		0		

PATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		eriod:	Worksheet D-3	3
	Component	CCN: 15-Z332 T	rom 01/01/2020 o 12/31/2020		pare
				6/22/2021 8:2	
			ving Beds - SNF		
Cost Center Description		Ratio of Cost		Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
		1.00	0.00	<u>col. 2)</u>	-
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	-
. 00 03000 ADULTS & PEDIATRICS			0		30
. 00 04300 ADDETS & FEDIATRICS			0		43
ANCI LLARY SERVICE COST CENTERS					43
00 05000 OPERATI NG ROOM		0. 309648	0	0	50
00 05200 DELIVERY ROOM & LABOR ROOM		0. 435463	0	-	
. 00 05300 ANESTHESI OLOGY		0. 247915	0	0	
. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 170255	3, 464	590	
00 05500 RADIOLOGY - THERAPEUTIC		0. 000000		0	
. 01 03630 ULTRA SOUND		0. 107937	754	81	
. 00 06000 LABORATORY		0. 266185	9, 301	2, 476	
. 00 06200 HABORATORT		0. 346424			
. 00 06500 RESPIRATORY THERAPY		0. 632708		10, 087	
. 00 06600 PHYSI CAL THERAPY		0. 410111	97, 691	40, 064	
. 00 06700 OCCUPATI ONAL THERAPY		0. 249085		24, 057	
00 06800 SPEECH PATHOLOGY					
. 00 06900 ELECTROCARDI OLOGY		0. 344428 0. 137588			
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 862589		20, 406	
. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 773742	23,037	20,408	
. 00 07300 DRUGS CHARGED TO PATIENTS		0. 427960	66, 472	28, 447	
OUTPATIENT SERVICE COST CENTERS		0.427900	00,472	20, 447	1/3
. 00 08800 RURAL HEALTH CLINIC		0.00000		0	88
01 08801 RURAL HEALTH CLINIC II		0. 000000		o o	
. 00 09000 CLINIC		0. 628904	0	o o	
. 01 09001 0NC0L0GY		0. 405196	0	-	
. 02 09002 OUTPATIENT CLINIC		1. 147392	0	-	
. 03 09003 PROVIDER BASED CLINIC - TCMP		0. 000000	0	U U	
. 04 09004 PROVIDER BASED CLINIC - DCPC		0. 000000	0	0	
. 05 09005 PROVIDER BASED CLINIC - WESTPORT		9. 257089	0	0	
. 06 09006 CLINIC		0. 259094	0	-	
. 07 09007 WOMEN' S HEALTH SERVICES		4. 375597	0	0	
. 08 09008 PAIN MANAGEMENT		0. 127641	0	0	
. 09 09009 GERIATRIC PSYCH		0. 679555	0	0	
. 10 09010 PROVIDER BASED CLINIC - DCPM		1. 135108	0	0	
. 11 09011 PROVIDER BASED CLINIC - NEPHROLOGY		2. 767597	0	0	
. 12 09012 DI ABETES CLINIC		1. 266112	0	l o	
13 09013 NEUROLOGY		0. 778578	0 0	0	
. 14 09014 FOOT AND ANKLE		0. 622075	0	0	
00 09100 EMERGENCY		0. 234283	0	0	
. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		1. 252083	0		
OTHER REIMBURSABLE COST CENTERS		1. 232003	0	0	1 ''
. 00 09500 AMBULANCE SERVICES					95
0.00 Total (sum of lines 50 through 94 and 96 through 9	78)		317, 261	127, 326	
			0,201	.2., 320	201
1.00 Less PBP Clinic Laboratory Services-Program only (

IPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1332	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Pre 6/22/2021 8:2	epare
	Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cos To Charges		Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1			
0. 00 03000 ADULTS & PEDIATRICS 0. 00 04300 NURSERY 0. 000 04300 CEDIMOR 000 CENTERS			193, 598 19, 409		30. 43.
ANCI LLARY SERVICE COST CENTERS		0. 30964	10 71 210	22.002	
2. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 30982		22, 083 8, 296	
2. 00 05300 ANESTHESI OLOGY		0. 24791		1, 244	
. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 17025		5,866	
00 05500 RADI OLOGY - THERAPEUTI C		0.00000		0	
0. 01 03630 ULTRA SOUND		0. 10793		429	55.
0. 00 06000 LABORATORY		0. 26618	35 38, 639	10, 285	
. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 34642	24 5, 311	1, 840	62.
0. 00 06500 RESPI RATORY THERAPY		0. 63270		35, 547	
0. 00 06600 PHYSI CAL THERAPY		0. 41011		7, 976	
00 06700 OCCUPATI ONAL THERAPY		0. 24908		4, 777	
		0. 35524		1,460	
0. 00 06900 ELECTROCARDI OLOGY . 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT		0. 13758		1, 954 31, 092	
2. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 77374		13, 226	
00 07300 DRUGS CHARGED TO PATIENTS		0. 42796		64, 194	
OUTPATIENT SERVICE COST CENTERS					
0. 00 08800 RURAL HEALTH CLINIC		3. 51952	23 0	0	88.
8. 01 08801 RURAL HEALTH CLINIC II		2.63583		0	
0. 00 09000 CLINIC		0. 62890		0	
0. 01 09001 0NC0L0GY		0.40519		19	
0.02 09002 OUTPATIENT CLINIC		1. 14739		2, 260	
0. 03 09003 PROVIDER BASED CLINIC - TCMP 0. 04 09004 PROVIDER BASED CLINIC - DCPC		0.00000		0	
0. 05 09005 PROVIDER BASED CLINIC - WESTPORT		0.00000		0	
0. 06 09006 CLINIC		0. 25909		104	
0. 07 09007 WOMEN'S HEALTH SERVICES		4. 37559		0	
0.08 09008 PALN MANAGEMENT		0. 12764		0	1
0. 09 09009 GERI ATRI C PSYCH		0. 67955		0	90
0. 10 09010 PROVIDER BASED CLINIC - DCPM		1. 13510		0	
0. 11 09011 PROVIDER BASED CLINIC - NEPHROLOGY		2. 76759		0	
0. 12 09012 DI ABETES CLINIC		1. 26611		0	
0. 13 09013 NEUROLOGY		0. 77857		0	
0. 14 09014 FOOT AND ANKLE		0. 62207		0	
. 00 09100 EMERGENCY 2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 23428		188 126	
OTHER REIMBURSABLE COST CENTERS		1.25208		120	
0.00 09500 AMBULANCE SERVICES 0.00 Total (sum of lines 50 through 94 and 96 through 98)			497, 339	212, 966	95
10.00 Less PBP Clinic Laboratory Services-Program only charge	s (line 61)		497, 339	212, 900	200
12.00 Net charges (line 200 minus line 201)			497, 339		201

	Financial Systems DECATUR CO. MEMORIAL I ATION OF REIMBURSEMENT SETTLEMENT Production	HOSPITAL ovider CCN: 15-1332	Period:	u of Form CMS-2 Worksheet E	2552-10
			From 01/01/2020 To 12/31/2020		
		Title XVIII	Hospi tal	Cost	
				1.00	
1 00	PART B - MEDICAL AND OTHER HEALTH SERVICES			0.0(0.005	1 00
1.00 2.00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instruction	ns)		9, 068, 295 0	
3.00	OPPS payments			0	
4.00 4.01	Outlier payment (see instructions) Outlier reconciliation amount (see instructions)			0	4.00 4.01
5.00	Enter the hospital specific payment to cost ratio (see instruction	ons)		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)			0.00	
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV,	col. 13, line 200		0	
10.00 11.00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0 9, 068, 295	10.00 11.00
	COMPUTATION OF LESSER OF COST OR CHARGES			.,,	
12.00	Reasonable charges Ancillary service charges			0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line	69)		0	
14.00	Total reasonable charges (sum of lines 12 and 13)			0	14.00
15.00	Customary charges Aggregate amount actually collected from patients liable for pay	ment for services on	a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for p			0	
17.00	had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17 00
18.00	Total customary charges (see instructions)			0.000000	
19.00	Excess of customary charges over reasonable cost (complete only	fline 18 exceeds l	ne 11) (see	0	19.00
20.00	instructions) Excess of reasonable cost over customary charges (complete only	fline 11 exceeds l	ne 18) (see	0	20.00
21.00	instructions) Lesser of cost or charges (see instructions)			9, 158, 978	21.00
22.00	Interns and residents (see instructions)			0	22.00
23.00 24.00	Cost of physicians' services in a teaching hospital (see instruc Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	tions)		0	
24.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	24.00
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)			116, 467	
26.00 27.00	Deductibles and Coinsurance amounts relating to amount on line 2 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plu			4, 680, 246 4, 362, 265	
	instructions)	50)			
28.00 29.00	Direct graduate medical education payments (from Wkst. E-4, line ESRD direct medical education costs (from Wkst. E-4, line 36)	50)		0	
30.00	Subtotal (sum of lines 27 through 29)			4, 362, 265	30.00
31.00 32.00	Primary payer payments Subtotal (line 30 minus line 31)			1, 594 4, 360, 671	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	1		4, 300, 071	52.00
	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)			0 512, 770	33.00 34.00
34.00	Adjusted reimbursable bad debts (see instructions)			333, 301	
36.00	Allowable bad debts for dual eligible beneficiaries (see instruc	ti ons)		402, 137	
37.00 38.00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			4, 693, 972 0	
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39.50 39.97	Pioneer ACO demonstration payment adjustment (see instructions) Demonstration payment adjustment amount before sequestration			0	39.50 39.97
39.98	Partial or full credits received from manufacturers for replaced	devices (see instru	ctions)	0	
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0	39.99
40. 00 40. 01	Subtotal (see instructions) Sequestration adjustment (see instructions)			4, 693, 972 30, 980	
40. 02	Demonstration payment adjustment amount after sequestration			0	40. 02
40. 03 41. 00	Sequestration adjustment-PARHM pass-throughs Interim payments			3, 476, 398	40.03 41.00
41.00	Interim payments-PARHM			3, 470, 370	41.00
	Tentative settlement (for contractors use only)			0	
42.01 43.00	Tentative settlement-PARHM (for contractor use only) Balance due provider/program (see instructions)			1, 186, 594	42.01 43.00
43.01	Balance due provider/program-PARHM (see instructions)				43.01
44.00	Protested amounts (nonallowable cost report items) in accordance §115.2	with CMS Pub. 15-2,	chapter 1,	0	44.00
00 00	TO BE COMPLETED BY CONTRACTOR			0	90.00
90.00 91.00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	
92.00	The rate used to calculate the Time Value of Money				92.00
93.00 94.00	Time Value of Money (see instructions) Total (sum of lines 91 and 93)			0	93.00 94.00

2.00 Interim payments payable on individual bills, either sorvices rendered in the cost reporting period. If none, write "NONE" or enter a zero. 0 0 3.00 List separately each retroactive lump sum adjustment anount 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)	ANALYS	I Financial Systems DECATUR CO. MEMO SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider C	CN: 15-1332	Period: From 01/01/2020 To 12/31/2020		pared:
Im/dd/yyyy Amount mm/dd/yyyy Amount 1.00 Total 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 3,476,398 3.00 1.00 3,476,398 3.00 1.00 3,476,398 3.00 1.00 3,476,398 3.00 1.00 3,476,398 3.00 1.00 3,476,398 3.00 1.00 3,476,398 3.00 1.00 0 1.00 1.00 3,476,398 3.00 1.00 0 3.00 1.00 0 1.01 1.02/02/02 133,000 3.02 0 0 3.04 0 0 3.05 ADJUSTMENTS TO PROGRAM 0 3.50 3,605,752 3,476,398 3.51 0 0 0 3.52 0 0 0 3.50 3,98 Subtotal (sum of lines 1, 2, and 3,99)							1
1.00 Total interim payments paid to provider 1.00 2.00 3.00 4.00 1.101 Total interim payments payable on individual bills, either 3.472,52 3.476,398 2.00 11terim payments payable on individual bills, either 3.472,52 3.476,398 3.00 11st separately each retroactive lump sum adjustment 3.472,52 3.476,398 3.00 11st separately each retroactive lump sum adjustment 3.00 0 1.00 11st separately each retroactive lump sum adjustment 3.00 0 1.01 Program to Provider 07/09/2020 133,000 0 3.01 ADJUSTMENTS TO PROVIDER 07/09/2020 133,000 0 3.03 ADJUSTMENTS TO PROGRAM 0 0 0 3.50 ADJUSTMENTS TO PROGRAM 0 0 0 3.51 0 0 0 0 0 3.52 0 0 0 0 0 3.53 0 0 0 0 0 3.52 0 0 0 0 0 3.53 0 0 0 0 0 3.54 0 0 0 0 0 3.55 0 0 </th <th></th> <th></th> <th>Inpatien</th> <th>it Part A</th> <th>Pa</th> <th>rt B</th> <th></th>			Inpatien	it Part A	Pa	rt B	
1.00 Total interim payments paid to provider 1.00 2.00 3.00 4.00 2.00 Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write 'WONE' or enter a zero 3.472, 52 3.476, 398 3.00 List separately each retroactive iump sum adjustment anount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'WONE' or enter a zero. (1) 07/09/2020 133, 000 0 701 AJUSTMENTS TO PROVIDER 07/09/2020 133, 000 0 0 3.01 AJUSTMENTS TO PROGRAM 0 0 0 3.50 AJUSTMENTS TO PROGRAM 0 0 0 3.51 AJUSTMENTS TO PROGRAM 0 0 0 3.52 0 0 0 0 3.53 AJUSTMENTS TO PROGRAM 0 0 0 3.54 0 0 0 0 3.55.3 0 0 0 0 3.50 0 0 0 0 3.50 0 0 0 0 3.50 0 0 0 0 3.50 0 0 0 0 3.50 <td< th=""><th></th><th></th><th>mm/dd/vvvv</th><th>Amount</th><th>mm/dd/vvvv</th><th>Amount</th><th></th></td<>			mm/dd/vvvv	Amount	mm/dd/vvvv	Amount	
2.00 Interim payments payable on individual bills, either sorvices rendered in the cost reporting period. If none, write "NONE" or enter a zero 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) 0 0 Program to Provider 0 0 0 3.01 AJJUSTMENTS TO PROVIDER 07/09/2020 133,000 0 3.03 0 0 0 3.04 0 0 0 3.05 Provider to Program 0 0 0 5.04 AJUSTMENTS TO PROGRAM 0 0 0 3.55 AJUSTMENTS TO PROGRAM 0 0 0 0 3.56 AJUSTMENTS TO PROGRAM 0 0 0 0 0 3.57 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.89) 133,000 0 0 0 0 0 3.58 JUSTMENTS TO PROGRAM 0<							
for the cost reporting period. Also show date of each program to Provider	2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		3, 472, 7			1.00 2.00 3.00
3 02 0 0 0 0 3 03 0 0 0 0 0 0 3 05 0		for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
3.03 0 0 0 0 3.04 0 0 0 0 3.05 Provider to Program 0 0 0 3.05 ADJUSTMENTS TO PROGRAM 0 0 0 3.51 0 0 0 0 0 3.52 0 0 0 0 0 0 3.53 0	3. 01		07/09/2020	133, 0	00	0	3.0
3.05 0					-		3.0
3.05 Provider to Program 0 0 3.50 ADJUSTMENTS TO PROGRAM 0 0 0 3.51 ADJUSTMENTS TO PROGRAM 0 0 0 0 3.52 0					-	-	3.0
Provider to Program ADJUSTMENTS TO PROGRAM 0 3.50 0 3.51 0 3.52 0 3.53 0 3.54 0 3.57 0 3.58 0 3.59 0 3.59 0 3.59 0 3.59 0 3.59 133,000 0 0 0 0 10 BE COMPLETED BY CONTRACTOR 10 BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 FINTATIVE TO PROVIDER 0						-	3.0
ADJUSTMENTS TO PROGRAM 0 0 0 3.51 0 0 0 0 3.52 0 0 0 0 3.53 0 0 0 0 0 3.54 0 0 0 0 0 0 3.54 0	5.05	Provider to Program					0.0
3.52 0 0 0 3.54 0 0 0 3.54 0 0 0 3.59 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 133,000 0 0 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E-3, line and column as appropriate) 3,605,752 3,476,398 TO BE COMPLETED BY CONTRACTOR 0 0 0 10 BE COMPLETED BY CONTRACTOR 0 0 0 11 CHE COMPLETED BY CONTRACTOR 0 0 0 12 BE COMPLETED BY CONTRACTOR 0 0 0 13 Starparatel y each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) 0 0 0 Program to Provider 0 0 0 0 0 5.01 TENTATIVE TO PROVIDER 0 0 0 0 0 5.02 0							3.50
3.53 0 0 0 3.54 0 0 0 3.59 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.09) 133,000 0 0 3.79 Subtotal interim payments (sum of lines 1, 2, and 3.99) 3,605,752 3,476,398 3,476,398 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) 0 3,605,752 3,476,398 TO BE COMPLETED BY CONTRACTOR 1 0 0 0 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) 0 0 0 Program to Provider 0 0 0 0 0 5.01 TENTATIVE TO PROVIDER 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td>-</td> <td></td>						-	
3.54 0 0 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 133,000 0 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) 3,605,752 3,476,398 TO BE COMPLETED BY CONTRACTOR 0 0 D List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) 0 0 Program to Provider 0 0 0 5.00 0 0 0 5.01 TENTATIVE TO PROVIDER 0 0 5.02 0 0 0 5.03 ENTATIVE TO PROGRAM 0 0 5.50 0 0 0 5.50 5.50 0 0 0 5.50 0 0 0 0 5.50 5.50-5.98) 0 0 0 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 806,719 1,186,594 6.01 SETLEMENT TO PROGRAM 0 0 0 6.02 SETLEMENT TO PROGRAM 0 0 0 6.02 SETLEMENT TO PROGRAM 0 0 6.02 <td< td=""><td></td><td></td><td></td><td></td><td></td><td>-</td><td>3.5 3.5</td></td<>						-	3.5 3.5
3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) 133,000 (Transfer to Wkst. E or Wkst. E-3, line and column as appropriate) 3,605,752 3,476,398 TO BE COMPLETED BY CONTRACTOR TO BE COMPLETED BY CONTRACTOR 0 0 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) 0 0 Program to Provider 0 0 0 5.01 TENTATIVE TO PROVIDER 0 0 5.50 TENTATIVE TO PROGRAM 0 0 5.51 0 0 0 5.52 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.52 0 0 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.52 0 0 0 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 806,719 1,186,594 0 0 6.01 SETTLEMENT TO PROKAM 0 0 0 0 0 0 7.00 Total Medicare program liability (see instructions) 4,412,471 4,662,992 NPR Date (MPC) MPR Date <td></td> <td></td> <td></td> <td></td> <td>-</td> <td>-</td> <td>3.5</td>					-	-	3.5
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate) Image: column a star in the star in t				133, 0	-	-	3.9
TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provi der 5.01 TENTATIVE TO PROVIDER 5.02 0 5.03 0 Provi der to Program 5.04 0 5.05 TENTATIVE TO PROGRAM 5.51 0 5.52 0 5.54 0 5.55 0 5.50 TENTATIVE TO PROGRAM 6.01 Settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROGRAM 6.02 SETTLEMENT TO PROGRAM 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 4, 412, 471 4, 662, 992 Number (Mo/Day/Yr)	4. 00	(transfer to Wkst. E or Wkst. E-3, line and column as		3, 605, 7	52	3, 476, 398	4.0
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) Image: Constraint of the settlement accord to the settlement payment. If none, write "NONE" or enter a zero. (1) Program to Provider 0 0 5.01 TENTATI VE TO PROVIDER 0 0 5.02 0 0 0 7.00 Provider to Program 0 0 0 5.50 TENTATI VE TO PROGRAM 0 0 0 5.50 TENTATI VE TO PROGRAM 0 0 0 5.51 0 0 0 0 0 5.52 0 0 0 0 0 0 0 0 5.52 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
write "NONE" or enter a zero. (1) Program to Provi der Program to Provi der 0 5.01 TENTATI VE TO PROVI DER 00 0 00 0 00 0 00 0 00 0 01 0 02 0 03 0 04 0 05.00 Provi der to Program 05.01 0 05.02 0 06 0 07 0 08 0 09 0 00 0 01 0 02 0 03 0 04 0 05.50 5.50-5.98) 05.00 Determined net settlement amount (balance due) based on the cost report. (1) 01 SETTLEMENT TO PROVI DER 02 SETTLEMENT TO PROVI DER 03 0 04.01 0 05.02 SETTLEMENT TO PROGRAM 00 0 00	5.00	List separately each tentative settlement payment after					5.0
Program to Provider 0 0 5.01 TENTATI VE TO PROVIDER 0 0 6.02 0 0 0 7.03 Provider to Program 0 0 7.04 TENTATI VE TO PROGRAM 0 0 7.05 TENTATI VE TO PROGRAM 0 0 7.05 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 0 0 7.00 SetTLEMENT TO PROVIDER 0 0 0 7.01 SETTLEMENT TO PROVIDER 806,719 1,186,594 0 7.00 Total Medicare program liability (see instructions) 4,412,471 4,662,992 Contractor NPR Date (Mo/Day/Yr)							
5.02 0 0 0 0 6.03 Provider to Program 0 0 0 7.50 TENTATI VE TO PROGRAM 0 0 0 5.50 TENTATI VE TO PROGRAM 0 0 0 5.51 0 0 0 0 0 5.52 0 0 0 0 0 0 5.52 0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
5.03 0 0 0 Provider to Program 5.50 TENTATI VE TO PROGRAM 0 0 5.51 0 0 0 0 5.51 0 0 0 0 5.52 0 0 0 0 5.52 0 0 0 0 5.52 0 0 0 0 5.50-5.98) 0 0 0 0 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 1, 186, 594 1, 186, 594 5.02 SETTLEMENT TO PROGRAM 0 0 0 7.00 Total Medicare program liability (see instructions) 4, 412, 471 4, 662, 992 Kumber Contractor NPR Date (Mo/Day/Yr)		TENTATI VE TO PROVI DER					5.0
Provider to Program 5.50 TENTATI VE TO PROGRAM 0 0.51 0.52 0 0 0.52 0 0 0.52 0 0 0.52 0 0 0.52 0 <							5.0
5.50 TENTATI VE TO PROGRAM 0 0 5.51 0 0 0 5.52 0 0 0 5.59 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 0 0 5.00 Determined net settlement amount (balance due) based on the cost report. (1) 0 0 5.01 SETTLEMENT TO PROVIDER 806,719 1,186,594 5.02 SETTLEMENT TO PROGRAM 0 0 7.00 Total Medicare program liability (see instructions) 4,412,471 4,662,992 Contractor NPR Date (Mo/Day/Yr)	5.03	Providor to Program		l	U	0	5.0
5.51 0 0 5.52 0 0 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 0 5.00 Determined net settlement amount (balance due) based on the cost report. (1) 0 5.01 SETTLEMENT TO PROVIDER 806,719 5.02 SETTLEMENT TO PROGRAM 0 7.00 Total Medicare program liability (see instructions) 4,412,471	5.50				0	0	5.5
5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 0 0 0 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 1 1,186,594 6.01 SETTLEMENT TO PROVIDER 806,719 1,186,594 6.02 SETTLEMENT TO PROGRAM 0 0 7.00 Total Medicare program liability (see instructions) 4,412,471 4,662,992 Kumber							5.5
5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 4,412,471 4,662,992 Contractor NPR Date (Mo/Day/Yr)						-	5.5
b. 00 Determined net settlement amount (balance due) based on the cost report. (1) 806,719 1,186,594 b. 01 SETTLEMENT TO PROVIDER 806,719 0 b. 02 SETTLEMENT TO PROGRAM 0 0 c. 02 SETTLEMENT TO PROGRAM 0 0 c. 00 Total Medicare program liability (see instructions) 4,412,471 4,662,992 Contractor NPR Date (Mo/Day/Yr)	5. 99				0	0	5.9
0.02 SETTLEMENT TO PROGRAM 0 0 7.00 Total Medicare program liability (see instructions) 4,412,471 4,662,992 Contractor Number NPR Date (Mo/Day/Yr)	o. 00	Determined net settlement amount (balance due) based on					6. C
7.00 Total Medicare program liability (see instructions) 4,412,471 4,662,992 Vertication Contractor NPR Date Number (Mo/Day/Yr)				806, 7	19		6.0
Contractor NPR Date Number (Mo/Day/Yr)					0	-	6.0
Number (Mo/Day/Yr)	1.00	lotal medicare program liability (see instructions)		4, 412, 4			7.0
0 1.00 2.00			(C	1.00	2.00	

IALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC Component C		Period: From 01/01/2020 To 12/31/2020		
					6/22/2021 8:2	
				<u>Swing Beds - SNF</u>		-
		Inpatien	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3, 00	4,00	
00	Total interim payments paid to provider		472,06	2	0	1.0
00	Interim payments payable on individual bills, either			0	0	2.0
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
~~	write "NONE" or enter a zero					
00	List separately each retroactive lump sum adjustment					3.
	amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
01	ADJUSTMENTS TO PROVIDER			0	0	13.
02				0	0	
03				0	0	3.
04				0	0	3.
05				0	0	3.
	Provider to Program					
50	ADJUSTMENTS TO PROGRAM			0	0	-
51				0	0	-
52				0	0	-
53				0	0	-
54 99	Subtatel (sum of lines 2 01 2 40 minus sum of lines			0	0	
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)		472,06	2	0	4.
00	(transfer to Wkst. E or Wkst. E-3, line and column as		172,00	-2	, o	··
	appropri ate)					
	TO BE COMPLÉTED BY CONTRACTOR					1
00	List separately each tentative settlement payment after					5
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					1 -
)1)2	TENTATI VE TO PROVI DER			0	0	
)2)3				0	0	
55	Provider to Program			0	0	1 3
50	TENTATI VE TO PROGRAM			0	0	15
51				0	0	
52				0	0	5
99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0	0	5
	5. 50-5. 98)					
00	Determined net settlement amount (balance due) based on					6.
1	the cost report. (1)		00 / 1	-		
)1)2	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		82, 61		0	
)2)0			554,67	0		
50	Total Medicare program liability (see instructions)		554, 67	Contractor	NPR Date	· /
				Number	(Mo/Day/Yr)	
		C)	1.00	2.00	
					2.00	1

Heal th	Financial Systems DECATUR CO. MEMOR	I AL HOSPI TAL	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1332	Period: From 01/01/2020 To 12/31/2020	Date/Time Pre 6/22/2021 8:2	epared:
		Title XVIII	Hospi tal	Cost	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION	N			
1.00	Total hospital discharges as defined in AARA §4102 from Wkst	. S-3, Pt. I col. 15 lin	e 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1,	8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1,	8-12			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				
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instructio	ns)		32.00

	inancial Systems DECATUR CO. MEMORIAL H FION OF REIMBURSEMENT SETTLEMENT - SWING BEDS Pro	vider CCN: 15-1332	Peri od:	u of Form CMS-2 Worksheet E-2	
ALCOLAI		ponent CCN: 15-Z332	From 01/01/2020 To 12/31/2020	Date/Time Pre	pared:
		Title XVIII	Swing Beds - SNF	6/22/2021 8:2 Cost	/ pili
			Part A	Part B	
C	OMPUTATION OF NET COST OF COVERED SERVICES		1.00	2.00	
	npatient routine services - swing bed-SNF (see instructions)		431, 871	0	1.00
	npatient routine services - swing bed-NF (see instructions)			-	2.00
	ncillary services (from Wkst. D-3, col. 3, line 200, for Part A,			0	3.00
	art V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-k	ed pass-through, se	9		
	nstructions) ursing and allied health payment-PARHM (see instructions)				3. 01
	er diem cost for interns and residents not in approved teaching	program (see		0.00	•
	nstructions)				
	rogram days		246	0	
	nterns and residents not in approved teaching program (see instr tilization review - physician compensation - SNF optional method	-	0	0	6.00 7.00
	ubtotal (sum of lines 1 through 3 plus lines 6 and 7)	i oni y	560, 470	0	8.00
	rimary payer payments (see instructions)		0	0	9.00
	ubtotal (line 8 minus line 9)		560, 470	0	10.00
	eductibles billed to program patients (exclude amounts applicabl	e to physician	0	0	11.00
	rofessional services) ubtotal (line 10 minus line 11)		560, 470	0	12.00
	oinsurance billed to program patients (from provider records) (e	exclude coinsurance	2, 112	0	13.00
	or physician professional services)		27.12	0	
	0% of Part B costs (line 12 x 80%)			0	
	ubtotal (see instructions)		558, 358	0	
	THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00 16.50
	ioneer ACO demonstration payment adjustment (see instructions) ural community hospital demonstration project (§410A Demonstrati	on) payment	0		16.50
	djustment (see instructions)	ony payment	0		
6.99 D	emonstration payment adjustment amount before sequestration		0	0	16.99
	llowable bad debts (see instructions)		0	0	
	djusted reimbursable bad debts (see instructions) Ilowable bad debts for dual eligible beneficiaries (see instruct	i onc)	0	0	
	otal (see instructions)	10115)	558, 358	0	
	equestration adjustment (see instructions)		3, 685	0	
9.02 D	emonstration payment adjustment amount after sequestration)		0	0	19.02
	equestration adjustment-PARHM pass-throughs				19.03
	nterim payments		472, 062	0	20.00 20.01
	nterim payments-PARHM entative settlement (for contractor use only)		0	0	
	entative settlement-PARHM (for contractor use only)		0	0	21.00
2.00 B	alance due provider/program (line 19 minus lines 19.01, 20, and	21)	82, 611	0	22.00
	alance due provider/program-PARHM (see instructions)				22.01
	rotested amounts (nonallowable cost report items) in accordance	with CMS Pub. 15-2,	0	0	23.00
	hapter 1, §115.2 ural Community Hospital Demonstration Project (§410A Demonstrati	on) Adjustment			
	s this the first year of the current 5-year demonstration period				200. 00
С	entury Cures Act? Enter "Y" for yes or "N" for no.				
	ost Reimbursement Indianna aming had SNE innationt rauting agains agata (fram Wyat	D 1 Dt 11 line	-		201 00
	edicare swing-bed SNF inpatient routine service costs (from Wks1 6 (title XVIII hospital))	D-I, PL. II, IIne			201.00
1	edicare swing-bed SNF inpatient ancillary service costs (from Wk	st. D-3, col. 3, li	ne		202.00
2	00 (title XVIII swing-bed SNF))				
	otal (sum of lines 201 and 202)				203.00
	edicare swing-bed SNF discharges (see instructions) omputation of Demonstration Target Amount Limitation (N/A in fir	st year of the curr	ant E year demons		204.00
	eriod)	st year of the curre	ent o-year demons		
	edicare swing-bed SNF target amount				205.00
06. OO M	edicare swing-bed SNF inpatient routine cost cap (line 205 times	5 line 204)			206.00
	djustment to Medicare Part A Swing-Bed SNF Inpatient Reimburseme				
	rogram reimbursement under the §410A Demonstration (see instruct		1		207.00
	edicare swing-bed SNF inpatient service costs (from Wkst. E-2, c nd 3)	οι. ι, sum of lines	I		208.00
	djustment to Medicare swing-bed SNF PPS payments (see instruction	ons)			209.00
10. 00 R	eserved for future use	-			210.00
	omparision of PPS versus Cost Reimbursement				
	otal adjustment to Medicare swing-bed SNF PPS payment (line 209	plus line 210) (see			215.00

ALCUL	Financial Systems DECATUR CO. MEN ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1332	Peri od:	u of Form CMS-2 Worksheet E-3	
			From 01/01/2020 To 12/31/2020		
		Title XVIII	Hospi tal	Cost	.7 pii
				1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDIC	CARE PART A SERVICES - COS	T REIMBURSEMENT		- · ·
. 00	Inpatient services			4, 776, 791	
. 00	Nursing and Allied Health Managed Care payment (see instru	uctions)		0	1
. 00 . 00	Organ acquisition			0	
. 00	Subtotal (sum of lines 1 through 3) Primary payer payments			4, 776, 791	4.
. 00	Total cost (line 4 less line 5). For CAH (see instructions	e)		4, 824, 559	
. 00	COMPUTATION OF LESSER OF COST OR CHARGES	5)		4, 024, 337	0.
	Reasonable charges				1
. 00	Routine service charges			0	7.
. 00	Ancillary service charges			0	
. 00	Organ acquisition charges, net of revenue			0	9.
0.00	Total reasonable charges			0	10.
	Customary charges				
1.00	Aggregate amount actually collected from patients liable			0	
2.00	Amounts that would have been realized from patients liable		on a charge basis	0	12
	had such payment been made in accordance with 42 CFR 413.	13(e)			
3.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000	
4.00	Total customary charges (see instructions)			0	
5.00	Excess of customary charges over reasonable cost (complete instructions)	e only if line 14 exceeds i	The 6) (see	0	15
6.00	Excess of reasonable cost over customary charges (complete	e only if line 6 exceeds li	no(14) (soo	0	16
0.00	instructions)	e only if the o exceeds if	110 14) (300	0	10
7.00	Cost of physicians' services in a teaching hospital (see	instructions)		0	17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	· · · · · · · · · · · · · · · · · · ·			
8.00	Direct graduate medical education payments (from Workshee	t E-4, line 49)		0	18
9.00	Cost of covered services (sum of lines 6, 17 and 18)			4, 824, 559	
D. 00	Deductibles (exclude professional component)			439, 120	
	Excess reasonable cost (from line 16)			0	
2.00	Subtotal (line 19 minus line 20 and 21)			4, 385, 439	
3.00	Coinsurance			2, 816	
	Subtotal (line 22 minus line 23)			4, 382, 623	
	Allowable bad debts (exclude bad debts for professional se	ervices) (see instructions)		91, 021	
5.00 7.00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see i	i petructi ope)		59, 164 50, 518	
7.00 3.00		riisti ucti olis)		4, 441, 787	
				4, 441, 787	
9.50 9.50	Pioneer ACO demonstration payment adjustment (see instruct	tions)		0	
7.99 7.99	Demonstration payment adjustment amount before sequestrat			0	
D. 00	Subtotal (see instructions)			4, 441, 787	
	Sequestration adjustment (see instructions)			29, 316	
0. 02	Demonstration payment adjustment amount after sequestration	on		0	
0. 03					30
	Interim payments			3, 605, 752	
	Interim payments-PARHM				31
2.00	Tentative settlement (for contractor use only)			0	
2.01	Tentative settlement-PARHM (for contractor use only)				32
3.00	Balance due provider/program (line 30 minus lines 30.01, 3			806, 719	
3.01 4.00	Balance due provider/program-PARHM (lines 2, 3, 18, and 2)				33
	Protested amounts (nonallowable cost report items) in according	ordance with (MS Pub 15-2	chapter 1	0	1 2/

	Financial Systems DECATUR CO. MEMC E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C	F	eriod: rom 01/01/2020 o 12/31/2020	u of Form CMS-2 Worksheet G Date/Time Pre 6/22/2021 8:2	pared:
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund 4.00	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
00	Cash on hand in banks	6, 697, 536	0	0	0	1.0
00	Temporary investments	41, 078, 677	0	0	0	2.0
00	Notes receivable	0	0	0	0	3.0
00	Accounts receivable	20, 121, 217	0	0	0	4.0
00	Other receivable	0	0	0	0	5.0
00	Allowances for uncollectible notes and accounts receivable	-11, 742, 757	0	0	0	6.0
00 00	Inventory Prepaid expenses	1, 636, 541	0	0	0	7.0 8.0
00	Other current assets	6, 534, 000	0	0	0	9.0
0.00	Due from other funds	0,001,000	0	0	0	10.0
	Total current assets (sum of lines 1-10)	64, 325, 214	0	-	0	11.0
	FI XED ASSETS		1 -			
. 00	Land	3, 550, 209	0	0	0	12.0
. 00	Land improvements	620, 290	0	0	0	13.0
	Accumulated depreciation	-473, 398		-	0	14.0
	Buildings	41, 835, 075		0	0	15.0
	Accumulated depreciation	-19, 316, 170		0	0	16.0
	Leasehold improvements	0	0	0	0	17.0
	Accumulated depreciation Fixed equipment	0 3, 977, 566	0	0	0	18. C
	Accumulated depreciation	-2, 895, 492		0	0	20.0
	Automobiles and trucks	267, 458	-	0	0	20.0
	Accumulated depreciation	-157, 290	-	0	0	22.0
	Major movable equipment	32, 108, 024	0	0	0	23.0
	Accumulated depreciation	-22, 291, 468	0	0	0	24.
	Minor equipment depreciable	0	0	0	0	25.
. 00	Accumulated depreciation	0	0	0	0	26.
. 00	HIT designated Assets	0	0	0	0	27.
. 00	Accumulated depreciation	0	0	0	0	28.
	Minor equipment-nondepreciable	0	0	0	0	29.0
. 00	Total fixed assets (sum of lines 12-29)	37, 224, 804	0	0	0	30.0
00	OTHER ASSETS Investments	7, 532	0	0	0	31.0
	Deposits on leases	7, 332	0	0	0	32.0
	Due from owners/officers	0	0	0	0	33.0
	Other assets	0	0	0	0	34.0
	Total other assets (sum of lines 31-34)	7, 532	0	0	0	35.0
. 00	Total assets (sum of lines 11, 30, and 35)	101, 557, 550		0	0	36.0
	CURRENT LIABILITIES					
	Accounts payable	3, 289, 149		-	0	37.0
	Salaries, wages, and fees payable	1, 291, 495			0	38.
	Payroll taxes payable	1, 254, 741	0	0	0	39.
	Notes and Loans payable (short term)	556, 271	0	0	0	
	Deferred income Accelerated payments	1, 600, 000	0	0	0	41. 42.
	Due to other funds	-4, 543, 753	о	0	0	
	Other current liabilities	4, 475, 892		-	0	
	Total current liabilities (sum of lines 37 thru 44)	7, 923, 795			0	
	LONG TERM LI ABI LI TI ES	.,,	-	-	-	
. 00	Mortgage payable	0	0	0	0	46.
. 00	Notes payable	9, 985, 734	0	0	0	47.
. 00	Unsecured Loans	0	0	0	0	48.
. 00	Other long term liabilities	4, 961, 405	0	0	0	49.
	Total long term liabilities (sum of lines 46 thru 49)	14, 947, 139		0	0	50.
. 00	Total liabilities (sum of lines 45 and 50)	22, 870, 934	0	0	0	51.
	CAPITAL ACCOUNTS	70 (0) (1)				1 50
	General fund balance	78, 686, 616				52.
	Specific purpose fund Donor created - endowment fund balance - restricted		0	0		53. 54.
. 00	Donor created - endowment fund balance - restricted			0		55.
	Governing body created - endowment fund balance			0		56.
. 00	Plant fund balance - invested in plant			0	0	57.
	Plant fund balance - reserve for plant improvement,				0	58.
	replacement, and expansion				0	
. 00	Total fund balances (sum of lines 52 thru 58)	78, 686, 616	0	0	0	59.

Health Financial Systems DI STATEMENT OF CHANGES IN FUND BALANCES	ECATUR CO. MEMOR	Provider CC	N: 15-1332		In Lie d: 01/01/2020 12/31/2020			ared:
	General	Fund	Speci al	Purpos	e Fund	Endowment Fund		
	1.00	2.00	3.00		4.00	5.00	+	
<pre>0 Fund balances at beginning of period 0 Net income (loss) (from Wkst. G-3, line 29) 1 Total (sum of line 1 and line 2) 0 CHANGE IN UPL TRANSFER 0 0 0 0 0 0 Total additions (sum of line 4-9) 0 Subtotal (line 3 plus line 10) 0 Deductions (debit adjustments) (specify) 00 00 00 00 00 00 00 00 00 00 00 00 00</pre>	7, 811, 752 0 0 0 0 0 0 0 0 0 0 0 0 0 0	64, 148, 844 13, 526, 020 77, 674, 864 7, 811, 752 85, 486, 616 0 85, 486, 616	64, 148, 844 13, 526, 020 77, 674, 864 7, 811, 752 85, 486, 616 0		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1.00 2.00 3.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 13.00 14.00 15.00 14.00 15.00 17.00 18.00 19.00	
	Endowment Fund	PI ant	Fund					
	6.00	7.00	8.00					
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)4.00CHANGE IN UPL TRANSFER5.006.007.008.009.009.00	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 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 	0	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
 18.00 Total deductions (sum of lines 12-17) 19.00 Fund balance at end of period per balance sheet (line 11 minus line 18) 	0 0			0				18. 19.

	IT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CC	N: 15-1332	Period:	Worksheet G-2	1
				From 01/01/2020 To 12/31/2020	Parts I & II	epared:
DA	Cost Center Description		I npati ent	Outpati ent	Total	
	· · · · · · · · · · · · · · · · · · ·		1.00	2.00	3.00	
	ART I – PATIENT REVENUES					
	eneral Inpatient Routine Services					4
	ospi tal		6, 804, 8	75	6, 804, 875	
	UBPROVIDER - IPF					2.00
	UBPROVIDER - IRF					3.00
	UBPROVIDER					4.00
1	wing bed - SNF			0	0	
1	wing bed - NF			0	0	
	KILLED NURSING FACILITY					7.00
	URSING FACILITY					8.00
	THER LONG TERM CARE					9.00
	otal general inpatient care services (sum of lines 1-9)		6, 804, 8	/5	6, 804, 875	10.00
	ntensive Care Type Inpatient Hospital Services					1
	NTENSI VE CARE UNI T					11.00
	ORONARY CARE UNIT					12.00
	URN INTENSIVE CARE UNIT					13.00
	URGI CAL I NTENSI VE CARE UNI T					14.00
	THER SPECIAL CARE (SPECIFY)				_	15.00
	otal intensive care type inpatient hospital services (sum of 1-15)	lines		0	0	16.00
17.00 To	otal inpatient routine care services (sum of lines 10 and 16)	6, 804, 8	75	6, 804, 875	17.00
18.00 Ar	ncillary services		13, 814, 0	49 121, 713, 895	135, 527, 944	18.00
19.00 Ou	utpatient services			0 669, 525	669, 525	19.00
20.00 RL	URAL HEALTH CLINIC			0 0	0	20.00
20. 01 RL	URAL HEALTH CLINIC II			0 0	0	20.01
21.00 FE	EDERALLY QUALIFIED HEALTH CENTER			0 0	0	21.00
22.00 HO	OME HEALTH AGENCY			0	0	22.00
23.00 AN	MBULANCE SERVICES			0 0	0	23.00
24.00 CN	MHC					24.00
25.00 AN	MBULATORY SURGICAL CENTER (D. P.)					25.00
26.00 HO	OSPI CE					26.00
27.00 01	THER REVENUE		1, 759, 1	44 128, 792	1, 887, 936	27.00
28.00 To	otal patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	22, 378, 0	68 122, 512, 212	144, 890, 280	28.00
	-3, line 1)					
PA	ART II - OPERATING EXPENSES					
29.00 Op	perating expenses (per Wkst. A, column 3, line 200)			76, 949, 427		29.00
30. 00 AE	DD (SPECI FY)			0		30.00
31.00				0		31.00
32.00				0		32.00
33.00				0		33.00
34.00				0		34.00
35.00				0		35.00
36.00 To	otal additions (sum of lines 30-35)			0		36.00
	EDUCT (SPECIFY)			0		37.00
38.00				0		38.00
39.00				0		39.00
40.00				0		40.00
41.00				0		41.00
42.00 To	otal deductions (sum of lines 37-41)			0		42.00
43.00 To	otal operating expenses (sum of lines 29 and 36 minus line 4	2)(transfer		76, 949, 427		43.00
to	o Wkst. G-3, line 4)					

STATEN	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-1332	Peri od:	Worksheet G-3	
			From 01/01/2020 To 12/31/2020	Date/Time Pre	narod
			10 12/31/2020	6/22/2021 8:2	
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lin	ne 28)		144, 890, 280	1.00
2.00	Less contractual allowances and discounts on patients' accourt	nts		83, 468, 982	2.00
3.00	Net patient revenues (line 1 minus line 2)			61, 421, 298	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		76, 949, 427	4.00
5.00	Net income from service to patients (line 3 minus line 4)			-15, 528, 129	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 miscellaneous communication	n servi ces		0	8.00
9.00	Revenue from television and radio service			0	9.00
	Purchase di scounts			0	10.00
	Rebates and refunds of expenses			0	11.00
	Parking lot receipts			0	12.00
	Revenue from Laundry and Linen service			0	
	Revenue from meals sold to employees and guests			0	14.00
	Revenue from rental of living quarters			0	15.00
	Revenue from sale of medical and surgical supplies to other	than patients		0	16.00
	Revenue from sale of drugs to other than patients			0	17.00
	Revenue from sale of medical records and abstracts			0	18.00
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
	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 REVENUES			29, 019, 416	24.00
24.50	COVI D-19 PHE Fundi ng			34, 733	24.50
	Total other income (sum of lines 6-24)			29, 054, 149	
	Total (line 5 plus line 25)			13, 526, 020	
	OTHER EXPENSES (SPECIFY)			0	27.00
	Total other expenses (sum of line 27 and subscripts)			0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)			13, 526, 020	29.00

		ECATUR CO. MEMO		N. 1E 1000		u of Form CMS-2	
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C		Period: From 01/01/2020	Worksheet M-1	
			Component		To 12/31/2020	Date/Time Pre	pared:
						6/22/2021 8:2	Żpm
					RHC I		
		Compensati on	Other Costs		1 Recl assi fi cat		
				+ col. 2)	i ons	Trial Balance	
						(col. 3 +	
		1.00	2.00	3.00	4.00	<u>col. 4)</u> 5.00	
	FACILITY HEALTH CARE STAFF COSTS	1.00	2.00	3.00	4.00	5.00	
I. 00	Physi ci an	967, 824	0	967, 82	-35, 519	932, 305	1 1.0
2.00	Physician Assistant	07,024	0	707,02	0 0	,32,309	1
3.00	Nurse Practitioner	590, 018	0	590, 01	8 -37,230	-	
1.00	Visiting Nurse	0,0,010	0	0,0,01	0 0	002,700	
5.00	Other Nurse	554, 098	0	554, 09	8 0	554,098	
5.00	Clinical Psychologist	0,01	0		0 0	0	1
7.00	Clinical Social Worker	34, 620	0	34, 62	0 0	34, 620	
3.00	Laboratory Techni ci an	0	0		0 0	0	
9.00	Other Facility Health Care Staff Costs	0	0		0 0	0	9.0
0.00	Subtotal (sum of lines 1 through 9)	2, 146, 560	0	2, 146, 56	-72, 749	2, 073, 811	10.0
1.00	Physician Services Under Agreement	0	0		0 0	0	
2.00	Physician Supervision Under Agreement	0	0		0 0	0	12.0
3.00	Other Costs Under Agreement	0	0		0 0	0	13.0
4.00	Subtotal (sum of lines 11 through 13)	0	0		0 0	0	14.0
5.00	Medical Supplies	0	49, 912	49, 91	2 0	49, 912	15.0
6.00	Transportation (Health Care Staff)	0	0		0 0	0	16.0
7.00	Depreciation-Medical Equipment	0	0		0 0	0	17.0
8.00	Professional Liability Insurance	0	0		0 0	0	18.0
9.00	Other Health Care Costs	0	0		0 0	0	19.0
20.00	Allowable GME Costs						20.0
1.00	Subtotal (sum of lines 15 through 20)	0	49, 912	49, 91	2 0	49, 912	21.0
22.00	Total Cost of Health Care Services (sum of	2, 146, 560	49, 912	2, 196, 47	2 -72, 749	2, 123, 723	22.0
	lines 10, 14, and 21)						1
	COSTS OTHER THAN RHC/FQHC SERVICES						
	Pharmacy	0	83, 721	83, 72		83, 721	
4.00	Dental	0	0		0 0	0	
5.00	Optometry	0	0		0 0	0	
5.01	Tel eheal th	0	0		0 72, 749		
5.02	Chronic Care Management	0	0		0 0	0	
6.00	All other nonreimbursable costs	0	0		0 0	0	
7.00	Nonallowable GME costs		00 704	00.70	70 740	457 470	27.0
8.00	Total Nonreimbursable Costs (sum of lines 23	0	83, 721	83, 72	21 72, 749	156, 470	28.0
	through 27)						
9.00	FACILITY OVERHEAD Facility Costs	0	11, 896	11, 89	0	11, 896	29.0
19.00 10.00	Administrative Costs	296, 217	66, 084			362, 301	
1.00	Total Facility Overhead (sum of lines 29 and		77, 980			362, 301	
, 1. 00	30)	270, 217	11,900	574, 15	0	574, 197	31.0
32.00	Total facility costs (sum of lines 22, 28	2, 442, 777	211, 613	2, 654, 39	0 0	2, 654, 390	32 0
2.00	and 31)	2, 772, 111	211,013	2,004,07	<u> </u>	2,057,570	52.0

IALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-1332	Peri od:	Worksheet	M-1
			Component	CCN: 15-8522	From 01/01/2020 To 12/31/2020	Date/Time 6/22/2021	
					RHC I	0/22/2021	0.27 pi
		Adjustments	Net Expenses				
		.,	for				
			Allocation				
			(col. 5 +				
			col. 6)	_			
		6.00	7.00				
~ ~	FACILITY HEALTH CARE STAFF COSTS	70.504	1 005 000	.1			
00	Physi ci an	73, 584		1			1
00	Physician Assistant	0					2
00 00	Nurse Practitioner	780	553, 568				3
	Visiting Nurse Other Nurse	0					5
00		0	554,098				6
00 00	Clinical Psychologist Clinical Social Worker	-18, 541	16, 079				7
00	Laboratory Techni ci an	-16, 541	10,079				8
00	Other Facility Health Care Staff Costs	0		•			9
00	Subtotal (sum of lines 1 through 9)	55, 823	2, 129, 634				10
00	Physician Services Under Agreement	03, 023	2, 129, 034	•			11
00	Physician Supervision Under Agreement	0	-				12
	Other Costs Under Agreement	0					13
. 00	Subtotal (sum of lines 11 through 13)	0					14
	Medical Supplies	0	-				15
	Transportation (Health Care Staff)	0		1			16
. 00	Depreciation-Medical Equipment	0		•			17
	Professional Liability Insurance	0					18
	Other Health Care Costs	0		•			19
	Allowable GME Costs	0					20
	Subtotal (sum of lines 15 through 20)	0	49, 912				21
	Total Cost of Health Care Services (sum of	55, 823	2, 179, 546	•			22
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES						
	Pharmacy	0					23
	Dental	0		•			24
	Optometry	0					25
01	Tel eheal th	0	72, 749	1			25
	Chronic Care Management	0	C				25
00	All other nonreimbursable costs	0	C				26
00	Nonallowable GME costs		15/ 170				27
. 00	Total Nonreimbursable Costs (sum of lines 23	0	156, 470				28
	through 27)						
00	FACILITY OVERHEAD Facility Costs	0	11, 896				29
. 00	Administrative Costs	229, 958		•			30
00	Total Facility Overhead (sum of lines 29 and	229, 958 229, 958		•			31
00	30)	227, 930	004,155	1			
. 00	Total facility costs (sum of lines 22, 28	285, 781	2, 940, 171				32
. 00	and 31)	200,701	2, 740, 171				32

Heal th	Financial Systems DE	ECATUR CO. MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C		Peri od:	Worksheet M-1	
			Component		From 01/01/2020 To 12/31/2020		
					RHC II	0/22/2021 0.2	
		Compensation	Other Costs	Total (col.	1 Recl assi fi cat	Recl assi fi ed	
				+ col. 2)	ions	Trial Balance	
						(col. 3 +	
						col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	1, 318, 334	0	1, 318, 33	4 -97, 557	1, 220, 777	1.00
2.00	Physician Assistant	0	0		0 0	0	2.00
3.00	Nurse Practitioner	360, 319	0	360, 31	9 -5, 405	354, 914	3.00
4.00	Visiting Nurse	0	0		0 0	0	
5.00	Other Nurse	351, 338	0	351, 33		351, 338	
6.00	Clinical Psychologist	0	0		0 0	0	
7.00	Clinical Social Worker	0	0		0 0	0	
8.00	Laboratory Techni ci an	0	0		0 0	0	
9.00	Other Facility Health Care Staff Costs	0	0		0 0	0	
10.00	Subtotal (sum of lines 1 through 9)	2, 029, 991	0	2, 029, 99			•
11.00	Physician Services Under Agreement	0	0		0 0	0	
12.00	Physician Supervision Under Agreement	0	0		0 0	0	12.00
13.00	Other Costs Under Agreement	0	0		0 0	0	
14.00	Subtotal (sum of lines 11 through 13)	0	0		0 0	0	
15.00	Medical Supplies	0	42, 677			42, 677	
16.00	Transportation (Health Care Staff)	0	144			144	
17.00	Depreciation-Medical Equipment	0	0		0 0	0	
18.00	Professional Liability Insurance	0	0		0 0	0	
19.00	Other Health Care Costs Allowable GME Costs	0	0		0 0	0	19.00 20.00
20.00 21.00	Subtotal (sum of lines 15 through 20)	0	42, 821	42, 82	1 0	42, 821	
21.00	Total Cost of Health Care Services (sum of	2,029,991	42, 821				
22.00	lines 10, 14, and 21)	2,029,991	42, 021	2,072,01	2 -102, 902	1, 909, 050	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	178, 640	178, 64	0 0	178, 640	23.00
24.00	Dental	0	0		0 0	0	
25.00	Optometry	o	0		0 0	0	
25.01	Tel eheal th	0	0		0 102, 962	102, 962	
25.02	Chronic Care Management	0	0		0 0	0	25.02
26.00	All other nonreimbursable costs	0	0		0 0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	178, 640	178, 64	0 102, 962	281, 602	28.00
	through 27)						
	FACILITY OVERHEAD						
29.00	Facility Costs	0	8, 595				
30.00	Administrative Costs	316, 521	79, 270			395, 791	
31.00	Total Facility Overhead (sum of lines 29 and	316, 521	87, 865	404, 38	6 0	404, 386	31.00
	30)						
32.00	Total facility costs (sum of lines 22, 28	2, 346, 512	309, 326	2, 655, 83	8 0	2, 655, 838	32.00
	and 31)						

		ECATUR CO. MEMO				u of Form CMS	
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-1332	Peri od:	Worksheet M-	1
			Component	CCN: 15-8521	From 01/01/2020 To 12/31/2020	Date/Time Pr 6/22/2021 8:	epared: 27 nm
					RHC II	0/22/2021 0.	27 pm
		Adjustments	Net Expenses			I	
			for				
			Allocation				
			(col. 5 +				
		(00	col. 6)				
	FACILITY HEALTH CARE STAFF COSTS	6.00	7.00				
1.00	Physician	-73, 584	1, 147, 193				1.00
2.00	Physician Assistant	-73, 564	1, 147, 193				2.00
3.00	Nurse Practitioner	-780	354, 134				3.00
4.00	Visiting Nurse	0	0				4.00
5.00	Other Nurse	0	351, 338				5.00
6.00	Clinical Psychologist	0	0				6.00
7.00	Clinical Social Worker	18, 541	18, 541				7.00
8.00	Laboratory Techni ci an	0	0				8.00
9.00	Other Facility Health Care Staff Costs	0	0				9.00
10.00	Subtotal (sum of lines 1 through 9)	-55, 823	1, 871, 206				10.00
11.00	Physician Services Under Agreement	0	0				11.00
12.00	Physician Supervision Under Agreement	0	0				12.00
13.00	Other Costs Under Agreement	0	0				13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0				14.00
15.00	Medical Supplies	0	42, 677				15.00
16.00	Transportation (Health Care Staff)	0	144				16.00
17.00	Depreciation-Medical Equipment	0	0				17.00
18.00	Professional Liability Insurance	0	0				18.00
19.00	Other Health Care Costs	0	0				19.00
20.00	Allowable GME Costs		10.001				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	42, 821				21.00
22.00	Total Cost of Health Care Services (sum of	-55, 823	1, 914, 027				22.00
	lines 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICES		L				
23.00	Pharmacy	0	178, 640				23.00
24.00	Dental	0	0				24.00
25.00	Optometry	0	0				25.00
25.01	Tel eheal th	0	102, 962				25.01
25.02	Chronic Care Management	0	0				25.02
26.00	All other nonreimbursable costs	0	0				26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	281, 602				28.00
	through 27)						
	FACILITY OVERHEAD						
29.00	Facility Costs	0					29.00
30.00	Administrative Costs	58, 618					30.00
31.00	Total Facility Overhead (sum of lines 29 and	58, 618	463, 004				31.00
22.00	30) Tatal facility costs (sum of lines 22, 20	0 705	0 / 50 / 00				
32.00	Total facility costs (sum of lines 22, 28	2, 795	2, 658, 633				32.00
	and 31)						1

Health Financial Systems			RIAL HOSPITAL			u of Form CMS-2	
ALLOCATION OF OVERHEAD TO HOSPITAL-BA	SED RHC/FQHC SERVICES	5	Provider C		Peri od:	Worksheet M-2	
			Component (From 01/01/2020 To 12/31/2020		pared
			oomponone		10 12/01/2020	6/22/2021 8:2	
					RHC I		
			Total Visits	Producti vi ty		Greater of	
	Pers	onnel		Standard (1)	Visits (col.	col. 2 or	
					1 x col. 3)	col. 4	
	1.	00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
00 Physi ci an		3.56	8, 647		1 4		1.(
00 Physician Assistant		0.00	0		1 0		2.0
00 Nurse Practitioner		5.15	8, 855		1 5		3.0
00 Subtotal (sum of lines 1 throug	gh 3)	8.71	17, 502		9	17, 502	
00 Visiting Nurse		0.00	0			0	5.0
00 Clinical Psychologist		0.00	0			0	6.
00 Clinical Social Worker		0.24	31			31	7.
01 Medical Nutrition Therapist (F		0.00	0			0	7.0
02 Diabetes Self Management Traini	ng (FQHC	0.00	0			0	7.0
only)							
00 Total FTEs and Visits (sum of)	ines 4	8. 95	17, 533			17, 533	8.0
through 7)	.						
00 Physician Services Under Agree	nents		0			0	9. (
						1.00	
DETERMINATION OF ALLOWABLE COST	APPLICABLE TO HOSPL	TAL_BASE	RHC/FOHC SEE	RVLCES		1.00	
0.00 Total costs of health care service						2, 179, 546	1 10.0
1.00 Total nonreimbursable costs (fi						156, 470	
2.00 Cost of all services (excluding			·			2, 336, 016	
8.00 Ratio of hospital-based RHC/FQ						0. 933018	
.00 Total hospital-based RHC/FQHC				ne 31)		604, 155	
. 00 Parent provider overhead alloca				/		3, 318, 850	
.00 Total overhead (sum of lines 14			- /			3, 923, 005	
.00 Allowable GME overhead (see ins						0,720,000	
3.00 Enter the amount from line 16						3, 923, 005	
0.00 Overhead applicable to hospital	-based RHC/FQHC serv	vices (lir	ne 13 x line [·]	18)		3, 660, 234	
0.00 Total allowable cost of besnit						E 020 700	

20.00 Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19) 5,839,780 20.00

Health Financial Systems		DECATUR CO. MEM				u of Form CMS-	
ALLOCATION OF OVERHEAD TO HOSPITAL	-BASED RHC/FQHC	SERVI CES	Provider C		Period: From 01/01/2020	Worksheet M-2	
			Component		To 12/31/2020	Date/Time Pre	
					RHC II	6/22/2021 8:2	/pm
		Number of FTF	Total Visits	Producti vi ty		Greater of	
		Personnel		Standard (1)		col. 2 or	
					$1 \times col.$ 3)	col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Posi ti ons							
00 Physi ci an		3. 31	10, 811		1 3		1.0
00 Physician Assistant		0.00			1 0		2.0
00 Nurse Practitioner		2.62	6, 338	8	1 3		3.0
00 Subtotal (sum of lines 1 th	rough 3)	5.93	17, 149		6	17, 149	4.0
00 Visiting Nurse		0.00	0)		0	5.0
00 Clinical Psychologist		0.00)		0	6.0
00 Clinical Social Worker		0. 28	37			37	7.0
01 Medical Nutrition Therapist	(FQHC only)	0.00	0			0	7.0
02 Diabetes Self Management Tr	aining (FQHC	0.00	0			0	7.0
onl y)							
00 Total FTEs and Visits (sum	oflines 4	6. 21	17, 186			17, 186	8.0
through 7)							
00 Physician Services Under Ag	reements		0)		0	9.0
						1.00	
			ED RHC/EOHC SE	DVI CES		1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1, 914, 027	1 10 0
	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					281, 602	
2.00 Cost of all services (exclu	•		,			2, 195, 629	
						0.871744	
Total hospital-based RHC/FOHC overhead - (from Worksheet, M-1, col. 7, line 31)					463,004		
					1, 877, 372		
.00 Total overhead (sum of line		., (inotra	,			2, 340, 376	
.00 Allowable GME overhead (see						0	
8.00 Enter the amount from line						2, 340, 376	
0.00 Overhead applicable to hosp		FOHC services (1	ine 13 x line	18)		2,040,209	
	stal all angle control shows the based which and so we so (the box the to and 10)					2,010,200	

 20.00
 Total allowable cost of hospital -based RHC/FQHC services (sum of lines 10 and 19)
 3,954,236
 20.00

	Financial Systems DECATUR CO. MEMORI. ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC		Peri od:	u of Form CMS-2 Worksheet M-3	
ERVIC			From 01/01/2020		
		Component CCN: 15-8522	To 12/31/2020		
		Title XVIII	RHC I	6/22/2021 8:2	/pm
				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
. 00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro			5, 839, 780	
. 00	Cost of vaccines and their administration (from Wkst. M-4, li	ne 15)		87, 368	
. 00	Total allowable cost excluding vaccine (line 1 minus line 2)			5, 752, 412	
. 00	Total Visits (from Wkst. M-2, column 5, line 8)			17, 533	
. 00 . 00	Physicians visits under agreement (from Wkst. M-2, column 5, Total adjusted visits (line 4 plus line 5)	TThe 9)		0 17, 533	
. 00	Adjusted cost per visit (line 3 divided by line 6)			328.09	
. 00	The Justed cost per visit (The Jurvided by The O)		Cal cul ati on		/.
			our our a tron	01 21 111 2 (1)	
			Prior to Jan.	On or After	
			1 (Rate	Jan. 1 (Rate	
			Period 1)	Period 2)	
00	Den visit normant limit (from CNC Dut 100 04 starts 0 000		1.00	2.00	-
00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20 Rate for Program covered visits (see instructions)	0.6 or your contractor)	86. 31 328. 09	86. 31 328. 09	
00	CALCULATION OF SETTLEMENT		520.09	520.09	- 7
0. 00	Program covered visits excluding mental health services (from	contractor records)	0	5, 388	1 10
1.00	Program cost excluding costs for mental health services (line		0	1, 767, 749	
2.00	5			0	
3.00	D Program covered cost from mental health services (line 9 x line 12) 0			0	13
4.00	Limit adjustment for mental health services (see instructions		0	0	
5.00	Graduate Medical Education Pass Through Cost (see instruction				15
6.00	5			1, 767, 749	
6.01				1,023,368	
6. 02 6. 03				92, 783 160, 271	
6.04	Total Program non-preventive costs ((line 16.02/11) e 10.01) times	-		1, 220, 522	
0.01	(Titles V and XIX see instructions.)			1, 220, 022	
6. 05	Total program cost (see instructions)		0	1, 380, 793	16
7.00	Primary payer amounts			0	17
8.00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		81, 825	18
	records)				
9.00	Beneficiary coinsurance for RHC/FQHC services (see instructio	ons) (from contractor		163, 126	19.
0. 00	records) Net Medicare cost excluding vaccines (see instructions)			1, 380, 793	20
1.00	Program cost of vaccines and their administration (from Wkst.	M-4 line 16)		28, 717	
2.00	Total reimbursable Program cost (line 20 plus line 21)			1, 409, 510	
3.00	Allowable bad debts (see instructions)			7, 071	
3. 01	Adjusted reimbursable bad debts (see instructions)			4, 596	23
4.00	Allowable bad debts for dual eligible beneficiaries (see inst	tructions)		2, 339	
5.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
5.50	Pioneer ACO demonstration payment adjustment (see instruction			0	
	Demonstration payment adjustment amount before sequestration Net reimbursable amount (see instructions)			0 1, 414, 106	
	Sequestration adjustment (see instructions)			9, 333	
6.00				⁷ , 333	
6. 00 6. 01	Demonstration payment adjustment amount after sequestration		1		
6. 00 6. 01 6. 02	Demonstration payment adjustment amount after sequestration Interim payments			864, 440	27
6. 00 6. 01 6. 02 7. 00				864, 440 0	
5. 99 6. 00 6. 01 6. 02 7. 00 8. 00 9. 00	Interim payments	02, 27, and 28)			28

CALCULA	Financial Systems DECATUR CO. MEMORI TION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC		Peri od:	u of Form CMS-2 Worksheet M-3	
SERVICES			From 01/01/2020		
		Component CCN: 15-8521	To 12/31/2020	Date/Time Pre 6/22/2021 8:2	
		Title XVIII	RHC II	0,22,202,012	., b
Ī	DETERMINATION OF DATE FOR HOCDITAL PACED DUG (FOUR CEDVICES			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES Total Allowable Cost of hospital-based RHC/FQHC Services (fro	m Wkst M_2 line 20)		3, 954, 236	1 1.0
1	Cost of vaccines and their administration (from Wkst. M-4, li			176, 718	
1	Total allowable cost excluding vaccine (line 1 minus line 2)			3, 777, 518	
1	Total Visits (from Wkst. M-2, column 5, line 8)			17, 186	
. 00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	5.
. 00	Total adjusted visits (line 4 plus line 5)			17, 186	6.
. 00	Adjusted cost per visit (line 3 divided by line 6)			219.80	7.
			Cal cul ati on	of Limit (1)	
			Prior to Jan.	On or After	
			1 (Rate	Jan. 1 (Rate	
			Period 1)	Period 2)	
00	Der vielt neument limit (from CNS Dub. 100.04. obenter 0. 500		1.00	2.00	0
	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20 Rate for Program covered visits (see instructions)	. o or your contractor)	86. 31 219. 80	86. 31 219. 80	
	CALCULATION OF SETTLEMENT		217.00	219.00	7.
	Program covered visits excluding mental health services (from	contractor records)	0	4, 171	1 10.
	Program cost excluding costs for mental health services (line		0	916, 786	
	Program covered visits for mental health services (from contr	,	0	0	
3.00	D Program covered cost from mental health services (line 9 x line 12) 0			0	13.
1	Limit adjustment for mental health services (see instructions		0	0	
1	5 ,				15.
1	5			916, 786	
1				817, 962	
				39, 805 44, 614	
1	Total Program non-preventive costs ((The 10.02/The 10.01) times	-		629, 364	
0.04	(Titles V and XIX see instructions.)			027, 304	10.
6.05	Total program cost (see instructions)		0	673, 978	16.
	Primary payer amounts			0	17.
8.00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		85, 467	18.
	records)				
	Beneficiary coinsurance for RHC/FQHC services (see instructio records)	ons) (from contractor		137, 310	19.
	Net Medicare cost excluding vaccines (see instructions)			673, 978	20.
1.00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		41, 098	21.
1	Total reimbursable Program cost (line 20 plus line 21)			715, 076	
	Allowable bad debts (see instructions)			7, 759	
1	Adjusted reimbursable bad debts (see instructions)	·····		5,043	
	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		1, 782	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction	le)		0	
	Demonstration payment adjustment amount before sequestration	13 <i>)</i>		0	
	Net reimbursable amount (see instructions)			720, 119	
1	Sequestration adjustment (see instructions)			4, 753	
	Demonstration payment adjustment amount after sequestration			0	
7.00	Interim payments			446, 523	27.
	Tentative settlement (for contractor use only)			0	
	Balance due component/program (line 26 minus lines 26.01, 26.	· · · · ·		268, 843	
0.00	Protested amounts (nonallowable cost report items) in accorda chapter I, §115.2	nce with CMS Pub. 15-II	r	0	30.

Heal th	Financial Systems DECATUR CO. MEMORIA	AL HOSPITAL	In Lie	u of Form CMS-2	2552-10
	ATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA	Provider CCN: 15-1332	Peri od:	Worksheet M-4	
VACCIN	IE COST	Component CCN: 15-8522	From 01/01/2020 To 12/31/2020	Date/Time Pre 6/22/2021 8:2	
		Title XVIII	RHC I		
			Pneumococcal	I nfl uenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		2, 129, 634		1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to tot				2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (li	,	935	3, 324	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (f		15, 953		4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plu		16, 888		5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksh	eet M-1, col. 7, line 22) 2, 179, 546	2, 179, 546	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		3, 660, 234		7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to to	tal direct cost (line 5	0. 007748	0. 007213	8.00
	divided by line 6)				
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x		28, 359		
10.00	Total pneumococcal and influenza vaccine cost and its (their) lines 5 and 9)	administration (sum of	45, 247	42, 121	10.00
11.00	Total number of pneumococcal and influenza vaccine injections	(from your records)	131	466	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 1	0/line 11)	345.40	90.39	12.00
13.00	Number of pneumococcal and influenza vaccine injections admin beneficiaries	istered to Program	52	119	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (t (line 12 x line 13)	heir) administration	17, 961	10, 756	14.00
15.00				87, 368	15.00
16.00		its (their)		28, 717	16. 00

Heal th	Financial Systems DECATUR CO. MEMORI	AL HOSPI TAL	In Lie	u of Form CMS-2	2552-10
	ATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA	Provider CCN: 15-1332	Period:	Worksheet M-4	
VACCIN	IE COST	Component CCN: 15-8521	From 01/01/2020 To 12/31/2020		
		Title XVIII	RHC II		· · · · · · · · · · · · · · · · · · ·
			Pneumococcal	I nfl uenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		1, 871, 206		1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to tot				2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (li	,	3, 275		3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (f		45, 802		4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plu		49, 077		5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksh	eet M-1, col. 7, line 22			6.00
7.00	Total overhead (from Wkst. M-2, line 19)		2, 040, 209		7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to to	tal direct cost (line 5	0. 025641	0. 019050	8.00
	divided by line 6)				
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x		52, 313		
10.00	Total pneumococcal and influenza vaccine cost and its (their) lines 5 and 9)	administration (sum of	101, 390	75, 328	10.00
11.00	Total number of pneumococcal and influenza vaccine injections	(from your records)	325	1, 066	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 1	0/line 11)	311.97	70.66	12.00
13.00	Number of pneumococcal and influenza vaccine injections admin beneficiaries	istered to Program	81	224	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (t (line 12 x line 13)	heir) administration	25, 270	15, 828	14.00
15.00				176, 718	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and administration (sum of cols. 1 and 2, line 14) (transfer this line 21)	its (their)		41, 098	16. 00

Heal th	Financial Systems DECATUR CO. MEMO	DRI AL HOSPI TAL	In Lie	eu of Form CMS-2	2552-10
ANALYS	IS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR	Provider CCN: 15-1332	Period:	Worksheet M-5	
SERVI C	ES RENDERED TO PROGRAM BENEFICIARIES		From 01/01/2020		
		Component CCN: 15-8522	To 12/31/2020	Date/Time Prep 6/22/2021 8:2	
			RHC I	0/22/2021 0.2	7 pili
				rt B	
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			814, 740	1.00
2.00	Interim payments payable on individual bills, either submit	tted or to be submitted to		0	2.00
	the contractor for services rendered in the cost reporting	period. If none, write			
	"NONE" or enter a zero				
3.00	List separately each retroactive lump sum adjustment amount				3.00
	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)				
0.01	Program to Provider		07 (4 4 (0000	40.700	0.01
3.01			07/14/2020	49, 700	3.01
3.02				0	3.02
3.03				0	3.03
3.04				0	3.04
3.05	Provider to Program			0	3.05
3.50				0	3.50
3.50				0	3.50
3.51				0	3.52
3.53				0	3.53
3.54				0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		49,700	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (trans		e	864, 440	4.00
	27)	· · · · · · · · · · · · · · · · · · ·	-		
	TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after des	sk review. Also show date o	of		5.00
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
5.01				0	5.01
5.02				0	5.02
5.03				0	5.03
F F0	Provider to Program				
5.50				0	5.50
5.51				0	5.51
5.52 5.99	Subtatal (our of lines E 01 E 40 minus our of lines E E0 E	08)		0	5.52
5.99 6.00	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5. Determined net settlement amount (balance due) based on the				5.99 6.00
6. 00 6. 01	SETTLEMENT TO PROVIDER			540, 333	6.01
6.02	SETTLEMENT TO PROGRAM			040, 333	6.02
0.02 7.00	Total Medicare program liability (see instructions)			1, 404, 773	7.00
7.00	iotal medicare program riability (see fiistraetrons)		Contractor	NPR Date	7.00
			Number	(Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

Health Financial Systems DECATUR CO. MEMO	ORI AL HOSPI TAL	In Lie	eu of Form CMS-2	2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FOHC PROVIDER FOR	Provider CCN: 15-1332	Peri od:	Worksheet M-5	
SERVICES RENDERED TO PROGRAM BENEFICIARIES	Component CCN: 15-8521	From 01/01/2020 To 12/31/2020	1	
		10 12/01/2020	6/22/2021 8:2	
		RHC II		
		Par	rt B	
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00 Total interim payments paid to hospital-based RHC/FQHC			446, 523	1.00
2.00 Interim payments payable on individual bills, either submit	tted or to be submitted to		0	2.00
the contractor for services rendered in the cost reporting	period. If none, write			
"NONE" or enter a zero				
3.00 List separately each retroactive lump sum adjustment amount				3.00
revision of the interim rate for the cost reporting period.	Also show date of each			
payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider				
3. 01			0	3.01
3. 02			0	3.02
3. 03			0	3.03
3. 04			0	3.04
3. 05			0	3.05
Provider to Program				
3. 50			0	3.50
3. 51			0	3.51
3. 52			0	3.52
3. 53			0	3.53
3. 54			0	3.54
3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	. 98)		0	3.99
4.00 Total interim payments (sum of lines 1, 2, and 3.99) (trans	sfer to Worksheet M-3, line	e	446, 523	4.00
27)				
TO BE COMPLETED BY CONTRACTOR				
5.00 List separately each tentative settlement payment after des	sk review. Also show date o	of		5.00
each payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider				
5. 01			0	5.01
5. 02			0	5.02
5. 03			0	5.03
Provider to Program				
5. 50			0	5.50
5. 51			0	5.51
5. 52			0	5.52
5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.			0	5.99
6.00 Determined net settlement amount (balance due) based on the	e cost report. (1)			6.00
6. 01 SETTLEMENT TO PROVIDER			268, 843	6.01
6.02 SETTLEMENT TO PROGRAM			0	6. 02
7.00 Total Medicare program liability (see instructions)			715, 366	7.00
		Contractor	NPR Date	
		Number	(Mo/Day/Yr)	
	0	1.00	2.00	
8.00 Name of Contractor				8.00