

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050 EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-0007	Period: From 01/01/2020 To 12/31/2020	Worksheet S Parts I-III Date/Time Prepared: 8/2/2021 3:38 pm
--	-----------------------	---------------------------------------	--

PART I - COST REPORT STATUS

Provider use only

1. Electronically prepared cost report
 2. Manually prepared cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. Cost Report Status
 (1) As Submitted
 (2) Settled without Audit
 (3) Settled with Audit
 (4) Reopened
 (5) Amended

6. Date Received:
 7. Contractor No.

8. Initial Report for this Provider CCN
 9. Final Report for this Provider CCN

10. NPR Date:
 11. Contractor's Vendor Code: 4
 12. If line 5, column 1 is 4: Enter number of times reopened = 0-9.

Date: 8/2/2021 Time: 3:38 pm

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COMMUNITY HOWARD REGIONAL HEALTH (15-0007) for the cost reporting period beginning 01/01/2020 and ending 12/31/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) HOLLY MILLARD
 Officer or Administrator of Provider(s)

NETWORK SVP OF FINANCE
 Title

(Dated when report is electronically signed.)
 Date

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	288,981	-67,001	0	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
5.00 Swing Bed - SNF	0	0	0	0	0	5.00
6.00 Swing Bed - NF	0	0	0	0	0	6.00
200.00 Total	0	288,981	-67,001	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 15-0007		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 8/2/2021 3:38 pm				
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 3500 SOUTH LAFOUNTAIN			PO Box:						1.00		
2.00	City: KOKOMO			State: IN		Zip Code: 46902		County: HOWARD		2.00		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
1.00		2.00		3.00	4.00	5.00	6.00	7.00	8.00			
Hospital and Hospital-Based Component Identification:												
3.00	Hospital			COMMUNITY HOWARD REGIONAL HEALTH	150007	29020	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF											4.00
5.00	Subprovider - IRF											5.00
6.00	Subprovider - (Other)											6.00
7.00	Swing Beds - SNF											7.00
8.00	Swing Beds - NF											8.00
9.00	Hospital-Based SNF											9.00
10.00	Hospital-Based NF											10.00
11.00	Hospital-Based OLTC											11.00
12.00	Hospital-Based HHA											12.00
13.00	Separately Certified ASC											13.00
14.00	Hospital-Based Hospice											14.00
15.00	Hospital-Based Health Clinic - RHC											15.00
16.00	Hospital-Based Health Clinic - FQHC											16.00
17.00	Hospital-Based (CMHC) I											17.00
18.00	Renal Dialysis											18.00
19.00	Other											19.00
							From:	To:				
							1.00	2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2020	12/31/2020		20.00		
21.00	Type of Control (see instructions)						2			21.00		
							1.00	2.00	3.00			
Inpatient PPS Information												
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N			22.00		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y			22.01		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		N	22.03		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						3		N	23.00		
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days			
				1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			700	92	4	4	3,974	11	24.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 15-0007		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 8/2/2021 3:38 pm	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of- State Medicaid paid days	Out-of- State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0		25.00
						Urban/Rural	S	Date of Geogr	
						1.00		2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1			26.00
27.00	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.					1			27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0			35.00
						Beginning:	Ending:		
						1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.								36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0			37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)								37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.								38.00
						Y/N	Y/N		
						1.00	2.00		
39.00	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 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		39.00
40.00	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. (see instructions)					N	N		40.00
						V	XVII	XIX	
						1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	Y	N	45.00
46.00	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
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? 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			56.00
57.00	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.								57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
				1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) 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) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.			N					60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0007		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 8/2/2021 3:38 pm	
	Y/N	IME	Direct GME	IME	Direct GME		
	1.00	2.00	3.00	4.00	5.00		
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
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
		Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00		
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 Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))		
			1.00	2.00	3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 15-0007

Period:
From 01/01/2020
To 12/31/2020

Worksheet S-2
Part I
Date/Time Prepared:
8/2/2021 3:38 pm

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
		1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00	
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))		
				1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010								
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
		1.00	2.00	3.00	4.00	5.00		
67.00	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 4)). (see instructions)			0.00	0.00	0.000000	67.00	
						1.00	2.00	3.00
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				N	N	0	71.00
Inpatient Rehabilitation Facility PPS								
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				N	N	0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0007	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 8/2/2021 3:38 pm			
			1.00				
Long Term Care Hospital PPS							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N	80.00			
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N	81.00			
TEFRA Providers							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N	85.00			
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00			
87.00	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	XIX 2.00			
Title V and XIX Services							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	90.00		
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	N	91.00		
92.00	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		
93.00	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.		N	N	93.00		
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N	94.00		
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	95.00		
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N	96.00		
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	97.00		
98.00	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.		Y	N	98.00		
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	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.		Y	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 for title V, and in column 2 for title XIX.		N	N	98.03		
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	N	98.04		
98.05	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 column 2 for title XIX.		Y	Y	98.05		
98.06	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.		Y	Y	98.06		
Rural Providers							
105.00	Does this hospital qualify as a CAH?		N		105.00		
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)		N		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 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)		N		107.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108.00		
			Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N	N	N	N	109.00
			1.00				
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.					N	110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0007	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 8/2/2021 3:38 pm
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	778,703	0	118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does 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.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB0720	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0007	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 8/2/2021 3:38 pm	
1.00		2.00		3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name: COMMUNITY HEALTH NETWORK	Contractor's Name: WISCONSIN PHYSICIAN SERVICES		Contractor's Number: 08101	
142.00	Street: 1500 NORTH RITTER	PO Box:			
143.00	City: INDIANAPOLIS	State: IN		Zip Code: 46219-3095	
144.00 Are provider based physicians' costs included in Worksheet A?					
				1.00	
				Y	
145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					
				1.00	
				Y	
146.00 Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.					
				2.00	
				N	
147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.					
				1.00	
				N	
148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.					
				2.00	
				N	
149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.					
		Part A	Part B	Title V	Title XIX
		1.00	2.00	3.00	4.00
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N
156.00	Subprovider - IPF	N	N	N	N
157.00	Subprovider - IRF	N	N	N	N
158.00	SUBPROVIDER				
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC	N	N	N	N
165.00 Multi campus Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					
				1.00	
				N	
		Name	County	State	Zip Code
		0	1.00	2.00	3.00
					4.00
					5.00
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					
				1.00	
				0.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act					
				1.00	
				Y	
168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					
				2.00	
				0.00	
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)					
				1.00	
				2.00	
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 1, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)					
				1.00	
				N	
				0	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0007		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part II Date/Time Prepared: 8/2/2021 3:38 pm	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N					3.00
		Y/N	Type				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	03/26/2020			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					1.00
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.				Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.				N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.				N		14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.				Y		15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N			16.00
17.00	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 in columns 2 and 4. (see instructions)	Y	06/26/2020	Y	06/26/2020		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0007	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 8/2/2021 3:38 pm		
		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)						
Capital Related Cost						
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N		25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N		27.00
Interest Expense						
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N		31.00
Purchased Services						
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N		33.00
Provider-Based Physicians						
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N		35.00
				Y/N	Date	
				1.00	2.00	
Home Office Costs						
36.00	Were home office costs claimed on the cost report?			Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.					40.00
		1.00		2.00		
Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SHIRLEY		BI SHOP		41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH NETWORK				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-355-4135		SBI SHOP@ECOMMUNITY.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 15-0007

Period:
From 01/01/2020
To 12/31/2020

Worksheet S-2
Part II
Date/Time Prepared:
8/2/2021 3:38 pm

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DI RECTOR REIMBURSEMENT	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0007

Period:
From 01/01/2020
To 12/31/2020

Worksheet S-3
Part I
Date/Time Prepared:
8/2/2021 3:38 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits / Trips	Title V
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	105	38,430	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		105	38,430	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	8	2,928	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		113	41,358	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		113				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0007

Period:
From 01/01/2020
To 12/31/2020

Worksheet S-3
Part I
Date/Time Prepared:
8/2/2021 3:38 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	4,931	631	14,390			1.00
2.00 HMO and other (see instructions)	3,101	3,641				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	4,931	631	14,390			7.00
8.00 INTENSIVE CARE UNIT	615	0	1,617			8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY		502	725			13.00
14.00 Total (see instructions)	5,546	1,133	16,732	0.00	647.15	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)			36			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	647.15	27.00
28.00 Observation Bed Days		342	1,707			28.00
29.00 Ambulance Trips	3					29.00
30.00 Employee discount days (see instruction)			120			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	11	156			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00
33.01 LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0007

Period:
From 01/01/2020
To 12/31/2020

Worksheet S-3
Part I
Date/Time Prepared:
8/2/2021 3:38 pm

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)			0	1,341	175	4,272	1.00
2.00 HMO and other (see instructions)				705	899		2.00
3.00 HMO IPF Subprovider					0		3.00
4.00 HMO IRF Subprovider					0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF							5.00
6.00 Hospital Adults & Peds. Swing Bed NF							6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)							7.00
8.00 INTENSIVE CARE UNIT							8.00
9.00 CORONARY CARE UNIT							9.00
10.00 BURN INTENSIVE CARE UNIT							10.00
11.00 SURGICAL INTENSIVE CARE UNIT							11.00
12.00 OTHER SPECIAL CARE (SPECIFY)							12.00
13.00 NURSERY							13.00
14.00 Total (see instructions)	0.00	0		1,341	175	4,272	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF							16.00
17.00 SUBPROVIDER - IRF							17.00
18.00 SUBPROVIDER							18.00
19.00 SKILLED NURSING FACILITY							19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21.00
22.00 HOME HEALTH AGENCY							22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE							24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC							25.00
26.00 RURAL HEALTH CLINIC							26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00						26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)							32.01
33.00 LTCH non-covered days				0			33.00
33.01 LTCH site neutral days and discharges				0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0007

Period:
From 01/01/2020
To 12/31/2020

Worksheet S-3
Part II
Date/Time Prepared:
8/2/2021 3:38 pm

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	46,018,318	-273,703	45,744,615	1,346,071.00	33.98
2.00	Non-physician anesthetist Part A		139,080	0	139,080	1,141.00	121.89
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		165,116	0	165,116	1,112.00	148.49
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		713,272	0	713,272	7,045.00	101.25
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		5,128,085	396,577	5,524,662	201,124.00	27.47
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		1,629,977	0	1,629,977	18,537.00	87.93
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		492,938	0	492,938	6,830.00	72.17
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		9,587,469	0	9,587,469	223,303.00	42.93
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		9,467,913	0	9,467,913		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		1,575,374	0	1,575,374		
20.00	Non-physician anesthetist Part A		11,262	0	11,262		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		11,790	0	11,790		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		74,694	0	74,694		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		1,969,499	0	1,969,499		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0007

Period:
From 01/01/2020
To 12/31/2020

Worksheet S-3
Part II
Date/Time Prepared:
8/2/2021 3:38 pm

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)	0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	168,470	-5,150	163,320	3,930.00	41.56	26.00
27.00	Administrative & General	6,502,212	-286,509	6,215,703	107,482.00	57.83	27.00
28.00	Administrative & General under contract (see inst.)	3,438,966	0	3,438,966	33,336.00	103.16	28.00
29.00	Maintenance & Repairs	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	1,413,278	-15,262	1,398,016	56,638.00	24.68	30.00
31.00	Laundry & Linen Service	58,890	-335	58,555	3,580.00	16.36	31.00
32.00	Housekeeping	1,033,199	-6,339	1,026,860	60,822.00	16.88	32.00
33.00	Housekeeping under contract (see instructions)	0	0	0	0.00	0.00	33.00
34.00	Dietary	928,184	-592,657	335,527	20,139.00	16.66	34.00
35.00	Dietary under contract (see instructions)	134,487	0	134,487	2,080.00	64.66	35.00
36.00	Cafeteria	0	584,756	584,756	32,814.00	17.82	36.00
37.00	Maintenance of Personnel	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	754,303	-1,036	753,267	19,730.00	38.18	38.00
39.00	Central Services and Supply	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	0	0	0	0.00	0.00	41.00
42.00	Social Service	570,240	0	570,240	14,103.00	40.43	42.00
43.00	Other General Service	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0007

Period:
From 01/01/2020
To 12/31/2020

Worksheet S-3
Part III
Date/Time Prepared:
8/2/2021 3:38 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	48,739,419	-273,703	48,465,716	1,373,301.00	35.29	1.00
2.00	Excluded area salaries (see instructions)	5,128,085	396,577	5,524,662	201,124.00	27.47	2.00
3.00	Subtotal salaries (line 1 minus line 2)	43,611,334	-670,280	42,941,054	1,172,177.00	36.63	3.00
4.00	Subtotal other wages & related costs (see inst.)	11,710,384	0	11,710,384	248,670.00	47.09	4.00
5.00	Subtotal wage-related costs (see inst.)	11,449,202	0	11,449,202	0.00	26.66	5.00
6.00	Total (sum of lines 3 thru 5)	66,770,920	-670,280	66,100,640	1,420,847.00	46.52	6.00
7.00	Total overhead cost (see instructions)	15,002,229	-322,532	14,679,697	354,654.00	41.39	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0007	Period: From 01/01/2020 To 12/31/2020	Worksheet S-3 Part IV Date/Time Prepared: 8/2/2021 3:38 pm
-----------------------------	-----------------------	---	---

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	928,295	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	4,304,493	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	643,480	9.00
10.00	Dental, Hearing and Vision Plan	36,673	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	1,422,230	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	502,602	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	4,588	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	3,242,105	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	56,566	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	11,141,032	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0007	Period: From 01/01/2020 To 12/31/2020	Worksheet S-3 Part V Date/Time Prepared: 8/2/2021 3:38 pm
Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	1,629,977	11,141,032	1.00
2.00	Hospital	1,629,977	9,565,658	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	1,575,374	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0007	Period: From 01/01/2020 To 12/31/2020	Worksheet S-10 Date/Time Prepared: 8/2/2021 3:38 pm
---	-----------------------	---	---

			1.00		
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.214895	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		22,815,701	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 supplemental payments from Medicaid?		Y	4.00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		-7,528,733	5.00	
6.00	Medicaid charges		99,762,450	6.00	
7.00	Medicaid cost (line 1 times line 6)		21,438,452	7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		6,151,484	8.00	
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP		0	9.00	
10.00	Stand-alone 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 enter zero)		0	12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
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 indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		6,151,484	19.00	
			Uninsured patients	Insured patients	Total (col. 1 + col. 2)
			1.00	2.00	3.00
Uncompensated Care (see instructions for each line)					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	5,407,317	844,036	6,251,353	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,162,005	844,036	2,006,041	21.00
22.00	Payments received from patients for amounts previously written off as charity care	2,702	0	2,702	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,159,303	844,036	2,003,339	23.00
			1.00		
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			8,179,507	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			207,023	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			318,497	27.01
28.00	Non-Medicare bad debt expense (see instructions)			7,861,010	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			1,800,766	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			3,804,105	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			9,955,589	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 15-0007		Period: From 01/01/2020 To 12/31/2020		Worksheet A	
Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	4,204,681	4,204,681	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	2,972,807	2,972,807	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	168,470	95,321	263,791	-14,252	249,539	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,502,212	48,097,033	54,599,245	-4,272,147	50,327,098	5.00
7.00	00700	OPERATION OF PLANT	1,413,278	6,336,441	7,749,719	-1,449,024	6,300,695	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	58,890	308,112	367,002	0	367,002	8.00
9.00	00900	HOUSEKEEPING	1,033,199	911,897	1,945,096	-25,422	1,919,674	9.00
10.00	01000	DIETARY	928,184	834,575	1,762,759	-1,206,882	555,877	10.00
11.00	01100	CAFETERIA	0	120	120	1,110,418	1,110,538	11.00
13.00	01300	NURSING ADMINISTRATION	754,303	262,597	1,016,900	-99,836	917,064	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	570,240	115,707	685,947	0	685,947	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
23.00	02300	PASTORAL CARE	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	9,855,462	6,270,671	16,126,133	-1,957,916	14,168,217	30.00
31.00	03100	INTENSIVE CARE UNIT	1,388,389	688,488	2,076,877	-176,655	1,900,222	31.00
43.00	04300	NURSERY	0	0	0	301,534	301,534	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,990,956	7,915,042	10,905,998	-5,272,137	5,633,861	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	931,955	931,955	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,471,989	1,383,712	2,855,701	-479,684	2,376,017	54.00
54.01	03480	ONCOLOGY	1,477,502	1,481,010	2,958,512	171,511	3,130,023	54.01
57.00	05700	CT SCAN	483,616	487,037	970,653	-155,353	815,300	57.00
58.00	05800	MRI	301,142	924,776	1,225,918	-389,266	836,652	58.00
59.00	05900	CARDIAC CATHETERIZATION	621,381	3,007,317	3,628,698	-2,652,708	975,990	59.00
60.00	06000	LABORATORY	0	4,969,198	4,969,198	-5,921	4,963,277	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,117,789	572,808	1,690,597	-93,203	1,597,394	65.00
66.00	06600	PHYSICAL THERAPY	804,780	281,063	1,085,843	-469,743	616,100	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	375,574	375,574	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,124	1,124	89,789	90,913	68.00
69.00	06900	ELECTROCARDIOLOGY	931,960	424,628	1,356,588	-28,089	1,328,499	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,536	23,973	25,509	-20,347	5,162	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	246,463	377,898	624,361	3,084,053	3,708,414	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,320,423	5,320,423	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,212,547	16,130,133	18,342,680	-39,946	18,302,734	73.00
74.00	07400	RENAL DIALYSIS	0	299,884	299,884	-1,450	298,434	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03950	WOUND CARE CENTER	316,085	335,539	651,624	-115,996	535,628	75.01
76.00	03160	CARDIOPULMONARY	130,737	55,057	185,794	-1,812	183,982	76.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	2,563,637	1,381,556	3,945,193	-260,588	3,684,605	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
93.00	04950	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
93.01	04951	GENESIS	1,135,546	516,672	1,652,218	703,896	2,356,114	93.01
93.02	04952	WOMEN'S CENTER	0	0	0	0	0	93.02
93.03	04953	RESIDENTIAL HOMES	0	0	0	0	0	93.03
93.04	04954	DR. STEELE	0	0	0	0	0	93.04
93.05	04955	DIABETIC EDUCATION	0	0	0	0	0	93.05
93.06	04956	HOWARD COUNTY CSS	427,947	211,995	639,942	47,933	687,875	93.06
93.07	04957	CLINTON COUNTY	360,162	261,851	622,013	147,383	769,396	93.07
93.18	04968	PSYCH MEDICATION	534,343	152,257	686,600	-686,600	0	93.18
93.43	04993	NEW BEGINNINGS	87,488	78,074	165,562	30,884	196,446	93.43
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,168,956	774,120	1,943,076	-148,872	1,794,204	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
114.00	11400	UTILIZATION REVIEW - SNF	0	0	0	0	0	114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	42,059,189	105,967,686	148,026,875	-531,008	147,495,867	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	COMMUNITY HOWARD FOUNDATION	70,094	14,405	84,499	-367	84,132	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,138,010	1,345,767	3,483,777	51,555	3,535,332	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	HEALTHY CHILDREN	0	0	0	0	0	194.00
194.08	07958	SOUTH BERKLEY BLDG	0	0	0	0	0	194.08
194.09	07959	MOBILE CLINIC	39,124	6,220	45,344	-2,060	43,284	194.09

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 15-0007		Period: From 01/01/2020 To 12/31/2020		Worksheet A Date/Time Prepared: 8/2/2021 3:38 pm	
Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
194.10	07960	PLASTIC SURGERY	0	12,085	12,085	0	12,085	194.10
194.11	07961	KOKOMO SCHOOL BASED	1,711,901	376,829	2,088,730	481,880	2,570,610	194.11
194.15	07965	INDIANA SURGERY CENTER	0	46	46	0	46	194.15
194.16	07966	PASTORAL CARE ALLIED HEALTH	0	0	0	0	0	194.16
200.00		TOTAL (SUM OF LINES 118 through 199)	46,018,318	107,723,038	153,741,356	0	153,741,356	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0007

Period:
From 01/01/2020
To 12/31/2020

Worksheet A
Date/Time Prepared:
8/2/2021 3:38 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	4,204,681	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	2,972,807	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,378,786	1,628,325	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-23,771,990	26,555,108	5.00
7.00	00700	OPERATION OF PLANT	-456,000	5,844,695	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	367,002	8.00
9.00	00900	HOUSEKEEPING	0	1,919,674	9.00
10.00	01000	DIETARY	-3,722	552,155	10.00
11.00	01100	CAFETERIA	-408,217	702,321	11.00
13.00	01300	NURSING ADMINISTRATION	1,044,410	1,961,474	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	721,185	721,185	16.00
17.00	01700	SOCIAL SERVICE	0	685,947	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
23.00	02300	PASTORAL CARE	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-74,526	14,093,691	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,900,222	31.00
43.00	04300	NURSERY	0	301,534	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-188	5,633,673	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	931,955	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	38,464	2,414,481	54.00
54.01	03480	ONCOLOGY	-22,884	3,107,139	54.01
57.00	05700	CT SCAN	-3,518	811,782	57.00
58.00	05800	MRI	-3,980	832,672	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	975,990	59.00
60.00	06000	LABORATORY	0	4,963,277	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	-5,135	1,592,259	65.00
66.00	06600	PHYSICAL THERAPY	0	616,100	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	375,574	67.00
68.00	06800	SPEECH PATHOLOGY	0	90,913	68.00
69.00	06900	ELECTROCARDIOLOGY	-5,516	1,322,983	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	5,162	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,569,414	5,277,828	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,320,423	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	297,859	18,600,593	73.00
74.00	07400	RENAL DIALYSIS	0	298,434	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
75.01	03950	WOUND CARE CENTER	-3,353	532,275	75.01
76.00	03160	CARDIOPULMONARY	0	183,982	76.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	105,764	3,790,369	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	92.01
93.00	04950	OTHER OUTPATIENT SERVICES	0	0	93.00
93.01	04951	GENESIS	-882,002	1,474,112	93.01
93.02	04952	WOMEN'S CENTER	0	0	93.02
93.03	04953	RESIDENTIAL HOMES	0	0	93.03
93.04	04954	DR. STEELE	0	0	93.04
93.05	04955	DIABETIC EDUCATION	0	0	93.05
93.06	04956	HOWARD COUNTY CSS	-484,692	203,183	93.06
93.07	04957	CLINTON COUNTY	-344,551	424,845	93.07
93.18	04968	PSYCH MEDICATION	0	0	93.18
93.43	04993	NEW BEGINNINGS	-75,928	120,518	93.43
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	-68,100	1,726,104	95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
114.00	11400	UTILIZATION REVIEW - SNF	0	0	114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-21,458,420	126,037,447	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
190.01	19001	COMMUNITY HOWARD FOUNDATION	0	84,132	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,535,332	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	HEALTHY CHILDREN	0	0	194.00
194.08	07958	SOUTH BERKLEY BLDG	0	0	194.08
194.09	07959	MOBILE CLINIC	0	43,284	194.09
194.10	07960	PLASTIC SURGERY	0	12,085	194.10
194.11	07961	KOKOMO SCHOOL BASED	0	2,570,610	194.11

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 15-0007	Period: From 01/01/2020 To 12/31/2020	Worksheet A Date/Time Prepared: 8/2/2021 3:38 pm
---	--	-----------------------	---	--

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
194.15	07965 INDIANA SURGERY CENTER	6.00	7.00	194.15
194.16	07966 PASTORAL CARE ALLIED HEALTH	0	46	194.16
200.00	TOTAL (SUM OF LINES 118 through 199)	-21,458,420	132,282,936	200.00

RECLASSIFICATIONS

Provider CCN: 15-0007

Period:
From 01/01/2020
To 12/31/2020

Worksheet A-6

Date/Time Prepared:
8/2/2021 3:38 pm

		Increases				
Cost Center		Line #	Salary	Other		
2.00	3.00	4.00	5.00			
A - Chargeable Medical Supplies						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	3,138,592		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
	TOTALS			3,138,592		
B - Implantable Device Recl ass						
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00		5,320,423		1.00
2.00						2.00
3.00						3.00
	TOTALS			5,320,423		
C - Drugs Charges to Pat						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	171,431		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
	TOTALS			171,431		
D - Depreciation Expense						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	7,057,648		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00

RECLASSIFICATIONS

Provider CCN: 15-0007

Period:
From 01/01/2020
To 12/31/2020

Worksheet A-6
Date/Time Prepared:
8/2/2021 3:38 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
	TOTALS		0	7,057,648	
F - Infusion Equipment Rental					
1.00	ONCOLOGY	54.01	0	824,839	1.00
				824,839	
G - STD BENEFIT RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	5,150	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	25,378	2.00
3.00	OPERATION OF PLANT	7.00	0	15,262	3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	0	335	4.00
5.00	HOUSEKEEPING	9.00	0	6,339	5.00
6.00	DIETARY	10.00	0	7,901	6.00
7.00	NURSING ADMINISTRATION	13.00	0	1,036	7.00
8.00	ADULTS & PEDIATRICS	30.00	0	74,494	8.00
9.00	INTENSIVE CARE UNIT	31.00	0	6,322	9.00
10.00	OPERATING ROOM	50.00	0	21,643	10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	27,475	11.00
12.00	ONCOLOGY	54.01	0	336	12.00
13.00	CT SCAN	57.00	0	2,024	13.00
14.00	MRI	58.00	0	424	14.00
15.00	RESPIRATORY THERAPY	65.00	0	12,004	15.00
16.00	PHYSICAL THERAPY	66.00	0	6,416	16.00
17.00	ELECTROCARDIOLOGY	69.00	0	3,819	17.00
18.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	1,599	18.00
19.00	DRUGS CHARGED TO PATIENTS	73.00	0	11,160	19.00
20.00	WOUND CARE CENTER	75.01	0	3,808	20.00
21.00	CARDIOPULMONARY	76.00	0	1,134	21.00
22.00	EMERGENCY	91.00	0	7,804	22.00
23.00	GENESIS	93.01	0	10,037	23.00
24.00	HOWARD COUNTY CSS	93.06	0	1,176	24.00
25.00	AMBULANCE SERVICES	95.00	0	6,707	25.00
26.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	13,564	26.00
27.00	KOKOMO SCHOOL BASED	194.11	0	356	27.00
	TOTALS		0	273,703	
H - Labor and Delivery					
1.00	NURSERY	43.00	213,605	87,929	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	660,192	271,763	2.00
	TOTALS		873,797	359,692	
I - Cafeteria Salary					
1.00	CAFETERIA	11.00	584,756	525,782	1.00
	TOTALS		584,756	525,782	
J - Therapy Recl ass					
1.00	OCCUPATIONAL THERAPY	67.00	279,487	96,087	1.00
2.00	SPEECH PATHOLOGY	68.00	66,817	22,972	2.00
	TOTALS		346,304	119,059	
K - Depreciation Expense					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	4,084,841	1.00
	TOTALS		0	4,084,841	
L - Capital Insurance Costs					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	119,840	1.00
	TOTALS		0	119,840	
M - Psych Admin Recl ass					
1.00	GENESIS	93.01	217,076	433,384	1.00
2.00	HOWARD COUNTY CSS	93.06	7,080	14,135	2.00
3.00	CLINTON COUNTY	93.07	25,776	51,460	3.00
4.00	NEW BEGINNINGS	93.43	11,199	22,357	4.00
	TOTALS		261,131	521,336	
O - Psych Medicine Clinic Recl ass					
1.00	GENESIS	93.01	41,646	11,790	1.00
2.00	HOWARD COUNTY CSS	93.06	20,823	5,895	2.00
3.00	CLINTON COUNTY	93.07	54,670	15,477	3.00
4.00	PHYSICIANS' PRIVATE OFFICES	192.00	41,646	11,791	4.00
5.00	KOKOMO SCHOOL BASED	194.11	375,558	106,322	5.00
	TOTALS		534,343	151,275	
500.00	Grand Total: Increases		2,600,331	22,668,461	500.00

RECLASSIFICATIONS

Provider CCN: 15-0007

Period:
From 01/01/2020
To 12/31/2020

Worksheet A-6

Date/Time Prepared:
8/2/2021 3:38 pm

Decreases							
Cost Center	Line #	Salary	Other	Wkst.	A-7 Ref.		
6.00	7.00	8.00	9.00	10.00			
A - Chargeable Medical Supplies							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	22,528	0		1.00
2.00	OPERATION OF PLANT	7.00	0	166	0		2.00
3.00	DIETARY	10.00	0	257	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	485,389	0		4.00
5.00	INTENSIVE CARE UNIT	31.00	0	95,730	0		5.00
6.00	OPERATING ROOM	50.00	0	655,504	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	198,900	0		7.00
8.00	ONCOLOGY	54.01	0	25,255	0		8.00
9.00	CT SCAN	57.00	0	87,561	0		9.00
10.00	MRI	58.00	0	80,971	0		10.00
11.00	CARDIAC CATHETERIZATION	59.00	0	1,108,317	0		11.00
12.00	LABORATORY	60.00	0	1,557	0		12.00
13.00	RESPIRATORY THERAPY	65.00	0	76,464	0		13.00
14.00	ELECTROCARDIOLOGY	69.00	0	464	0		14.00
15.00	DRUGS CHARGED TO PATIENTS	73.00	0	84,341	0		15.00
16.00	RENAL DIALYSIS	74.00	0	721	0		16.00
17.00	WOUND CARE CENTER	75.01	0	9,211	0		17.00
18.00	CARDIOPULMONARY	76.00	0	1,812	0		18.00
19.00	EMERGENCY	91.00	0	162,023	0		19.00
20.00	PSYCH MEDICATION	93.18	0	327	0		20.00
21.00	AMBULANCE SERVICES	95.00	0	40,895	0		21.00
22.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	199	0		22.00
TOTALS			0	3,138,592			
B - Implantable Device Reclass							
1.00	OPERATING ROOM	50.00		4,094,542			1.00
2.00	CARDIAC CATHETERIZATION	59.00		1,138,186			2.00
3.00	WOUND CARE CENTER	75.01		87,695			3.00
TOTALS			0	5,320,423			
C - Drugs Charges to Pat							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	5,834	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	1,263	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	15,270	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	4,130	0		4.00
5.00	OPERATING ROOM	50.00	0	1,290	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,378	0		6.00
7.00	ONCOLOGY	54.01	0	2,211	0		7.00
8.00	CT SCAN	57.00	0	60,717	0		8.00
9.00	MRI	58.00	0	23,532	0		9.00
10.00	CARDIAC CATHETERIZATION	59.00	0	24,672	0		10.00
11.00	RESPIRATORY THERAPY	65.00	0	48	0		11.00
12.00	ELECTROCARDIOLOGY	69.00	0	6,912	0		12.00
13.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	78	0		13.00
14.00	RENAL DIALYSIS	74.00	0	729	0		14.00
15.00	WOUND CARE CENTER	75.01	0	10,996	0		15.00
16.00	EMERGENCY	91.00	0	5,447	0		16.00
17.00	PSYCH MEDICATION	93.18	0	655	0		17.00
18.00	AMBULANCE SERVICES	95.00	0	526	0		18.00
19.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1,683	0		19.00
20.00	MOBILE CLINIC	194.09	0	2,060	0		20.00
TOTALS			0	171,431			
D - Depreciation Expense							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	8,418	9		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	3,346,049	0		2.00
3.00	OPERATION OF PLANT	7.00	0	624,019	0		3.00
4.00	HOUSEKEEPING	9.00	0	25,422	0		4.00
5.00	DIETARY	10.00	0	96,087	0		5.00
6.00	CAFETERIA	11.00	0	120	0		6.00
7.00	NURSING ADMINISTRATION	13.00	0	99,836	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	223,768	0		8.00
9.00	INTENSIVE CARE UNIT	31.00	0	76,795	0		9.00
10.00	OPERATING ROOM	50.00	0	520,801	0		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	277,406	0		11.00
12.00	ONCOLOGY	54.01	0	625,862	0		12.00
13.00	CT SCAN	57.00	0	7,075	0		13.00
14.00	MRI	58.00	0	284,763	0		14.00
15.00	CARDIAC CATHETERIZATION	59.00	0	381,533	0		15.00
16.00	LABORATORY	60.00	0	4,364	0		16.00
17.00	RESPIRATORY THERAPY	65.00	0	16,691	0		17.00
18.00	PHYSICAL THERAPY	66.00	0	4,380	0		18.00
19.00	ELECTROCARDIOLOGY	69.00	0	20,713	0		19.00
20.00	ELECTROENCEPHALOGRAPHY	70.00	0	20,347	0		20.00

RECLASSIFICATIONS

Provider CCN: 15-0007

Period:
From 01/01/2020
To 12/31/2020

Worksheet A-6
Date/Time Prepared:
8/2/2021 3:38 pm

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
21.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	54,461	0	21.00
22.00	DRUGS CHARGED TO PATIENTS	73.00	0	127,036	0	22.00
23.00	WOUND CARE CENTER	75.01	0	8,094	0	23.00
24.00	EMERGENCY	91.00	0	93,118	0	24.00
25.00	NEW BEGINNINGS	93.43	0	2,672	0	25.00
26.00	AMBULANCE SERVICES	95.00	0	107,451	0	26.00
27.00	COMMUNITY HOWARD FOUNDATION	190.01	0	367	0	27.00
	TOTALS		0	7,057,648		
F - Infusion Equipment Rental						
1.00	OPERATION OF PLANT	7.00	0	824,839		1.00
	TOTALS		0	824,839		
G - STD BENEFIT RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	5,150	0	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	25,378	0	0	2.00
3.00	OPERATION OF PLANT	7.00	15,262	0	0	3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	335	0	0	4.00
5.00	HOUSEKEEPING	9.00	6,339	0	0	5.00
6.00	DIETARY	10.00	7,901	0	0	6.00
7.00	NURSING ADMINISTRATION	13.00	1,036	0	0	7.00
8.00	ADULTS & PEDIATRICS	30.00	74,494	0	0	8.00
9.00	INTENSIVE CARE UNIT	31.00	6,322	0	0	9.00
10.00	OPERATING ROOM	50.00	21,643	0	0	10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	27,475	0	0	11.00
12.00	ONCOLOGY	54.01	336	0	0	12.00
13.00	CT SCAN	57.00	2,024	0	0	13.00
14.00	MRI	58.00	424	0	0	14.00
15.00	RESPIRATORY THERAPY	65.00	12,004	0	0	15.00
16.00	PHYSICAL THERAPY	66.00	6,416	0	0	16.00
17.00	ELECTROCARDIOLOGY	69.00	3,819	0	0	17.00
18.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	1,599	0	0	18.00
19.00	DRUGS CHARGED TO PATIENTS	73.00	11,160	0	0	19.00
20.00	WOUND CARE CENTER	75.01	3,808	0	0	20.00
21.00	CARDIOPULMONARY	76.00	1,134	0	0	21.00
22.00	EMERGENCY	91.00	7,804	0	0	22.00
23.00	GENESIS	93.01	10,037	0	0	23.00
24.00	HOWARD COUNTY CSS	93.06	1,176	0	0	24.00
25.00	AMBULANCE SERVICES	95.00	6,707	0	0	25.00
26.00	PHYSICIANS' PRIVATE OFFICES	192.00	13,564	0	0	26.00
27.00	KOKOMO SCHOOL BASED	194.11	356	0	0	27.00
	TOTALS		273,703	0		
H - Labor and Delivery						
1.00	ADULTS & PEDIATRICS	30.00	873,797	359,692	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		873,797	359,692		
I - Cafeteria Salary						
1.00	DIETARY	10.00	584,756	525,782	0	1.00
	TOTALS		584,756	525,782		
J - Therapy Recl ass						
1.00	PHYSICAL THERAPY	66.00	346,304	119,059	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		346,304	119,059		
K - Depreciation Expense						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	4,084,841	9	1.00
	TOTALS		0	4,084,841		
L - Capital Insurance Costs						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	119,840	12	1.00
	TOTALS		0	119,840		
M - Psych Admin Recl ass						
1.00	ADMINISTRATIVE & GENERAL	5.00	261,131	521,336	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
	TOTALS		261,131	521,336		
O - Psych Medicine Clinic Recl ass						
1.00	PSYCH MEDICATION	93.18	534,343	151,275	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
	TOTALS		534,343	151,275		
500.00	Grand Total: Decreases		2,874,034	22,394,758		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0007

Period:
From 01/01/2020
To 12/31/2020

Worksheet A-7
Part I
Date/Time Prepared:
8/2/2021 3:38 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	4,583,000	0	0	0	1.00
2.00	Land Improvements	4,193,828	0	0	0	2.00
3.00	Buildings and Fixtures	104,778,873	5,123,686	0	5,123,686	3,427,353
4.00	Building Improvements	139,419	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	31,562,310	0	0	0	-4,121,401
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	145,257,430	5,123,686	0	5,123,686	-694,048
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	145,257,430	5,123,686	0	5,123,686	-694,048
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	4,583,000	0			1.00
2.00	Land Improvements	4,193,828	0			2.00
3.00	Buildings and Fixtures	106,475,206	0			3.00
4.00	Building Improvements	139,419	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	35,683,711	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	151,075,164	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	151,075,164	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0007

Period:
From 01/01/2020
To 12/31/2020

Worksheet A-7
Part II
Date/Time Prepared:
8/2/2021 3:38 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	0				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0007

Period:
From 01/01/2020
To 12/31/2020

Worksheet A-7
Part III
Date/Time Prepared:
8/2/2021 3:38 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	115,391,454	0	115,391,454	0.763802	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	35,683,711	0	35,683,711	0.236198	0	2.00
3.00	Total (sum of lines 1-2)	151,075,165	0	151,075,165	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	4,084,841	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,972,807	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	7,057,648	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	119,840	0	0	4,204,681	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	2,972,807	2.00
3.00	Total (sum of lines 1-2)	0	119,840	0	0	7,177,488	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0007

Period:
From 01/01/2020
To 12/31/2020

Worksheet A-8

Date/Time Prepared:
8/2/2021 3:38 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center		Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)			0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)	B		0	ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			0		0.00	0	7.00
8.00 Television and radio service (chapter 21)			0		0.00	0	8.00
9.00 Parking lot (chapter 21)			0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-158,249				0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)			0		0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	-3,855,572				0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-408,217	CAFETERIA		11.00	0	14.00
15.00 Rental of quarters to employee and others			0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00	0	16.00
17.00 Sale of drugs to other than patients			0		0.00	0	17.00
18.00 Sale of medical records and abstracts			0		0.00	0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00 Vending machines			0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	UTILIZATION REVIEW - SNF	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist			0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0007

Period:
From 01/01/2020
To 12/31/2020

Worksheet A-8

Date/Time Prepared:
8/2/2021 3:38 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
			1.00	2.00		3.00
33.00 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.00
33.01 Misc Revenue	B	-1,314	ADMINISTRATIVE & GENERAL	5.00	0 33.01	
33.02 Misc Revenue	B	-15,000	ADULTS & PEDIATRICS	30.00	0 33.02	
33.03 Misc Revenue	B	-188	OPERATING ROOM	50.00	0 33.03	
33.04 Misc Revenue	B	-22,884	ONCOLOGY	54.01	0 33.04	
33.05 Misc Revenue	B	-5,516	ELECTROCARDIOLOGY	69.00	0 33.05	
33.06 Misc Revenue	B	-33,316	EMERGENCY	91.00	0 33.06	
33.07 Misc Revenue	B	-68,100	AMBULANCE SERVICES	95.00	0 33.07	
33.08 Purchased Discounts	B	-2,032	ADMINISTRATIVE & GENERAL	5.00	0 33.08	
33.09 Vending Revenue	B	-3,722	DIETARY	10.00	0 33.09	
33.10 Space Rental Income	B	-456,000	OPERATION OF PLANT	7.00	0 33.10	
34.00 HAF Tax Offset	A	-7,541,193	ADMINISTRATIVE & GENERAL	5.00	0 34.00	
35.00 Bad Debt	A	-6,966,933	ADMINISTRATIVE & GENERAL	5.00	0 35.00	
35.01 Bad Debt	A	-919	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 35.01	
35.02 Bad Debt	A	-541	ADULTS & PEDIATRICS	30.00	0 35.02	
35.03 Bad Debt	A	-3,353	WOUND CARE CENTER	75.01	0 35.03	
35.04 Bad Debt	A	-124,509	GENESIS	93.01	0 35.04	
35.05 Bad Debt	A	-3,473	HOWARD COUNTY CSS	93.06	0 35.05	
35.06 Bad Debt	A	-44,437	CLINTON COUNTY	93.07	0 35.06	
35.07 Bad Debt	A	-4,337	NEW BEGINNINGS	93.43	0 35.07	
35.08 Sponsorship	A	-35,283	ADMINISTRATIVE & GENERAL	5.00	0 35.08	
35.09 Non-Allow Interest Expense	A	-18,640	ADMINISTRATIVE & GENERAL	5.00	0 35.09	
35.10 Charitable	A	-25,955	ADMINISTRATIVE & GENERAL	5.00	0 35.10	
35.11 Charitable	A	-500	CLINTON COUNTY	93.07	0 35.11	
35.12 Advertising Expense Offset	A	-44,933	ADMINISTRATIVE & GENERAL	5.00	0 35.12	
35.13 Governing Board-Offset	A	-3,387	ADMINISTRATIVE & GENERAL	5.00	0 35.13	
35.14 BH Professional Billing Expense	A	-757,493	GENESIS	93.01	0 35.14	
35.15 BH Professional Billing Expense	A	-481,219	HOWARD COUNTY CSS	93.06	0 35.15	
35.16 BH Professional Billing Expense	A	-299,614	CLINTON COUNTY	93.07	0 35.16	
35.17 BH Professional Billing Expense	A	-71,591	NEW BEGINNINGS	93.43	0 35.17	
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-21,458,420			50.00	

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 15-0007

Period: From 01/01/2020 To 12/31/2020

Worksheet A-8-1

Date/Time Prepared: 8/2/2021 3:38 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	SPECIALTY PURCH SVCS-A&G	378,113	354,009 1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	SPECIALTY PURCHASED PATIENT	58,931	0 2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	SPECIALTY PURCHASED PATIENT	0	9,230 3.00
3.01	57.00	CT SCAN	SPECIALTY PURCHASED PATIENT	0	3,518 3.01
3.02	58.00	MRI	SPECIALTY PURCHASED PATIENT	0	3,980 3.02
3.03	65.00	RESPIRATORY THERAPY	SPECIALTY PURCHASED PATIENT	0	5,135 3.03
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	1,379,705	0 4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	15,003,195	24,125,421 4.01
4.02	13.00	NURSING ADMINISTRATION	HOME OFFICE	1,044,410	0 4.02
4.03	71.00	MEDICAL SUPPLIES CHARGED TO	HOME OFFICE	1,569,414	0 4.03
4.04	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE	721,185	0 4.04
4.05	30.00	ADULTS & PEDIATRICS	HOME OFFICE	6,135	0 4.05
4.06	54.00	RADIOLOGY-DIAGNOSTIC	HOME OFFICE	47,694	0 4.06
4.07	73.00	DRUGS CHARGED TO PATIENTS	HOME OFFICE	297,859	0 4.07
4.08	91.00	EMERGENCY	CPN STAND BY	139,080	0 4.08
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			20,645,721	24,501,293 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.

Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
			Name	Percentage of Ownership
1.00	2.00	3.00	4.00	5.00
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:				

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

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

6.00	B	CHNW	100.00	0.00	6.00
7.00			0.00	0.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or non-financial) specify:				100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 15-0007

Period:
From 01/01/2020
To 12/31/2020

Worksheet A-8-1

Date/Time Prepared:
8/2/2021 3:38 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	24,104	0		1.00
2.00	58,931	0		2.00
3.00	-9,230	0		3.00
3.01	-3,518	0		3.01
3.02	-3,980	0		3.02
3.03	-5,135	0		3.03
4.00	1,379,705	0		4.00
4.01	-9,122,226	0		4.01
4.02	1,044,410	0		4.02
4.03	1,569,414	0		4.03
4.04	721,185	0		4.04
4.05	6,135	0		4.05
4.06	47,694	0		4.06
4.07	297,859	0		4.07
4.08	139,080	0		4.08
5.00	-3,855,572	0		5.00

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

Related Organization(s) and/or Home Office	Type of Business		
	6.00		
B. INTERRELATIONSHIP TO 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 requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00			6.00
7.00			7.00
8.00			8.00
9.00			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 organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0007

Period:
From 01/01/2020
To 12/31/2020

Worksheet A-8-2

Date/Time Prepared:
8/2/2021 3:38 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	206,200	41,084	165,116	211,500	1,112	1.00
2.00	30.00	ADULTS & PEDIATRICS	65,120	65,120	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			271,320	106,204	165,116		1,112	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	113,071	5,654	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			113,071	5,654	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	113,071	52,045	93,129	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	65,120	2.00
3.00	0.00		0	0	0	0	3.00
4.00	0.00		0	0	0	0	4.00
5.00	0.00		0	0	0	0	5.00
6.00	0.00		0	0	0	0	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	113,071	52,045	158,249	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0007

Period:
From 01/01/2020
To 12/31/2020

Worksheet B
Part I
Date/Time Prepared:
8/2/2021 3:38 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst Allocation 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	4,204,681	4,204,681			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	2,972,807		2,972,807		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,628,325	38,201	27,009	1,693,535	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	26,555,108	1,044,281	738,331	230,938	5.00
7.00 00700	OPERATION OF PLANT	5,844,695	427,104	301,972	51,942	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	367,002	22,085	15,615	2,176	8.00
9.00 00900	HOUSEKEEPING	1,919,674	23,858	16,868	38,152	9.00
10.00 01000	DIETARY	552,155	42,724	30,207	12,466	10.00
11.00 01100	CAFETERIA	702,321	69,607	49,214	21,726	11.00
13.00 01300	NURSING ADMINISTRATION	1,961,474	7,406	5,236	27,987	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	721,185	30,306	21,427	0	16.00
17.00 01700	SOCIAL SERVICE	685,947	0	0	21,187	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
23.00 02300	PASTORAL CARE	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	14,093,691	581,883	411,405	330,945	30.00
31.00 03100	INTENSIVE CARE UNIT	1,900,222	53,226	37,632	51,349	31.00
43.00 04300	NURSERY	301,534	16,625	11,754	7,936	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	5,633,673	201,720	142,621	110,322	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	931,955	51,372	36,321	24,529	52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,414,481	195,598	138,292	53,669	54.00
54.01 03480	ONCOLOGY	3,107,139	209,177	147,893	54,883	54.01
57.00 05700	CT SCAN	811,782	6,112	4,321	17,893	57.00
58.00 05800	MRI	832,672	0	0	11,173	58.00
59.00 05900	CARDIAC CATHETERIZATION	975,990	42,785	30,250	23,087	59.00
60.00 06000	LABORATORY	4,963,277	49,966	35,327	0	60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00 06500	RESPIRATORY THERAPY	1,592,259	44,761	31,647	41,084	65.00
66.00 06600	PHYSICAL THERAPY	616,100	6,632	4,689	16,796	66.00
67.00 06700	OCCUPATIONAL THERAPY	375,574	11,206	7,923	10,384	67.00
68.00 06800	SPEECH PATHOLOGY	90,913	4,554	3,219	2,483	68.00
69.00 06900	ELECTROCARDIOLOGY	1,322,983	1,059	749	34,484	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	5,162	3,250	2,298	57	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,277,828	65,593	46,376	9,098	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	5,320,423	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	18,600,593	34,829	24,625	81,790	73.00
74.00 07400	RENAL DIALYSIS	298,434	0	0	0	74.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
75.01 03950	WOUND CARE CENTER	532,275	21,046	14,880	11,602	75.01
76.00 03160	CARDIOPULMONARY	183,982	0	0	4,815	76.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	3,790,369	232,902	164,667	94,959	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
92.01 09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	92.01
93.00 04950	OTHER OUTPATIENT SERVICES	0	0	0	0	93.00
93.01 04951	GENESIS	1,474,112	0	0	51,430	93.01
93.02 04952	WOMEN'S CENTER	0	0	0	0	93.02
93.03 04953	RESIDENTIAL HOMES	0	0	0	0	93.03
93.04 04954	DR. STEELE	0	0	0	0	93.04
93.05 04955	DIABETIC EDUCATION	0	0	0	0	93.05
93.06 04956	HOWARD COUNTY CSS	203,183	0	0	16,893	93.06
93.07 04957	CLINTON COUNTY	424,845	0	0	16,370	93.07
93.18 04968	PSYCH MEDICATION	0	0	0	0	93.18
93.43 04993	NEW BEGINNINGS	120,518	0	0	3,667	93.43
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	1,726,104	17,623	12,460	43,182	95.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE	0	0	0	0	113.00
114.00 11400	UTILIZATION REVIEW - SNF	0	0	0	0	114.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	126,037,447	3,557,491	2,515,228	1,531,454	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
190.01 19001	COMMUNITY HOWARD FOUNDATION	84,132	0	0	2,604	190.01
192.00 19200	PHYSICIANS' PRIVATE OFFICES	3,535,332	306,868	216,963	80,479	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
194.00 07950	HEALTHY CHILDREN	0	0	0	0	194.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0007

Period:
From 01/01/2020
To 12/31/2020

Worksheet B
Part I
Date/Time Prepared:
8/2/2021 3:38 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
194.08 07958 SOUTH BERKLEY BLDG	0	0	0	0	0	194.08
194.09 07959 MOBILE CLINIC	43,284	0	0	1,454	44,738	194.09
194.10 07960 PLASTIC SURGERY	12,085	0	0	0	12,085	194.10
194.11 07961 KOKOMO SCHOOL BASED	2,570,610	0	0	77,544	2,648,154	194.11
194.15 07965 INDIANA SURGERY CENTER	46	340,322	240,616	0	580,984	194.15
194.16 07966 PASTORAL CARE ALLIED HEALTH	0	0	0	0	0	194.16
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	132,282,936	4,204,681	2,972,807	1,693,535	132,282,936	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0007

Period:
From 01/01/2020
To 12/31/2020

Worksheet B
Part I
Date/Time Prepared:
8/2/2021 3:38 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	28,568,658				5.00
7.00	00700	OPERATION OF PLANT	1,825,086	8,450,799			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	112,077	51,173	570,128		8.00
9.00	00900	HOUSEKEEPING	550,511	55,280	0	2,604,343	9.00
10.00	01000	DIETARY	175,617	98,995	0	30,897	943,061
11.00	01100	CAFETERIA	232,172	161,286	0	50,339	0
13.00	01300	NURSING ADMINISTRATION	551,489	17,160	0	5,356	0
16.00	01600	MEDICAL RECORDS & LIBRARY	212,904	70,222	0	21,917	0
17.00	01700	SOCIAL SERVICE	194,784	0	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
23.00	02300	PASTORAL CARE	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,246,944	1,348,280	490,326	420,810	811,059
31.00	03100	INTENSIVE CARE UNIT	562,597	123,331	55,098	38,493	91,139
43.00	04300	NURSERY	93,062	38,522	24,704	12,023	40,863
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,677,063	467,405	0	145,881	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	287,624	119,035	0	37,152	0
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	771,836	453,219	0	141,454	0
54.01	03480	ONCOLOGY	969,351	484,683	0	151,274	0
57.00	05700	CT SCAN	231,412	14,162	0	4,420	0
58.00	05800	MRI	232,441	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	295,319	99,137	0	30,941	0
60.00	06000	LABORATORY	1,390,654	115,777	0	36,135	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	470,959	103,716	0	32,371	0
66.00	06600	PHYSICAL THERAPY	177,453	15,366	0	4,796	0
67.00	06700	OCCUPATIONAL THERAPY	111,583	25,964	0	8,104	0
68.00	06800	SPEECH PATHOLOGY	27,868	10,551	0	3,293	0
69.00	06900	ELECTROCARDIOLOGY	374,419	2,455	0	766	0
70.00	07000	ELECTROENCEPHALOGRAPHY	2,966	7,530	0	2,350	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,487,153	151,986	0	47,436	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,465,537	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	5,162,575	80,702	0	25,188	0
74.00	07400	RENAL DIALYSIS	82,205	0	0	0	0
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0
75.01	03950	WOUND CARE CENTER	159,710	48,766	0	15,220	0
76.00	03160	CARDIOPULMONARY	52,005	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	1,179,745	539,657	0	168,432	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0
93.00	04950	OTHER OUTPATIENT SERVICES	0	0	0	0	0
93.01	04951	GENESIS	420,218	709,133	0	221,327	0
93.02	04952	WOMEN'S CENTER	0	0	0	0	0
93.03	04953	RESIDENTIAL HOMES	0	0	0	0	0
93.04	04954	DR. STEELE	0	0	0	0	0
93.05	04955	DIABETIC EDUCATION	0	0	0	0	0
93.06	04956	HOWARD COUNTY CSS	60,621	237,715	0	74,193	0
93.07	04957	CLINTON COUNTY	121,535	10,622	0	3,315	0
93.18	04968	PSYCH MEDICATION	0	0	0	0	0
93.43	04993	NEW BEGINNINGS	34,207	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	495,645	40,835	0	12,745	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
114.00	11400	UTILIZATION REVIEW - SNF					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	26,499,347	5,702,665	570,128	1,746,628	943,061
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
190.01	19001	COMMUNITY HOWARD FOUNDATION	23,892	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,140,285	1,886,543	0	588,805	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
194.00	07950	HEALTHY CHILDREN	0	0	0	0	0
194.08	07958	SOUTH BERKLEY BLDG	0	0	0	0	0
194.09	07959	MOBILE CLINIC	12,323	0	0	0	0
194.10	07960	PLASTIC SURGERY	3,329	0	0	0	0
194.11	07961	KOKOMO SCHOOL BASED	729,447	73,031	0	22,793	0
194.15	07965	INDIANA SURGERY CENTER	160,035	788,560	0	246,117	0

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0007

Period:
From 01/01/2020
To 12/31/2020

Worksheet B
Part I
Date/Time Prepared:
8/2/2021 3:38 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
194.16	07966 PASTORAL CARE ALLIED HEALTH	0	0	0	0	0	194.16
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	28,568,658	8,450,799	570,128	2,604,343	943,061	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0007

Period:
From 01/01/2020
To 12/31/2020

Worksheet B
Part I
Date/Time Prepared:
8/2/2021 3:38 pm

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	
		11.00	13.00	16.00	17.00	19.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	1,286,665					11.00
13.00	01300	34,639	2,610,747				13.00
16.00	01600	0	0	1,077,961			16.00
17.00	01700	26,187	60,816	0	988,921		17.00
19.00	01900	0	0	0	0	0	19.00
23.00	02300	0	0	0	0		23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	412,463	1,200,698	91,030	850,501	0	30.00
31.00	03100	63,758	185,483	16,215	95,570	0	31.00
43.00	04300	9,809	34,999	2,121	42,850	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	137,351	418,571	126,217	0	0	50.00
52.00	05200	30,317	108,172	6,555	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	67,597	0	42,425	0	0	54.00
54.01	03480	67,850	90,178	58,796	0	0	54.01
57.00	05700	22,209	0	65,703	0	0	57.00
58.00	05800	3,625	0	21,661	0	0	58.00
59.00	05900	28,535	89,590	82,325	0	0	59.00
60.00	06000	0	0	101,868	0	0	60.00
63.00	06300	0	0	0	0	0	63.00
65.00	06500	51,331	0	17,238	0	0	65.00
66.00	06600	21,054	0	2,490	0	0	66.00
67.00	06700	12,835	0	1,539	0	0	67.00
68.00	06800	3,068	0	368	0	0	68.00
69.00	06900	42,797	42,690	22,830	0	0	69.00
70.00	07000	71	0	23	0	0	70.00
71.00	07100	11,318	0	20,818	0	0	71.00
72.00	07200	0	0	30,696	0	0	72.00
73.00	07300	101,605	0	206,498	0	0	73.00
74.00	07400	0	0	1,260	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
75.01	03950	14,515	44,571	5,898	0	0	75.01
76.00	03160	6,004	16,483	1,774	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	117,727	318,496	126,649	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
92.01	09201	0	0	0	0	0	92.01
93.00	04950	0	0	0	0	0	93.00
93.01	04951	0	0	7,744	0	0	93.01
93.02	04952	0	0	0	0	0	93.02
93.03	04953	0	0	0	0	0	93.03
93.04	04954	0	0	0	0	0	93.04
93.05	04955	0	0	0	0	0	93.05
93.06	04956	0	0	2,276	0	0	93.06
93.07	04957	0	0	1,742	0	0	93.07
93.18	04968	0	0	0	0	0	93.18
93.43	04993	0	0	696	0	0	93.43
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	12,506	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
114.00	11400						114.00
118.00		1,286,665	2,610,747	1,077,961	988,921	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
190.01	19001	0	0	0	0	0	190.01
192.00	19200	0	0	0	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
194.08	07958	0	0	0	0	0	194.08
194.09	07959	0	0	0	0	0	194.09
194.10	07960	0	0	0	0	0	194.10
194.11	07961	0	0	0	0	0	194.11

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0007			Period: From 01/01/2020 To 12/31/2020		Worksheet B Part I Date/Time Prepared: 8/2/2021 3:38 pm	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS		
		11.00	13.00	16.00	17.00	19.00		
194.15	07965 INDIANA SURGERY CENTER	0	0	0	0	0	0	194.15
194.16	07966 PASTORAL CARE ALLIED HEALTH	0	0	0	0	0	0	194.16
200.00	Cross Foot Adjustments							200.00
201.00	Negative Cost Centers	0	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	1,286,665	2,610,747	1,077,961	988,921		0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS				Provider CCN: 15-0007	Period: From 01/01/2020 To 12/31/2020	Worksheet B Part I Date/Time Prepared: 8/2/2021 3:38 pm
Cost Center Description			PASTORAL CARE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total
			23.00	24.00	25.00	26.00
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
23.00	02300	PASTORAL CARE	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	25,290,035	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,274,113	0	31.00
43.00	04300	NURSERY	0	636,802	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	9,060,824	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,633,032	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,278,571	0	54.00
54.01	03480	ONCOLOGY	0	5,341,224	0	54.01
57.00	05700	CT SCAN	0	1,178,014	0	57.00
58.00	05800	MRI	0	1,101,572	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,697,959	0	59.00
60.00	06000	LABORATORY	0	6,693,004	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	2,385,366	0	65.00
66.00	06600	PHYSICAL THERAPY	0	865,376	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	565,112	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	146,317	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,845,232	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	23,707	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	7,117,606	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,816,656	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	24,318,405	0	73.00
74.00	07400	RENAL DIALYSIS	0	381,899	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	75.00
75.01	03950	WOUND CARE CENTER	0	868,483	0	75.01
76.00	03160	CARDIOPULMONARY	0	265,063	0	76.00
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	6,733,603	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	92.01
93.00	04950	OTHER OUTPATIENT SERVICES	0	0	0	93.00
93.01	04951	GENESIS	0	2,883,964	0	93.01
93.02	04952	WOMEN'S CENTER	0	0	0	93.02
93.03	04953	RESIDENTIAL HOMES	0	0	0	93.03
93.04	04954	DR. STEELE	0	0	0	93.04
93.05	04955	DIABETIC EDUCATION	0	0	0	93.05
93.06	04956	HOWARD COUNTY CSS	0	594,881	0	93.06
93.07	04957	CLINTON COUNTY	0	578,429	0	93.07
93.18	04968	PSYCH MEDICATION	0	0	0	93.18
93.43	04993	NEW BEGINNINGS	0	159,088	0	93.43
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	2,361,100	0	95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
114.00	11400	UTILIZATION REVIEW - SNF				114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	119,095,437	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
190.01	19001	COMMUNITY HOWARD FOUNDATION	0	110,628	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7,755,275	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	193.00
194.00	07950	HEALTHY CHILDREN	0	0	0	194.00
194.08	07958	SOUTH BERKLEY BLDG	0	0	0	194.08
194.09	07959	MOBILE CLINIC	0	57,061	0	194.09

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0007

Period:
From 01/01/2020
To 12/31/2020

Worksheet B
Part I
Date/Time Prepared:
8/2/2021 3:38 pm

Cost Center Description			PASTORAL CARE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			23.00	24.00	25.00	26.00	
194.10	07960	PLASTIC SURGERY	0	15,414	0	15,414	194.10
194.11	07961	KOKOMO SCHOOL BASED	0	3,473,425	0	3,473,425	194.11
194.15	07965	INDIANA SURGERY CENTER	0	1,775,696	0	1,775,696	194.15
194.16	07966	PASTORAL CARE ALLIED HEALTH	0	0	0	0	194.16
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	132,282,936	0	132,282,936	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0007		Period: From 01/01/2020 To 12/31/2020		Worksheet B Part II Date/Time Prepared: 8/2/2021 3:38 pm	
Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT			
		BLDG & FIXT	MVBLE EQUIP					
		0	1.00				2.00	2A
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	38,201	27,009	65,210	65,210	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,815	1,044,281	738,331	1,797,427	8,895	5.00
7.00	00700	OPERATION OF PLANT	231,084	427,104	301,972	960,160	2,001	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	22,085	15,615	37,700	84	8.00
9.00	00900	HOUSEKEEPING	7,708	23,858	16,868	48,434	1,469	9.00
10.00	01000	DIETARY	0	42,724	30,207	72,931	480	10.00
11.00	01100	CAFETERIA	0	69,607	49,214	118,821	837	11.00
13.00	01300	NURSING ADMINISTRATION	0	7,406	5,236	12,642	1,078	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	30,306	21,427	51,733	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	816	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
23.00	02300	PASTORAL CARE	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	146	581,883	411,405	993,434	12,729	30.00
31.00	03100	INTENSIVE CARE UNIT	2	53,226	37,632	90,860	1,978	31.00
43.00	04300	NURSERY	0	16,625	11,754	28,379	306	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	115,429	201,720	142,621	459,770	4,249	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	51,372	36,321	87,693	945	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	134,598	195,598	138,292	468,488	2,067	54.00
54.01	03480	ONCOLOGY	724,839	209,177	147,893	1,081,909	2,114	54.01
57.00	05700	CT SCAN	99,308	6,112	4,321	109,741	689	57.00
58.00	05800	MRI	447,734	0	0	447,734	430	58.00
59.00	05900	CARDIAC CATHETERIZATION	5,670	42,785	30,250	78,705	889	59.00
60.00	06000	LABORATORY	0	49,966	35,327	85,293	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	619	44,761	31,647	77,027	1,582	65.00
66.00	06600	PHYSICAL THERAPY	0	6,632	4,689	11,321	647	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	11,206	7,923	19,129	400	67.00
68.00	06800	SPEECH PATHOLOGY	0	4,554	3,219	7,773	96	68.00
69.00	06900	ELECTROCARDIOLOGY	119,848	1,059	749	121,656	1,328	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	3,250	2,298	5,548	2	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	26,418	65,593	46,376	138,387	350	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	381,015	34,829	24,625	440,469	3,150	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03950	WOUND CARE CENTER	19,870	21,046	14,880	55,796	447	75.01
76.00	03160	CARDIOPULMONARY	0	0	0	0	185	76.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	2	232,902	164,667	397,571	3,657	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
93.00	04950	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
93.01	04951	GENESIS	130	0	0	130	1,981	93.01
93.02	04952	WOMEN'S CENTER	0	0	0	0	0	93.02
93.03	04953	RESIDENTIAL HOMES	0	0	0	0	0	93.03
93.04	04954	DR. STEELE	0	0	0	0	0	93.04
93.05	04955	DIABETIC EDUCATION	0	0	0	0	0	93.05
93.06	04956	HOWARD COUNTY CSS	2,391	0	0	2,391	651	93.06
93.07	04957	CLINTON COUNTY	69,768	0	0	69,768	631	93.07
93.18	04968	PSYCH MEDICATION	0	0	0	0	0	93.18
93.43	04993	NEW BEGINNINGS	24,109	0	0	24,109	141	93.43
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	17,623	12,460	30,083	1,663	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW - SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,425,503	3,557,491	2,515,228	8,498,222	58,967	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	COMMUNITY HOWARD FOUNDATION	0	0	0	0	100	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	293,698	306,868	216,963	817,529	3,100	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	HEALTHY CHILDREN	0	0	0	0	0	194.00
194.08	07958	SOUTH BERKLEY BLDG	0	0	0	0	0	194.08

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0007

Period:
From 01/01/2020
To 12/31/2020

Worksheet B
Part II
Date/Time Prepared:
8/2/2021 3:38 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
	0			2A	4.00	
194.09 07959 MOBILE CLINIC	0	0	0	0	56	194.09
194.10 07960 PLASTIC SURGERY	12,085	0	0	12,085	0	194.10
194.11 07961 KOKOMO SCHOOL BASED	3,450	0	0	3,450	2,987	194.11
194.15 07965 INDIANA SURGERY CENTER	0	340,322	240,616	580,938	0	194.15
194.16 07966 PASTORAL CARE ALLIED HEALTH	0	0	0	0	0	194.16
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	2,734,736	4,204,681	2,972,807	9,912,224	65,210	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0007		Period: From 01/01/2020 To 12/31/2020		Worksheet B Part II Date/Time Prepared: 8/2/2021 3:38 pm	
Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,806,322					5.00
7.00	00700	OPERATION OF PLANT	115,393	1,077,554				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	7,086	6,525	51,395			8.00
9.00	00900	HOUSEKEEPING	34,807	7,049	0	91,759		9.00
10.00	01000	DIETARY	11,104	12,623	0	1,089	98,227	10.00
11.00	01100	CAFETERIA	14,679	20,565	0	1,774	0	11.00
13.00	01300	NURSING ADMINISTRATION	34,869	2,188	0	189	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	13,461	8,954	0	772	0	16.00
17.00	01700	SOCIAL SERVICE	12,315	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
23.00	02300	PASTORAL CARE	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	268,519	171,918	44,201	14,826	84,478	30.00
31.00	03100	INTENSIVE CARE UNIT	35,571	15,726	4,967	1,356	9,493	31.00
43.00	04300	NURSERY	5,884	4,912	2,227	424	4,256	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	106,034	59,598	0	5,140	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	18,185	15,178	0	1,309	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	48,800	57,790	0	4,984	0	54.00
54.01	03480	ONCOLOGY	61,289	61,802	0	5,330	0	54.01
57.00	05700	CT SCAN	14,631	1,806	0	156	0	57.00
58.00	05800	MRI	14,696	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	18,672	12,641	0	1,090	0	59.00
60.00	06000	LABORATORY	87,926	14,763	0	1,273	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	29,777	13,225	0	1,141	0	65.00
66.00	06600	PHYSICAL THERAPY	11,220	1,959	0	169	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,055	3,311	0	286	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,762	1,345	0	116	0	68.00
69.00	06900	ELECTROCARDIOLOGY	23,673	313	0	27	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	188	960	0	83	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	94,027	19,380	0	1,671	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	92,660	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	326,443	10,290	0	887	0	73.00
74.00	07400	RENAL DIALYSIS	5,198	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03950	WOUND CARE CENTER	10,098	6,218	0	536	0	75.01
76.00	03160	CARDIOPULMONARY	3,288	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	74,591	68,811	0	5,934	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
93.00	04950	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
93.01	04951	GENESIS	26,569	90,421	0	7,798	0	93.01
93.02	04952	WOMEN'S CENTER	0	0	0	0	0	93.02
93.03	04953	RESIDENTIAL HOMES	0	0	0	0	0	93.03
93.04	04954	DR. STEELE	0	0	0	0	0	93.04
93.05	04955	DIABETIC EDUCATION	0	0	0	0	0	93.05
93.06	04956	HOWARD COUNTY CSS	3,833	30,311	0	2,614	0	93.06
93.07	04957	CLINTON COUNTY	7,684	1,354	0	117	0	93.07
93.18	04968	PSYCH MEDICATION	0	0	0	0	0	93.18
93.43	04993	NEW BEGINNINGS	2,163	0	0	0	0	93.43
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	31,338	5,207	0	449	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW - SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,675,488	727,143	51,395	61,540	98,227	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	COMMUNITY HOWARD FOUNDATION	1,511	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	72,096	240,550	0	20,745	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	HEALTHY CHILDREN	0	0	0	0	0	194.00
194.08	07958	SOUTH BERKLEY BLDG	0	0	0	0	0	194.08
194.09	07959	MOBILE CLINIC	779	0	0	0	0	194.09
194.10	07960	PLASTIC SURGERY	210	0	0	0	0	194.10
194.11	07961	KOKOMO SCHOOL BASED	46,120	9,312	0	803	0	194.11
194.15	07965	INDIANA SURGERY CENTER	10,118	100,549	0	8,671	0	194.15

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0007

Period:
From 01/01/2020
To 12/31/2020

Worksheet B
Part II
Date/Time Prepared:
8/2/2021 3:38 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
194.16	07966 PASTORAL CARE ALLIED HEALTH	0	0	0	0	0	194.16
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	1,806,322	1,077,554	51,395	91,759	98,227	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0007		Period: From 01/01/2020 To 12/31/2020		Worksheet B Part II Date/Time Prepared: 8/2/2021 3:38 pm	
Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	
			11.00	13.00	16.00	17.00	19.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	156,676					11.00
13.00	01300	NURSING ADMINISTRATION	4,218	55,184				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	74,920			16.00
17.00	01700	SOCIAL SERVICE	3,189	1,286	0	17,606		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
23.00	02300	PASTORAL CARE	0	0	0	0		23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	50,222	25,377	6,318	15,142		30.00
31.00	03100	INTENSIVE CARE UNIT	7,764	3,921	1,125	1,701		31.00
43.00	04300	NURSERY	1,194	740	147	763		43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	16,725	8,848	8,761	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,692	2,287	455	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,231	0	2,945	0		54.00
54.01	03480	ONCOLOGY	8,262	1,906	4,081	0		54.01
57.00	05700	CT SCAN	2,704	0	4,560	0		57.00
58.00	05800	MRI	441	0	1,503	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	3,475	1,894	5,714	0		59.00
60.00	06000	LABORATORY	0	0	7,070	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	6,251	0	1,196	0		65.00
66.00	06600	PHYSICAL THERAPY	2,564	0	173	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,563	0	107	0		67.00
68.00	06800	SPEECH PATHOLOGY	374	0	26	0		68.00
69.00	06900	ELECTROCARDIOLOGY	5,212	902	1,585	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	9	0	2	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,378	0	1,445	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	2,131	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,373	0	14,434	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	87	0		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0		75.00
75.01	03950	WOUND CARE CENTER	1,768	942	409	0		75.01
76.00	03160	CARDIOPULMONARY	731	348	123	0		76.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	14,336	6,733	8,791	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0		92.01
93.00	04950	OTHER OUTPATIENT SERVICES	0	0	0	0		93.00
93.01	04951	GENESIS	0	0	537	0		93.01
93.02	04952	WOMEN'S CENTER	0	0	0	0		93.02
93.03	04953	RESIDENTIAL HOMES	0	0	0	0		93.03
93.04	04954	DR. STEELE	0	0	0	0		93.04
93.05	04955	DIABETIC EDUCATION	0	0	0	0		93.05
93.06	04956	HOWARD COUNTY CSS	0	0	158	0		93.06
93.07	04957	CLINTON COUNTY	0	0	121	0		93.07
93.18	04968	PSYCH MEDICATION	0	0	0	0		93.18
93.43	04993	NEW BEGINNINGS	0	0	48	0		93.43
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	868	0		95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW - SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	156,676	55,184	74,920	17,606	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
190.01	19001	COMMUNITY HOWARD FOUNDATION	0	0	0	0		190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
194.00	07950	HEALTHY CHILDREN	0	0	0	0		194.00
194.08	07958	SOUTH BERKLEY BLDG	0	0	0	0		194.08
194.09	07959	MOBILE CLINIC	0	0	0	0		194.09
194.10	07960	PLASTIC SURGERY	0	0	0	0		194.10
194.11	07961	KOKOMO SCHOOL BASED	0	0	0	0		194.11

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0007			Period: From 01/01/2020 To 12/31/2020		Worksheet B Part II Date/Time Prepared: 8/2/2021 3:38 pm	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS		
		11.00	13.00	16.00	17.00	19.00		
194.15	07965 INDIANA SURGERY CENTER	0	0	0	0			194.15
194.16	07966 PASTORAL CARE ALLIED HEALTH	0	0	0	0			194.16
200.00	Cross Foot Adjustments							0 200.00
201.00	Negative Cost Centers	0	0	0	0			0 201.00
202.00	TOTAL (sum lines 118 through 201)	156,676	55,184	74,920	17,606			0 202.00

ALLOCATION OF CAPITAL RELATED COSTS				Provider CCN: 15-0007	Period: From 01/01/2020 To 12/31/2020	Worksheet B Part II Date/Time Prepared: 8/2/2021 3:38 pm
Cost Center	Description	PASTORAL CARE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		23.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
23.00	02300	PASTORAL CARE	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,687,164	0	1,687,164	30.00
31.00	03100	INTENSIVE CARE UNIT	174,462	0	174,462	31.00
43.00	04300	NURSERY	49,232	0	49,232	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	669,125	0	669,125	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	129,744	0	129,744	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	593,305	0	593,305	54.00
54.01	03480	ONCOLOGY	1,226,693	0	1,226,693	54.01
57.00	05700	CT SCAN	134,287	0	134,287	57.00
58.00	05800	MRI	464,804	0	464,804	58.00
59.00	05900	CARDIAC CATHETERIZATION	123,080	0	123,080	59.00
60.00	06000	LABORATORY	196,325	0	196,325	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	130,199	0	130,199	65.00
66.00	06600	PHYSICAL THERAPY	28,053	0	28,053	66.00
67.00	06700	OCCUPATIONAL THERAPY	31,851	0	31,851	67.00
68.00	06800	SPEECH PATHOLOGY	11,492	0	11,492	68.00
69.00	06900	ELECTROCARDIOLOGY	154,696	0	154,696	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	6,792	0	6,792	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	256,638	0	256,638	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	94,791	0	94,791	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	808,046	0	808,046	73.00
74.00	07400	RENAL DIALYSIS	5,285	0	5,285	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	75.00
75.01	03950	WOUND CARE CENTER	76,214	0	76,214	75.01
76.00	03160	CARDIOPULMONARY	4,675	0	4,675	76.00
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	580,424	0	580,424	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	92.01
93.00	04950	OTHER OUTPATIENT SERVICES	0	0	0	93.00
93.01	04951	GENESIS	127,436	0	127,436	93.01
93.02	04952	WOMEN'S CENTER	0	0	0	93.02
93.03	04953	RESIDENTIAL HOMES	0	0	0	93.03
93.04	04954	DR. STEELE	0	0	0	93.04
93.05	04955	DIABETIC EDUCATION	0	0	0	93.05
93.06	04956	HOWARD COUNTY CSS	39,958	0	39,958	93.06
93.07	04957	CLINTON COUNTY	79,675	0	79,675	93.07
93.18	04968	PSYCH MEDICATION	0	0	0	93.18
93.43	04993	NEW BEGINNINGS	26,461	0	26,461	93.43
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	69,608	0	69,608	95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
114.00	11400	UTILIZATION REVIEW - SNF				114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	7,980,515	0	7,980,515
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
190.01	19001	COMMUNITY HOWARD FOUNDATION	1,611	0	1,611	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,154,020	0	1,154,020	192.00
193.00	19300	NONPAID WORKERS	0	0	0	193.00
194.00	07950	HEALTHY CHILDREN	0	0	0	194.00
194.08	07958	SOUTH BERKLEY BLDG	0	0	0	194.08
194.09	07959	MOBILE CLINIC	835	0	835	194.09

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0007

Period:
From 01/01/2020
To 12/31/2020

Worksheet B
Part II
Date/Time Prepared:
8/2/2021 3:38 pm

Cost Center Description			PASTORAL CARE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			23.00	24.00	25.00	26.00	
194.10	07960	PLASTIC SURGERY		12,295	0	12,295	194.10
194.11	07961	KOKOMO SCHOOL BASED		62,672	0	62,672	194.11
194.15	07965	INDIANA SURGERY CENTER		700,276	0	700,276	194.15
194.16	07966	PASTORAL CARE ALLIED HEALTH		0	0	0	194.16
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	9,912,224	0	9,912,224	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0007

Period:
From 01/01/2020
To 12/31/2020

Worksheet B-1
Date/Time Prepared:
8/2/2021 3:38 pm

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00	4.00				
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS-BLDG & FIXT	412,756					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		412,756				2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	3,750	3,750	45,581,295			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	102,513	102,513	6,215,703	-28,568,658	103,714,278	5.00
7.00 00700	OPERATION OF PLANT	41,927	41,927	1,398,016	0	6,625,713	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	2,168	2,168	58,555	0	406,878	8.00
9.00 00900	HOUSEKEEPING	2,342	2,342	1,026,860	0	1,998,552	9.00
10.00 01000	DIETARY	4,194	4,194	335,527	0	637,552	10.00
11.00 01100	CAFETERIA	6,833	6,833	584,756	0	842,868	11.00
13.00 01300	NURSING ADMINISTRATION	727	727	753,267	0	2,002,103	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	2,975	2,975	0	0	772,918	16.00
17.00 01700	SOCIAL SERVICE	0	0	570,240	0	707,134	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
23.00 02300	PASTORAL CARE	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	57,121	57,121	8,907,171	0	15,417,924	30.00
31.00 03100	INTENSIVE CARE UNIT	5,225	5,225	1,382,067	0	2,042,429	31.00
43.00 04300	NURSERY	1,632	1,632	213,605	0	337,849	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	19,802	19,802	2,969,313	0	6,088,336	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	5,043	5,043	660,192	0	1,044,177	52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	19,201	19,201	1,444,514	0	2,802,040	54.00
54.01 03480	ONCOLOGY	20,534	20,534	1,477,166	0	3,519,092	54.01
57.00 05700	CT SCAN	600	600	481,592	0	840,108	57.00
58.00 05800	MRI	0	0	300,718	0	843,845	58.00
59.00 05900	CARDIAC CATHETERIZATION	4,200	4,200	621,381	0	1,072,112	59.00
60.00 06000	LABORATORY	4,905	4,905	0	0	5,048,570	60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00 06500	RESPIRATORY THERAPY	4,394	4,394	1,105,785	0	1,709,751	65.00
66.00 06600	PHYSICAL THERAPY	651	651	452,060	0	644,217	66.00
67.00 06700	OCCUPATIONAL THERAPY	1,100	1,100	279,487	0	405,087	67.00
68.00 06800	SPEECH PATHOLOGY	447	447	66,817	0	101,169	68.00
69.00 06900	ELECTROCARDIOLOGY	104	104	928,141	0	1,359,275	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	319	319	1,536	0	10,767	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,439	6,439	244,864	0	5,398,895	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	5,320,423	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	3,419	3,419	2,201,387	0	18,741,837	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	298,434	74.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01 03950	WOUND CARE CENTER	2,066	2,066	312,277	0	579,803	75.01
76.00 03160	CARDIOPULMONARY	0	0	129,603	0	188,797	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00 09100	EMERGENCY	22,863	22,863	2,555,833	0	4,282,897	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
92.01 09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
93.00 04950	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
93.01 04951	GENESIS	0	0	1,384,231	0	1,525,542	93.01
93.02 04952	WOMEN'S CENTER	0	0	0	0	0	93.02
93.03 04953	RESIDENTIAL HOMES	0	0	0	0	0	93.03
93.04 04954	DR. STEELE	0	0	0	0	0	93.04
93.05 04955	DIABETIC EDUCATION	0	0	0	0	0	93.05
93.06 04956	HOWARD COUNTY CSS	0	0	454,674	0	220,076	93.06
93.07 04957	CLINTON COUNTY	0	0	440,608	0	441,215	93.07
93.18 04968	PSYCH MEDICATION	0	0	0	0	0	93.18
93.43 04993	NEW BEGINNINGS	0	0	98,687	0	124,185	93.43
OTHER REIMBURSABLE COST CENTERS							
95.00 09500	AMBULANCE SERVICES	1,730	1,730	1,162,249	0	1,799,369	95.00
SPECIAL PURPOSE COST CENTERS							
113.00 11300	INTEREST EXPENSE						113.00
114.00 11400	UTILIZATION REVIEW - SNF						114.00
118.00 11800	SUBTOTALS (SUM OF LINES 1 through 117)	349,224	349,224	41,218,882	-28,568,658	96,201,939	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01 19001	COMMUNITY HOWARD FOUNDATION	0	0	70,094	0	86,736	190.01
192.00 19200	PHYSICIANS' PRIVATE OFFICES	30,124	30,124	2,166,092	0	4,139,642	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00 07950	HEALTHY CHILDREN	0	0	0	0	0	194.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0007

Period:
From 01/01/2020
To 12/31/2020

Worksheet B-1

Date/Time Prepared:
8/2/2021 3:38 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
194.08 07958 SOUTH BERKLEY BLDG	0	0	0	0	0	194.08
194.09 07959 MOBILE CLINIC	0	0	39,124	0	44,738	194.09
194.10 07960 PLASTIC SURGERY	0	0	0	0	12,085	194.10
194.11 07961 KOKOMO SCHOOL BASED	0	0	2,087,103	0	2,648,154	194.11
194.15 07965 INDIANA SURGERY CENTER	33,408	33,408	0	0	580,984	194.15
194.16 07966 PASTORAL CARE ALLIED HEALTH	0	0	0	0	0	194.16
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	4,204,681	2,972,807	1,693,535		28,568,658	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	10.186844	7.202335	0.037154		0.275455	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)			65,210		1,806,322	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)			0.001431		0.017416	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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0007

Period:
From 01/01/2020
To 12/31/2020

Worksheet B-1

Date/Time Prepared:
8/2/2021 3:38 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (SALARIES)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	358,025				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,168	16,732			8.00
9.00	00900	HOUSEKEEPING	2,342	0	353,515		9.00
10.00	01000	DIETARY	4,194	0	4,194	16,732	10.00
11.00	01100	CAFETERIA	6,833	0	6,833	0	28,018,310
13.00	01300	NURSING ADMINISTRATION	727	0	727	0	754,303
16.00	01600	MEDICAL RECORDS & LIBRARY	2,975	0	2,975	0	0
17.00	01700	SOCIAL SERVICE	0	0	0	0	570,240
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
23.00	02300	PASTORAL CARE	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	57,121	14,390	57,121	14,390	8,981,665
31.00	03100	INTENSIVE CARE UNIT	5,225	1,617	5,225	1,617	1,388,389
43.00	04300	NURSERY	1,632	725	1,632	725	213,606
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	19,802	0	19,802	0	2,990,956
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,043	0	5,043	0	660,192
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,201	0	19,201	0	1,471,989
54.01	03480	ONCOLOGY	20,534	0	20,534	0	1,477,502
57.00	05700	CT SCAN	600	0	600	0	483,616
58.00	05800	MRI	0	0	0	0	78,937
59.00	05900	CARDIAC CATHETERIZATION	4,200	0	4,200	0	621,381
60.00	06000	LABORATORY	4,905	0	4,905	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	4,394	0	4,394	0	1,117,789
66.00	06600	PHYSICAL THERAPY	651	0	651	0	458,476
67.00	06700	OCCUPATIONAL THERAPY	1,100	0	1,100	0	279,487
68.00	06800	SPEECH PATHOLOGY	447	0	447	0	66,817
69.00	06900	ELECTROCARDIOLOGY	104	0	104	0	931,960
70.00	07000	ELECTROENCEPHALOGRAPHY	319	0	319	0	1,536
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,439	0	6,439	0	246,463
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	3,419	0	3,419	0	2,212,547
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0
75.01	03950	WOUND CARE CENTER	2,066	0	2,066	0	316,085
76.00	03160	CARDIOPULMONARY	0	0	0	0	130,737
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	22,863	0	22,863	0	2,563,637
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0
93.00	04950	OTHER OUTPATIENT SERVICES	0	0	0	0	0
93.01	04951	GENESIS	30,043	0	30,043	0	0
93.02	04952	WOMEN'S CENTER	0	0	0	0	0
93.03	04953	RESIDENTIAL HOMES	0	0	0	0	0
93.04	04954	DR. STEELE	0	0	0	0	0
93.05	04955	DIABETIC EDUCATION	0	0	0	0	0
93.06	04956	HOWARD COUNTY CSS	10,071	0	10,071	0	0
93.07	04957	CLINTON COUNTY	450	0	450	0	0
93.18	04968	PSYCH MEDICATION	0	0	0	0	0
93.43	04993	NEW BEGINNINGS	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	1,730	0	1,730	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
114.00	11400	UTILIZATION REVIEW - SNF					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	241,598	16,732	237,088	16,732	28,018,310
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
190.01	19001	COMMUNITY HOWARD FOUNDATION	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	79,925	0	79,925	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
194.00	07950	HEALTHY CHILDREN	0	0	0	0	0
194.08	07958	SOUTH BERKLEY BLDG	0	0	0	0	0
194.09	07959	MOBILE CLINIC	0	0	0	0	0
194.10	07960	PLASTIC SURGERY	0	0	0	0	0

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0007

Period:
From 01/01/2020
To 12/31/2020

Worksheet B-1

Date/Time Prepared:
8/2/2021 3:38 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (SALARIES)	
		7.00	8.00	9.00	10.00	11.00	
194.11	07961 KOKOMO SCHOOL BASED	3,094	0	3,094	0	0	194.11
194.15	07965 INDIANA SURGERY CENTER	33,408	0	33,408	0	0	194.15
194.16	07966 PASTORAL CARE ALLIED HEALTH	0	0	0	0	0	194.16
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	8,450,799	570,128	2,604,343	943,061	1,286,665	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	23.603935	34.074109	7.366994	56.362718	0.045922	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	1,077,554	51,395	91,759	98,227	156,676	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	3.009717	3.071659	0.259562	5.870607	0.005592	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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0007

Period:
From 01/01/2020
To 12/31/2020

Worksheet B-1

Date/Time Prepared:
8/2/2021 3:38 pm

Cost Center Description		NURSING ADMINISTRATION (NURSING SALARIES)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	PASTORAL CARE (ASSIGNED TIME)	
		13.00	16.00	17.00	19.00	23.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	13,118,514					13.00
16.00	01600		554,203,937				16.00
17.00	01700	305,592		16,732			17.00
19.00	01900				0		19.00
23.00	02300					0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	6,033,266	46,801,875	14,390	0	0	30.00
31.00	03100	932,019	8,336,857	1,617	0	0	31.00
43.00	04300	175,864	1,090,400	725	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	2,103,245	64,892,812	0	0	0	50.00
52.00	05200	543,544	3,370,103	0	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	21,812,103	0	0	0	54.00
54.01	03480	453,128	30,229,396	0	0	0	54.01
57.00	05700	0	33,780,575	0	0	0	57.00
58.00	05800	0	11,136,583	0	0	0	58.00
59.00	05900	450,175	42,326,509	0	0	0	59.00
60.00	06000	0	52,374,045	0	0	0	60.00
63.00	06300	0	0	0	0	0	63.00
65.00	06500	0	8,862,586	0	0	0	65.00
66.00	06600	0	1,280,072	0	0	0	66.00
67.00	06700	0	791,357	0	0	0	67.00
68.00	06800	0	189,428	0	0	0	68.00
69.00	06900	214,510	11,737,627	0	0	0	69.00
70.00	07000	0	11,655	0	0	0	70.00
71.00	07100	0	10,703,234	0	0	0	71.00
72.00	07200	0	15,781,859	0	0	0	72.00
73.00	07300	0	106,152,904	0	0	0	73.00
74.00	07400	0	647,729	0	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
75.01	03950	223,961	3,032,395	0	0	0	75.01
76.00	03160	82,826	911,874	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	1,600,384	65,115,197	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
92.01	09201	0	0	0	0	0	92.01
93.00	04950	0	0	0	0	0	93.00
93.01	04951	0	3,981,384	0	0	0	93.01
93.02	04952	0	0	0	0	0	93.02
93.03	04953	0	0	0	0	0	93.03
93.04	04954	0	0	0	0	0	93.04
93.05	04955	0	0	0	0	0	93.05
93.06	04956	0	1,169,975	0	0	0	93.06
93.07	04957	0	895,792	0	0	0	93.07
93.18	04968	0	0	0	0	0	93.18
93.43	04993	0	357,824	0	0	0	93.43
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	6,429,787	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
114.00	11400						114.00
118.00		13,118,514	554,203,937	16,732	0	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
190.01	19001	0	0	0	0	0	190.01
192.00	19200	0	0	0	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
194.08	07958	0	0	0	0	0	194.08
194.09	07959	0	0	0	0	0	194.09

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0007

Period:
From 01/01/2020
To 12/31/2020

Worksheet B-1

Date/Time Prepared:
8/2/2021 3:38 pm

Cost Center Description		NURSING ADMINISTRATION (NURSING SALARIES)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	PASTORAL CARE (ASSIGNED TIME)	
		13.00	16.00	17.00	19.00	23.00	
194.10	07960 PLASTIC SURGERY	0	0	0	0	0	194.10
194.11	07961 KOKOMO SCHOOL BASED	0	0	0	0	0	194.11
194.15	07965 INDIANA SURGERY CENTER	0	0	0	0	0	194.15
194.16	07966 PASTORAL CARE ALLIED HEALTH	0	0	0	0	0	194.16
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	2,610,747	1,077,961	988,921	0	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.199012	0.001945	59.103574	0.000000	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	55,184	74,920	17,606	0	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.004207	0.000135	1.052235	0.000000	0.000000	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)					0	206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)					0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0007

Period:
From 01/01/2020
To 12/31/2020

Worksheet C
Part I
Date/Time Prepared:
8/2/2021 3:38 pm

		Title XVIII		Hospital		PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS		25,290,035	0	25,290,035	30.00	
31.00	03100 INTENSIVE CARE UNIT		3,274,113	0	3,274,113	31.00	
43.00	04300 NURSERY		636,802	0	636,802	43.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM		9,060,824	0	9,060,824	50.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM		1,633,032	0	1,633,032	52.00	
53.00	05300 ANESTHESIOLOGY		0	0	0	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC		4,278,571	0	4,278,571	54.00	
54.01	03480 ONCOLOGY		5,341,224	0	5,341,224	54.01	
57.00	05700 CT SCAN		1,178,014	0	1,178,014	57.00	
58.00	05800 MRI		1,101,572	0	1,101,572	58.00	
59.00	05900 CARDIAC CATHETERIZATION		1,697,959	0	1,697,959	59.00	
60.00	06000 LABORATORY		6,693,004	0	6,693,004	60.00	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.		0	0	0	63.00	
65.00	06500 RESPIRATORY THERAPY	0	2,385,366	0	2,385,366	65.00	
66.00	06600 PHYSICAL THERAPY	0	865,376	0	865,376	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0	565,112	0	565,112	67.00	
68.00	06800 SPEECH PATHOLOGY	0	146,317	0	146,317	68.00	
69.00	06900 ELECTROCARDIOLOGY		1,845,232	0	1,845,232	69.00	
70.00	07000 ELECTROENCEPHALOGRAPHY		23,707	0	23,707	70.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		7,117,606	0	7,117,606	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		6,816,656	0	6,816,656	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS		24,318,405	0	24,318,405	73.00	
74.00	07400 RENAL DIALYSIS		381,899	0	381,899	74.00	
75.00	07500 ASC (NON-DISTINCT PART)		0	0	0	75.00	
75.01	03950 WOUND CARE CENTER		868,483	0	868,483	75.01	
76.00	03160 CARDIOPULMONARY		265,063	0	265,063	76.00	
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY		6,733,603	0	6,733,603	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		2,681,868	0	2,681,868	92.00	
92.01	09201 OBSERVATION BEDS (DISTINCT PART)		0	0	0	92.01	
93.00	04950 OTHER OUTPATIENT SERVICES		0	0	0	93.00	
93.01	04951 GENESIS		2,883,964	0	2,883,964	93.01	
93.02	04952 WOMEN'S CENTER		0	0	0	93.02	
93.03	04953 RESIDENTIAL HOMES		0	0	0	93.03	
93.04	04954 DR. STEELE		0	0	0	93.04	
93.05	04955 DIABETIC EDUCATION		0	0	0	93.05	
93.06	04956 HOWARD COUNTY CSS		594,881	0	594,881	93.06	
93.07	04957 CLINTON COUNTY		578,429	0	578,429	93.07	
93.18	04968 PSYCH MEDICATION		0	0	0	93.18	
93.43	04993 NEW BEGINNINGS		159,088	0	159,088	93.43	
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES		2,361,100	0	2,361,100	95.00	
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE					113.00	
114.00	11400 UTILIZATION REVIEW - SNF					114.00	
200.00	Subtotal (see instructions)		121,777,305	0	121,777,305	200.00	
201.00	Less Observation Beds		2,681,868	0	2,681,868	201.00	
202.00	Total (see instructions)		119,095,437	0	119,095,437	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0007		Period: From 01/01/2020 To 12/31/2020		Worksheet C Part I Date/Time Prepared: 8/2/2021 3:38 pm		
			Title XVIII			Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00	9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	43,989,059		43,989,059				30.00
31.00	03100	INTENSIVE CARE UNIT	8,336,857		8,336,857				31.00
43.00	04300	NURSERY	1,090,400		1,090,400				43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	29,179,618	35,713,194	64,892,812	0.139628	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,370,103	0	3,370,103	0.484564	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,259,270	18,552,833	21,812,103	0.196156	0.000000		54.00
54.01	03480	ONCOLOGY	181,840	30,047,556	30,229,396	0.176690	0.000000		54.01
57.00	05700	CT SCAN	7,448,909	26,331,666	33,780,575	0.034873	0.000000		57.00
58.00	05800	MRI	980,229	10,156,354	11,136,583	0.098915	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	14,266,737	28,059,772	42,326,509	0.040116	0.000000		59.00
60.00	06000	LABORATORY	19,631,457	32,742,588	52,374,045	0.127792	0.000000		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	0.000000		63.00
65.00	06500	RESPIRATORY THERAPY	6,646,949	2,215,637	8,862,586	0.269150	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	1,050,107	229,965	1,280,072	0.676037	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	691,415	99,942	791,357	0.714105	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	112,629	76,799	189,428	0.772415	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	2,695,435	9,042,192	11,737,627	0.157207	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	11,655	11,655	2.034063	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,964,760	5,738,474	10,703,234	0.664996	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,536,578	8,245,281	15,781,859	0.431930	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,712,053	89,440,851	106,152,904	0.229088	0.000000		73.00
74.00	07400	RENAL DIALYSIS	647,729	0	647,729	0.589597	0.000000		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000		75.00
75.01	03950	WOUND CARE CENTER	209,195	2,823,200	3,032,395	0.286402	0.000000		75.01
76.00	03160	CARDIOPULMONARY	2,661	909,213	911,874	0.290679	0.000000		76.00
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY	14,175,514	50,939,683	65,115,197	0.103411	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	840,719	1,972,097	2,812,816	0.953446	0.000000		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0.000000	0.000000		92.01
93.00	04950	OTHER OUTPATIENT SERVICES	0	0	0	0.000000	0.000000		93.00
93.01	04951	GENESIS	0	3,981,384	3,981,384	0.724362	0.000000		93.01
93.02	04952	WOMEN'S CENTER	0	0	0	0.000000	0.000000		93.02
93.03	04953	RESIDENTIAL HOMES	0	0	0	0.000000	0.000000		93.03
93.04	04954	DR. STEELE	0	0	0	0.000000	0.000000		93.04
93.05	04955	DIABETIC EDUCATION	0	0	0	0.000000	0.000000		93.05
93.06	04956	HOWARD COUNTY CSS	0	1,169,975	1,169,975	0.508456	0.000000		93.06
93.07	04957	CLINTON COUNTY	0	895,792	895,792	0.645718	0.000000		93.07
93.18	04968	PSYCH MEDICATION	0	0	0	0.000000	0.000000		93.18
93.43	04993	NEW BEGINNINGS	0	357,824	357,824	0.444598	0.000000		93.43
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0	6,429,787	6,429,787	0.367213	0.000000		95.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
114.00	11400	UTILIZATION REVIEW - SNF							114.00
200.00		Subtotal (see instructions)	188,020,223	366,183,714	554,203,937				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	188,020,223	366,183,714	554,203,937				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0007	Period: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Prepared: 8/2/2021 3:38 pm
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.139628		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.484564		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.196156		54.00
54.01	03480 ONCOLOGY	0.176690		54.01
57.00	05700 CT SCAN	0.034873		57.00
58.00	05800 MRI	0.098915		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.040116		59.00
60.00	06000 LABORATORY	0.127792		60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
65.00	06500 RESPIRATORY THERAPY	0.269150		65.00
66.00	06600 PHYSICAL THERAPY	0.676037		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.714105		67.00
68.00	06800 SPEECH PATHOLOGY	0.772415		68.00
69.00	06900 ELECTROCARDIOLOGY	0.157207		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	2.034063		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.664996		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.431930		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.229088		73.00
74.00	07400 RENAL DIALYSIS	0.589597		74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000		75.00
75.01	03950 WOUND CARE CENTER	0.286402		75.01
76.00	03160 CARDIOPULMONARY	0.290679		76.00
	OUTPATIENT SERVICE COST CENTERS			
91.00	09100 EMERGENCY	0.103411		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.953446		92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0.000000		92.01
93.00	04950 OTHER OUTPATIENT SERVICES	0.000000		93.00
93.01	04951 GENESIS	0.724362		93.01
93.02	04952 WOMEN'S CENTER	0.000000		93.02
93.03	04953 RESIDENTIAL HOMES	0.000000		93.03
93.04	04954 DR. STEELE	0.000000		93.04
93.05	04955 DIABETIC EDUCATION	0.000000		93.05
93.06	04956 HOWARD COUNTY CSS	0.508456		93.06
93.07	04957 CLINTON COUNTY	0.645718		93.07
93.18	04968 PSYCH MEDICATION	0.000000		93.18
93.43	04993 NEW BEGINNINGS	0.444598		93.43
	OTHER REIMBURSABLE COST CENTERS			
95.00	09500 AMBULANCE SERVICES	0.367213		95.00
	SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE			113.00
114.00	11400 UTILIZATION REVIEW - SNF			114.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0007

Period:
From 01/01/2020
To 12/31/2020

Worksheet C
Part I
Date/Time Prepared:
8/2/2021 3:38 pm

		Title XIX		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		25,290,035	0	25,290,035	30.00
31.00	03100 INTENSIVE CARE UNIT		3,274,113	0	3,274,113	31.00
43.00	04300 NURSERY		636,802	0	636,802	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		9,060,824	0	9,060,824	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		1,633,032	0	1,633,032	52.00
53.00	05300 ANESTHESIOLOGY		0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		4,278,571	0	4,278,571	54.00
54.01	03480 ONCOLOGY		5,341,224	0	5,341,224	54.01
57.00	05700 CT SCAN		1,178,014	0	1,178,014	57.00
58.00	05800 MRI		1,101,572	0	1,101,572	58.00
59.00	05900 CARDIAC CATHETERIZATION		1,697,959	0	1,697,959	59.00
60.00	06000 LABORATORY		6,693,004	0	6,693,004	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.		0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	2,385,366	0	2,385,366	65.00
66.00	06600 PHYSICAL THERAPY	0	865,376	0	865,376	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	565,112	0	565,112	67.00
68.00	06800 SPEECH PATHOLOGY	0	146,317	0	146,317	68.00
69.00	06900 ELECTROCARDIOLOGY		1,845,232	0	1,845,232	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		23,707	0	23,707	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		7,117,606	0	7,117,606	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		6,816,656	0	6,816,656	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		24,318,405	0	24,318,405	73.00
74.00	07400 RENAL DIALYSIS		381,899	0	381,899	74.00
75.00	07500 ASC (NON-DISTINCT PART)		0	0	0	75.00
75.01	03950 WOUND CARE CENTER		868,483	0	868,483	75.01
76.00	03160 CARDIOPULMONARY		265,063	0	265,063	76.00
OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY		6,733,603	0	6,733,603	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		2,681,868	0	2,681,868	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)		0	0	0	92.01
93.00	04950 OTHER OUTPATIENT SERVICES		0	0	0	93.00
93.01	04951 GENESIS		2,883,964	0	2,883,964	93.01
93.02	04952 WOMEN'S CENTER		0	0	0	93.02
93.03	04953 RESIDENTIAL HOMES		0	0	0	93.03
93.04	04954 DR. STEELE		0	0	0	93.04
93.05	04955 DIABETIC EDUCATION		0	0	0	93.05
93.06	04956 HOWARD COUNTY CSS		594,881	0	594,881	93.06
93.07	04957 CLINTON COUNTY		578,429	0	578,429	93.07
93.18	04968 PSYCH MEDICATION		0	0	0	93.18
93.43	04993 NEW BEGINNINGS		159,088	0	159,088	93.43
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES		2,361,100	0	2,361,100	95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
114.00	11400 UTILIZATION REVIEW - SNF					114.00
200.00	Subtotal (see instructions)		121,777,305	0	121,777,305	200.00
201.00	Less Observation Beds		2,681,868	0	2,681,868	201.00
202.00	Total (see instructions)		119,095,437	0	119,095,437	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0007

Period:
From 01/01/2020
To 12/31/2020

Worksheet C
Part I
Date/Time Prepared:
8/2/2021 3:38 pm

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	Cost
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	43,989,059		43,989,059		30.00
31.00	03100	INTENSIVE CARE UNIT	8,336,857		8,336,857		31.00
43.00	04300	NURSERY	1,090,400		1,090,400		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	29,179,618	35,713,194	64,892,812	0.139628	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,370,103	0	3,370,103	0.484564	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,259,270	18,552,833	21,812,103	0.196156	54.00
54.01	03480	ONCOLOGY	181,840	30,047,556	30,229,396	0.176690	54.01
57.00	05700	CT SCAN	7,448,909	26,331,666	33,780,575	0.034873	57.00
58.00	05800	MRI	980,229	10,156,354	11,136,583	0.098915	58.00
59.00	05900	CARDIAC CATHETERIZATION	14,266,737	28,059,772	42,326,509	0.040116	59.00
60.00	06000	LABORATORY	19,631,457	32,742,588	52,374,045	0.127792	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	6,646,949	2,215,637	8,862,586	0.269150	65.00
66.00	06600	PHYSICAL THERAPY	1,050,107	229,965	1,280,072	0.676037	66.00
67.00	06700	OCCUPATIONAL THERAPY	691,415	99,942	791,357	0.714105	67.00
68.00	06800	SPEECH PATHOLOGY	112,629	76,799	189,428	0.772415	68.00
69.00	06900	ELECTROCARDIOLOGY	2,695,435	9,042,192	11,737,627	0.157207	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	11,655	11,655	2.034063	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,964,760	5,738,474	10,703,234	0.664996	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,536,578	8,245,281	15,781,859	0.431930	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,712,053	89,440,851	106,152,904	0.229088	73.00
74.00	07400	RENAL DIALYSIS	647,729	0	647,729	0.589597	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	75.00
75.01	03950	WOUND CARE CENTER	209,195	2,823,200	3,032,395	0.286402	75.01
76.00	03160	CARDIOPULMONARY	2,661	909,213	911,874	0.290679	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	14,175,514	50,939,683	65,115,197	0.103411	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	840,719	1,972,097	2,812,816	0.953446	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0.000000	92.01
93.00	04950	OTHER OUTPATIENT SERVICES	0	0	0	0.000000	93.00
93.01	04951	GENESIS	0	3,981,384	3,981,384	0.724362	93.01
93.02	04952	WOMEN'S CENTER	0	0	0	0.000000	93.02
93.03	04953	RESIDENTIAL HOMES	0	0	0	0.000000	93.03
93.04	04954	DR. STEELE	0	0	0	0.000000	93.04
93.05	04955	DIABETIC EDUCATION	0	0	0	0.000000	93.05
93.06	04956	HOWARD COUNTY CSS	0	1,169,975	1,169,975	0.508456	93.06
93.07	04957	CLINTON COUNTY	0	895,792	895,792	0.645718	93.07
93.18	04968	PSYCH MEDICATION	0	0	0	0.000000	93.18
93.43	04993	NEW BEGINNINGS	0	357,824	357,824	0.444598	93.43
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	6,429,787	6,429,787	0.367213	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW - SNF					114.00
200.00		Subtotal (see instructions)	188,020,223	366,183,714	554,203,937		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	188,020,223	366,183,714	554,203,937		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0007	Period: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Prepared: 8/2/2021 3:38 pm
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital
		11.00		Cost
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	03480 ONCOLOGY	0.000000		54.01
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MRI	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	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
74.00	07400 RENAL DIALYSIS	0.000000		74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000		75.00
75.01	03950 WOUND CARE CENTER	0.000000		75.01
76.00	03160 CARDIOPULMONARY	0.000000		76.00
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0.000000		92.01
93.00	04950 OTHER OUTPATIENT SERVICES	0.000000		93.00
93.01	04951 GENESIS	0.000000		93.01
93.02	04952 WOMEN'S CENTER	0.000000		93.02
93.03	04953 RESIDENTIAL HOMES	0.000000		93.03
93.04	04954 DR. STEELE	0.000000		93.04
93.05	04955 DIABETIC EDUCATION	0.000000		93.05
93.06	04956 HOWARD COUNTY CSS	0.000000		93.06
93.07	04957 CLINTON COUNTY	0.000000		93.07
93.18	04968 PSYCH MEDICATION	0.000000		93.18
93.43	04993 NEW BEGINNINGS	0.000000		93.43
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
114.00	11400 UTILIZATION REVIEW - SNF			114.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-0007		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part I Date/Time Prepared: 8/2/2021 3:38 pm	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	PPS Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	1,687,164	0	1,687,164	16,097	104.81	30.00
31.00	INTENSIVE CARE UNIT	174,462		174,462	1,617	107.89	31.00
43.00	NURSERY	49,232		49,232	725	67.91	43.00
200.00	Total (lines 30 through 199)	1,910,858		1,910,858	18,439		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	4,931	516,818				
31.00	INTENSIVE CARE UNIT	615	66,352				
43.00	NURSERY	0	0				
200.00	Total (lines 30 through 199)	5,546	583,170				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0007	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part II Date/Time Prepared: 8/2/2021 3:38 pm
--	--	-----------------------	---	---

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
Title XVIII								
Hospital								
PPS								
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	669,125	64,892,812	0.010311	9,595,968	98,944	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	129,744	3,370,103	0.038499	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	593,305	21,812,103	0.027201	1,266,837	34,459	54.00
54.01	03480	ONCOLOGY	1,226,693	30,229,396	0.040579	93,490	3,794	54.01
57.00	05700	CT SCAN	134,287	33,780,575	0.003975	3,093,657	12,297	57.00
58.00	05800	MRI	464,804	11,136,583	0.041737	365,160	15,241	58.00
59.00	05900	CARDIAC CATHETERIZATION	123,080	42,326,509	0.002908	5,305,271	15,428	59.00
60.00	06000	LABORATORY	196,325	52,374,045	0.003749	7,953,510	29,818	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	130,199	8,862,586	0.014691	2,839,762	41,719	65.00
66.00	06600	PHYSICAL THERAPY	28,053	1,280,072	0.021915	495,332	10,855	66.00
67.00	06700	OCCUPATIONAL THERAPY	31,851	791,357	0.040249	326,751	13,151	67.00
68.00	06800	SPEECH PATHOLOGY	11,492	189,428	0.060667	61,557	3,734	68.00
69.00	06900	ELECTROCARDIOLOGY	154,696	11,737,627	0.013179	1,124,689	14,822	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	6,792	11,655	0.582754	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	256,638	10,703,234	0.023978	1,685,920	40,425	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	94,791	15,781,859	0.006006	3,062,277	18,392	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	808,046	106,152,904	0.007612	5,990,240	45,598	73.00
74.00	07400	RENAL DIALYSIS	5,285	647,729	0.008159	379,307	3,095	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
75.01	03950	WOUND CARE CENTER	76,214	3,032,395	0.025133	116,453	2,927	75.01
76.00	03160	CARDIOPULMONARY	4,675	911,874	0.005127	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	580,424	65,115,197	0.008914	5,125,709	45,691	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	178,915	2,812,816	0.063607	423,762	26,954	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0.000000	0	0	92.01
93.00	04950	OTHER OUTPATIENT SERVICES	0	0	0.000000	0	0	93.00
93.01	04951	GENESIS	127,436	3,981,384	0.032008	0	0	93.01
93.02	04952	WOMEN'S CENTER	0	0	0.000000	0	0	93.02
93.03	04953	RESIDENTIAL HOMES	0	0	0.000000	0	0	93.03
93.04	04954	DR. STEELE	0	0	0.000000	0	0	93.04
93.05	04955	DIABETIC EDUCATION	0	0	0.000000	0	0	93.05
93.06	04956	HOWARD COUNTY CSS	39,958	1,169,975	0.034153	0	0	93.06
93.07	04957	CLINTON COUNTY	79,675	895,792	0.088944	0	0	93.07
93.18	04968	PSYCH MEDICATION	0	0	0.000000	0	0	93.18
93.43	04993	NEW BEGINNINGS	26,461	357,824	0.073950	0	0	93.43
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	6,178,964	494,357,834		49,305,652	477,344	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 15-0007		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part III Date/Time Prepared: 8/2/2021 3:38 pm		
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
			1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00	
43.00	04300	NURSERY	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of col. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 + col. 6)	Inpatient Program Days		
			4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	16,097	0.00	4,931	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	1,617	0.00	615	31.00	
43.00	04300	NURSERY		0	725	0.00	0	43.00	
200.00		Total (lines 30 through 199)		0	18,439		5,546	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
			9.00						
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0						30.00
31.00	03100	INTENSIVE CARE UNIT	0						31.00
43.00	04300	NURSERY	0						43.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0007

Period:
From 01/01/2020
To 12/31/2020

Worksheet D
Part IV
Date/Time Prepared:
8/2/2021 3:38 pm

Cost Center Description		Title XVIII				Hospital		PPS
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health		
		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 ANESTHESIOLOGY	0	0	0	0	0	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00	
54.01	03480 ONCOLOGY	0	0	0	0	0	54.01	
57.00	05700 CT SCAN	0	0	0	0	0	57.00	
58.00	05800 MRI	0	0	0	0	0	58.00	
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00	
60.00	06000 LABORATORY	0	0	0	0	0	60.00	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00	
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00	
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00	
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00	
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00	
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	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00	
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00	
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00	
75.01	03950 WOUND CARE CENTER	0	0	0	0	0	75.01	
76.00	03160 CARDIOPULMONARY	0	0	0	0	0	76.00	
OUTPATIENT SERVICE COST CENTERS								
91.00	09100 EMERGENCY	0	0	0	0	0	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00	
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01	
93.00	04950 OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00	
93.01	04951 GENESIS	0	0	0	0	0	93.01	
93.02	04952 WOMEN'S CENTER	0	0	0	0	0	93.02	
93.03	04953 RESIDENTIAL HOMES	0	0	0	0	0	93.03	
93.04	04954 DR. STEELE	0	0	0	0	0	93.04	
93.05	04955 DIABETIC EDUCATION	0	0	0	0	0	93.05	
93.06	04956 HOWARD COUNTY CSS	0	0	0	0	0	93.06	
93.07	04957 CLINTON COUNTY	0	0	0	0	0	93.07	
93.18	04968 PSYCH MEDICATION	0	0	0	0	0	93.18	
93.43	04993 NEW BEGINNINGS	0	0	0	0	0	93.43	
OTHER REIMBURSABLE COST CENTERS								
95.00	09500 AMBULANCE SERVICES	0	0	0	0	0	95.00	
200.00	Total (lines 50 through 199)	0	0	0	0	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0007	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part IV Date/Time Prepared: 8/2/2021 3:38 pm
--	-----------------------	---	---

Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	64,892,812	0.000000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	3,370,103	0.000000	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	21,812,103	0.000000	54.00
54.01 03480 ONCOLOGY	0	0	0	30,229,396	0.000000	54.01
57.00 05700 CT SCAN	0	0	0	33,780,575	0.000000	57.00
58.00 05800 MRI	0	0	0	11,136,583	0.000000	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	42,326,509	0.000000	59.00
60.00 06000 LABORATORY	0	0	0	52,374,045	0.000000	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0.000000	63.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	8,862,586	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	1,280,072	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	791,357	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	189,428	0.000000	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	11,737,627	0.000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	11,655	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	10,703,234	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	15,781,859	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	106,152,904	0.000000	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	647,729	0.000000	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0.000000	75.00
75.01 03950 WOUND CARE CENTER	0	0	0	3,032,395	0.000000	75.01
76.00 03160 CARDIOPULMONARY	0	0	0	911,874	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	0	0	0	65,115,197	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,812,816	0.000000	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0.000000	92.01
93.00 04950 OTHER OUTPATIENT SERVICES	0	0	0	0	0.000000	93.00
93.01 04951 GENESIS	0	0	0	3,981,384	0.000000	93.01
93.02 04952 WOMEN'S CENTER	0	0	0	0	0.000000	93.02
93.03 04953 RESIDENTIAL HOMES	0	0	0	0	0.000000	93.03
93.04 04954 DR. STEELE	0	0	0	0	0.000000	93.04
93.05 04955 DIABETIC EDUCATION	0	0	0	0	0.000000	93.05
93.06 04956 HOWARD COUNTY CSS	0	0	0	1,169,975	0.000000	93.06
93.07 04957 CLINTON COUNTY	0	0	0	895,792	0.000000	93.07
93.18 04968 PSYCH MEDICATION	0	0	0	0	0.000000	93.18
93.43 04993 NEW BEGINNINGS	0	0	0	357,824	0.000000	93.43
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	0	0	494,357,834		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0007	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part IV Date/Time Prepared: 8/2/2021 3:38 pm
--	-----------------------	---	---

Cost Center Description		Title XVIII						
		Hospital		PPS				
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	9,595,968	0	5,984,502	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,266,837	0	4,781,835	0	54.00
54.01	03480	ONCOLOGY	0.000000	93,490	0	10,296,569	0	54.01
57.00	05700	CT SCAN	0.000000	3,093,657	0	7,490,917	0	57.00
58.00	05800	MRI	0.000000	365,160	0	2,764,107	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	5,305,271	0	12,375,633	0	59.00
60.00	06000	LABORATORY	0.000000	7,953,510	0	5,341,947	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	2,839,762	0	722,429	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	495,332	0	39,012	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	326,751	0	2,718	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	61,557	0	1,338	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	1,124,689	0	3,084,251	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	2,921	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,685,920	0	1,712,139	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	3,062,277	0	2,605,561	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	5,990,240	0	33,597,436	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	379,307	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
75.01	03950	WOUND CARE CENTER	0.000000	116,453	0	1,303,733	0	75.01
76.00	03160	CARDIOPULMONARY	0.000000	0	0	537,449	0	76.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0.000000	5,125,709	0	9,457,129	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	423,762	0	1,863,458	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	0	0	92.01
93.00	04950	OTHER OUTPATIENT SERVICES	0.000000	0	0	0	0	93.00
93.01	04951	GENESIS	0.000000	0	0	105,061	0	93.01
93.02	04952	WOMEN'S CENTER	0.000000	0	0	0	0	93.02
93.03	04953	RESIDENTIAL HOMES	0.000000	0	0	0	0	93.03
93.04	04954	DR. STEELE	0.000000	0	0	0	0	93.04
93.05	04955	DIABETIC EDUCATION	0.000000	0	0	0	0	93.05
93.06	04956	HOWARD COUNTY CSS	0.000000	0	0	0	0	93.06
93.07	04957	CLINTON COUNTY	0.000000	0	0	0	0	93.07
93.18	04968	PSYCH MEDICATION	0.000000	0	0	0	0	93.18
93.43	04993	NEW BEGINNINGS	0.000000	0	0	0	0	93.43
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		49,305,652	0	104,070,145	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0007	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part V Date/Time Prepared: 8/2/2021 3:38 pm
--	--	-----------------------	---	--

Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				Costs	
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000 OPERATING ROOM	0.139628	5,984,502	0	0	835,604	50.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.484564	0	0	0	0	52.00	
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.196156	4,781,835	0	0	937,986	54.00	
54.01	03480 ONCOLOGY	0.176690	10,296,569	0	56	1,819,301	54.01	
57.00	05700 CT SCAN	0.034873	7,490,917	0	0	261,231	57.00	
58.00	05800 MRI	0.098915	2,764,107	0	0	273,412	58.00	
59.00	05900 CARDIAC CATHETERIZATION	0.040116	12,375,633	0	0	496,461	59.00	
60.00	06000 LABORATORY	0.127792	5,341,947	141	0	682,658	60.00	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00	
65.00	06500 RESPIRATORY THERAPY	0.269150	722,429	0	0	194,442	65.00	
66.00	06600 PHYSICAL THERAPY	0.676037	39,012	0	0	26,374	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0.714105	2,718	0	0	1,941	67.00	
68.00	06800 SPEECH PATHOLOGY	0.772415	1,338	0	0	1,033	68.00	
69.00	06900 ELECTROCARDIOLOGY	0.157207	3,084,251	0	0	484,866	69.00	
70.00	07000 ELECTROENCEPHALOGRAPHY	2.034063	2,921	0	0	5,941	70.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.664996	1,712,139	0	0	1,138,566	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.431930	2,605,561	0	0	1,125,420	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	0.229088	33,597,436	0	54,622	7,696,769	73.00	
74.00	07400 RENAL DIALYSIS	0.589597	0	0	0	0	74.00	
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00	
75.01	03950 WOUND CARE CENTER	0.286402	1,303,733	0	0	373,392	75.01	
76.00	03160 CARDIOPULMONARY	0.290679	537,449	0	0	156,225	76.00	
OUTPATIENT SERVICE COST CENTERS								
91.00	09100 EMERGENCY	0.103411	9,457,129	0	505	977,971	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.953446	1,863,458	0	0	1,776,707	92.00	
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	0	0	92.01	
93.00	04950 OTHER OUTPATIENT SERVICES	0.000000	0	0	0	0	93.00	
93.01	04951 GENESIS	0.724362	105,061	0	0	76,102	93.01	
93.02	04952 WOMEN'S CENTER	0.000000	0	0	0	0	93.02	
93.03	04953 RESIDENTIAL HOMES	0.000000	0	0	0	0	93.03	
93.04	04954 DR. STEELE	0.000000	0	0	0	0	93.04	
93.05	04955 DIABETIC EDUCATION	0.000000	0	0	0	0	93.05	
93.06	04956 HOWARD COUNTY CSS	0.508456	0	0	0	0	93.06	
93.07	04957 CLINTON COUNTY	0.645718	0	0	0	0	93.07	
93.18	04968 PSYCH MEDICATION	0.000000	0	0	0	0	93.18	
93.43	04993 NEW BEGINNINGS	0.444598	0	0	0	0	93.43	
OTHER REIMBURSABLE COST CENTERS								
95.00	09500 AMBULANCE SERVICES	0.367213	0	0	0	0	95.00	
200.00	Subtotal (see instructions)		104,070,145	141	55,183	19,342,402	200.00	
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00	
202.00	Net Charges (line 200 - line 201)		104,070,145	141	55,183	19,342,402	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0007

Period:
From 01/01/2020
To 12/31/2020

Worksheet D
Part V
Date/Time Prepared:
8/2/2021 3:38 pm

		Title XVIII		Hospital	PPS
Cost Center Description		Costs			
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.) 6.00	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) 7.00		
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300 ANESTHESIOLOGY	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	03480 ONCOLOGY	0	10		54.01
57.00	05700 CT SCAN	0	0		57.00
58.00	05800 MRI	0	0		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000 LABORATORY	18	0		60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500 RESPIRATORY THERAPY	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	12,513		73.00
74.00	07400 RENAL DIALYSIS	0	0		74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0		75.00
75.01	03950 WOUND CARE CENTER	0	0		75.01
76.00	03160 CARDIOPULMONARY	0	0		76.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0	52		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0		92.01
93.00	04950 OTHER OUTPATIENT SERVICES	0	0		93.00
93.01	04951 GENESIS	0	0		93.01
93.02	04952 WOMEN'S CENTER	0	0		93.02
93.03	04953 RESIDENTIAL HOMES	0	0		93.03
93.04	04954 DR. STEELE	0	0		93.04
93.05	04955 DIABETIC EDUCATION	0	0		93.05
93.06	04956 HOWARD COUNTY CSS	0	0		93.06
93.07	04957 CLINTON COUNTY	0	0		93.07
93.18	04968 PSYCH MEDICATION	0	0		93.18
93.43	04993 NEW BEGINNINGS	0	0		93.43
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0	0		95.00
200.00	Subtotal (see instructions)	18	12,575		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0	0		201.00
202.00	Net Charges (line 200 - line 201)	18	12,575		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0007

Period:
From 01/01/2020
To 12/31/2020

Worksheet D
Part V
Date/Time Prepared:
8/2/2021 3:38 pm

		Title XIX		Hospital		Cost	
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.139628	0	860,509	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.484564	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.196156	0	503,953	0	0	54.00
54.01	03480 ONCOLOGY	0.176690	0	787,517	0	0	54.01
57.00	05700 CT SCAN	0.034873	0	993,517	0	0	57.00
58.00	05800 MRI	0.098915	0	153,096	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.040116	0	186,541	0	0	59.00
60.00	06000 LABORATORY	0.127792	0	925,522	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.269150	0	26,237	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.676037	0	1,388	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.714105	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.772415	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.157207	0	90,613	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	2.034063	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.664996	0	23,965	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.431930	0	102,883	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.229088	0	851,908	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.589597	0	0	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
75.01	03950 WOUND CARE CENTER	0.286402	0	49,656	0	0	75.01
76.00	03160 CARDIOPULMONARY	0.290679	0	4,218	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	0.103411	0	3,196,626	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.953446	0	0	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	0	0	92.01
93.00	04950 OTHER OUTPATIENT SERVICES	0.000000	0	0	0	0	93.00
93.01	04951 GENESIS	0.724362	0	139,736	0	0	93.01
93.02	04952 WOMEN'S CENTER	0.000000	0	0	0	0	93.02
93.03	04953 RESIDENTIAL HOMES	0.000000	0	0	0	0	93.03
93.04	04954 DR. STEELE	0.000000	0	0	0	0	93.04
93.05	04955 DIABETIC EDUCATION	0.000000	0	0	0	0	93.05
93.06	04956 HOWARD COUNTY CSS	0.508456	0	4,393	0	0	93.06
93.07	04957 CLINTON COUNTY	0.645718	0	0	0	0	93.07
93.18	04968 PSYCH MEDICATION	0.000000	0	0	0	0	93.18
93.43	04993 NEW BEGINNINGS	0.444598	0	0	0	0	93.43
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0.367213	0	0	0	0	95.00
200.00	Subtotal (see instructions)		0	8,902,278	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00	Net Charges (line 200 - line 201)		0	8,902,278	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0007	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part V Date/Time Prepared: 8/2/2021 3:38 pm
	Title XIX	Hospital	Cost

Cost Center Description	Costs		Hospital	Cost
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	120,151	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	98,853	0		54.00
54.01 03480 ONCOLOGY	139,146	0		54.01
57.00 05700 CT SCAN	34,647	0		57.00
58.00 05800 MRI	15,143	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	7,483	0		59.00
60.00 06000 LABORATORY	118,274	0		60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00 06500 RESPIRATORY THERAPY	7,062	0		65.00
66.00 06600 PHYSICAL THERAPY	938	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	14,245	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	15,937	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	44,438	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	195,162	0		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		75.00
75.01 03950 WOUND CARE CENTER	14,222	0		75.01
76.00 03160 CARDIOPULMONARY	1,226	0		76.00
OUTPATIENT SERVICE COST CENTERS				
91.00 09100 EMERGENCY	330,566	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0		92.01
93.00 04950 OTHER OUTPATIENT SERVICES	0	0		93.00
93.01 04951 GENESIS	101,219	0		93.01
93.02 04952 WOMEN'S CENTER	0	0		93.02
93.03 04953 RESIDENTIAL HOMES	0	0		93.03
93.04 04954 DR. STEELE	0	0		93.04
93.05 04955 DIABETIC EDUCATION	0	0		93.05
93.06 04956 HOWARD COUNTY CSS	2,234	0		93.06
93.07 04957 CLINTON COUNTY	0	0		93.07
93.18 04968 PSYCH MEDICATION	0	0		93.18
93.43 04993 NEW BEGINNINGS	0	0		93.43
OTHER REIMBURSABLE COST CENTERS				
95.00 09500 AMBULANCE SERVICES	0	0		95.00
200.00 Subtotal (see instructions)	1,260,946	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0	0		201.00
202.00 Net Charges (line 200 - line 201)	1,260,946	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0007	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 8/2/2021 3:38 pm
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		16,097	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		16,097	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		14,390	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		4,931	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		25,290,035	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		25,290,035	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		25,290,035	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,571.10	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		7,747,094	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		7,747,094	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0007		Period: From 01/01/2020 To 12/31/2020		Worksheet D-1 Date/Time Prepared: 8/2/2021 3:38 pm	
Cost Center Description			Title XVIII		Hospital		PPS	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)			
42.00	NURSERY (title V & XIX only)	0	0.00	0	0	0	42.00	
Intensive Care Type Inpatient Hospital Units								
43.00	INTENSIVE CARE UNIT	3,274,113	1,617	2,024.81	615	1,245,258	43.00	
44.00	CORONARY CARE UNIT						44.00	
45.00	BURN INTENSIVE CARE UNIT						45.00	
46.00	SURGICAL INTENSIVE CARE UNIT						46.00	
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00	
Cost Center Description								
						1.00		
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					9,542,176	48.00	
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					18,534,528	49.00	
PASS THROUGH COST ADJUSTMENTS								
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					583,170	50.00	
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					477,344	51.00	
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,060,514	52.00	
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					17,474,014	53.00	
TARGET AMOUNT AND LIMIT COMPUTATION								
54.00	Program discharges					0	54.00	
55.00	Target amount per discharge					0.00	55.00	
56.00	Target amount (line 54 x line 55)					0	56.00	
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00	
58.00	Bonus payment (see instructions)					0	58.00	
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00	
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00	
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00	
62.00	Relief payment (see instructions)					0	62.00	
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00	
PROGRAM INPATIENT ROUTINE SWING BED COST								
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00	
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00	
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00	
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00	
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00	
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00	
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY								
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00	
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00	
72.00	Program routine service cost (line 9 x line 71)						72.00	
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00	
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00	
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00	
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00	
77.00	Program capital-related costs (line 9 x line 76)						77.00	
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00	
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00	
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00	
81.00	Inpatient routine service cost per diem limitation						81.00	
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00	
83.00	Reasonable inpatient routine service costs (see instructions)						83.00	
84.00	Program inpatient ancillary services (see instructions)						84.00	
85.00	Utilization review - physician compensation (see instructions)						85.00	
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00	
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST								
87.00	Total observation bed days (see instructions)					1,707	87.00	
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,571.10	88.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,681,868	89.00	

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0007

Period:
From 01/01/2020
To 12/31/2020

Worksheet D-1
Date/Time Prepared:
8/2/2021 3:38 pm

Cost Center Description	Cost	Title XVIII		Hospital	PPS	
		Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	1,687,164	25,290,035	0.066713	2,681,868	178,915	90.00
91.00 Nursing School cost	0	25,290,035	0.000000	2,681,868	0	91.00
92.00 Allied health cost	0	25,290,035	0.000000	2,681,868	0	92.00
93.00 All other Medical Education	0	25,290,035	0.000000	2,681,868	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0007	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 8/2/2021 3:38 pm
Cost Center Description		Title XIX	Hospital	Cost
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		16,097	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		16,097	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		14,390	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		631	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		725	15.00
16.00	Nursery days (title V or XIX only)		502	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		25,290,035	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		25,290,035	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		25,290,035	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,571.10	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		991,364	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		991,364	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0007	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 8/2/2021 3:38 pm		
Cost Center Description			Title XIX		Hospital	Cost	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00	NURSERY (title V & XIX only)	636,802	725	878.35	502	440,932	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	3,274,113	1,617	2,024.81	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					712,546	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,144,842	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					1,707	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,571.10	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,681,868	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0007

Period:
From 01/01/2020
To 12/31/2020

Worksheet D-1
Date/Time Prepared:
8/2/2021 3:38 pm

Cost Center Description	Cost	Title XIX		Hospital	Cost	
		Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	1,687,164	25,290,035	0.066713	2,681,868	178,915	90.00
91.00 Nursing School cost	0	25,290,035	0.000000	2,681,868	0	91.00
92.00 Allied health cost	0	25,290,035	0.000000	2,681,868	0	92.00
93.00 All other Medical Education	0	25,290,035	0.000000	2,681,868	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0007	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 8/2/2021 3:38 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		12,193,909		30.00
31.00	03100 INTENSIVE CARE UNIT		3,178,639		31.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.139628	9,595,968	1,339,866	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.484564	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.196156	1,266,837	248,498	54.00
54.01	03480 ONCOLOGY	0.176690	93,490	16,519	54.01
57.00	05700 CT SCAN	0.034873	3,093,657	107,885	57.00
58.00	05800 MRI	0.098915	365,160	36,120	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.040116	5,305,271	212,826	59.00
60.00	06000 LABORATORY	0.127792	7,953,510	1,016,395	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.269150	2,839,762	764,322	65.00
66.00	06600 PHYSICAL THERAPY	0.676037	495,332	334,863	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.714105	326,751	233,335	67.00
68.00	06800 SPEECH PATHOLOGY	0.772415	61,557	47,548	68.00
69.00	06900 ELECTROCARDIOLOGY	0.157207	1,124,689	176,809	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	2.034063	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.664996	1,685,920	1,121,130	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.431930	3,062,277	1,322,689	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.229088	5,990,240	1,372,292	73.00
74.00	07400 RENAL DIALYSIS	0.589597	379,307	223,638	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
75.01	03950 WOUND CARE CENTER	0.286402	116,453	33,352	75.01
76.00	03160 CARDIOPULMONARY	0.290679	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.103411	5,125,709	530,055	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.953446	423,762	404,034	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	92.01
93.00	04950 OTHER OUTPATIENT SERVICES	0.000000	0	0	93.00
93.01	04951 GENESIS	0.724362	0	0	93.01
93.02	04952 WOMEN'S CENTER	0.000000	0	0	93.02
93.03	04953 RESIDENTIAL HOMES	0.000000	0	0	93.03
93.04	04954 DR. STEELE	0.000000	0	0	93.04
93.05	04955 DIABETIC EDUCATION	0.000000	0	0	93.05
93.06	04956 HOWARD COUNTY CSS	0.508456	0	0	93.06
93.07	04957 CLINTON COUNTY	0.645718	0	0	93.07
93.18	04968 PSYCH MEDICATION	0.000000	0	0	93.18
93.43	04993 NEW BEGINNINGS	0.444598	0	0	93.43
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		49,305,652	9,542,176	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		49,305,652		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0007	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 8/2/2021 3:38 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		1,519,935	30.00
31.00	03100	INTENSIVE CARE UNIT		341,745	31.00
43.00	04300	NURSERY		228,554	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.139628	615,705	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.484564	126,692	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.196156	94,538	54.00
54.01	03480	ONCOLOGY	0.176690	2,251	54.01
57.00	05700	CT SCAN	0.034873	234,375	57.00
58.00	05800	MRI	0.098915	44,007	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.040116	497,927	59.00
60.00	06000	LABORATORY	0.127792	726,526	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.269150	171,729	65.00
66.00	06600	PHYSICAL THERAPY	0.676037	25,812	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.714105	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.772415	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.157207	66,015	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2.034063	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.664996	151,316	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.431930	83,738	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.229088	611,409	73.00
74.00	07400	RENAL DIALYSIS	0.589597	12,459	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	75.00
75.01	03950	WOUND CARE CENTER	0.286402	10,204	75.01
76.00	03160	CARDIOPULMONARY	0.290679	0	76.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.103411	577,520	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.953446	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	92.01
93.00	04950	OTHER OUTPATIENT SERVICES	0.000000	0	93.00
93.01	04951	GENESIS	0.724362	0	93.01
93.02	04952	WOMEN'S CENTER	0.000000	0	93.02
93.03	04953	RESIDENTIAL HOMES	0.000000	0	93.03
93.04	04954	DR. STEELE	0.000000	0	93.04
93.05	04955	DIABETIC EDUCATION	0.000000	0	93.05
93.06	04956	HOWARD COUNTY CSS	0.508456	0	93.06
93.07	04957	CLINTON COUNTY	0.645718	0	93.07
93.18	04968	PSYCH MEDICATION	0.000000	0	93.18
93.43	04993	NEW BEGINNINGS	0.444598	0	93.43
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,052,223	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		4,052,223	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0007	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 8/2/2021 3:38 pm
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		8,681,422	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		3,834,503	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)			2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)		154,233	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		27,820	2.04
3.00	Managed Care Simulated Payments		6,750,041	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		108.24	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		7.33	30.00
31.00	Percentage of Medicaid patient days (see instructions)		28.13	31.00
32.00	Sum of lines 30 and 31		35.46	32.00
33.00	Allowable disproportionate share percentage (see instructions)		18.47	33.00
34.00	Disproportionate share adjustment (see instructions)		577,923	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0007	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 8/2/2021 3:38 pm
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)	8,350,599,096	8,290,014,521	35.00
35.01	Factor 3 (see instructions)	0.000193285	0.000117171	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,614,048	971,347	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	1,208,331	244,833	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,453,164		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0	46.00
47.00	Subtotal (see instructions)	14,729,065		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0	48.00
				Amount
				1.00
49.00	Total payment for inpatient operating costs (see instructions)		14,729,065	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,046,631	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		157,492	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		15,933,188	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		15,933,188	61.00
62.00	Deductibles billed to program beneficiaries		1,326,864	62.00
63.00	Coinurance billed to program beneficiaries		6,831	63.00
64.00	Allowable bad debts (see instructions)		100,615	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		65,400	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		61,990	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		14,664,893	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		63,854	70.93
70.94	HRR adjustment amount (see instructions)		-61,491	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0007	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 8/2/2021 3:38 pm
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		14,667,256	71.00
71.01	Sequestration adjustment (see instructions)		96,804	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs		0	71.03
72.00	Interim payments		14,281,471	72.00
72.01	Interim payments-PARHM			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		288,981	74.00
74.01	Balance due provider/program-PARHM (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		480,076	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)			90.00
91.00	Capital outlier from Wkst. L, Pt. 1, line 2			91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)			95.00
96.00	Time value of money for capital related expenses (see instructions)			96.00
			Prior to 10/1	On/After 10/1
			1.00	2.00
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)		0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)		0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. 11, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0007	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 8/2/2021 3:38 pm
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		12,593	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		19,342,402	2.00
3.00	OPPS payments		14,514,481	3.00
4.00	Outlier payment (see instructions)		72,870	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		12,593	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		55,324	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		55,324	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		55,324	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		42,731	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		12,593	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		14,587,351	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		28	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		2,533,654	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		12,066,262	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		12,066,262	30.00
31.00	Primary payer payments		41	31.00
32.00	Subtotal (line 30 minus line 31)		12,066,221	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		217,882	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		141,623	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		203,016	36.00
37.00	Subtotal (see instructions)		12,207,844	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		12,207,844	40.00
40.01	Sequestration adjustment (see instructions)		80,572	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		12,194,273	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		-67,001	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0007

Period:
From 01/01/2020
To 12/31/2020

Worksheet E-1
Part I
Date/Time Prepared:
8/2/2021 3:38 pm

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		14,281,471		12,194,273	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		14,281,471		12,194,273	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		288,981		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		67,001	6.02	
7.00	Total Medicare program liability (see instructions)		14,570,452		12,127,272	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 15-0007	Period: From 01/01/2020 To 12/31/2020	Worksheet E-1 Part II Date/Time Prepared: 8/2/2021 3:38 pm
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 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 certified HIT technology Wkst. S-2, Pt. I line 168			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 instructions)			32.00

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

Provider CCN: 15-0007

Period:
From 01/01/2020
To 12/31/2020

Worksheet G

Date/Time Prepared:
8/2/2021 3:38 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	40,892	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	16,667	0	0	0	3.00
4.00	Accounts receivable	78,650,986	0	0	0	4.00
5.00	Other receivable	111,903	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-54,828,012	0	0	0	6.00
7.00	Inventory	4,456,345	0	0	0	7.00
8.00	Prepaid expenses	652,301	0	0	0	8.00
9.00	Other current assets	1,234,021	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	30,335,103	0	0	0	11.00
FIXED ASSETS						
12.00	Land	4,583,000	0	0	0	12.00
13.00	Land improvements	4,193,828	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	106,475,207	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	139,419	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	35,319,441	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	364,270	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	-55,133,266	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	95,941,899	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	123,393,463	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	123,393,463	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	249,670,465	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	835,989	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	11,161,804	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	11,997,793	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	11,506,625	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	11,506,625	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	23,504,418	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	226,166,047	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	226,166,047	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	249,670,465	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0007

Period:
From 01/01/2020
To 12/31/2020

Worksheet G-1

Date/Time Prepared:
8/2/2021 3:38 pm

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		202,788,526		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		23,377,521			2.00
3.00	Total (sum of line 1 and line 2)		226,166,047		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		226,166,047		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		226,166,047		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 15-0007

Period:
From 01/01/2020
To 12/31/2020

Worksheet G-2
Parts I & II
Date/Time Prepared:
8/2/2021 3:38 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	21,820,836		21,820,836	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	21,820,836		21,820,836	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	8,330,723		8,330,723	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	8,330,723		8,330,723	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	30,151,559		30,151,559	17.00
18.00	Ancillary services	152,388,378	387,807,991	540,196,369	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	464,174	464,174	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	182,539,937	388,272,165	570,812,102	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		153,741,356		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		153,741,356		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-0007

Period:
From 01/01/2020
To 12/31/2020

Worksheet G-3

Date/Time Prepared:
8/2/2021 3:38 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	570,812,102	1.00
2.00	Less contractual allowances and discounts on patients' accounts	411,951,513	2.00
3.00	Net patient revenues (line 1 minus line 2)	158,860,589	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	153,741,356	4.00
5.00	Net income from service to patients (line 3 minus line 4)	5,119,233	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	147,508	6.00
7.00	Income from investments	5,769,228	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	2,032	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	404,495	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	3,722	22.00
23.00	Governmental appropriations	2,435,780	23.00
24.00	MISC REVENUE	4,915,462	24.00
24.50	COVID-19 PHE Funding	4,577,412	24.50
25.00	Total other income (sum of lines 6-24)	18,255,639	25.00
26.00	Total (line 5 plus line 25)	23,374,872	26.00
27.00	INCOME TAX	-2,649	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	-2,649	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	23,377,521	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0007	Period: From 01/01/2020 To 12/31/2020	Worksheet L Parts I-III Date/Time Prepared: 8/2/2021 3:38 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		965,604	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		9,186	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		44.49	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		7.33	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		28.13	8.00
9.00	Sum of lines 7 and 8		35.46	9.00
10.00	Allowable disproportionate share percentage (see instructions)		7.44	10.00
11.00	Disproportionate share adjustment (see instructions)		71,841	11.00
12.00	Total prospective capital payments (see instructions)		1,046,631	12.00
		1.00		
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
		1.00		
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00