Heal th Financia	al Systems	DEARBORN COUNTY H	OSPI TAI	Inlie	u of Form CMS-2552-10				
This report is	required by law (42 USC 139) since the beginning of the co	5g; 42 CFR 413.20(b)). Failu	re to report can r	esult in all interim	· · · · · · · · · · · · · · · · · · ·				
HOSPITAL AND H AND SETTLEMENT	OSPITAL HEALTH CARE COMPLEX ('SUMMARY	COST REPORT CERTIFICATION	Provider CCN: 1500	From 01/01/2014					
PART I - COST	To 12/31/2014 Date/Time Prepared: 5/29/2015 10:53 am I - COST REPORT STATUS ider 1. [X] Electronically filed cost report Date: 5/29/2015 Time: 10:53 am								
Provi der use only				Date: 5/29/20	015 Time: 10:53 am				
	 [0] If this is an amende [F] Medicare Utilization 	d report enter the number of . Enter "F" for full or "L"	f times the provide for low.	er resubmitted this c	ost report				
Contractor use only	5. [1]Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened		this Provider CCN						

PART II - CERTIFICATION

(5) Amended

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by DEARBORN COUNTY HOSPITAL (150086) for the cost reporting period beginning 01/01/2014 and ending 12/31/2014 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.

(Si gned)	
	Officer or Administrator of Provider(s)
Title	
Date	

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-115, 929	-26, 020	54, 184	-998, 270	1.00
2.00	Subprovi der - IPF	0	0	0		0	2.00
3.00	Subprovi der - I RF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5. 00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9. 00
200.00	Total	0	-115, 929	-26, 020	54, 184	-998, 270	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.

	will cit lifethou is used to determine medical duays on in					9	IN	23.00
1	1, enter 1 if date of admission, 2 if census days, or	⁻ 3 if date	of dischar	ge. Is the				
n	method of identifying the days in this cost reporting	period dit	fferent fro	om the metho	od			
l	used in the prior cost reporting period? In column 2	2, enter "Y	for yes c	or "N" for r	no.			
		In-State	In-State	Out-of	Out-of	Medi cai d	0ther	
		Medicaid	Medi cai d	State	State	HMO days	Medi cai d	
		paid days	eligible	Medi cai d	Medi cai d		days	
		'	unpai d	paid days	eligible			
			days		unpai d			
		1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
24. 00 I	If this provider is an IPPS hospital, enter the	1, 147	485	0	534	874	0	24. 00
li li	in-state Medicaid paid days in column 1, in-state							
V	Medicaid eligible unpaid days in column 2,							
c	out-of-state Medicaid paid days in column 3,							
c	out-of-state Medicaid eligible unpaid days in column							
1	4, Medicaid HMO paid and eligible but unpaid days in							
	column 5, and other Medicaid days in column 6.							
	If this provider is an IRF, enter the in-state	l ol	0	0	0	0		25. 00
	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.							
l,	ino para ana erigibi e bat anpara days in cordini 5.	ı		1	I	1	l	I

Ν

23.00

23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column

care or general surgery. (see instructions)

Health Financial Systems DEARBORN COUNTY HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 150086 Peri od: Worksheet S-2 From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/29/2015 8:57 am Program Name Program Code Unweighted IME Unwei ghted Direct GME FTE FTE Count Count 1.00 2.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0.00 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count. 61. 20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column direct GME FTE unweighted count. 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 62 01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter N 63.00 for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions) Unwei ahted Ratio (col. 1/ Unwei ahted **FTES** FTEs in (col . 1 + col Nonprovi der Hospi tal 2)) Si te 1. 00 2.00 3.00 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. 64.00 Enter in column 1, if line 63 is yes, or your facility trained residents 0.000000 64.00 0.00 n the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider 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) Unwei ghted Program Name Program Code Unwei ghted Ratio (col. 3/ FTĔs FTEs in (col. 3 + col. Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 0.00 0.00 0.000000 65.00 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)

Health Financial Systems DEARBORN COUNTY HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 150086 Peri od: Worksheet S-2 From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/29/2015 8:57 am Unwei ghted Unwei ghted Ratio (col. (col. 1 + col FTEs FTEs in Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 0. 00 66.00 Enter in column 1 the number of unweighted non-primary care resident 0.00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Program Code Unwei ghted Unwei ghted Ratio (col. 3/ FTEs FTEs in (col. 3 + colNonprovi der Hospi tal 4)) Si te 1.00 2 00 3. 00 4.00 5 00 67.00 Enter in column 1, the program 0.00 0.00 0.000000 67.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS 70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? N 70.00 Enter "Y" for yes or "N" for no. If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most 71.00 0 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF Ν 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most 0 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions) 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. 80.00 N 81.00 | Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter N 81.00 Y" for yes and "N" for no. 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. 86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section N 85.00 86.00 §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.

Health Financial Systems	DEARBORN COU	NTY HOSPITAL			In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provi der	CCN: 150086	Peri od:	/01 /2014	Worksheet S-	2
					/01/2014 /31/2014	Part I Date/Time Pr	
						5/29/2015 8:	57 am
					1. 00	2. 00	
128.00 If this is a Medicare certified I in column 1 and termination date,			cation date	!			128. 00
129.00 If this is a Medicare certified I	ung transplant center, ent		cation date	in			129. 00
column 1 and termination date, if 130.00 of this is a Medicare certified page 130.00 column 1 and termination date, if		enter the cert	ification				130. 00
date in column 1 and termination	date, if applicable, in co	olumn 2.					
131.00 If this is a Medicare certified in date in column 1 and termination	•	•	ertification				131. 00
132.00 If this is a Medicare certified is			cation date				132. 00
in column 1 and termination date, 133.00 If this is a Medicare certified or			cation date	,			133. 00
in column 1 and termination date, 134.00 If this is an organ procurement or			n column 1				134. 00
and termination date, if applicab		The OFO Humber 1	TI COLUMNI I				134.00
All Providers 140.00 Are there any related organization	n or home office costs as	defined in CMS	Dub 15_1		N		140. 00
chapter 10? Enter "Y" for yes or				s	IV.		140.00
are claimed, enter in column 2 the	e home office chain number		i ons)		3. 00		
If this facility is part of a cha			ugh 143 the	name and		of the	
home office and enter the home of 141.00 Name:	fice contractor name and of Contractor's Name:	contractor number		tor's Num	her:		141. 00
142. 00 Street:	PO Box:		Contrac	toi s ivuii	ibei .		142. 00
143. 00 Ci ty:	State:		Zi p Cod	e:			143. 00
						1.00	
144.00 Are provider based physicians' con 145.00 If costs for renal services are continuous and services are continuous are continuous and services are continuous			octo for in	nationt o	sorvi coc	Y N	144. 00 145. 00
only? Enter "Y" for yes or "N" for		ie 74, are the c	.0515 101 111	patrents	sei vi ces	IN	145.00
					1 00	2.00	
146.00 Has the cost allocation methodolog	gy changed from the previo	ously filed cost	report?		1. 00 N	2.00	146. 00
Enter "Y" for yes or "N" for no in the approval date (mm/dd/yyyy) in	n column 1. (See CMS Pub.			r			
147.00Was there a change in the statist		yes or "N" for	no.		N		147. 00
148.00 Was there a change in the order of				_	N		148. 00
149.00 Was there a change to the simplifunc.	rea cost finaing methoa? E	inter y for ye	es or N To	·r	N		149. 00
		Part A 1.00	Part B 2.00		tle V 3.00	Title XIX 4.00	
Does this facility contain a prov	ider that qualifies for an						
or charges? Enter "Y" for yes or 155.00 Hospi tal	"N" for no for each compo	nent for Part A	and Part B.	(See 42	CFR §413	· '	155. 00
156.00 Subprovider - IPF		N N	N N		N	N N	156. 00
157. 00 Subprovi der – IRF		N	N		N	N	157. 00
158. 00 SUBPROVI DER 159. 00 SNF		N	N		N	N	158. 00 159. 00
160.00 HOME HEALTH AGENCY		N	N N		N	N	160.00
161. 00 CMHC			N N		N	N	161. 00
Mul ti campus						1. 00	
Multicampus 165.00 Is this hospital part of a Multica	ampus hospital that has or	ne or more campu	uses in diff	erent CBS	SAs?	N	165. 00
Enter "Y" for yes or "N" for no.						FTF /Compute	
	Name 0	County 1.00	2. 00	i p Code 3.00	4. 00	FTE/Campus 5.00	_
166.00 If line 165 is yes, for each campus enter the name in column							00 166. 00
O, county in column 1, state in							
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in							
column 5 (see instructions)							
						1. 00	
Health Information Technology (HI							
167.00 is this provider a meaningful use 168.00 if this provider is a CAH (line 10					the	Y	167. 00 0168. 00
reasonable cost incurred for the	HIT assets (see instructio	ons)					
169.00 If this provider is a meaningful transition factor. (see instruction		lis not a CAH ((line 105 is	"N"), er	nter the	0.5	50169.00
THE STATE OF THE PARTY OF THE STATE OF THE S	one,					I	I

Health Financial Systems	DEARBORN COUNTY H	OSPI TAL	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENT	IFICATION DATA	Provi der CCN: 150086	Peri od:	Worksheet S-2	
			From 01/01/2014		
			To 12/31/2014		
			Begi nni ng	5/29/2015 8:5	/ am
	Endi ng				
	2.00				
170.00 Enter in columns 1 and 2 the EHR beginning period respectively (mm/dd/yyyy)	01/01/2014	12/31/2014	170. 00		
				1.00	
171.00 If line 167 is "Y", does this provider had Medicare cost plans reported on Wkst. S-3 (see instructions)				N	171. 00

Description Y/N Date Y/N Date Y/N Date Y/N Date Description Y/N Date Description Y/N Date Date Y/N Date Description Y/N Date D					-	To 12/31/2014	Date/Time P 5/29/2015 8	
Description Y/N Date Y/N Date Y/N Description Y/N Description Y/N Description Y/N Description Y/N Description Y/N Description N N N N N N N N N					Pa	rt A		. 57 a
O 1.00 2.00 3.00 N N N N N N N N N			Descr	iption				
Name								
provider's records? If yes, see 1.00	00 Was the o	rost report prepared only using the				2.00		21
instructions. 1.00					IN IN		IN IN	-
COMPLETED BY COST REIMBURSED AND TERRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related Cost Native assets been relifed for Medicare purposes? If yes, see instructions Native assets been relifed for Medicare depreciation expense due to appraisals made during the cost no Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost neporting period? If yes, see instructions Native new Leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions. Native there been new capitalized leases entered into during the cost reporting period? If yes, see instructions. Native there been new capitalized leases entered into during the cost reporting period? If yes, see instructions. Native assets subject to Sec, 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions. Native assets subject to Sec, 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions. Native assets subject to Sec, 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions. Native assets subject to Sec, 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions. Native asset in the cost reporting period? If yes, see instructions. Native asset in the cost reporting period? If yes, see instructions. Native asset in yes, yes and the provider asset physicians? Native asset in yes, yes and yes asset yes asset yes and yes asset yes asset yes and yes asset yes yes asset yes asset yes yes asset yes asset yes yes asset								
COMPLETED BY COST REIMBURSD AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related Cost Capital Related Cost Nave assets been relifed for Medicare purposes? If yes, see instructions Nave new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see Instructions. Nave new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see National Nave new Leases and/or amendments to existing leases entered into during the cost reporting period? If yes, see National Nave new Leaves and/or both or the cost reporting period? If yes, see National Nave new Leaves Nave Nave Nave Nave Nave Nave Nave Nave	ITHSTIUCTI	UIS.						
COMPLETED BY COST REIMBURSD AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related Cost Capital Related Cost Nave assets been relifed for Medicare purposes? If yes, see instructions Nave new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see Instructions. Nave new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see National Nave new Leases and/or amendments to existing leases entered into during the cost reporting period? If yes, see National Nave new Leaves and/or both or the cost reporting period? If yes, see National Nave new Leaves Nave Nave Nave Nave Nave Nave Nave Nave							4.00	_
Capital Related Cost OB Have assess been relifed for Medicare purposes? If yes, see instructions N reporting period? If yes, see N reporting period? If yes, see N respective N reporting period? If yes, see N respective N reporting period? If yes, see N respective N res							1. 00	
0.0 Have assets been relifed for Medicare purposes? If yes, see instructions	COMPLETED	BY COST REIMBURSED AND TEFRA HOSPIT	TALS ONLY (EXC	EPT CHILDRENS H	OSPI TALS)			
0.0 Have assets been relifed for Medicare purposes? If yes, see instructions	Capital R	elated Cost						
Name			es? If yes se	e instructions			N	7 22
Ower one leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions. Note: The provider is a provider in the provider is a provider in the provider in the provider is a provider in the provider is a provider in the provider in the provider is a part of the provider in the provider is a part of the provider in the provider					ala mada duni.	ag +ba aga+		2
Vere new leases and/or amendments to existing leases entered into during this cost reporting period? Y If yes, see instructions			ati on expense	uue to apprais	ars made durri	ig the cost	IN	2.
Ol Have there been new capitalized leases entered into during the cost reporting period? If yes, see								
Name	.00 Were new	leases and/or amendments to existing	g Leases enter	ed into during	this cost repo	orting period?	Y	2
OWER ASSETS subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see N instructions. OWER OWER OWER OWER OWER OWER OWER OWER	If yes, s	see instructions						
OWER ASSETS subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see N instructions. OWER OWER OWER OWER OWER OWER OWER OWER	.00 Have ther	re been new capitalized Leases entere	ed into durina	the cost repor	ting period? I	lf ves. see	N	2
Now		•			9	,		-
Ol Has the provider's capitalization policy changed during the cost reporting period? If yes, submit N copy. Interest Expense OWere new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions. OD bid the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) N treated as a funded depreciation account? If yes, see instructions OD Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see y instructions. OD Has existing debt been recalled before scheduled maturity without issuance of new debt? If yes, see N instructions. OD Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N instructions. OD Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. OD Have changes or new agreements or Sec. 2135.2 applied pertaining to competitive bidding? If yes, see instructions. OD If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If yes, see instructions. OD If yes, see yes, has a home office cost statement been prepared by the home office? OD If yes, yes, yes, yes, yes, yes, yes, yes,			il mad diimi ma +l	ha aaat mamamti	na noniodo If		N.	2
Name			arred durring ti	ne cost reporti	ng perrou? II	yes, see	IN	-
Copy. Interest Expense								
Interest Expense	.00 Has the p	orovider's capitalization policy char	nged during the	e cost reportin	ng period? If y	yes, submit	N	2
Were new Loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions. N	copy.							
Were new Loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions. N	Interest	Expense						
Depriod? If yes, see instructions. Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) N treated as a funded depreciation account? If yes, see instructions Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions. Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see Instructions. Purchased Services N Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. Provider-Based Physicians Of If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions. Provider-Based Physicians Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions. Provider-Based Physicians Are services furnished at the provider facility under an arrangements with the provider-based N if yes, see instructions and yes, were there new agreements or amended existing agreements with the provider-based N if yes, see instructions during the cost reporting period? If yes, see instructions. Were home office costs claimed on the cost report? Office Costs Were home office costs claimed on the cost report? If Jine 36 is yes, has a home office cost statement been prepared by the home office? If Jine 36 is yes, has a home office cost statement been prepared by the home office. Office Si yes, did the provider render services to other chain components? If yes, see instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report preparer in columns 1, 2, and 3, respectively. Enter the telephone number and email address of the cost 317-713-7957 Enter the telephone number and email address of the cost 317-713-7957			rs of credit e	ntered into dur	ing the cost i	renortina	V	$\neg \mid_{2}$
Did the provider have a funded depreciation account? If yes, see instructions N			or credit of	intered Tinto dui	ing the cost i	epor triig	· ·	^
treated as a funded depreciation account? If yes, see instructions Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions. Oh Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions. Purchased Services Oh Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions. Provider-Based Physicians Or services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions. If line 34 is yes, were there new agreements or amended existing agreements with the provider-based N physicians during the cost reporting period? If yes, see instructions. Were home office Costs Owere home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been prepared by the home office? If line 36 is yes, was the fiscal year end of the home office? If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. If line 36 is yes, did the provider render services to the home office? If line 36 is yes, did the provider render services to the home office? If line 36 is yes, did the provider render services to the home office? Oo lenter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Cost Report Preparer Contact Information Denter the employer/company name of the cost report preparer in the telephone number and email address of the cost 317-713-7957 Enter the telephone number and email address of the cost 317-713-7957 Enter the telephone number and email address of the cost 317-713-7957 Enter the telephone number and email address of the cost 317-713-7957			/	h1 - (D-	L+ C	FI)	N.	2
Name					bt Service Res	serve Funa)	IN IN	4
Instructions Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N								
Name Office Costs Name Office Costs Name office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been prepared by the home office? If line 36 is yes, did the provider render services to the home office? If line 36 is yes, did the provider render services to the home office? If yes, see instructions. Name of the cost report preparer. Name of the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report preparer. SMITH=BLUEANDCO. COM See Cost IT+@BLUEANDCO. COM If line 36 is yes/company name of the cost report in patient care services furnished through contractual of the provider of the provider facility under an arrangement with provider company to competitive bidding? If no, see instructions. Y If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians? Y If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians? N Date 1.00 2.00 N Date 1.00 2.00 N Date 1.00 2.00 Date 1.00 2.00 Date 1.00 Date 1.00 Date 1.00 Date 1.00 Date	00 Has exist	ing debt been replaced prior to its	scheduled mati	urity with new	debt? If yes,	see	Y	3
Name Office Costs Name Office Costs Name office costs claimed on the cost report? If line 36 is yes, was the fiscal year end of the home office? If line 36 is yes, did the provider render services to the home office? If line 36 is yes, did the provider render services to the home office? If yes, see instructions. Name Office Cost Report Preparer Contact Information Name Office Cost Report Preparer Company name of the cost report Shuff Preparer Company name of the cost report Preparer Company name of the cost report Shuff Preparer Company name of the cost report Shu	instructi	ons.						
Instructions Purchased Services Purchased Services	1		rity without i	ssuance of new	debt? If ves	see	N	3
Purchased Services Note			. ty thout		405t you,			`
Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.								
arrangements with suppliers of services? If yes, see instructions. If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions. Provider-Based Physicians Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions. 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. Home Office Costs Y/N Date			<u> </u>					
If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions. Provider-Based Physicians					d through con	tractual	Y	3
no, see instructions. Provider-Based Physicians OA re services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions. If line 34 is yes, were there new agreements or amended existing agreements with the provider-based N physicians during the cost reporting period? If yes, see instructions. PYN Date 1.00 2.00 Were home office Costs OB Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been prepared by the home office? 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. OB If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. OB If line 36 is yes, did the provider render services to the home office? If yes, see instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. DE Enter the employer/company name of the cost report preparer. OB Enter the telephone number and email address of the cost 317-713-7957 KCSMITHeBLUEANDCO. COM	arrangeme	ents with suppliers of services? If y	yes, see instr	uctions.				
no, see instructions. Provider-Based Physicians .00 Are services furnished at the provider facility under an arrangement with provider-based physicians? Y If yes, see instructions. .00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based N physicians during the cost reporting period? If yes, see instructions.	.00 If line 3	32 is yes, were the requirements of S	Sec. 2135.2 app	plied pertainin	g to competiti	ive bidding? If		3
Provider-Based Physicians Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions. N Home Office Costs Were home office costs claimed on the cost report? If yes, see instructions. N Home Office Costs OU Were home office costs claimed on the cost report? If yes, see instructions. N If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions. If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. If line 36 is yes, did the provider render services to the home office? If yes, see instructions. OU If line 36 is yes, did the provider render services to the home office? If yes, see instructions. OU If line 36 is yes, did the provider render services to the home office? If yes, see instructions. OU Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. OU Enter the employer/company name of the cost report preparer. OU Enter the telephone number and email address of the cost 317-713-7957 KCSMI TH@BLUEANDCO. COM	no, see i	nstructions.			•	-		
Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions. N If line 34 is yes, were there new agreements or amended existing agreements with the provider-based N physicians during the cost reporting period? If yes, see instructions. N								
If yes, see instructions. If line 34 is yes, were there new agreements or amended existing agreements with the provider-based N N			ty under an a	rrangomont with	nrovi don base	nd physicians?	V	3
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. Y/N Date 1.00 2.00			ty under an a	rrangement wrth	provider-base	eu physicians?	ı	د ا
physicians during the cost reporting period? If yes, see instructions. Y/N Date 1.00 2.00								
Home Office Costs Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been prepared by the home office? If line 36 is yes, has a home office cost statement been prepared by the home office? If line 36 is yes, see instructions. If line 36 is yes, enter in column 2 the fiscal year end of the home office. If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. If line 36 is yes, did the provider render services to the home office? If yes, see instructions. If line 36 is yes, did the provider render services to the home office? If yes, see instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report preparer. BLUE & CO., LLC preparer. KCSMITH@BLUEANDCO. COM	.00 If line 3	34 is yes, were there new agreements	or amended exi	isting agreemen	ıts with the pı	rovi der-based	N	3
Home Office Costs Were home office costs claimed on the cost report? Office Costs was a home office cost statement been prepared by the home office? If yes, see instructions. Office Costs 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. Office Costs was the fiscal year end of the home office. Office Costs was the fiscal year end of the home office. Office Costs was the fiscal year end of the home office. Office Costs was the fiscal year end of the home office. Office Costs was the fiscal year end of the home office. Office Costs was the fiscal year end of the home office. Office Costs was the fiscal year end of the home office. Office Costs was the fiscal year end of the home office. Office Costs was the fiscal year end of the home office. Office Costs was the fiscal year end of the home office. Office Costs was the fiscal year end of the home office. Office Costs was the fiscal year end of the home office. Office Costs was the fiscal year end of the home office. Office Costs was the fiscal year end of the home office. Office Costs was the fiscal year end of the home office. Office Costs was the fiscal year end of the home office. Office Costs was the fiscal year end of the home office. Office Costs was the fiscal year end of the home office. Office Costs was the fiscal year end of the home office. Office Costs was the fiscal year end of the home office. Office Costs was the fiscal year end of the home office. Office Costs was the fiscal year end of the home office. Office Costs was the fiscal year end of the home office. Office Costs was the fiscal year end of the home office. Office Costs was the fiscal year end of the home office. Office Costs was the fiscal year end of the home office. Office Costs was the fiscal year end of the home office. Office Costs was the fiscal year end of the home office. Office Costs was the fiscal year end of the home office. Office Costs was the fisca	physi ci ar	is during the cost reporting period?	If yes, see in	nstructions.				
Home Office Costs Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions. 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. If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. If line 36 is yes, did the provider render services to the home office? If yes, see instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report preparer. BLUE & CO. , LLC preparer. KCSMITH@BLUEANDCO. COM						Y/N	Date	
Home Office Costs Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions. OI 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. If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. If line 36 is yes, did the provider render services to the home office? If yes, see instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report BLUE & CO., LLC preparer. Enter the telephone number and email address of the cost 317-713-7957 KCSMITH@BLUEANDCO.COM								
Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions. 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. If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. If line 36 is yes, did the provider render services to the home office? If yes, see instructions. If line 36 is yes, did the provider render services to the home office? If yes, see In 1.00 2.00 Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. On Enter the employer/company name of the cost report Preparer. Description: BLUE & CO., LLC Preparer. Cost It in 26 is yes, did the provider render services to the home office. N N N N N N N N N N N N Enter the home office? If yes, see If yes, see In 1.00 2.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report Preparer. Enter the telephone number and email address of the cost 317-713-7957 Enter the telephone number and email address of the cost 317-713-7957 Enter the telephone number and email address of the cost 317-713-7957	Homo Offi	co Costs				1.00	2.00	
If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions. 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. If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. If line 36 is yes, did the provider render services to the home office? If yes, see instructions. 1.00 2.00			+2			I N		-
If yes, see instructions. 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. If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. If line 36 is yes, did the provider render services to the home office? If yes, see instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report preparer. Enter the telephone number and email address of the cost 317-713-7957 KCSMITH@BLUEANDCO. COM						N		3
O			atement been p	repared by the	home office?			3
Of If I in a 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. If I in a 36 is yes, did the provider render services to other chain components? If yes, see instructions. If I in a 36 is yes, did the provider render services to the home office? If yes, see instructions. If I in a 36 is yes, did the provider render services to the home office? If yes, see I 1.00 2.00 Cost Report Preparer Contact Information Enter the first name, I ast name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. On Enter the employer/company name of the cost report BLUE & CO., LLC Preparer. Cost Report Preparer Contact Information KYLE SMITH KCSMITH@BLUEANDCO. COM	If yes, s	see instructions.		-				
the provider? If yes, enter in column 2 the fiscal year end of the home office. If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. If line 36 is yes, did the provider render services to the home office? If yes, see In 1.00 2.00 Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Ou Enter the employer/company name of the cost report Enter the telephone number and email address of the cost 317-713-7957 KCSMITH@BLUEANDCO. COM			of the home of	fice different	from that of			- 1 3
OU If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. OU If line 36 is yes, did the provider render services to the home office? If yes, see If line 36 is yes, did the provider render services to the home office? If yes, see In 1.00 2.00 Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. OU Enter the employer/company name of the cost report preparer. OU Enter the telephone number and email address of the cost 317-713-7957 KCSMITH@BLUEANDCO.COM								Ι,
see instructions. If line 36 is yes, did the provider render services to the home office? If yes, see 1.00 Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report preparer. OU Enter the telephone number and email address of the cost 317-713-7957 KCSMITH@BLUEANDCO.COM								3
00 If line 36 is yes, did the provider render services to the home office? If yes, see 1.00 2.00 Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report preparer. O0 Enter the telephone number and email address of the cost 317-713-7957 KCSMITH@BLUEANDCO.COM			ervices to othe	er charn compon	ents: 11 yes,			3
Instructions.								
Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. OU Enter the employer/company name of the cost report preparer. OU Enter the telephone number and email address of the cost 317-713-7957 ENTER TOWN 1.00 2.00 ENTER TOWN 1.00 2.00 ENTER TOWN 1.00 2.00 ENTER THE BLUE & CO., LLC			ervices to the	home office?	If yes, see			4
Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. OU Enter the employer/company name of the cost report preparer. OU Enter the telephone number and email address of the cost 317-713-7957 ENTER TO 1.00 2.00 ENTER TO 2.00 ENTER TO 3.00 ENTER TO	instructi	ons.					<u></u>	
Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Ou Enter the employer/company name of the cost report BLUE & CO., LLC preparer. Enter the telephone number and email address of the cost 317-713-7957 KCSMITH@BLUEANDCO.COM								
Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. OU Enter the employer/company name of the cost report BLUE & CO., LLC preparer. OU Enter the telephone number and email address of the cost 317-713-7957 KCSMITH@BLUEANDCO.COM				1	00	2	00	
On Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. On Enter the employer/company name of the cost report preparer. On Enter the telephone number and email address of the cost 317-713-7957 KYLE SMITH SMITH SMITH KCSMITH@BLUEANDCO.COM	Cost Dono	rt Propagor Contact Information		1.		2.		
held by the cost report preparer in columns 1, 2, and 3, respectively. Output Description: Descri			/ ' ' '	lou F		CM TU		┥.
respectively. Ou Enter the employer/company name of the cost report preparer. Ou Enter the telephone number and email address of the cost 317-713-7957 KCSMITH@BLUEANDCO.COM		·		KYLE		SMI IH		4
respectively. Ou Enter the employer/company name of the cost report preparer. Ou Enter the telephone number and email address of the cost 317-713-7957 KCSMITH@BLUEANDCO.COM	held by t	he cost report preparer in columns 1	1, 2, and 3,					
00 Enter the employer/company name of the cost report BLUE & CO., LLC preparer. 00 Enter the telephone number and email address of the cost 317-713-7957 KCSMITH@BLUEANDCO.COM								
preparer. Ou Enter the telephone number and email address of the cost 317-713-7957 KCSMITH@BLUEANDCO.COM			report	BLUE & CO LL	C			4
.00 Enter the telephone number and email address of the cost 317-713-7957 KCSMITH@BLUEANDCO.COM			opor t	CO. , LL				"
			-6 -1	217 712 7057		VOCAL TU-PLUE ***	DCO CON	- ∥ .
Treport preparer in columns 1 and 2 respectively				311-113-1951		KC2MI IH@RFNFWN	DCU. CUM	4
1. opo. c. p. opo. o. 111 ooi diiii o. 1 diid 2, 1 oopooti voi y.	report pr	eparer in columns 1 and 2, respectiv	vei y.					

Health Financial Systems	DEARBORN COUNT	TY HOSPITAL	In Lie	u of Form CMS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMEN	T QUESTI ONNAI RE	Provi der CCN: 150086	Peri od: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part II Date/Time Prepared:

					From 01/01/2014 Fo 12/31/2014	Part II Date/Time Pre	
						5/29/2015 8:5	7 am
		Part B	4				
		Date	4				
		4. 00			<u> </u>		
	PS&R Data						
16. 00	Was the cost report prepared using the PS&R	05/06/2015					16. 00
	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						
47.00	instructions)						47.00
17. 00	Was the cost report prepared using the PS&R						17. 00
	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						
18. 00	2 and 4. (see instructions)						18. 00
16.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional						16.00
	claims that have been billed but are not						
	included on the PS&R Report used to file						
	this cost report? If yes, see instructions.						
19. 00							19.00
17.00	made to PS&R Report data for corrections of						17.00
	other PS&R Report information? If yes, see						
	instructions.						
20.00							20.00
	made to PS&R Report data for Other? Describe						
	the other adjustments:						
21.00	Was the cost report prepared only using the						21. 00
	provider's records? If yes, see						
	i nstructi ons.						
				3. 00			
44 00	Cost Report Preparer Contact Information	, , , , ,	MANAGE				44 00
41.00	Enter the first name, last name and the title		MANAGE	R			41. 00
	held by the cost report preparer in columns 1	i, 2, and 3,					
42.00	respectively. Enter the employer/company name of the cost r	conort	1				42. 00
42. 00	preparer.	epor t					42.00
43. 00	1	of the cost					43. 00
43.00	report preparer in columns 1 and 2, respective						43.00
	proport proparer in corumns rand 2, respectiv	/C1 y.	1		1		ı

Health Financial Systems DEARBOOM
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provi der CCN: 150086

						To 12/31/2014	Date/Time P 5/29/2015 8		
				l			I/P Days / 0		aiii
							Visits / Tri		
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V		
	·	Line Number			Avai I abl e				
		1. 00		2. 00	3.00	4. 00	5. 00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		70	25, 55	0.00		0	1.00
	8 exclude Swing Bed, Observation Bed and								
	Hospice days) (see instructions for col. 2								
0.00	for the portion of LDP room available beds)								0.00
2.00	HMO and other (see instructions)								2.00
3. 00 4. 00	HMO IPF Subprovider								3. 00 4. 00
4. 00 5. 00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF							o	4. 00 5. 00
6.00	Hospital Adults & Peds. Swing Bed NF							0	6. 00
7. 00	Total Adults and Peds. (exclude observation			70	25, 55	0.00		0	7. 00
7.00	beds) (see instructions)			70	25, 55	0.00		٩	7.00
8. 00	INTENSIVE CARE UNIT	31. 00		8	2, 92	0.00		o	8. 00
9. 00	CORONARY CARE UNIT				_,]		Ĭ	9. 00
10.00	BURN INTENSIVE CARE UNIT								10.00
11.00	SURGICAL INTENSIVE CARE UNIT							- 1	11.00
12.00	OTHER SPECIAL CARE (SPECIFY)								12.00
13.00	NURSERY	43. 00						0	13.00
14.00	Total (see instructions)			78	28, 47	0.00		0	14.00
15.00	CAH visits							0	15.00
16. 00	SUBPROVI DER - I PF								16.00
17. 00	SUBPROVI DER - I RF								17.00
18. 00	SUBPROVI DER								18. 00
19. 00	SKILLED NURSING FACILITY								19. 00
20. 00	NURSING FACILITY								20. 00
21. 00	OTHER LONG TERM CARE	404 00							21. 00
22. 00	HOME HEALTH AGENCY	101. 00						0	22. 00
23. 00 24. 00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE	116. 00		0		0		- 1	23. 00 24. 00
24. 00	HOSPICE (non-distinct part)	30.00		U	'l	٥		1	24. 00
25. 00	CMHC - CMHC	30.00						1	25. 00
26. 00	RURAL HEALTH CLINIC								26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER								26. 25
27. 00	Total (sum of lines 14-26)			78	8				27. 00
28. 00	Observation Bed Days							o	28. 00
29.00	Ambul ance Trips							1	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								32. 01
	outpatient days (see instructions)								
33. 00	LTCH non-covered days				I				33. 00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Peri od: Worksheet S-3 From 01/01/2014 Part I Date/Time Prepared: 12/31/2014

33.00

5/29/2015 8:57 am Full Time Equivalents I/P Days / O/P Visits / Trips Title XVIII Component Title XIX Total All Total Interns Employees On Pati ents & Residents Payrol I 10.00 6.00 7.00 8.00 9.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 6, 693 1, 093 13, 350 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2 00 HMO and other (see instructions) 1, 633 1, 893 2 00 3.00 HMO IPF Subprovider 3.00 HMO IRF Subprovider 4.00 0 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 0 0 5.00 Hospital Adults & Peds. Swing Bed NF 6.00 0 6.00 7.00 Total Adults and Peds. (exclude observation 6,693 1,093 13, 350 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 1, 140 2, 208 8.00 CORONARY CARE UNIT 9.00 9.00 10.00 BURN INTENSIVE CARE UNIT 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 NURSERY 704 13.00 14.00 Total (see instructions) 7,833 1,093 16, 262 0.00 602.06 14.00 CAH visits 15.00 15.00 SUBPROVIDER - IPF 16.00 16.00 SUBPROVIDER - IRF 17.00 17.00 18.00 SUBPROVI DER 18.00 19.00 SKILLED NURSING FACILITY 19.00 20 00 NURSING FACILITY 20 00 21.00 OTHER LONG TERM CARE 21.00 22.00 HOME HEALTH AGENCY 6,030 783 8, 965 0.00 18. 28 22.00 23.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 HOSPI CE 4, 987 4.38 24 00 3.424 748 0.00 24.00 24. 10 HOSPICE (non-distinct part) 24.10 25. 00 CMHC - CMHC 25.00 26.00 RURAL HEALTH CLINIC 26, 00 FEDERALLY QUALIFIED HEALTH CENTER 26.25 26.25 27.00 Total (sum of lines 14-26) 0.00 624.72 27.00 28.00 Observation Bed Days 172 1,588 28.00 29.00 29.00 Ambul ance Trips 0 30.00 Employee discount days (see instruction) 0 30.00 31.00 Employee discount days - IRF 0 31.00 Labor & delivery days (see instructions) 54 87 32.00 32.00 0 Total ancillary labor & delivery room 32.01 0 32.01 outpatient days (see instructions)

33.00 LTCH non-covered days

| In Lieu of Form CMS-2552-10 | Provider CCN: 150086 | Period: | Worksheet S-3 | From 01/01/2014 | Part I | To 1/03/2014 | Part I | Proposed | Part I | Part Health Financial Systems DEARBOR HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

					Ť	0 12/31/2014	Date/Time Prep 5/29/2015 8:5	
		Full Time Equivalents			Di sch	arges	0,2,,2010 010	Z
	Component	Nonpai d	Titl	e V	Title XVIII	Title XIX	Total All	
		Workers					Pati ents	
		11. 00	12.		13. 00	14. 00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)			О	,,,,,,		4, 364	1. 00
2.00	HMO and other (see instructions)				346	668		2. 00
3.00	HMO IPF Subprovider							3. 00
4. 00 5. 00	HMO IRF Subprovider							4. 00 5. 00
6. 00	Hospital Adults & Peds. Swing Bed SNF 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, 908	232	4, 364	
15. 00	CAH visits							15. 00
16. 00	SUBPROVI DER - I PF							16. 00
17. 00	SUBPROVI DER - I RF							17. 00
18. 00	SUBPROVI DER							18. 00
19. 00	SKILLED NURSING FACILITY							19.00
20.00	NURSING FACILITY							20.00
21. 00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY	0. 00						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)							23. 00
24.00	HOSPI CE	0. 00						24.00
24. 10	HOSPICE (non-distinct part)							24. 10
25. 00	CMHC - CMHC							25. 00
26. 00	RURAL HEALTH CLINIC							26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER							26. 25
27. 00	Total (sum of lines 14-26)	0. 00						27. 00
28. 00	Observation Bed Days							28. 00
29. 00								29. 00
30.00	Employee discount days (see instruction)							30.00
31. 00	Employee discount days - IRF							31.00
32.00	Labor & delivery days (see instructions)							32.00
32. 01	Total ancillary labor & delivery room							32. 01
00.5-	outpatient days (see instructions)							
33. 00	LTCH non-covered days	l l			1	l l		33. 00

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 150086

					Т	o 12/31/2014	Date/Time Pre 5/29/2015 8:5	
		Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries	Adj usted Sal ari es	Paid Hours Related to	Average Hourly Wage (col. 4 ÷	
				(from Worksheet A-6)	(col.2 ± col. 3)	Salaries in col. 4	col . 5)	
	PART II - WAGE DATA	1. 00	2. 00	3.00	4.00	5. 00	6. 00	
	SALARIES							1
1.00	Total salaries (see instructions)	200. 00	31, 917, 686	0	31, 917, 686	1, 293, 750. 00	24. 67	1.00
2.00	Non-physician anesthetist Part		0	0	0	0.00	0.00	2.00
3. 00	Non-physician anesthetist Part		0	0	0	0.00	0. 00	3. 00
4. 00	Physician-Part A -		0	0	0	0.00	0. 00	4. 00
4. 01	Administrative Physicians - Part A - Teaching		100.041	0	0	0.00	•	
5. 00 6. 00	Physician-Part B Non-physician-Part B		132, 261 0	0	132, 261 0	1, 590. 00 0. 00	1	
7. 00	Interns & residents (in an approved program)	21. 00	0	0	0	0.00		1
7. 01	Contracted interns and residents (in an approved		0	0	0	0.00	0. 00	7. 01
8. 00	programs) Home office personnel			0		0.00	0. 00	8.00
9. 00	SNF	44. 00	0	0	0	0.00	1	
10. 00	Excluded area salaries (see instructions)		1, 675, 967	12, 122	1, 688, 089	64, 557. 00	26. 15	10.00
11 00	OTHER WAGES & RELATED COSTS		272 000		272 000	F 00F 00	F2 //	11 00
11. 00	Contract labor: Direct Patient Care		272, 880		,	·		11. 00
12. 00	Contract labor: Top level management and other		0	0	0	0.00	0.00	12.00
40.00	management and administrative services					4 500 00	400.05	10.00
13. 00	Contract Labor: Physician-Part A - Administrative		300, 583			·		13. 00
14. 00	Home office salaries & wage-related costs		0	0	0	0.00		14.00
15. 00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15. 00
16. 00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16. 00
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		10, 171, 984	0	10, 171, 984			17. 00
18. 00	instructions) Wage-related costs (other)		0	0	0			18. 00
19. 00	(see instructions) Excluded areas		534, 234	0	534, 234			19. 00
20. 00	Non-physician anesthetist Part		034, 234	0	0 0			20.00
21. 00	Non-physician anesthetist Part		0	0	0			21. 00
22. 00	Physician Part A - Administrative		0	0	0			22. 00
22. 01	Physician Part A - Teaching		0	О				22. 01
23. 00 24. 00	Physician Part B Wage-related costs (RHC/FQHC)		19, 749	0	19, 749			23. 00 24. 00
25. 00	Interns & residents (in an approved program)		0	0	0			25. 00
	OVERHEAD COSTS - DIRECT SALARIE			_				1
26. 00 27. 00	Employee Benefits Department Administrative & General	4. 00 5. 00	417, 231 4, 075, 001		, , ,			
28. 00	Administrative & General under contract (see inst.)		155, 366		155, 366		1	
29. 00	Maintenance & Repairs	6. 00	0	0	0	0.00	1	1
30. 00 31. 00	Operation of Plant Laundry & Linen Service	7. 00 8. 00	1, 002, 306 162, 630		990, 184 162, 630		•	1
32. 00 33. 00	Housekeeping Housekeeping under contract	9. 00	742, 938 146, 251	0	742, 938 146, 251		11. 46	32. 00
	(see instructions)	40.00				·		
34. 00 35. 00	Dietary Dietary under contract (see	10. 00	1, 054, 489 126, 888		281, 865 126, 888	· ·	1	1
36. 00	i nstructi ons) Cafeteri a	11. 00	0	772, 624	772, 624		1	1
37. 00 38. 00	Maintenance of Personnel Nursing Administration	12. 00 13. 00	922, 874	0	922, 874	0. 00 23, 371. 00		37. 00 38. 00
39. 00	Central Services and Supply	14. 00	301, 324	0	301, 324	18, 833. 00	16. 00	39. 00
40. 00	Pharmacy	15. 00	1, 568, 631	0	1, 568, 631	43, 985. 00)J 35. 66	40. 00

Health Financial Systems		DEARBORN COUN	NTY HOSPITAL		In Lieu of Form CMS-2552-10			
HOSPITAL WAGE INDEX INFORMATION		Provi der CCN: 150086			Peri od: Worksheet S-3			
				-	From 01/01/2014 To 12/31/2014	Part II Date/Time Pre	nared:	
						5/29/2015 8: 5		
	Worksheet A	Amount	Recl assi fi cati			Average Hourly		
	Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷		
			(from	(col.2 ± col.	Salaries in	col . 5)		
			Worksheet A-6)	3)	col. 4			
	1.00	2. 00	3.00	4. 00	5. 00	6. 00		
41.00 Medical Records & Medical	16. 00	806, 281	0	806, 28	39, 255. 00	20. 54	41. 00	
Records Library								
42.00 Social Service	17. 00	289, 926	0	289, 92	10, 210. 00	28. 40	42.00	
43.00 Other General Service	18. 00	0) o		0.00	0. 00	43. 00	

LICCULTA								
HOSPITAL WAGE INDEX INFORMATION				Provi der		Period: From 01/01/2014 To 12/31/2014	Date/Time Pre	pared:
		Worksheet A	Amount	Reclassi fi cati	Adj usted	Pai d Hours	5/29/2015 8:5 Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	$(col.2 \pm col.$	Salaries in	col . 5)	
				Worksheet A-6)	3)	col. 4		
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
-	PART III - HOSPITAL WAGE INDEX	SUMMARY						
	Net salaries (see		32, 213, 930	0	32, 213, 93	0 1, 301, 387. 00	24. 75	1.00
	instructions)							
	Excluded area salaries (see		1, 675, 967	12, 122	1, 688, 08	9 64, 557. 00	26. 15	2. 00
	instructions)							
	Subtotal salaries (line 1		30, 537, 963	-12, 122	30, 525, 84	1, 236, 830. 00	24. 68	3. 00
	minus line 2)		F70 4/0		F70 4/		05.04	4.00
	Subtotal other wages & related		573, 463	0	573, 46	3 6, 675. 00	85. 91	4. 00
	costs (see inst.)		40 474 004		40 474 00	4	00.00	F 0/
	Subtotal wage-related costs		10, 171, 984	0	10, 171, 98	4 0.00	33. 32	5. 00
	(see inst.)		41 202 410	12 122	41 071 00	1 242 505 00	22.10	/ 00
- 1	Total (sum of lines 3 thru 5)		41, 283, 410				1	
	Total overhead cost (see		11, 772, 136	-12, 122	11, 760, 01	4 505, 920. 00	23. 24	7. 00
	instructions)							

Health Financial Systems	DEARBORN COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 150086	Peri od: Worksheet S-3
		From 01/01/2014 Part IV
		T- 10/01/0011 D-+-/T: D

	To 12/31/2014	Date/Time Prep 5/29/2015 8:5	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		l
	RETI REMENT COST		l
1.00	401K Employer Contributions	1, 233, 622	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		1
8.00	Health Insurance (Purchased or Self Funded)	6, 218, 362	8. 00
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	206, 674	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	42, 151	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)	110, 972	13. 00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15. 00	'Workers' Compensation Insurance	209, 494	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumulative portion)		ł
	TAXES		
17. 00	FICA-Employers Portion Only	1, 842, 986	17. 00
18. 00	Medicare Taxes - Employers Portion Only	438, 546	18. 00
19. 00	Unempl oyment Insurance	14, 072	19. 00
20.00	State or Federal Unemployment Taxes	0	20. 00
	OTHER		l
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see	0	21. 00
	instructions))		l
22. 00	Day Care Cost and Allowances	0	22. 00
23.00	Tuition Reimbursement	209, 088	23. 00
24.00	Total Wage Related cost (Sum of lines 1 -23)	10, 525, 967	24. 00
	Part B - Other than Core Related Cost		l
25. 00	OTHER WAGE RELATED COST	90, 527	25. 00

Heal th	Financial Systems	DEARBORN COUNTY HO	ISPI TAI	In lie	u of Form CMS-2	2552-10
	AL CONTRACT LABOR AND BENEFIT COST		Provi der CCN: 150086	Peri od:	Worksheet S-3	
				From 01/01/2014		
				To 12/31/2014	Date/Time Pre 5/29/2015 8:5	
	Cost Center Description			Contract Labor		/ alli
	cost center bescription			1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			1.00	2.00	
	Hospital and Hospital-Based Component Identif	fication:				
1.00	Total facility's contract labor and benefit of			0	0	1.00
2.00	Hospi tal	0031		0	0	2. 00
3.00	Subprovider - IPF				Ŭ	3. 00
4. 00	Subprovi der - IRF					4.00
5. 00	Subprovider - (Other)			0	0	
6. 00	Swing Beds - SNF			0	0	
7. 00	Swi ng Beds - NF			0	0	ı
8. 00	Hospi tal -Based SNF					8.00
9. 00	Hospi tal -Based NF					9.00
10.00	Hospi tal -Based OLTC					10.00
11. 00	Hospital-Based HHA			0	0	11. 00
12.00	Separately Certified ASC					12.00
13.00	Hospi tal -Based Hospi ce			0	0	13. 00
14.00	Hospital-Based Health Clinic RHC					14. 00
15.00	Hospital-Based Health Clinic FQHC					15. 00
16.00	Hospi tal -Based-CMHC					16.00
17.00	Renal Dialysis					17. 00
18.00	Other			0	0	18. 00

	Financial Systems	DEARBORN COUN		2011 152001 5		eu of Form CMS-2	
HOME I	HEALTH AGENCY STATISTICAL DATA			F	eriod: rom 01/01/2014	Worksheet S-4	
			Componen	CCN: 157055 T		5/29/2015 8: 5	
					Home Health Agency I	PPS	
					1	00	
0.00	County				DEARBORN		0. 00
		Title V 1.00	Title XVIII 2.00	Title XIX 3.00	0ther 4.00	Total 5.00	
4.00	HOME HEALTH AGENCY STATISTICAL DATA						1.00
1. 00 2. 00	Home Health Aide Hours Unduplicated Census Count (see instructions)	0.00					1. 00 2. 00
				Number of Empl	oyees (Full Ti	me Equivalent)	
		Enter the numb	er of hours in	Staff	Contract	Total	
		your normal	l work week				
			0	1.00	2. 00	3. 00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES	I					
3. 00 4. 00	Administrator and Assistant Administrator(s) Director(s) and Assistant Director(s)		40. 00	2. 84 0. 00			3. 00 4. 00
5.00	Other Administrative Personnel			0.00			5. 00
6. 00 7. 00	Direct Nursing Service Nursing Supervisor			10. 81 0. 00			6. 00 7. 00
8. 00 9. 00	Physical Therapy Service Physical Therapy Supervisor			1. 70 0. 00			8. 00 9. 00
10. 00	Occupational Therapy Service			0. 00			
11. 00 12. 00	Occupational Therapy Supervisor Speech Pathology Service			0. 00 0. 19			11. 00 12. 00
13. 00	Speech Pathology Supervisor			0.00	0.00	0.00	13. 00
14. 00 15. 00	Medical Social Service Medical Social Service Supervisor			0. 32 0. 00			
16. 00	Home Health Aide			1. 94	0.00	1. 94	16. 00
17. 00 18. 00	Home Health Aide Supervisor PERSONAL CARE ATTENDANT			0. 00 0. 01			17. 00 18. 00
10.00	HOME HEALTH AGENCY CBSA CODES			1			10.00
19. 00	Enter in column 1 the number of CBSAs where you provided services during the cost			4			19. 00
20. 00	reporting period. List those CBSA code(s) in column 1 serviced			 17140			20. 00
	during this cost reporting period (line 20						
20. 01	contains the first code).			50031			20. 01
20. 02 20. 03				50034 99915			20. 02 20. 03
20.03			pi sodes				20.03
		Without Outliers	With Outliers	LUPA Epi sodes	PEP Only Episodes	Total (cols. 1-4)	
	DDC ACTIVITY DATA	1.00	2.00	3.00	4. 00	5. 00	
21. 00	PPS ACTIVITY DATA Skilled Nursing Visits	2, 704					
22. 00 23. 00	Skilled Nursing Visit Charges Physical Therapy Visits	487, 723 1, 109	l .				22. 00 23. 00
24. 00	Physical Therapy Visit Charges	235, 060	O	12, 995	4, 185	252, 240	24. 00
25. 00 26. 00	Occupational Therapy Visits Occupational Therapy Visit Charges	279 61, 450	l .			291 64, 093	25. 00 26. 00
27. 00	Speech Pathology Visits	105	0	5	9	119	27. 00
28. 00 29. 00	Speech Pathology Visit Charges Medical Social Service Visits	22, 025 30			1, 982 3	24, 668 35	28. 00 29. 00
30. 00 31. 00	Medical Social Service Visit Charges Home Health Aide Visits	8, 994 696			899	10, 493 1, 008	30. 00 31. 00
32. 00	Home Health Aide Visit Charges	133, 387	82, 578	234		216, 783	32. 00
33. 00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	4, 923	652	354	101	6, 030	33. 00
34. 00	Other Charges	0	0			_	34. 00
35. 00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	948, 639	151, 116	53, 484	18, 967	1, 172, 206	35. 00
36. 00	Total Number of Episodes (standard/non outlier)	349		95	11	455	36. 00
37. 00	Total Number of Outlier Episodes	_	9		0		37. 00
38. 00	Total Non-Routine Medical Supply Charges	21, 130	3, 935	2, 296	105	27, 466	38. 00

Health Financial Systems		DEARBORN COUNTY HOSPITAL				In Lieu of Form CMS-2552-1		
HOSPITAL IDENTIFICATION DATA		Provi der CCN: 150086		CCN: 150086	Peri od:	Worksheet S-9		
						From 01/01/2014		
			Co	Component	CCN: 151531	To 12/31/2014		
							5/29/2015 8: 5	7 am
						Hospi ce I		
	Unduplicated							
	Days							
	Title XVIII	Title XIX	Title	XVIII	Title XIX	All Other	Total (sum of	
			Ski	Hed	Nursi ng		cols. 1, 2 &	
			Nurs	si ng	Facility		5)	

		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
				Skilled	Nursi ng		cols. 1, 2 &	
				Nursi ng	Facility		5)	
				Facility	,			
		1.00	2. 00	3.00	4. 00	5. 00	6. 00	
	PART I - ENROLLMENT DAYS							
1.00	Continuous Home Care	0	0	0	0	0	0	1. 00
2.00	Routine Home Care	3, 313	748	0	0	815	4, 876	2. 00
3.00	Inpatient Respite Care	0	0	0	0	0	0	3. 00
4.00	General Inpatient Care	111	0	0	0	0	111	4. 00
5.00	Total Hospice Days	3, 424	748	0	0	815	4, 987	5. 00
	Part II - CENSUS DATA							l
6.00	Number of Patients Receiving	120	8	0	0	26	154	6. 00
	Hospi ce Care							l
7.00	Total Number of Unduplicated	0. 00		0.00				7. 00
	Continuous Care Hours Billable							l
	to Medicare							l
8.00	Average Length of Stay (line	28. 53	93. 50	0.00	0.00	31. 35	32. 38	8. 00
	5/line 6)							l
9.00	Unduplicated Census Count	108	8	0	0	26	142	9. 00

	Financial Systems DEARBORN COUNTY HOS			eu of Form CMS-2	
HOSPI I	AL UNCOMPENSATED AND INDIGENT CARE DATA	rovider CCN: 150086		Worksheet S-1	0
			From 01/01/2014 To 12/31/2014	Date/Time Pre 5/29/2015 8:5	
				1. 00	
	Uncompensated and indigent care cost computation			•	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divid	ed by line 202 colu	ımn 8)	0. 345308	1.00
	Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid			6, 416, 242	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 or supplemental p		ni d?	N	4. 00
5.00	If line 4 is "no", then enter DSH or supplemental payments from M	edi cai d		-1, 631, 784	
6.00	Medi cai d charges			20, 628, 657	
7. 00	Medicaid cost (line 1 times line 6)			7, 123, 240	1
8. 00	Difference between net revenue and costs for Medicaid program (li < zero then enter zero)	ne 7 minus sum of I	ines 2 and 5; if	2, 338, 782	8. 00
	State Children's Health Insurance Program (SCHIP) (see instruction	ns for each line)			1
9.00	Net revenue from stand-alone SCHIP			0	9. 00
10.00	Stand-alone SCHIP charges		0	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)			0	11. 00
12.00	Difference between net revenue and costs for stand-alone SCHIP (I	ine 11 minus line 9	; if < zero then	0	12. 00
	enter zero)]
	Other state or local government indigent care program (see instru			T .	
13. 00	Net revenue from state or local indigent care program (Not includ	·	,	0	
14. 00	Charges for patients covered under state or local indigent care p	rogram (Not include	ed in lines 6 or	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 indig	ent care program (I	ine 15 minus line	0	16. 00
	13; if < zero then enter zero)]
	Uncompensated care (see instructions for each line)				1
17. 00	Private grants, donations, or endowment income restricted to fund	5		0	
	Government grants, appropriations or transfers for support of hos			0	
19. 00	Total unreimbursed cost for Medicaid , SCHIP and state and local 8, 12 and 16)	indigent care progr	ams (sum of lines	2, 338, 782	19. 00
		Uni nsure		Total (col. 1	
		patients		+ col . 2)	
20.00	T-+-1 :-::::-1:::	1.00	2. 00	3.00	20.00
20. 00	Total initial obligation of patients approved for charity care (a charges excluding non-reimbursable cost centers) for the entire f		704 0	2, 012, 704	20. 00
21. 00	Cost of initial obligation of patients approved for charity care		003	695, 003	21. 00
21.00	times line 20)	(11116-1 073,	003	075,005	21.00
					1
22 00				0	22 00
22. 00 23. 00	Partial payment by patients approved for charity care	695	0 0	695 003	
22. 00 23. 00	Partial payment by patients approved for charity care	695,	-	695, 003	
23. 00	Partial payment by patients approved for charity care Cost of charity care (line 21 minus line 22)	,	003	695, 003	23. 00
	Partial payment by patients approved for charity care Cost of charity care (line 21 minus line 22) Does the amount in line 20 column 2 include charges for patient d	ays beyond a length	003	695, 003	
23. 00	Partial payment by patients approved for charity care Cost of charity care (line 21 minus line 22) Does the amount in line 20 column 2 include charges for patient d imposed on patients covered by Medicaid or other indigent care pr	ays beyond a length	oo3 0	695, 003	23. 00
24. 00 25. 00	Partial payment by patients approved for charity care Cost of charity care (line 21 minus line 22) Does the amount in line 20 column 2 include charges for patient d imposed on patients covered by Medicaid or other indigent care pr If line 24 is "yes," charges for patient days beyond an indigent	ays beyond a length ogram? care program's ler	oo3 0	695, 003 1. 00 N	23. 00
23. 00 24. 00 25. 00 26. 00	Partial payment by patients approved for charity care Cost of charity care (line 21 minus line 22) Does the amount in line 20 column 2 include charges for patient d imposed on patients covered by Medicaid or other indigent care pr If line 24 is "yes," charges for patient days beyond an indigent Total bad debt expense for the entire hospital complex (see instr	ays beyond a length ogram? care program's ler uctions)	oo3 0	1.00 N 0 9,474,617	23. 00 24. 00 25. 00 26. 00
24. 00 25. 00	Partial payment by patients approved for charity care Cost of charity care (line 21 minus line 22) Does the amount in line 20 column 2 include charges for patient d imposed on patients covered by Medicaid or other indigent care pr If line 24 is "yes," charges for patient days beyond an indigent Total bad debt expense for the entire hospital complex (see instructi	ays beyond a length ogram? care program's ler uctions) ons)	oo3 0	695, 003 1. 00 N 0 9, 474, 617 124, 196	23. 00 24. 00 25. 00 26. 00 27. 00
23. 00 24. 00 25. 00 26. 00 27. 00	Partial payment by patients approved for charity care Cost of charity care (line 21 minus line 22) Does the amount in line 20 column 2 include charges for patient d imposed on patients covered by Medicaid or other indigent care pr If line 24 is "yes," charges for patient days beyond an indigent Total bad debt expense for the entire hospital complex (see instr	ays beyond a length ogram? care program's ler uctions) ons) 26 minus line 27)	n of stay limit	1.00 N 0 9,474,617	23. 00 24. 00 25. 00 26. 00 27. 00 28. 00
23. 00 24. 00 25. 00 26. 00 27. 00 28. 00	Partial payment by patients approved for charity care Cost of charity care (line 21 minus line 22) Does the amount in line 20 column 2 include charges for patient d imposed on patients covered by Medicaid or other indigent care pr If line 24 is "yes," charges for patient days beyond an indigent Total bad debt expense for the entire hospital complex (see instructi Medicare bad debts for the entire hospital complex (see instructi Non-Medicare and non-reimbursable Medicare bad debt expense (line	ays beyond a length ogram? care program's ler uctions) ons) 26 minus line 27)	n of stay limit	695, 003 1. 00 N 0 9, 474, 617 124, 196 9, 350, 421	23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00

Heal th	Financial Systems	DEARBORN COUNTY	Y HOSPITAL		In Lie	eu of Form CMS-	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (OF EXPENSES	Provi der		Period: From 01/01/2014 To 12/31/2014	Worksheet A Date/Time Pre 5/29/2015 8:5	
	Cost Center Description	Sal ari es	Other	Total (col. + col. 2)	Reclassificati ons (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 NEW CAP REL COSTS-BLDG & FIXT		3, 417, 476				1. 00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		2, 316, 530	2, 316, 53	0 51, 583		
3.00	00300 OTHER CAPITAL RELATED COSTS	447.004	0	44 0// 05	0	0	
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT 01160 COMMUNI CATIONS	417, 231	10, 848, 826				4.00
5. 01 5. 02	00550 DATA PROCESSING	120, 961 844, 044	178, 688 890, 531				1
5. 02	00560 PURCHASING RECEIVING AND STORES	230, 494	66, 364				
5. 04	00570 ADMITTING	608, 690	83, 180				1
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	728, 298	487, 150			1	1
5.06	00591 OTHER ADMINISTRATIVE AND GENERAL	1, 542, 514	10, 960, 889	12, 503, 40	3 -128, 153	12, 375, 250	5. 06
7.00	00700 OPERATION OF PLANT	1, 002, 306	2, 040, 694	3, 043, 00	0 -57, 925	2, 985, 075	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	162, 630	125, 589				
9.00	00900 HOUSEKEEPI NG	742, 938	261, 805			1	1
10.00	01000 DI ETARY	1, 054, 489	891, 672				1
11. 00 13. 00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	922, 874	0 26, 791		0 1, 425, 952 5 0	1	•
14. 00	01400 CENTRAL SERVICE & SUPPLY	301, 324	692, 583			949, 665 437, 374	
15. 00	01500 PHARMACY	1, 568, 631	151, 977				
16. 00	01600 MEDI CAL RECORDS & LI BRARY	806, 281	137, 185				
17. 00	01700 SOCIAL SERVICE	289, 926	5, 037				
	INPATIENT ROUTINE SERVICE COST CENTERS	<u>'</u>		•	•	•	1
30.00	03000 ADULTS & PEDIATRICS	5, 756, 384	866, 601	6, 622, 98	5 -761, 328	5, 861, 657	30.00
31. 00	03100 I NTENSI VE CARE UNI T	1, 233, 415	71, 648	1, 305, 06	3 -162	1, 304, 901	31. 00
43.00	04300 NURSERY	0	0		0 482, 786	482, 786	43. 00
	ANCILLARY SERVICE COST CENTERS	1 7/0 005	0.005.504			0 000 070	
50.00	05000 OPERATI NG ROOM	1, 762, 205	2, 095, 581			2, 329, 879	
51.00	05100 RECOVERY ROOM	720, 599	31, 481 0				1
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY		1, 286, 677				1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	2, 336, 523	1, 043, 234				1
54. 01	05401 ULTRASOUND	196, 893	43, 957				1
55. 00	05500 RADI OLOGY-THERAPEUTI C	411, 662	370, 906	1			1
57.00	05700 CT SCAN	0	432, 665				1
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	320, 969	320, 96	9 -8, 757	312, 212	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	
60.00	06000 LABORATORY	2, 230, 668	3, 061, 613	5, 292, 28	-1, 210	l	1
60. 01	06001 BLOOD LABORATORY	0	0		0 0	0	
65. 00	06500 RESPI RATORY THERAPY 03950 SLEEP CLINIC	788, 009	121, 304				
65. 01 66. 00	06600 PHYSI CAL THERAPY	928, 750	189, 153 53, 668				
67. 00		235, 310	16, 837				1
	06800 SPEECH PATHOLOGY	183, 264	3, 263			l	•
	06900 ELECTROCARDI OLOGY	466, 849	870, 313				
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 2, 652, 956		
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	2, 447, 164	2, 447, 16	4 0	2, 447, 164	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	3, 408, 637	3, 408, 63	7 0	3, 408, 637	73. 00
	OUTPATIENT SERVICE COST CENTERS						
	09100 EMERGENCY	1, 647, 557	219, 291	1, 866, 84	-7, 048	1, 859, 800	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
101 00	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	1, 083, 422	148, 331	1, 231, 75	3 -13, 231	1, 218, 522	101 00
101.00	SPECIAL PURPOSE COST CENTERS	1,003,422	140, 331	1, 231, 73	3 -13, 231	1, 210, 322	1101.00
113 00	11300 INTEREST EXPENSE		0		0 0	0	113. 00
	11600 H0SPI CE	283, 340	190, 451	•			
118.00		31, 608, 481	50, 876, 711				1
	NONREI MBURSABLE COST CENTERS						1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	73, 374	0			73, 374	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	131, 482				
	19201 PHYSICIAN CLINIC	75, 716	36, 756				
	19202 LI FELI NE	0	37, 100				192. 02
	3 19203 CREDIT UNION	0	0		0		192. 03
	19204 BREAST MRI STUDY	0	1 104 004	1 104 00	0 0		192.04
	5 19205 HOSPI TALI ST 07950 COMMUNI TY MENTAL HEALTH	0	1, 184, 904	1, 184, 90	0 0		194. 00
	07951 MARKETI NG	112, 922	133, 712	246, 63		l	
	207953 OCCUPATI ONAL HEALTH	47, 193	1, 263				194. 01
	07952 PATHS EDUCATION	0	37, 347				194. 03
200.00		31, 917, 686	52, 439, 275				

	n Financial Systems SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (DEARBORN COUN		CCN: 150086	In Lie	u of Form CMS- Worksheet A	-2552-10
RECLA	SSIFICATION AND ADJUSTMENTS OF TRIAL DALANCE (JF EXPENSES	Provider	CCN. 130066	From 01/01/2014 To 12/31/2014		enared:
		1			10 12/31/2014	5/29/2015 8:	
	Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	1			
	JOSEPH OSPINIOS COOT OSPITSPO	6.00	7. 00	1			
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT	-177, 014	3, 308, 675				1.00
2.00	00200 NEW CAP REL COSTS BEDG & TTXT	-1, 109		1			2. 00
3.00	00300 OTHER CAPITAL RELATED COSTS	0	0				3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-16, 263		1			4. 00
5. 01 5. 02	O1160 COMMUNI CATI ONS O0550 DATA PROCESSI NG	-11, 407 0					5. 01 5. 02
5. 02	00560 PURCHASING RECEIVING AND STORES						5. 02
5. 04	00570 ADMITTING		1				5. 04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	-19, 623					5. 05
5.06	00591 OTHER ADMINISTRATIVE AND GENERAL	-10, 157, 685		1			5. 06
7.00	00700 OPERATION OF PLANT	-101, 774		1			7. 00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	0	1	1			8. 00 9. 00
10.00	01000 DI ETARY	-2, 360		1			10.00
11. 00	01100 CAFETERI A	-404, 094		1			11. 00
13.00	01300 NURSING ADMINISTRATION	0	949, 665	5			13. 00
14. 00	01400 CENTRAL SERVICE & SUPPLY	0		1			14. 00
15.00	01500 PHARMACY	20, 100	1,,	1			15. 00
16. 00 17. 00	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	-29, 189		1			16. 00 17. 00
17.00	INPATIENT ROUTINE SERVICE COST CENTERS		274,700	<u>'</u>			17.00
30.00	03000 ADULTS & PEDIATRICS	-386, 740	5, 474, 917	7			30.00
31. 00	03100 INTENSIVE CARE UNIT	0		1			31. 00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	482, 786				43. 00
50. 00	05000 OPERATING ROOM	-66, 000	2, 263, 879				50.00
51. 00	05100 RECOVERY ROOM	00,000		1			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		1			52. 00
53. 00	05300 ANESTHESI OLOGY	-1, 212, 276					53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	-11, 478					54. 00
54. 01 55. 00	05401 ULTRASOUND 05500 RADI OLOGY-THERAPEUTI C	0	1				54. 01 55. 00
57. 00	05700 CT SCAN	-2, 600					57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		1			58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0				59. 00
60.00	06000 LABORATORY	-112, 738	5, 178, 333	3			60.00
60. 01 65. 00	06001 BLOOD LABORATORY 06500 RESPI RATORY THERAPY	-11, 852	825, 531)			60. 01 65. 00
65. 00	03950 SLEEP CLINIC	-11, 652	1	1			65. 01
66. 00	06600 PHYSI CAL THERAPY			1			66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	243, 327	<u>'</u>			67. 00
68. 00	06800 SPEECH PATHOLOGY	0	1,	1			68. 00
69. 00 71. 00		-305, 656					69. 00 71. 00
	07200 IMPL. DEV. CHARGED TO PATIENT	0					72.00
	07300 DRUGS CHARGED TO PATIENTS	-918, 097					73. 00
	OUTPATIENT SERVICE COST CENTERS						
91.00		-175, 440	1, 684, 360				91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS		1				92. 00
101.00	10100 HOME HEALTH AGENCY	0	1, 218, 522	2			101.00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE	0	-	1			113.00
	0 11600 HOSPI CE	-4, 602					116.00
118. 00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	-14, 127, 997	68, 301, 317	1			118. 00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	73, 374	Į .			190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	187, 698	3			192. 00
	1 19201 PHYSI CI AN CLI NI C	0	1				192. 01
	2 19202 LI FELI NE	0	1	1			192. 02
	3 19203 CREDIT UNION 4 19204 BREAST MRI STUDY						192. 03 192. 04
	5 19205 HOSPI TALI ST		1	í			192. 04
	07950 COMMUNITY MENTAL HEALTH	0					194. 00
194. 01	1 07951 MARKETI NG	0		1			194. 01
	2 07953 OCCUPATI ONAL HEALTH	0					194. 02
194. 03 200. 00	3 07952 PATHS EDUCATION TOTAL (SUM OF LINES 118-199)	-14, 127, 997					194. 03 200. 00
∠∪∪. ∪(PI TOTAL (SOM OF LINES 110-199)	- 14, 127, 797	1 10, 220, 904	TI .			1200.00

| Peri od: | Worksheet A-6 | From 01/01/2014 | To 12/31/2014 | Date/Time Prepared: Provi der CCN: 150086

Cost Center						lo	12/31/2014 Date/Ii 5/29/20	me Prepared: 15 8:57 am
1.00 CAFETERIA 11.00 772.624 653,328 1.00			Increases			<u> </u>	0727720	10 0.07 4
A - CAFETERIA 11.00 772,624 653,328 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00		Cost Center	Li ne #	Sal ary	0ther			
1.00			3. 00	4. 00	5. 00			
O		A - CAFETERIA						
1.00 NURSERY	1.00	CAFETERI A	11. 00	772, 624	653, 328			1. 00
1.00 2.00 0 LIVERY ROOM & LABOR ROOM \$2.00 210.326 44.269 2.00 0 C - UTILIZATION REVIEW COST 517.098 126.283 1.00 0 SECURITY GUARD 5.06 0 2.243 0 O SECURITY GUARD 7.00 0 2.00 0 SECURITY GUARD 7.00 0 2.00 0 SECURITY GUARD 7.00 0 2.00 0 PHYSICIANS PRIVATE OFFICES 192.00 0 2.652,956 PATIENTS 0 0 0 0 0 0 0 SECURITY GUARD 7.00 0 0 0 0 0 SECURITY GUARD 7.00 7.00 0 0 0 SECURITY GUARD 7.00 0 0 0 0 SECURITY GUARD 7.00 7.00 0 0 0 SECURITY GUARD 7.00 7.00 7.00 7.00 0 SECURITY GUARD 7.00 7.00 7.00 7.00 7.00 0 SECURITY GUARD 7.00 7.00 7.00 7.00 7.00 7.00 0 SECURITY GUARD 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.		0		772, 624	653, 328			
DELI VERY ROOM & LABOR ROOM 52,00 216,326 44,269 126,283 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.0		B - NURSERY						
1.00 C	1.00	NURSERY	43.00	400, 772	82, 014			1. 00
1.00	2.00	DELIVERY ROOM & LABOR ROOM	52. 00	216, 326	44, 269			2. 00
1.00 OTHER ADMINISTRATI VE AND 5.06 0 2.243		0		617, 098	126, 283			
CEMERAL		C - UTILIZATION REVIEW COST						
1.00	1.00	OTHER ADMINISTRATIVE AND	5. 06	0	2, 243			1. 00
D - SECURITY GUARD 1.00 12.1122 30.697		GENERAL						
1.00		0		0	2, 243			
1.00		D - SECURITY GUARD						
Company Comp	1.00	PHYSICIANS' PRIVATE OFFICES	192. 00	1 <u>2, 1</u> 22	<u>30, 6</u> 97			1. 00
1.00 MEDICAL SUPPLIES CHARGED TO 71.00 0 2,652,956 1.00 2.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.		0		12, 122	30, 697			
PATIENTS								
2.00 3.00 4.00 4.00 5.00 6.00 6.00 6.00 6.00 6.00 6.00 6	1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	2, 652, 956			1. 00
3.00		PATI ENTS						
4.00 5.00 6.00 6.00 6.00 6.00 6.00 6.00 6	2.00			0	0			2. 00
5.00 0.00 0.00 0 0.00 0 0.00 0				0				3. 00
6.00	4.00			0				4. 00
7. 00	5.00			0				5. 00
8. 00 9. 00 9. 00 10. 00 10. 00 11. 00 11. 00 12. 00 13. 00 14. 00 14. 00 15. 00 16. 00 16. 00 17. 00 18. 00 18. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 28. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 0	6.00		0.00	0				6. 00
9.00 10.00 10.00 10.00 10.00 0.00 0.00 0	7.00		0.00	0	0			7. 00
10.00	8.00		0.00	0	0			8. 00
11.00	9.00		0.00	0				9. 00
12. 00 13. 00 14. 00 15. 00 16. 00 16. 00 17. 00 18. 00 18. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 24. 00 25. 00 26. 00 27. 00 28. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10.00		0.00	0	0			10. 00
13.00	11. 00		0.00	0				11. 00
14.00	12.00		0.00	0	0			12. 00
15. 00	13.00		0.00	0	0			13. 00
16.00 17.00 18.00 18.00 19.00 19.00 19.00 20.00 21.00 22.00 23.00 24.00 24.00 25.00 26.00 27.00 28.00 28.00 28.00 29.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00	14.00		0.00	0				14. 00
17. 00 18. 00 19. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0.	15.00		0.00	0	0			15. 00
18. 00 19. 00 19. 00 19. 00 0	16.00		0.00	0	0			16. 00
19. 00 20. 00 20. 00 20. 00 21. 00 21. 00 22. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 26. 00 27. 00 28. 00 28. 00 29. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20	17.00		0.00	0				17. 00
20. 00 21. 00 21. 00 22. 00 22. 00 23. 00 24. 00 24. 00 25. 00 26. 00 27. 00 28. 00 0	18.00		0.00	0	0			18. 00
21. 00 22. 00 22. 00 23. 00 24. 00 24. 00 25. 00 26. 00 27. 00 28. 00 28. 00 0	19.00		0.00	0	0			19. 00
22. 00 23. 00 24. 00 24. 00 25. 00 26. 00 27. 00 28. 00	20.00		0.00	0				20. 00
23. 00 24. 00 24. 00 25. 00 26. 00 27. 00 28. 00 0	21.00		0.00	0	0			21. 00
24.00	22.00		0.00	0	0			22. 00
25. 00 26. 00 26. 00 27. 00 28. 00 0	23.00			0				
26. 00 27. 00 28. 00 0 0 0 0 0 0 27. 00 28. 00 0 0 0 0 0 0 28. 00 F - POB HOUSEKEEPING 1. 00 HOUSEKEEPING 9. 00 0 11, 985 2. 00 PHYSICIANS' PRIVATE OFFICES 192. 00 0 14, 852 G - INSURANCE 1. 00 OTHER CAPITAL RELATED COSTS 3. 00 0 119, 796 0 0 10, 530 0 0 130, 326	24.00		0.00	0				24. 00
27. 00 28. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0				
28. 00 0 0 0 0 28. 00	26.00		0.00	0	0			26. 00
O O Z, 652, 956	27.00		0.00	0	0			27. 00
F - POB HOUSEKEEPI NG 1. 00 HOUSEKEEPI NG 9. 00 0 11, 985 2. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 0 2, 867 0 0 14, 852 G - I NSURANCE 1. 00 OTHER CAPITAL RELATED COSTS 3. 00 0 119, 796 2. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 0 10, 530 0 0 130, 326	28.00		0.00		0			28. 00
1. 00 HOUSEKEEPING 9. 00 0 11, 985 2. 00 PHYSICIANS' PRIVATE OFFICES 192. 00 0 2, 867 0 2. 00 0 14, 852 2. 00 0 0 14, 852 2. 00 0 0 19, 796 0 1. 00 0 19, 796 0 1. 00 0 19, 530 0 0 130, 326 0 0 130, 326		0		0	2, 652, 956			
2. 00 PHYSICIANS' PRIVATE OFFICES 192. 00 0 2,867 0 14,852 G - INSURANCE 1. 00 OTHER CAPITAL RELATED COSTS 3. 00 0 119,796 1. 00 PHYSICIANS' PRIVATE OFFICES 192. 00 0 130,326 2. 00								
0 14, 852 G - I NSURANCE 1. 00 OTHER CAPITAL RELATED COSTS 3. 00 0 119, 796 2. 00 PHYSICIANS' PRIVATE OFFICES 192. 00 0 10, 530 0 0 130, 326				0				
G - I NSURANCE 1. 00 OTHER CAPITAL RELATED COSTS 3. 00 0 119, 796 1. 00 2. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 0 10, 530 2. 00 0 0 130, 326	2.00	PHYSICIANS' PRIVATE OFFICES	192. 00					2. 00
1. 00 OTHER CAPITAL RELATED COSTS 3. 00 0 119, 796 2. 00 PHYSICIANS' PRIVATE OFFICES 192. 00 0 130, 326		0		0	14, 852			
2. 00 PHYSICIANS' PRIVATE OFFICES 192. 00 10, 530 2. 00 130, 326		G - INSURANCE		<u> </u>				
2. 00 PHYSICIANS' PRIVATE OFFICES 192. 00 10, 530 2. 00 130, 326	1.00	OTHER CAPITAL RELATED COSTS	3.00	0	119, 796			1. 00
0 130, 326	2.00	PHYSICIANS' PRIVATE OFFICES	1 <u>92.</u> 00	0				2. 00
500 00 (Crand Total: Increases 1 401 944 2 610 695		0		0	130, 326			
300. 00 gi aliu 10ta i . Tilci eases	500.00	Grand Total: Increases		1, 401, 844	3, 610, 685			500.00

| Peri od: | Worksheet A-6 | From 01/01/2014 | To 12/31/2014 | Date/Time Prepared: Provi der CCN: 150086

					10	5/29/2015	8: 57 am
		Decreases		•			
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	A - CAFETERIA						
1.00	DIETARY	10. 00	77 <u>2, 6</u> 24	65 <u>3, 3</u> 28			1. 00
Į.	0		772, 624	653, 328			
-	B - NURSERY						
	ADULTS & PEDIATRICS	30. 00	617, 098	126, 283			1.00
2.00	+	0.00	0	0	0		2. 00
Į.	U LITEL LIZATION DEVILENCE COST		617, 098	126, 283			
4 00	C - UTILIZATION REVIEW COST	44.00	ما	0.040			4 00
1.00	MEDICAL RECORDS & LIBRARY	16. 00	0				1. 00
1	D SECTION TV CHARD		U	2, 243			
	D - SECURITY GUARD	7 00	10 100	20 (07			1 00
1.00	OPERATION OF PLANT		12, 122	3 <u>0, 6</u> 97			1. 00
	E - MED SUPPLY RECLASS		12, 122	30, 697			
	PURCHASING RECEIVING AND	5. 03	ol	208	0		1.00
	STORES	5.03	U	200	U U		1.00
	OTHER ADMINISTRATIVE AND	5. 06	0	70	0		2. 00
	GENERAL CONTROL OF THE AND	3.00	ď	70	٥		2.00
	OPERATION OF PLANT	7. 00	0	254	o		3.00
	HOUSEKEEPI NG	9.00	Ö	81			4. 00
	DI ETARY	10.00	o	2	o		5. 00
	CENTRAL SERVICE & SUPPLY	14. 00	Ö	556, 533			6. 00
	PHARMACY	15. 00	o	19, 256			7. 00
	ADULTS & PEDIATRICS	30.00	o	17, 947			8.00
	INTENSIVE CARE UNIT	31.00	0	162	1		9. 00
	OPERATING ROOM	50.00	0	1, 527, 907	o		10.00
	RECOVERY ROOM	51.00	o	13, 983			11. 00
	ANESTHESI OLOGY	53. 00	o	44, 071	o		12. 00
	RADI OLOGY-DI AGNOSTI C	54.00	o	17, 150	I I		13. 00
	ULTRASOUND	54. 01	o	9, 950			14. 00
	RADI OLOGY-THERAPEUTI C	55. 00	o	181, 673	1		15. 00
	CT SCAN	57. 00	o	88, 972			16. 00
	MAGNETIC RESONANCE IMAGING	58.00	o	8, 757	1		17. 00
	(MRI)			-,			
	LABORATORY	60.00	o	1, 210	o		18. 00
19.00	RESPI RATORY THERAPY	65.00	o	71, 930			19. 00
20.00	SLEEP CLINIC	65. 01	О	154	o		20. 00
21. 00	PHYSICAL THERAPY	66.00	o	5, 879			21.00
	OCCUPATI ONAL THERAPY	67.00	o	8, 820	1		22. 00
23. 00	SPEECH PATHOLOGY	68.00	o	5			23. 00
24.00	ELECTROCARDI OLOGY	69. 00	o	558	o		24. 00
	EMERGENCY	91.00	o	7, 048	1		25. 00
	HOME HEALTH AGENCY	101.00	o	13, 231	o		26. 00
	HOSPI CE	116. 00	o	56, 807			27. 00
	PHYSICIAN CLINIC	192. 01	o	338			28. 00
	0			2, 652, 956			
li	F - POB HOUSEKEEPING		-1				
-	OPERATION OF PLANT	7.00	0	14, 852	0		1.00
2.00		0.00	o	0	o		2. 00
l	$\overline{} = \overline{} = \overline{} = \overline{}$	+		14, 852			1
l	G - INSURANCE	<u>'</u>			<u> </u>		
	OTHER ADMINISTRATIVE AND	5. 06	0	130, 326	0		1.00
	GENERAL		1	,			
2.00		0.00	ol	0	o		2. 00
to	$\overline{}$ $\overline{}$ $\overline{}$ $\overline{}$ $\overline{}$	+		130, 326			
500 00 0	Grand Total: Decreases		1, 401, 844	3, 610, 685			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 150086 Peri od: Worksheet A-7 From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/29/2015 8:57 am Acqui si ti ons Begi nni ng Purchases Total Di sposal s and Donati on Bal ances Retirements 2.00 3.00 4. 00 1 00 5 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 75, 208 1.00 0 1.00 1, 491, 456 0 23, 065 2.00 Land Improvements 23, 065 0 2.00 62, 337, 108 531, 938 0 531, 938 3.00 Buildings and Fixtures 229, 940 3.00 0 4.00 Building Improvements 0 4.00 5.00 Fixed Equipment 0 5.00 0 6.00 Movable Equipment 45, 914, 056 4, 717, 751 4, 717, 751 2, 061, 232 6.00 0 7.00 HIT designated Assets 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 109, 817, 828 5, 272, 754 5, 272, 754 2, 291, 172 8.00 9.00 Reconciling Items 0 9.00 109, 817, 828 5, 272, 754 Total (line 8 minus line 9) 10.00 0 5, 272, 754 2, 291, 172 10.00 Endi ng Bal ance Fully Depreciated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 75, 208 0 1.00 2.00 Land Improvements 1, 514, 521 0 2.00 3.00 Buildings and Fixtures 62, 639, 106 0 3.00 0) 4.00 Building Improvements 4.00 5.00 Fi xed Equipment 0 5.00 Movable Equipment

48, 570, 575

112, 799, 410

112, 799, 410

0

0

0

0

6.00

7.00

8.00

9.00

10.00

6.00

7.00

8.00

9.00

HIT designated Assets

10.00 Total (line 8 minus line 9)

Reconciling Items

Subtotal (sum of lines 1-7)

Heal th	Financial Systems	DEARBORN COUN	TY HOSPITAL		In Lieu of Form CMS-2552-10		
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150086	Peri od:	Worksheet A-7	
					From 01/01/2014 To 12/31/2014		nared:
		5/29/2015 8					
			SL	JMMARY OF CAP	TAL		
					T		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	,	
					instructions)		
		9. 00	10. 00	11. 00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK						
1.00	NEW CAP REL COSTS-BLDG & FLXT	2, 985, 388	0	432, 08	88 0	0	1. 00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1, 896, 766	419, 764		0	0	2. 00
3.00	Total (sum of lines 1-2)	4, 882, 154	419, 764	432, 08	0	0	3. 00
	· · · · · · · · · · · · · · · · · · ·	SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
	·	Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)	,				
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A. COLUM	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FLXT	0	3, 417, 476				1.00
2. 00	NEW CAP REL COSTS-MVBLE EQUIP	0	2, 316, 530	1			2. 00
3.00	Total (sum of lines 1-2)	0	5, 734, 006				3. 00
5.00	10tal (3am 01 111103 1 Z)	١	3,754,000	I			0.00

Health Financial Systems	DEARBORN COUN	ITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 01/01/2014 To 12/31/2014	Worksheet A-7 Part III Date/Time Prep 5/29/2015 8:5	
	COM	PUTATION OF RAT	ΓΙΟS	ALLOCATION OF	OTHER CAPITAL	7 alli
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
		Leases	for Ratio	instructions)		
			(col . 1 - col 2)			
	1. 00	2.00	3.00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS C		2.00	0.00	1. 00	0.00	
1.00 NEW CAP REL COSTS-BLDG & FLXT	64, 228, 835	0	64, 228, 83	5 0. 569408	68, 213	1. 00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	48, 570, 575	0	48, 570, 57	5 0. 430592	51, 583	2.00
3.00 Total (sum of lines 1-2)	112, 799, 410		112, 799, 41			3. 00
	ALLOCA ²	TION OF OTHER (CAPI TAL	SUMMARY O	F CAPITAL	
Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
		Capi tal -Relate				
		d Costs	through 7)	0.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	6. 00	7. 00	8. 00	9. 00	10. 00	
1.00 NEW CAP REL COSTS-BLDG & FLXT	INTERS		68, 21	3 2, 861, 796	0	1. 00
2. 00 NEW CAP REL COSTS-BEBU & TTXT	0	ľ	51, 58			2. 00
3.00 Total (sum of lines 1-2)	0		119, 79			3. 00
		Sl	JMMARY OF CAPI			<u> </u>
Cook Combon Doorminshing	1	l	T (Other	Total (2) (sum	
Cost Center Description	Interest	Insurance (see	,	Capi tal -Rel ate	` ' '	
		I IIS LI UC LI UIIS)	I IIS LI UC LI OIIS,	d Costs (see	through 14)	
				instructions)	till ough 14)	
	11. 00	12.00	13. 00	14. 00	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00 NEW CAP REL COSTS-BLDG & FLXT	378, 666			0 0	3, 308, 675	1. 00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	,		0 0	2, 367, 004	2. 00
3.00 Total (sum of lines 1-2)	378, 666	119, 796		0 0	5, 675, 679	3. 00

| Peri od: | Worksheet A-8 | From 01/01/2014 | To 12/31/2014 | Date/Time Prepared: Health Financial Systems
ADJUSTMENTS TO EXPENSES Provi der CCN: 150086

				To	12/31/2014	Date/Time Prep 5/29/2015 8:57	pared:
				Expense Classification on		3/24/2013 8.3	/ alli
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4. 00	Wkst. A-7 Ref. 5.00	
1.00	Investment income - NEW CAP			NEW CAP REL COSTS-BLDG &	1.00	0	1. 00
	REL COSTS-BLDG & FLXT (chapter 2)			FIXT			
2. 00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter		0	NEW CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
0.00	2)				0.00		0.00
3. 00	Investment income - other (chapter 2)		0		0. 00	0	3. 00
4. 00	Trade, quantity, and time discounts (chapter 8)	В	-13, 208	OTHER ADMINISTRATIVE AND GENERAL	5. 06	0	4. 00
5.00	Refunds and rebates of		0		0. 00	0	5. 00
6.00	expenses (chapter 8) Rental of provider space by		0		0. 00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay	А	-11, 407	COMMUNI CATI ONS	5. 01	0	7. 00
	stations excluded) (chapter 21)						
8.00	Television and radio service	А	-1, 109	NEW CAP REL COSTS-MVBLE	2. 00	9	8. 00
9. 00	(chapter 21) Parking Lot (chapter 21)		0	EQUI P	0. 00	0	9. 00
10. 00	Provider-based physician adjustment	A-8-2	-2, 256, 979			O	10.00
11. 00	Sale of scrap, waste, etc.		0		0. 00	0	11. 00
12. 00	(chapter 23) Related organization	A-8-1	0			0	12. 00
13. 00	transactions (chapter 10) Laundry and linen service		0		0. 00	0	13. 00
14. 00	Cafeteria-employees and guests		-404, 094	CAFETERI A	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		0		0. 00	0	16. 00
17.00	patients		010 007	DDUCC CHARGED TO DATIENTS	72.00		17.00
17. 00	Sale of drugs to other than patients	В		DRUGS CHARGED TO PATIENTS	73. 00	0	
18. 00	Sale of medical records and abstracts	В	-29, 189	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	Nursing school (tuition, fees, books, etc.)		0		0. 00	О	19. 00
20. 00	Vendi ng machi nes		0		0. 00	0	20. 00
21. 00	Income from imposition of interest, finance or penalty		0		0. 00	0	21. 00
22. 00	charges (chapter 21) Interest expense on Medicare		0		0. 00	0	22. 00
22.00	overpayments and borrowings to		J		0.00		22.00
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
05.00	limitation (chapter 14)						05.00
25. 00	Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
26. 00	(chapter 21) Depreciation - NEW CAP REL		0	NEW CAP REL COSTS-BLDG &	1. 00	0	26. 00
	COSTS-BLDG & FLXT			FLXT			
27. 00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			NEW CAP REL COSTS-MVBLE EQUIP	2. 00	0	
28. 00 29. 00	Non-physician Anesthetist Physicians' assistant		0	*** Cost Center Deleted ***	19. 00 0. 00	0	28. 00 29. 00
30. 00	Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30. 00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
	limitation (chapter 14)						
32. 00	CAH HIT Adjustment for Depreciation and Interest		0		0. 00	0	32. 00
	•	· "		· '		· '	

				To	o 12/31/2014	Date/Time Prep 5/29/2015 8:5	
				Expense Classification on	Worksheet A		
				To/From Which the Amount is			
					•		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1.00	2.00	3. 00	4. 00	5. 00	
33. 00	REV - FITNESS CENTER	В	-16, 263	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 00
34.00	AMBULANCE BILLING OFFSET	В	-19, 623	CASHI ERI NG/ACCOUNTS	5. 05	0	34.00
				RECEI VABLE			
35.00	HEALTH SERV/WIC MANAGMNT FEE	В	-4, 627	OTHER ADMINISTRATIVE AND	5. 06	0	35. 00
				GENERAL			
36.00	RENT - LUDLOW HILL CLINIC	В	-9, 510	OTHER ADMINISTRATIVE AND	5. 06	0	36. 00
				GENERAL			
37.00	DIET - NUTRITION COUNSELING	В		DI ETARY	10.00	0	37. 00
38.00	REV - COMMUNITY EDUCATION	В	-18, 237	ADULTS & PEDIATRICS	30.00	0	38. 00
	PROGRAM						
39. 00	CLINIC INCOME	В		ADULTS & PEDIATRICS	30.00	0	39. 00
40.00	MI SCELLANEOUS I NCOME	В		RADI OLOGY-DI AGNOSTI C	54.00	-	40. 00
41.00	ADVERTI SI NG	A		OTHER ADMINISTRATIVE AND	5. 06	0	41. 00
				GENERAL			
42.00	AHA & IHA DUES	A		OTHER ADMINISTRATIVE AND	5. 06	0	42. 00
				GENERAL			
43.00	MI SC. OFFSET	A		OTHER ADMINISTRATIVE AND	5. 06	0	43. 00
				GENERAL			
44.00	ADVERTISING STAFF	A		OTHER ADMINISTRATIVE AND	5. 06	0	44. 00
				GENERAL			
45. 00	NON ALLOWABLE REPAIRS	A		OPERATION OF PLANT	7. 00	0	45. 00
45. 01	PHYSICIAN RECRUITMENT & HSC	A		OTHER ADMINISTRATIVE AND	5. 06	0	45. 01
	LOSS			GENERAL			
45. 02	MENTAL HEALTH UTILITIES	A		OPERATION OF PLANT	7. 00	0	45. 02
45. 03	NON-ALLOWABLE DEPRECIATION	A		NEW CAP REL COSTS-BLDG &	1. 00	9	45. 03
				FI XT			
45. 04	NON ALLOWABLE INTEREST	A		NEW CAP REL COSTS-BLDG &	1. 00	11	45. 04
				FIXT	447.00		
45. 05	MI SC. NONALLOWABLE	A		HOSPI CE	116. 00		45. 05
45. 06	HAF OFFSET	A		OTHER ADMINISTRATIVE AND	5. 06	0	45. 06
F0 00	TOTAL (C.I. 4			GENERAL			F0 00
50. 00	TOTAL (sum of lines 1 thru 49)		-14, 127, 997				50. 00
	(Transfer to Worksheet A,						
	column 6, line 200.)			ONC D 1 45 4			

⁽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.

| In Lieu of Form CMS-2552-10 | Provider CCN: 150086 | Period: | Worksheet A-8-2 | From 01/01/2014 | To 12/31/2014 | Date/Time Prepared: Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT

							To 12/31/2014	Date/Time Pre 5/29/2015 8:5	
	Wkst. A Line #	Cost Center/Physician	Total	Profe	ssi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Comp	onent	Component		ider Component	
								Hours	
	1. 00	2. 00	3.00	4	. 00	5. 00	6. 00	7. 00	
1.00	30. 00	ADULTS & PEDIATRICS	359, 557		359, 557	0	0	0	1. 00
2.00		OPERATING ROOM	66, 000		66, 000	0	0	0	2.00
3.00		ANESTHESI OLOGY	1, 212, 276	1	, 212, 276	0	0	0	3.00
4.00	54. 00	RADI OLOGY-DI AGNOSTI C	10, 860		10, 860	0	0	0	4.00
5.00	57. 00	CT SCAN	2, 600		2, 600	0	0	0	5. 00
6.00	60. 00	LABORATORY	175, 000		0	175, 000	219, 500	590	6. 00
7.00	65. 00 l	RESPI RATORY THERAPY	11, 852		11, 852	0	0	0	7. 00
8.00	69. 00	ELECTROCARDI OLOGY	305, 656		305, 656	0	0	0	8. 00
9. 00	91. 00	EMERGENCY	257, 844		132, 261	125, 583	171, 400	1, 000	9. 00
10.00	0. 00		0		0	0	0	0	10.00
200.00			2, 401, 645		, 101, 062			1, 590	200.00
	Wkst. A Line #		Unadjusted RCE			Cost of		Physician Cost	
		ldentifier	Limit			Memberships &		of Malpractice	
				Li	mi t	Conti nui ng	Share of col.	Insurance	
				_		Educati on	12		
1 00	1. 00	2.00	8.00	9	. 00	12. 00	13.00	14. 00	4 00
1.00		ADULTS & PEDIATRICS	0		0	-	0	1	1.00
2.00		OPERATING ROOM	0		0	0	0	l ~	2.00
3.00		ANESTHESI OLOGY	0		0	0	0	0	3.00
4. 00 5. 00		RADI OLOGY-DI AGNOSTI C CT SCAN	0		0	0	0	l ~	4. 00 5. 00
6. 00		LABORATORY	62, 262		3, 113	J	0	0	6. 00
7. 00		RESPI RATORY THERAPY	02, 202		3, 113			0	7. 00
8.00		ELECTROCARDI OLOGY			0	_		0	8. 00
9. 00		EMERGENCY	82, 404		4, 120			0	9. 00
10. 00	0.00	LIMENGENCI	02, 404		4, 120			0	10.00
200.00	0.00		144, 666		7, 233			0	200. 00
	Wkst. A Line #	Cost Center/Physician	Provi der		ted RCE	RCE	Adjustment	J	200.00
	MRSt. A Ellio "	I denti fi er	Component	, ,	mi t	Di sal I owance	naj as tilient		
		1 45.111 1 5.	Share of col.			Di Gai i Gilanos			
			14						
	1. 00	2. 00	15. 00	16	5. 00	17. 00	18. 00		
1.00	30. 00	ADULTS & PEDIATRICS	0		0	0	359, 557		1.00
2.00	50. 00	OPERATING ROOM	0		0	0	66, 000		2. 00
3.00		ANESTHESI OLOGY	0		0	0	1, 212, 276		3.00
4.00		RADI OLOGY-DI AGNOSTI C	0		0	0	10, 860		4.00
5. 00	1	CT SCAN	0		0	0	2, 600		5. 00
6.00		LABORATORY	0	1	62, 262	112, 738			6. 00
7. 00		RESPI RATORY THERAPY	0		0	0	11, 852		7. 00
8. 00		ELECTROCARDI OLOGY	0		0	0	305, 656		8. 00
9. 00		EMERGENCY	0		82, 404				9. 00
10.00	0. 00		0		0	_	·		10.00
200.00			0	1	144, 666	155, 917	2, 256, 979		200.00

Health Financial Systems

DEARBORN COUNTY HOSPITAL

In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150086

Period:
From 01/01/2014
To 12/31/2014

Date/Time Prepared:
5/29/2015 8:57 am

						Date/Time Pre 5/29/2015 8:5	
			CAPI TAL REL	CAPITAL RELATED COSTS		372772013 6.3	/ aiii
	Cost Center Description	Net Expenses	NEW BLDG &	NEW MVBLE	EMPLOYEE	COMMUNI CATI ONS	
	oust deliter bescription	for Cost	FLXT	EQUI P	BENEFI TS	COMMON CATTONS	
		Allocation			DEPARTMENT		
		(from Wkst A col. 7)					
		0	1. 00	2. 00	4. 00	5. 01	
4 00	GENERAL SERVICE COST CENTERS	2 202 (75	2 202 (75			ı	4 00
1. 00 2. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP	3, 308, 675 2, 367, 004	3, 308, 675	2, 367, 00	1		1. 00 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	11, 249, 794	18, 446	13, 35			4. 00
5. 01	01160 COMMUNI CATI ONS	288, 242	3, 479	2, 51		337, 561	5. 01
5. 02	00550 DATA PROCESSING	1, 734, 575	20, 917	15, 14	·		5. 02
5. 03 5. 04	00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING	296, 650 691, 870	73, 130 39, 535	52, 95 28, 62			5. 03 5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	1, 195, 825	39, 569	28, 65			5. 05
5.06	00591 OTHER ADMINISTRATIVE AND GENERAL	2, 217, 565	120, 446	87, 21			5. 06
7.00	00700 OPERATION OF PLANT	2, 883, 301	1, 116, 707	808, 63:			7. 00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	288, 219 1, 016, 647	18, 217 13, 480	13, 19 ⁻ 9, 76 ⁻			8. 00 9. 00
10. 00	01000 DI ETARY	517, 847	45, 771	33, 14			10.00
11. 00	01100 CAFETERI A	1, 021, 858	32, 463	23, 50			11. 00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON	949, 665	6, 866	4, 97:			13. 00 14. 00
15. 00	01400 CENTRAL SERVICE & SUPPLY 01500 PHARMACY	437, 374 1, 701, 352	63, 942 13, 365	46, 30: 9, 678		3, 781 11, 344	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	912, 034	55, 005	39, 83			16. 00
17. 00	01700 SOCIAL SERVICE	294, 963	6, 671	4, 83	1 103, 834	3, 781	17. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	E 474 017	420 050	449, 57	9 1, 840, 585	42 212	30.00
30.00	03100 I NTENSI VE CARE UNI T	5, 474, 917 1, 304, 901	620, 859 84, 676	61, 31			30.00
43. 00	04300 NURSERY	482, 786	4, 577	3, 31			43. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	2, 263, 879 738, 097	295, 062 13, 308	213, 66 ⁹			50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	260, 595	5, 767	4, 17			52.00
53. 00	05300 ANESTHESI OLOGY	30, 330	183	13:		687	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 351, 129	131, 946	95, 54	·		54.00
54. 01 55. 00	05401 ULTRASOUND 05500 RADI OLOGY-THERAPEUTI C	230, 900 600, 895	7, 094 13, 216	5, 13 ⁻ 9, 570			54. 01 55. 00
57. 00	05700 CT SCAN	341, 093	13, 210		0	2, 400	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	312, 212	9, 189	6, 65	4 O	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	7/ 005	FF (0:	0	12.750	59.00
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	5, 178, 333	76, 895 0	55, 68:	798, 894	13, 750 0	60. 00 60. 01
65. 00	06500 RESPI RATORY THERAPY	825, 531	13, 319	9, 64	282, 218	-	65. 00
65. 01	03950 SLEEP CLINIC	188, 999	0	(0	6, 187	65. 01
66.00	06600 PHYSI CAL THERAPY	976, 539	86, 553	62, 67	·		66.00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	243, 327 186, 522	9, 086 4, 852	6, 57 ⁹ 3, 51			67. 00 68. 00
	06900 ELECTROCARDI OLOGY	1, 030, 948	54, 479	39, 44		0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 652, 956	0	(0	0	71. 00
72.00		2, 447, 164	0	(0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	2, 490, 540	U		<u> </u>	0	73. 00
91. 00	09100 EMERGENCY	1, 684, 360	110, 811	80, 24	1 590, 058	9, 969	91. 00
92. 00	,						92.00
101 00	OTHER REIMBURSABLE COST CENTERS 0 10100 HOME HEALTH AGENCY	1, 218, 522	35, 301	25, 56	388, 018	2 062	101. 00
101.00	SPECIAL PURPOSE COST CENTERS	1, 210, 322	33, 301	25, 50.	2 300,010	2,002	101.00
	11300 I NTEREST EXPENSE						113. 00
	11600 HOSPI CE	412, 382	3, 604	2, 610			116.00
118. 00	SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	68, 301, 317	3, 268, 786	2, 367, 00	11, 166, 517	302, 499	118. 00
190. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	73, 374	27, 920	(26, 278	1, 719	190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	187, 698	0	(4, 341	24, 406	
	1 19201 PHYSI CI AN CLI NI C	112, 134	0	(27, 117		192. 01
	2	37, 100	0 11, 969	(192. 02 192. 03
	4 19204 BREAST MRI STUDY		11, 909	·			192. 03
	5 19205 HOSPI TALI ST	1, 184, 904	0	(0	0	192. 05
	07950 COMMUNITY MENTAL HEALTH	0	0	(0		194. 00
	1 07951 MARKETI NG 2 07953 OCCUPATI ONAL HEALTH	246, 634 48, 456	0		0 40, 442 0 16, 902		194. 01 194. 02
	3 07952 PATHS EDUCATION	37, 347	ol		0 10, 302		194. 02
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers		0	(0	0	201. 00

Health Financial Syste	DEARBORN COUNTY HOSPITAL			In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENE		Provi der		Peri od:	Worksheet B		
					From 01/01/2014 Fo 12/31/2014	Part I Date/Time Pre	pared:
						5/29/2015 8:5	7 am
			CAPI TAL REI	LATED COSTS			
Cost Cent	er Description	Net Expenses	NEW BLDG &	NEW MVBLE		COMMUNI CATI ONS	
		for Cost	FIXT	EQUI P	BENEFI TS		
		Allocation			DEPARTMENT		
		(from Wkst A					
		col. 7)					
		0	1.00	2.00	4. 00	5. 01	
202.00 TOTAL (sui	m lines 118-201)	70, 228, 964	3, 308, 675	2, 367, 004	11, 281, 597	337, 561	202. 00

Provi der CCN: 150086

			Т	o 12/31/2014	Date/Time Prep 5/29/2015 8:57	
Cost Center Description	DATA	PURCHASI NG	ADMITTING	CASHI ERI NG/ACC	Subtotal	GIII
	PROCESSI NG	RECEIVING AND		OUNTS		
	5. 02	STORES 5. 03	5. 04	RECEI VABLE 5. 05	5A. 05	
GENERAL SERVICE COST CENTERS	5.02	5.03	5.04	5.05	5A. U5	
1. 00 O0100 NEW CAP REL COSTS-BLDG & FLXT						1. 00
2.00 OO200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01 01160 COMMUNI CATI ONS						5. 01
5. 02 00550 DATA PROCESSING	2, 090, 801					5. 02
5.03 O0560 PURCHASING RECEIVING AND STORES 5.04 O0570 ADMITTING	25, 090 68, 996					5. 03 5. 04
5. 05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	106, 631	1, 180				5. 05
5. 06 00591 OTHER ADMINISTRATIVE AND GENERAL	112, 903		1		3, 104, 016	5. 06
7.00 00700 OPERATION OF PLANT	27, 180			o	5, 224, 471	7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	0			0	383, 528	8.00
9. 00 00900 HOUSEKEEPI NG	10, 454			-	1, 327, 820	9. 00
10. 00 01000 DI ETARY	66, 906		1	0	778, 462	10.00
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON	0 35, 544	0 636	1	0	1, 354, 536 1, 333, 358	11. 00 13. 00
14. 00 01400 CENTRAL SERVI CE & SUPPLY	43, 907	l .		0	741, 428	14. 00
15. 00 01500 PHARMACY	64, 815			o	2, 366, 944	15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	112, 903			0	1, 439, 422	16.00
17. 00 01700 SOCIAL SERVICE	18, 817	217	0	0	433, 114	17. 00
INPATIENT ROUTINE SERVICE COST CENTERS	070 074	15.530	1 0/5 070	400,000	0.004.457	
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 NTENSIVE CARE UNIT	370, 071				9, 804, 157	30.00
31.00 03100 I NTENSI VE CARE UNI T 43.00 04300 NURSERY	56, 452 0				2, 093, 309 723, 257	31. 00 43. 00
ANCI LLARY SERVI CE COST CENTERS		0	04, 077	4, 340	123, 231	43.00
50. 00 05000 OPERATI NG ROOM	129, 630	107, 980	0	190, 934	3, 855, 983	50.00
51.00 05100 RECOVERY ROOM	0	1, 825	0	26, 152	1, 051, 220	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0		0	,	360, 698	52.00
53. 00 05300 ANESTHESI OLOGY	0	-,			47, 363	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	100, 358		0	,	4, 726, 671	54.00
54. 01 05401 ULTRASOUND 55. 00 05500 RADI OLOGY-THERAPEUTI C	20, 908 0	1, 601 16, 485	0	32, 534 56, 579	369, 376 846, 584	54. 01 55. 00
57. 00 05700 CT SCAN	0			174, 664	525, 838	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	Ö		Ö		389, 079	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.00
60. 00 06000 LABORATORY	140, 084	99, 845		312, 906	6, 676, 389	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
65. 00 06500 RESPI RATORY THERAPY 65. 01 03950 SLEEP CLI NI C	73, 178	4, 179 34	0		1, 265, 353 202, 044	65. 00 65. 01
66. 00 06600 PHYSI CAL THERAPY	45, 998	l .	1	6, 824 42, 070	1, 551, 190	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	13, 770	779			350, 068	67. 00
68. 00 06800 SPEECH PATHOLOGY	Ō	62			276, 514	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	1, 908	0		1, 359, 181	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0		2, 698, 946	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0		1		2, 620, 852	72.00
73. 00 O7300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	0	0	106, 142	2, 596, 682	73. 00
91. 00 O9100 EMERGENCY	71, 087	4, 106	0	74, 723	2, 625, 355	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	71,007	1, 100		71,720	0	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	83, 632	2, 273	0	15, 366	1, 770, 736	101. 00
SPECIAL PURPOSE COST CENTERS		1				
113. 00 11300 INTEREST EXPENSE		2 770		((21		113.00
116.00 11600 HOSPICE 118.00 SUBTOTALS (SUM OF LINES 1-117)	1, 785, 544	3, 779 532, 896		6, 631 1, 648, 160	530, 482 67, 804, 426	
NONREI MBURSABLE COST CENTERS	1, 700, 544	332, 690	1,037,107	1, 040, 100	07, 004, 420	110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	129, 291	190. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	275, 986	768	0	o	493, 199	
192. 01 19201 PHYSI CI AN CLI NI C	18, 817	267	0	0	162, 804	
192. 02 19202 LI FELI NE	0	_	0	-	37, 105	
192. 03 19203 CREDIT UNION 192. 04 19204 BREAST MRI STUDY	0		0	0	15, 406	192. 03 192. 04
192. 05 19205 HOSPI TALI ST	8, 363	_	0	0	1, 193, 352	
194. OO 07950 COMMUNI TY MENTAL HEALTH	0, 303	0	١			194. 00
194. 01 07951 MARKETI NG	2, 091	371	Ö	o	290, 569	
194. 02 07953 OCCUPATI ONAL HEALTH	0	30		О	65, 388	194. 02
194. 03 07952 PATHS EDUCATION	0	77	0	0	37, 424	
200.00 Cross Foot Adjustments	_	_	_			200. 00
201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118-201)	2, 090, 801	534, 499	1, 059, 189	1, 648, 160		201.00
(30111 (30111 (11103 (110 201)	2,070,001	1 554, 477	1, 557, 107	1, 515, 150	. 5, 225, 764	_02.00

Peri od: Worksheet B From 01/01/2014 Part I To 12/31/2014 Date/Time Prepared: 5/29/2015 8:57 am Provi der CCN: 150086

				''	0 12/31/2014	5/29/2015 8:5	
	Cost Center Description	OTHER ADMI NI STRATI VE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	7 4111
		5. 06	7. 00	8. 00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS						
1. 00 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 01160 COMMUNI CATI ONS 00550 DATA PROCESSI NG 00560 PURCHASI NG RECEIVI NG AND STORES 00570 ADMITTI NG						1. 00 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04
5. 05 5. 06 7. 00 8. 00 9. 00 10. 00	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00591 OTHER ADMI NI STRATI VE AND GENERAL 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY	3, 104, 016 241, 590 17, 735 61, 401 35, 998	5, 466, 061 53, 065 39, 266 133, 330	454, 328 74, 179	1, 502, 666	999, 591	5. 05 5. 06 7. 00 8. 00 9. 00
11. 00	01100 CAFETERI A	62, 636	94, 564	•		0	11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	61, 657	19, 999		-,	0	13. 00
14.00	01400 CENTRAL SERVICE & SUPPLY	34, 285	186, 262			0	14.00
15. 00	01500 PHARMACY	109, 452	38, 932		.,	0	15.00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	66, 562 20, 028	160, 229 19, 433	•	,	0	16. 00 17. 00
17.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	20, 020	19, 433	0	5, 454	0	17.00
30. 00	03000 ADULTS & PEDIATRICS	453, 386	1, 808, 555	157, 438	505, 729	778, 380	30.00
31. 00	03100 I NTENSI VE CARE UNI T	96, 799	246, 660			68, 707	
43.00	04300 NURSERY	33, 445	13, 333			0	1
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATI NG ROOM	178, 308	859, 511			0	
51.00	05100 RECOVERY ROOM	48, 611	38, 766		10, 840	2, 561	
52.00	05200 DELIVERY ROOM & LABOR ROOM	16, 679	16, 800		.,	0	
53. 00 54. 00	05300 ANESTHESI OLOGY	2, 190	533		149	0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C 05401 ULTRASOUND	218, 571 17, 081	384, 357 20, 666			0	54. 00 54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	39, 148	38, 499			0	55. 00
57. 00	05700 CT SCAN	24, 316	00, 177	0		0	57.00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	17, 992	26, 766		_	0	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0		0	1
60.00	06000 LABORATORY	308, 730	223, 994		62, 636	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
65. 00 65. 01	06500 RESPI RATORY THERAPY 03950 SLEEP CLI NI C	58, 512 9, 343	38, 799	5, 296 1, 811	10, 849	0	65. 00 65. 01
66. 00	06600 PHYSI CAL THERAPY	71, 730	252, 127		70, 503	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	16, 188	26, 466		7, 401	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	12, 787	14, 133			0	68. 00
69.00	06900 ELECTROCARDI OLOGY	62, 851	158, 696	1, 916	44, 376	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	124, 805	0	0	0	0	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	121, 193	0			0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	120, 076	0	0	0	0	73. 00
01 00	OUTPATIENT SERVICE COST CENTERS 09100 EMERGENCY	121, 402	322, 792	76, 380	90, 263	11 010	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	121, 402	322, 172	70, 300	70, 203	11, 710	92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	81, 882	102, 831	0	28, 755	0	101. 00
	SPECIAL PURPOSE COST CENTERS			1			
	11300 INTEREST EXPENSE	24 521	10 500		2 02/	0	113.00
118.00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1-117)	24, 531 2, 991, 900	10, 500 5, 349, 864		2, 936 1, 470, 173	861, 558	116.00
110.00	NONREI MBURSABLE COST CENTERS	2, 991, 900	3, 349, 604	440, 044	1,470,173	001, 000	1116.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	5, 979	81, 331	0	22, 743	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	22, 807	0	354		0	192. 00
192. 01	19201 PHYSICIAN CLINIC	7, 528	0	0	0	0	192. 01
	2 19202 LI FELI NE	1, 716	0	0			192. 02
	19203 CREDIT UNION	712	34, 866	1	.,		192. 03
	19204 BREAST MRI STUDY	0	0	0	-		192.04
	19205 HOSPI TALI ST	55, 183	0	7 120	0		192. 05
	07950 COMMUNITY MENTAL HEALTH	13, 436	0	7, 130		138, 033 0	194. 00
	2 07953 OCCUPATI ONAL HEALTH	3, 024	0	0			194. 01
	07755 GGGGT/TT GIGNE TIENETT	1, 731	o O	Ö			194. 03
200.00		' ' '					200. 00
201.00	Negative Cost Centers	0	0	0	o		201. 00
202.00	TOTAL (sum lines 118-201)	3, 104, 016	5, 466, 061	454, 328	1, 502, 666	999, 591	202. 00

Provi der CCN: 150086

			To	12/31/2014	Date/Time Pre 5/29/2015 8:5	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	, diii
	/	ADMI NI STRATI ON	SERVI CE & SUPPLY		RECORDS & LI BRARY	
	11.00	13. 00	14. 00	15. 00	16. 00	
GENERAL SERVICE COST CENTERS						
1. 00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 OO200 NEW CAP REL COSTS-MVBLE EQUIP 4.00 OO400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 01 01160 COMMUNI CATI ONS						5. 01
5. 02 00550 DATA PROCESSING						5. 02
5. 03 00560 PURCHASING RECEIVING AND STORES						5. 03
5. 04 00570 ADMI TTI NG						5. 04
5. 05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
5. 06 00591 OTHER ADMINISTRATIVE AND GENERAL						5. 06
7. 00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LI NEN SERVI CE 9.00 00900 HOUSEKEEPI NG						8. 00 9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A	1, 538, 179					11. 00
13.00 01300 NURSING ADMINISTRATION	40, 438	1, 461, 044				13. 00
14.00 01400 CENTRAL SERVICE & SUPPLY	32, 671	61, 495	1, 109, 046			14. 00
15. 00 01500 PHARMACY	76, 157	0	0	2, 602, 372	4 770 400	15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE	68, 170 17, 666	0	0	0	1, 779, 188 0	16. 00 17. 00
INPATIENT ROUTINE SERVICE COST CENTERS	17,000	U _I	U	<u> </u>	0	17.00
30. 00 03000 ADULTS & PEDIATRICS	371, 609	699, 474	0	0	120, 303	30.00
31.00 03100 INTENSIVE CARE UNIT	77, 972	146, 765	0	0	29, 783	31. 00
43. 00 04300 NURSERY	23, 734	44, 674	0	0	4, 844	43. 00
ANCI LLARY SERVI CE COST CENTERS	100.04	005 000	ام	ما	212 125	
50. 00 05000 0PERATI NG ROOM 51. 00 05100 RECOVERY ROOM	109, 066	205, 293	0	0	212, 135 29, 135	50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	39, 107 12, 811	73, 611 24, 113	0	0	13, 845	51. 00 52. 00
53. 00 05300 ANESTHESI OLOGY	0	24, 113	0	Ö	14, 115	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	155, 134	o	0	o	180, 998	54. 00
54. 01 05401 ULTRASOUND	11, 953	0	0	0	36, 246	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	20, 967	0	0	0	62, 861	55. 00
57. 00 05700 CT SCAN	0	0	0	0	194, 591	1
58.00 O5800 MAGNETIC RESONANCE I MAGING (MRI) 59.00 O5900 CARDIAC CATHETERIZATION	0	0	0	0	63, 692 0	58. 00 59. 00
60. 00 06000 LABORATORY	180, 915	0	0	0	348, 673	60.00
60. 01 06001 BLOOD LABORATORY	0	o	0	Ö	0	60. 01
65. 00 06500 RESPIRATORY THERAPY	49, 584	O	0	0	60, 365	65.00
65. 01 03950 SLEEP CLINIC	0	0	0	0	7, 603	65. 01
66. 00 06600 PHYSI CAL THERAPY	58, 121	0	0	0	46, 870	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	10, 857	0	0	0	6, 327	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	7, 762 33, 446	0	0	O O	5, 110 63, 978	68. 00 69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	33, 440	0	1, 109, 046	0	51, 237	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	o	Ö	0	Ö	24, 986	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	O	0	2, 602, 372	118, 252	73. 00
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	109, 240	205, 619	0	0	83, 239	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92. 00
101. 00 10100 HOME HEALTH AGENCY	0	0	0	O	0	101. 00
SPECIAL PURPOSE COST CENTERS	<u> </u>	<u> </u>	<u> </u>	<u> </u>		
113. 00 11300 NTEREST EXPENSE						113. 00
116. 00 11600 H0SPI CE	0	0	0	0		116. 00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	1, 507, 380	1, 461, 044	1, 109, 046	2, 602, 372	1, 779, 188	118. 00
NONREI MBURSABLE COST CENTERS	12 205	ما		ما	0	100.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES	12, 295 715	0	0	0		190. 00 192. 00
192. 01 19201 PHYSI CI AN CLINI C	9, 580	0	0	0		192. 01
192. 02 19202 LI FELI NE	0	Ö	0	Ö		192. 02
192. 03 19203 CREDIT UNION	o	0	0	O	0	192. 03
192.04 19204 BREAST MRI STUDY	0	0	0	0		192. 04
192. 05 19205 HOSPI TALI ST	0	0	0	O		192. 05
194.00 07950 COMMUNITY MENTAL HEALTH	0 4 0 5 0	0	0	0		194.00
194. 01 07951 MARKETI NG 194. 02 07953 OCCUPATI ONAL HEALTH	6, 852 1, 357	0	0	o o		194. 01 194. 02
194. 03 07952 PATHS EDUCATION	1, 357	0	0	0		194. 02
200.00 Cross Foot Adjustments		J	J	٩	O	200. 00
201.00 Negative Cost Centers	o	O	0	О		201. 00
202.00 TOTAL (sum lines 118-201)	1, 538, 179	1, 461, 044	1, 109, 046	2, 602, 372	1, 779, 188	202. 00

Health Financial Systems COST ALLOCATION - GENERAL SERVICE COSTS	DEARBORN COUNT			eriod: com 01/01/2014	u of Form CMS-2552-10 Worksheet B Part I Date/Time Prepared: 5/29/2015 8:57 am
Cost Center Description	SOCI AL SERVI CE		Intern & Residents Cost & Post Stepdown Adjustments	Total	
GENERAL SERVICE COST CENTERS	17. 00	24. 00	25. 00	26. 00	
1.00	495, 675				1. 00 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 5. 05 5. 06 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	462, 697	15, 161, 728	O	15, 161, 728	30.00
31.00 03100 INTENSIVE CARE UNIT	17, 914	2, 873, 774	0	2, 873, 774	31.00
43. 00	0 611 7,328 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	847, 015 5, 687, 237 1, 321, 060 449, 644 64, 350 5, 797, 546 467, 727 1, 022, 847 744, 745 505, 014 0 7, 801, 392 0 1, 488, 758 220, 801 2, 056, 805 417, 734 320, 258 1, 724, 444 3, 984, 034 2, 767, 031 5, 437, 382 1, 984, 204	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5, 687, 237 1, 321, 060 449, 644 64, 350 5, 797, 546 467, 727 1, 022, 847 744, 745 505, 014 0 7, 801, 392 0 1, 488, 758 220, 801 2, 056, 805 417, 734 320, 258 1, 724, 444 3, 984, 034 2, 767, 031 5, 437, 382	43. 00 50. 00 51. 00 52. 00 53. 00 54. 00 54. 01 55. 00 57. 00 58. 00 60. 00 60. 01 65. 00 65. 01 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 91. 00 92. 00
113.00 11300 INTEREST EXPENSE		F/0, 440		F/O 440	113. 00
116.00 11600 HOSPICE 118.00 SUBTOTALS (SUM OF LINES 1-117)	0 495, 471	568, 449 67, 367, 100	0 0	568, 449 67, 367, 100	116. 00 118. 00
NONREI MBURSABLE COST CENTERS 190. 00	0 204 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	251, 639 517, 279 179, 912 38, 821 60, 734 0 1, 248, 535 145, 163 310, 857 69, 769 39, 155 0 70, 228, 964	0 0 0 0 0 0 0 0 0 0	251, 639, 517, 279, 179, 912, 38, 821, 60, 734, 0, 1, 248, 535, 145, 163, 310, 857, 69, 769, 39, 155, 0, 70, 228, 964	190. 00 192. 00 192. 01 192. 02 192. 03 192. 04 192. 05 194. 00 194. 01 194. 02 194. 03 200. 00 201. 00 202. 00

| Peri od: | Worksheet B | From 01/01/2014 | Part | I | To 12/31/2014 | Date/Time Prepared: | Part | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Part | Prepared: | Part | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 150086

				Io	12/31/2014	Date/lime Pre 5/29/2015 8:5	
			CAPI TAL REI	ATED COSTS		0,27,2010 0.0	
	Cost Center Description	Di rectly Assigned New Capital	NEW BLDG & FIXT	NEW MVBLE EQUI P	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		Related Costs 0	1. 00	2.00	2A	4. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	_					2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	18, 446	·	31, 803	31, 803	1
5. 01	01160 COMMUNI CATI ONS	0	3, 479		5, 998	122	1
5. 02 5. 03	00550 DATA PROCESSING 00560 PURCHASING RECEIVING AND STORES	0	20, 917 73, 130		36, 064 126, 085	852 233	1
5. 04	00570 ADMITTING	0	39, 535		68, 163	615	1
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	39, 569		68, 222	736	1
5.06	00591 OTHER ADMINISTRATIVE AND GENERAL	0	120, 446	1	207, 664	1, 558	1
7.00	00700 OPERATION OF PLANT	0	1, 116, 707	1	1, 925, 339	1, 000	1
8.00	00800 LAUNDRY & LINEN SERVICE	0	18, 217	13, 191	31, 408	164	8. 00
9.00	00900 HOUSEKEEPI NG	0	13, 480		23, 241	750	1
10.00	01000 DI ETARY	0	45, 771		78, 915	285	1
11.00	01100 CAFETERI A	0	32, 463		55, 970	780	1
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON	0	6, 866		11, 838	932	1
15. 00	01400 CENTRAL SERVI CE & SUPPLY 01500 PHARMACY	0	63, 942 13, 365		110, 244 23, 043	304 1, 584	14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	55, 005		94, 836	814	1
17. 00	01700 SOCI AL SERVI CE	o	6, 671		11, 502	293	1
	INPATIENT ROUTINE SERVICE COST CENTERS	·!			,		
30.00	03000 ADULTS & PEDI ATRI CS	0	620, 859	449, 579	1, 070, 438	5, 179	30. 00
31. 00	03100 INTENSIVE CARE UNIT	0	84, 676		145, 992	1, 246	1
43. 00	04300 NURSERY	0	4, 577	3, 314	7, 891	405	43. 00
F0 00	ANCI LLARY SERVI CE COST CENTERS		205 242	040 (/4	500 700l	4 700	
50. 00 51. 00	05000 OPERATI NG ROOM 05100 RECOVERY ROOM	0	295, 062 13, 308		508, 723 22, 945	1, 780 728	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	5, 767		9, 943	218	1
53. 00	05300 ANESTHESI OLOGY	0	183		316	0	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	o	131, 946		227, 491	2, 360	1
54. 01	05401 ULTRASOUND	0	7, 094		12, 231	199	1
55.00	05500 RADI OLOGY-THERAPEUTI C	0	13, 216	9, 570	22, 786	416	55. 00
57.00	05700 CT SCAN	0	0	I	0	0	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	9, 189	6, 654	15, 843	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	7, 205	0	100 577	0	
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	0	76, 895	55, 682 0	132, 577	2, 253 0	60. 00 60. 01
65. 00	06500 RESPIRATORY THERAPY	0	13, 319	١	22, 964	796	1
65. 01	03950 SLEEP CLINIC	0	13, 317	7, 045	22, 704	0	65. 01
66. 00	06600 PHYSI CAL THERAPY	0	86, 553	62, 675	149, 228	938	1
67.00	06700 OCCUPATI ONAL THERAPY	0	9, 086		15, 665	238	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	4, 852	3, 513	8, 365	185	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	54, 479		93, 928	472	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	١	0	0	1
	07200 I MPL. DEV. CHARGED TO PATIENT	0	0		0	0	1
73.00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	l o	U	U	υ	0	73. 00
91. 00	09100 EMERGENCY	0	110, 811	80, 241	191, 052	1, 664	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		110,011	00,211	0	1,001	92. 00
	OTHER REIMBURSABLE COST CENTERS				-,		1
101.00	10100 HOME HEALTH AGENCY	0	35, 301	25, 562	60, 863	1, 094	101. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE						113. 00
	11600 HOSPI CE	0	3, 604		6, 214		116.00
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	0	3, 268, 786	2, 367, 004	5, 635, 790	31, 479	118. 00
100 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	27, 920	0	27, 920	7.1	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	27, 720	1	27, 720		192. 00
	19201 PHYSI CI AN CLI NI C	0	0	0	0		192. 01
	19202 LI FELI NE	0	0	0	Ö		192. 02
192. 03	19203 CREDIT UNION	0	11, 969	0	11, 969	0	192. 03
	19204 BREAST MRI STUDY	0	0	0	0		192. 04
	19205 HOSPI TALI ST	0	0	0	0		192. 05
	07950 COMMUNITY MENTAL HEALTH	0	0	0	0		194. 00
	07951 MARKETI NG	0	0	0	0		194. 01
	07953 OCCUPATI ONAL HEALTH		0	0	0		194. 02
200.00	07952 PATHS EDUCATION Cross Foot Adjustments		0		0	0	194. 03 200. 00
200.00			0	0	٥	n	200.00
201.00		0	3, 308, 675		5, 675, 679		202. 00
		1				,	

Provi der CCN: 150086

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2014	Part II
To 12/31/2014	Date/Time Prepared:
5/29/2015 8:57 am	

) 12/31/2014	5/29/2015 8:5	
	Cost Center Description	COMMUNI CATI ONS	DATA	PURCHASI NG	ADMI TTI NG	CASHI ERI NG/ACC	
			PROCESSI NG	RECEIVING AND		OUNTS	
				STORES		RECEI VABLE	
	CENEDAL CEDVICE COCT CENTEDS	5. 01	5. 02	5. 03	5. 04	5. 05	
1. 00	GENERAL SERVICE COST CENTERS OO100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-BEDG & TTXT	1					2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	1		•			4. 00
5. 01	01160 COMMUNI CATI ONS	6, 120					5. 01
5. 02	00550 DATA PROCESSING	324	37, 240	i			5. 02
5. 03	00560 PURCHASING RECEIVING AND STORES	75	447	1			5. 03
5.04	00570 ADMITTING	181	1, 229	521	70, 709		5. 04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	280	1, 899	280	0	71, 417	5. 05
5.06	00591 OTHER ADMINISTRATIVE AND GENERAL	218	2, 011	336	0	0	5. 06
7. 00	00700 OPERATION OF PLANT	455	484		0	0	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	6	0	1 ., 20.	0	0	8. 00
9.00	00900 HOUSEKEEPI NG	81	186		0	0	9.00
10.00	01000 DI ETARY	131	1, 192 0		0	0	10.00
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	93	633		0	0	11. 00 13. 00
14. 00	01400 CENTRAL SERVICE & SUPPLY	69	782		0	0	14. 00
15. 00	01500 PHARMACY	206	1, 154		0	Ö	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	536	2, 011		0	Ö	16. 00
17. 00	01700 SOCIAL SERVICE	69	335	1	0	0	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			•			1
30.00	03000 ADULTS & PEDI ATRI CS	786	6, 593	3, 697	57, 764	5, 373	30. 00
31. 00	03100 INTENSIVE CARE UNIT	106	1, 005	529	7, 291	1, 167	31. 00
43.00	04300 NURSERY	0	0	0	5, 654	188	43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	430	2, 309		0		50.00
51.00	05100 RECOVERY ROOM	75	0	1	0	.,	1
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0	0	0 797	0	550 549	52.00
54. 00	05400 RADI OLOGY - DI AGNOSTI C	12 399	1, 788		0	7, 210	53. 00 54. 00
54. 00	05400 RADI OLOGI - DI AGNOSTI C	12	372		0	1, 410	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	44	3/2	1	0	2, 452	1
57. 00	05700 CT SCAN	0	0	2, 392	0	7, 570	1
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	782	0	2, 502	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	O	0	0	0	59. 00
60.00	06000 LABORATORY	249	2, 495	23, 693	0	13, 551	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
65.00	06500 RESPI RATORY THERAPY	44	1, 303	992	0	2, 378	
65. 01	03950 SLEEP CLINIC	112	0	8	0	296	65. 01
66. 00	06600 PHYSI CAL THERAPY	62	819	1	0	1, 823	1
67. 00	06700 OCCUPATI ONAL THERAPY	6	0	185	0	246	1
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	206	0	15	0	199	68. 00 69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0	453 0	0	2, 826 1, 993	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT		0	36, 101	0	935	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	Ö	0	0	4, 600	1
	OUTPATIENT SERVICE COST CENTERS		-	-1	-	.,	
91.00	09100 EMERGENCY	181	1, 266	974	0	3, 238	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	37	1, 490	539	0	666	101. 00
440.00	SPECIAL PURPOSE COST CENTERS	1		1			
	11300 INTEREST EXPENSE			007	0	207	113.00
118.00	11600 HOSPI CE	0	21 002	897	70.700		116. 00 118. 00
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	5, 485	31, 803	126, 461	70, 709	/1,41/	1118.00
100 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	31	0	o	0	0	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	442	4, 916		0	l e	192. 00
	19201 PHYSI CI AN CLI NI C	81	335	1	0		192. 01
	19202 LI FELI NE	o	0	1	0		192. 02
192. 03	19203 CREDIT UNION	62	0	0	0	0	192. 03
192. 04	19204 BREAST MRI STUDY	0	0	0	0		192. 04
	5 19205 HOSPI TALI ST	0	149	1	0		192. 05
	07950 COMMUNITY MENTAL HEALTH	0	0		0	l	194. 00
	07951 MARKETI NG	19	37	88	0	l	194. 01
	207953 OCCUPATIONAL HEALTH	0	0	7	0	l	194. 02
200.00	BO7952 PATHS EDUCATION Cross Foot Adjustments	۱	Ü	18	0		194. 03 200. 00
200.00		0	0	0	Λ	n	200.00
202.00		6, 120	37, 240		70, 709		202.00
_000	1 (201)	0,120	37,240		. 0, 707		,

ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 150086

Peri od: Worksheet B From 01/01/2014 Part II To 12/31/2014 Date/Time Prepared:

5/29/2015 8:57 am Cost Center Description OTHER OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY ADMI NI STRATI VE **PLANT** LINEN SERVICE AND GENERAL 7.00 8.00 9. 00 10.00 5.06 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.01 01160 COMMUNI CATI ONS 5.01 00550 DATA PROCESSING 5.02 5.02 5.03 00560 PURCHASING RECEIVING AND STORES 5.03 00570 ADMITTING 5.04 5 04 5.05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.05 5.06 00591 OTHER ADMINISTRATIVE AND GENERAL 211, 787 5 06 00700 OPERATION OF PLANT 16, 483 7.00 1, 945, 881 7.00 00800 LAUNDRY & LINEN SERVICE 1, 210 52, 940 8.00 18, 891 8.00 9.00 00900 HOUSEKEEPI NG 4, 189 13, 978 8,644 52, 714 9.00 10.00 01000 DI ETARY 2, 456 47, 465 1,692 1, 308 135, 017 10.00 01100 CAFETERI A 4, 274 33, 664 928 11.00 11.00 0 0 01300 NURSING ADMINISTRATION 13.00 4, 207 7, 120 0 196 0 13.00 14.00 01400 CENTRAL SERVICE & SUPPLY 2, 339 66, 308 14.00 96 1,827 0 15.00 01500 PHARMACY 7, 468 13, 860 0 382 0 15.00 01600 MEDICAL RECORDS & LIBRARY 57.041 0 16,00 4.541 1, 572 Ω 16,00 17.00 01700 SOCIAL SERVICE 1,366 6, 918 0 191 0 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30, 940 643, 834 18, 344 17, 739 105, 138 30.00 03100 INTENSIVE CARE UNIT 9, 280 31.00 6,604 87, 809 3, 133 2, 420 31.00 43.00 04300 NURSERY 2, 282 4,746 131 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 12 166 305, 980 3 028 8 431 n 50 00 05100 RECOVERY ROOM 51.00 3, 317 13,800 2, 317 380 346 51.00 5, 981 52.00 05200 DELIVERY ROOM & LABOR ROOM 1, 138 165 52.00 0 53.00 05300 ANESTHESI OLOGY 149 190 0 5 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 14, 913 54.00 136, 828 2,836 3, 770 0 54.00 54.01 05401 ULTRASOUND 1, 165 7, 357 772 203 0 54.01 05500 RADI OLOGY-THERAPEUTI C 55.00 2,671 13, 705 469 378 0 55.00 57 00 05700 CT SCAN 1 659 Ω 0 57 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 1, 228 9, 529 0 263 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0 0 59.00 60.00 06000 LABORATORY 21,064 79, 740 2, 197 0 60.00 6 06001 BLOOD LABORATORY 60 01 0 0 60 01 65.00 06500 RESPIRATORY THERAPY 3, 992 13,812 617 381 0 65.00 03950 SLEEP CLINIC 65.01 637 211 0 65.01 66.00 06600 PHYSI CAL THERAPY 4,894 89, 755 730 2.473 0 66.00 06700 OCCUPATIONAL THERAPY 9, 422 67 00 1, 104 50 260 0 67.00 68.00 06800 SPEECH PATHOLOGY 872 5, 031 C 139 0 68.00 69.00 06900 ELECTROCARDI OLOGY 4, 288 56, 495 223 1.557 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 8.515 0 71.00 C 07200 IMPL. DEV. CHARGED TO PATIENT 72.00 8 269 0 0 0 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 8, 193 0 0 73.00 OUTPATIENT SERVICE COST CENTERS 1, 609 91.00 09100 EMERGENCY 114, 912 8. 900 91.00 8, 283 3, 166 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 5, 587 36, 607 0 1, 009 0 101. 00 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113 00 116. 00 11600 HOSPI CE 1,674 3, 738 103 0 116.00 <u>116, 373</u> 118. 00 SUBTOTALS (SUM OF LINES 1-117) 1, 904, 516 52, 068 118.00 204, 137 51, 574 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 408 28, 953 C 798 192.00 19200 PHYSICIANS' PRIVATE OFFICES 1,556 41 0 192.00 0 192. 01 19201 PHYSICIAN CLINIC 514 0 0 0 192, 01 192. 02 19202 LI FELI NE 117 0 0 0 192. 02 192. 03 19203 CREDIT UNION 49 12, 412 0 342 0 192. 03 192.04 19204 BREAST MRI STUDY 0 0 192.04 C 0 192. 05 19205 HOSPI TALI ST 0 192, 05 3,765 C 0 0 194. 00 07950 COMMUNITY MENTAL HEALTH C 831 0 18, 644 194. 00 194. 01 07951 MARKETI NG 0 0 194. 01 917 0 0 0 194. 02 07953 OCCUPATIONAL HEALTH 206 C 0 0 194.02 194. 03 07952 PATHS EDUCATION 0 0 194, 03 118 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 201.00 202.00 TOTAL (sum lines 118-201) 211, 787 1, 945, 881 52 940 52 714 135, 017 202. 00

Provi der CCN: 150086

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2014	Part II
To 12/31/2014	Date/Time Prepared:
5/29/2015 8:57 am	

			10) 12/31/2014	5/29/2015 8: 5	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVI CE & SUPPLY		RECORDS & LI BRARY	
	11.00	13. 00	14. 00	15. 00	16. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT						1. 00
2.00 OO200 NEW CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01 01160 COMMUNI CATI ONS						5. 01
5. 02 00550 DATA PROCESSING						5. 02
5. 03 00560 PURCHASING RECEIVING AND STORES						5. 03
5. 04 00570 ADMI TTI NG 5. 05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 04 5. 05
5. 06 00591 OTHER ADMINISTRATIVE AND GENERAL						5. 06
7. 00 00700 OPERATION OF PLANT						7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A	95, 616					11. 00
13.00 O1300 NURSING ADMINISTRATION	2, 514					13. 00
14.00 01400 CENTRAL SERVICE & SUPPLY	2, 031		194, 231			14. 00
15. 00 01500 PHARMACY	4, 734		0	53, 522	4/5 000	15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	4, 238		0	0	165, 903	16.00
17. 00 01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	1, 098	0	0	U	0	17. 00
30. 00 03000 ADULTS & PEDIATRICS	23, 101	13, 254	0	o	11, 221	30. 00
31. 00 03100 I NTENSI VE CARE UNIT	4, 847		0	Ö	2, 778	31. 00
43. 00 04300 NURSERY	1, 475		0	Ö	452	43. 00
ANCI LLARY SERVI CE COST CENTERS		,		-1		
50.00 05000 OPERATING ROOM	6, 780	3, 890	0	0	19, 787	50. 00
51.00 05100 RECOVERY ROOM	2, 431	1, 395	0	0	2, 718	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	796		0	0	1, 291	52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	0	0	1, 317	53. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	9, 643		0	0	16, 882	54.00
54. 01 05401 ULTRASOUND 55. 00 05500 RADI OLOGY-THERAPEUTI C	743		0	0	3, 381	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C 57. 00 05700 CT SCAN	1, 303	0	0	0	5, 863 18, 150	55. 00 57. 00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	5, 941	58. 00
59. 00 05900 CARDIAC CATHETERIZATION	0	Ö	0	0	0, 711	59. 00
60. 00 06000 LABORATORY	11, 246	o	0	o	32, 473	60.00
60. 01 06001 BLOOD LABORATORY	0	1	0	0	0	60. 01
65. 00 06500 RESPIRATORY THERAPY	3, 082	o	0	0	5, 630	65. 00
65. 01 03950 SLEEP CLINIC	0	0	0	0	709	65. 01
66. 00 06600 PHYSI CAL THERAPY	3, 613	0	0	0	4, 372	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	675	0	0	0	590	67. 00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	482 2, 079	0	0	0	477	68.00
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	2,079	1	194, 231	0	5, 967 4, 779	69. 00 71. 00
72. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			174, 231	0	2, 331	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0		Ö	53, 522	11, 030	73. 00
OUTPATIENT SERVICE COST CENTERS			-1			
91. 00 09100 EMERGENCY	6, 791	3, 896	0	0	7, 764	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
OTHER REIMBURSABLE COST CENTERS	1	1		- I		
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	0	0	0	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	93, 702	27, 684	194, 231	53, 522	165, 903	
NONREI MBURSABLE COST CENTERS	707702	27,001	1717201	00,022	1007 700	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	764	0	0	0	0	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	44		0	0		192. 00
192. 01 19201 PHYSICIAN CLINIC	596	1	0	0		192. 01
192. 02 19202 LI FELI NE	0	1	0	0		192. 02
192. 03 19203 CREDIT UNION	0	1	0	0		192. 03 192. 04
192. 04 19204 BREAST MRI STUDY 192. 05 19205 HOSPITALIST	0	0	0	0		192. 04 192. 05
192.00 07950 COMMUNI TY MENTAL HEALTH		0	0	0		194. 00
194. 01 07951 MARKETI NG	426	1	0	0		194. 00
194. 02 07953 OCCUPATI ONAL HEALTH	84		0	ő		194. 02
194. 03 07952 PATHS EDUCATION	0	l ő	O	ol		194. 03
200.00 Cross Foot Adjustments			اً ا			200. 00
201.00 Negative Cost Centers	0	1	0	0		201. 00
202.00 TOTAL (sum lines 118-201)	95, 616	27, 684	194, 231	53, 522	165, 903	202. 00

	Financial Systems TION OF CAPITAL RELATED COSTS	DEARBORN COUNT			In Lie eriod: rom 01/01/2014	u of Form CMS-2552-10 Worksheet B Part II
				T		Date/Time Prepared: 5/29/2015 8:57 am
	Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown	Total	
		17. 00	24. 00	Adjustments 25.00	26. 00	
	GENERAL SERVICE COST CENTERS	17.00	24.00	25.00	20.00	
	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP					1.00
	00400 EMPLOYEE BENEFITS DEPARTMENT					2. 00 4. 00
	01160 COMMUNI CATI ONS					5. 01
	00550 DATA PROCESSING 00560 PURCHASING RECEIVING AND STORES					5. 02 5. 03
	00570 ADMITTING					5. 04
	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00591 OTHER ADMINI STRATI VE AND GENERAL					5. 05 5. 06
	00700 OPERATION OF PLANT					7.00
	00800 LAUNDRY & LINEN SERVICE					8. 00
	00900 HOUSEKEEPI NG 01000 DI ETARY					9. 00 10. 00
	01100 CAFETERI A					11. 00
	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CE & SUPPLY					13. 00 14. 00
	01500 PHARMACY					15. 00
	01600 MEDICAL RECORDS & LIBRARY	04.000				16.00
17. 00	01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	21, 823				17. 00
	03000 ADULTS & PEDIATRICS	20, 370	2, 033, 771	1		30.00
	03100 INTENSIVE CARE UNIT 04300 NURSERY	789 0	277, 777 24, 070			31. 00 43. 00
	ANCILLARY SERVICE COST CENTERS		24, 070) <u>0</u>	24, 070	45.00
	05000 OPERATING ROOM	27	907, 230		907, 230	50.00
	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	323	52, 341 20, 539		52, 341 20, 539	51. 00 52. 00
53. 00	05300 ANESTHESI OLOGY	0	3, 335	0	3, 335	53. 00
	05400 RADI OLOGY-DI AGNOSTI C 05401 ULTRASOUND	0	429, 462 28, 225		429, 462 28, 225	54. 00 54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	Ö	53, 999	0	53, 999	55. 00
	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	29, 771 36, 088		29, 771 36, 088	57. 00 58. 00
	05900 CARDI AC CATHETERI ZATI ON		30, 080	1	30, 088	59. 00
	06000 LABORATORY	0	321, 544		321, 544	60.00
	06001 BL00D LABORATORY 06500 RESPI RATORY THERAPY		55, 991	0	55, 991	60. 01 65. 00
65. 01	03950 SLEEP CLINIC	0	1, 973	0	1, 973	65. 01
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	259, 014 28, 441	1	259, 014 28, 441	66. 00 67. 00
	06800 SPEECH PATHOLOGY		15, 971	1		68. 00
	06900 ELECTROCARDI OLOGY	0	168, 288		168, 288	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	209, 518 47, 636		209, 518 47, 636	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	77, 345			73. 00
	OUTPATIENT SERVICE COST CENTERS 09100 EMERGENCY	305	354, 001	0	354, 001	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			ő	00.700.	92.00
	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	0	107, 892	2 0	107, 892	101. 00
101.00	SPECIAL PURPOSE COST CENTERS		107, 072	-1	107, 072	101.00
	11300 INTEREST EXPENSE 11600 HOSPI CE		13, 199	9 0	13, 199	113. 00 116. 00
118.00		21, 814	5, 557, 421			118. 00
400.00	NONREI MBURSABLE COST CENTERS					100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	58, 948 7, 202	1	58, 948 7, 202	190. 00 192. 00
192. 01	19201 PHYSICIAN CLINIC	Ö	1, 665	0	1, 665	192. 01
	19202 LI FELI NE 19203 CREDI T UNI ON	0	118 24, 834		118 24, 834	192. 02 192. 03
	19204 BREAST MRI STUDY	o	24, 034	o o	0	192. 04
	19205 HOSPI TALI ST	0	3, 934	1	3, 934	192. 05
	07950 COMMUNITY MENTAL HEALTH 07951 MARKETING		19, 475 1, 601	1	19, 475 1, 601	194. 00 194. 01
194. 02	07953 OCCUPATI ONAL HEALTH	0	345	0	345	194. 02
194. 03 200. 00	07952 PATHS EDUCATION Cross Foot Adjustments	0	136	0 0	136	194. 03 200. 00
201. 00	Negative Cost Centers	0	C	0	O	201. 00
202. 00	TOTAL (sum lines 118-201)	21, 823	5, 675, 679	o o	5, 675, 679	202. 00

	n Financial Systems ALLOCATION - STATISTICAL BASIS	DEARBORN COUNT		CCN: 150086 P	<u>In Lie</u> eriod:	u of Form CMS-: Worksheet B-1	
0031 /	ALLOCATION - STATISTICAL BASIS		1 TOVI del	F	rom 01/01/2014 o 12/31/2014	Date/Time Pre	pared:
		CAPITAL RELA	ATED COSTS			5/29/2015 8:5	/ am
	Cost Center Description	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUI P (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS	COMMUNI CATI ONS (PHONES)	DATA PROCESSING (DP EQUIPMENT)	
		·		SALARI ES)	F 01	F 02	
	GENERAL SERVICE COST CENTERS	1.00	2. 00	4.00	5. 01	5. 02	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	289, 151					1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		285, 665				2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 612	1, 612	31, 500, 455			4. 00
5. 01 5. 02	O1160 COMMUNI CATI ONS O0550 DATA PROCESSI NG	304 1, 828	304 1, 828	120, 961 844, 044		1, 000	5. 01 5. 02
5. 03	00560 PURCHASING RECEIVING AND STORES	6, 391	6, 391	230, 494		12	5. 03
5.04	00570 ADMI TTI NG	3, 455	3, 455	608, 690		33	
5. 05 5. 06	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00591 OTHER ADMINI STRATI VE AND GENERAL	3, 458 10, 526	3, 458 10, 526	728, 298 1, 542, 514		51 54	5. 05 5. 06
7. 00	00700 OPERATION OF PLANT	97, 591	97, 591	990, 184		13	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	1, 592	1, 592	162, 630		0	1
9.00	00900 HOUSEKEEPI NG	1, 178	1, 178	742, 938		5	
10. 00 11. 00		4, 000 2, 837	4, 000 2, 837	281, 865 772, 624		32 0	1
13. 00	•	600	600	922, 874		17	13. 00
14. 00		5, 588	5, 588	301, 324		21	14. 00
15. 00		1, 168	1, 168	1, 568, 631		31	1
16. 00 17. 00		4, 807 583	4, 807 583	806, 281 289, 926		54 9	1
	INPATIENT ROUTINE SERVICE COST CENTERS		333	207,720		,]
30.00		54, 258	54, 258	5, 139, 286		177	1
31. 00 43. 00		7, 400	7, 400 400	1, 233, 415 400, 772		27 0	1
10. 00	ANCILLARY SERVICE COST CENTERS	100	100	100, 112			10.00
50.00		25, 786	25, 786	1, 762, 205		62	1
51. 00 52. 00		1, 163	1, 163	720, 599		0	
53. 00		504 16	504 16	216, 326 0		0	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	11, 531	11, 531	2, 336, 523	64	48	54. 00
54. 01	05401 ULTRASOUND	620	620	196, 893		10	
55. 00 57. 00	•	1, 155	1, 155 0	411, 662 0		0	
58. 00	•	803	803	Ö	Ö	0	1
59. 00		0	0	C	0	0	
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	6, 720	6, 720 0	2, 230, 668	40	67 0	60. 00 60. 01
65. 00		1, 164	1, 164	788, 009		35	
65. 01		0	0	· C	18		
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	7, 564	7, 564	928, 750 235, 310		22 0	1
68. 00		794 424	794 424	183, 264		0	
69. 00	06900 ELECTROCARDI OLOGY	4, 761	4, 761	466, 849		0	1
71.00		0	0	C	0	0	
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	0	0	0		0	
70.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>			<u> </u>		70.00
	09100 EMERGENCY	9, 684	9, 684	1, 647, 557	29	34	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
101.00	D 10100 HOME HEALTH AGENCY	3, 085	3, 085	1, 083, 422	. 6	40	101. 00
	SPECIAL PURPOSE COST CENTERS				1		
	0 11300 NTEREST EXPENSE 0 11600 HOSPI CE	315	315	283, 340	o	0	113. 00 116. 00
118.00		285, 665	285, 665	31, 179, 128			118. 00
	NONREI MBURSABLE COST CENTERS						1
	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 19200 PHYSICIANS' PRIVATE OFFICES	2, 440	0	73, 374			190. 00 192. 00
	1 19201 PHYSICIAN CLINIC	0	0	12, 122 75, 716			192. 00
	19202 LI FELI NE	0	0	C			192. 02
	3 19203 CREDIT UNION	1, 046	0	C			192. 03
	4 19204 BREAST MRI STUDY 5 19205 HOSPITALIST	0	0	0	0		192. 04 192. 05
	DO7950 COMMUNITY MENTAL HEALTH		0	C	o		194. 00
194.0	1 07951 MARKETI NG	0	0	112, 922		1	194. 01
	2 07953 OCCUPATI ONAL HEALTH	0	0	47, 193	0		194. 02
200.00	3 07952 PATHS EDUCATION Cross Foot Adjustments		U		, O	0	194. 03 200. 00
201.00							201. 00
		·					

Health Financial Systems	DEARBORN COUNT	ΓΥ HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS				Peri od:	Worksheet B-1	
				From 01/01/2014 Fo 12/31/2014	Date/Time Pre 5/29/2015 8:5	
	CAPITAL REL	ATED COSTS				
Cost Center Description	NEW BLDG &	NEW MVBLE EQUIP	EMPLOYEE BENEFITS	COMMUNI CATI ONS	DATA PROCESSI NG	
	(SQUARE FEET)	(SQUARE FEET)	DEPARTMENT (GROSS SALARI ES)	(PHONES)	(DP EQUI PMENT)	
	1.00	2.00	4.00	5. 01	5. 02	
202.00 Cost to be allocated (per Wkst. B, Part I)	3, 308, 675	2, 367, 004	11, 281, 59	337, 561	2, 090, 801	202. 00
203.00 Unit cost multiplier (Wkst. B, Part I)	11. 442724	8. 285943	0. 358141	343. 748473	2, 090. 801000	203. 00
204.00 Cost to be allocated (per Wkst. B, Part II)			31, 80	6, 120	37, 240	204. 00
205.00 Unit cost multiplier (Wkst. B, Part			0. 001010	6. 232179	37. 240000	205. 00

Health Financial Sys		DEARBORN COUN			In Lie	u of Form CMS-2	
COST ALLOCATION - S	FATISTICAL BASIS		Provi der		eriod: rom 01/01/2014	Worksheet B-1	
				Т	o 12/31/2014	Date/Time Pre 5/29/2015 8:5	
Cost Ce	nter Description	PURCHASI NG RECEI VI NG AND	ADMITTING (ADMISSIONS)	CASHI ERI NG/ACC OUNTS	Reconciliation	OTHER ADMI NI STRATI VE	
		STORES	(ADMI 331 0N3)	RECEI VABLE		AND GENERAL	
		(SUPPLY EXPENSE)		(GROSS CHARGES)		(ACCUM. COST)	
		5. 03	5. 04	5. 05	5A. 06	5. 06	
	CE COST CENTERS REL COSTS-BLDG & FLXT						1.00
2.00 00200 NEW CAP	REL COSTS-MVBLE EQUIP						2. 00
4. 00 00400 EMPLOYE 5. 01 01160 COMMUNI	E BENEFITS DEPARTMENT						4. 00 5. 01
5. 02 00550 DATA PR							5. 02
	ING RECEIVING AND STORES	8, 599, 136	4 750				5. 03
5. 04 00570 ADMI TTI 5. 05 00580 CASHI ER	NG ING/ACCOUNTS RECEIVABLE	35, 301 18, 982	4, 752 0	197, 316, 424			5. 04 5. 05
5. 06 00591 OTHER A	DMINISTRATIVE AND GENERAL	22, 758	0	C	-3, 104, 016	67, 124, 948	5. 06
7. 00 00700 0PERATI 8. 00 00800 LAUNDRY	ON OF PLANT & LINEN SERVICE	143, 706 85, 481	0			5, 224, 471 383, 528	
9. 00 00900 HOUSEKE		111, 525	0	C	o	1, 327, 820	
10. 00 01000 DI ETARY 11. 00 01100 CAFETER	1.0	106, 630 0	0		0	778, 462 1, 354, 536	
	ADMINISTRATION	10, 231	0		0	1, 334, 336	
14.00 01400 CENTRAL	SERVI CE & SUPPLY	614, 669	0	Q	0	741, 428	14. 00
15. 00 01500 PHARMAC 16. 00 01600 MEDI CAL	Y RECORDS & LI BRARY	73, 990 21, 321	0		0	2, 366, 944 1, 439, 422	
17.00 01700 SOCIAL	SERVI CE	3, 486	0			433, 114	
30. 00 O3000 ADULTS	TINE SERVICE COST CENTERS	250, 633	3, 882	14, 842, 756	ol	9, 804, 157	30.00
31. 00 03100 I NTENSI		35, 871	490			2, 093, 309	
43. 00 04300 NURSERY	AU OF COOT OFNITEDS	0	380	520, 552	o	723, 257	43. 00
50. 00 05000 OPERATI	VICE COST CENTERS NG ROOM	1, 737, 208	0	22, 858, 131	l ol	3, 855, 983	50.00
51. 00 05100 RECOVER	Y ROOM	29, 367	0	3, 130, 829	0	1, 051, 220	51. 00
52. 00 05200 DELI VER 53. 00 05300 ANESTHE	Y ROOM & LABOR ROOM	0 54, 049	0	1, 518, 633 1, 516, 770		360, 698 47, 363	1
54. 00 05400 RADI OLO		362, 173	0	19, 918, 158		4, 726, 671	
54. 01 05401 ULTRAS0		25, 751	0	3, 894, 892		369, 376	
55. 00 05500 RADI OLO 57. 00 05700 CT SCAN	GY-THERAPEUTI C	265, 217 162, 180	0	6, 773, 442 20, 910, 286		846, 584 525, 838	
58. 00 05800 MAGNETI	C RESONANCE IMAGING (MRI)	53, 038	0	6, 910, 982		389, 079	58. 00
59. 00 05900 CARDI AC 60. 00 06000 LABORAT	CATHETERI ZATI ON	0 1, 606, 335	0	37, 463, 256	0	0 6, 676, 389	59. 00 60. 00
60. 01 06001 BL00D L	ABORATORY	0	0	07, 403, 230	o	0, 070, 307	60. 01
65. 00 06500 RESPI RA		67, 229	0	6, 569, 777		1, 265, 353	1
65. 01 03950 SLEEP C 66. 00 06600 PHYSI CA		550 20, 829	0	816, 965 5, 036, 491		202, 044 1, 551, 190	
67. 00 06700 OCCUPAT	I ONAL THERAPY	12, 539	0	679, 873	0	350, 068	67. 00
68. 00 06800 SPEECH 69. 00 06900 ELECTRO		993 30, 694	0	549, 127 7, 805, 491		276, 514 1, 359, 181	
71. 00 07100 MEDI CAL	SUPPLIES CHARGED TO PATIENTS	0	0	5, 505, 804		2, 698, 946	
	EV. CHARGED TO PATIENT	2, 447, 164	0	2, 583, 333		2, 620, 852	
73. 00 O7300 DRUGS COUTPATIENT SE	RVICE COST CENTERS	ı o	0	12, 707, 091	l o	2, 596, 682	73. 00
91. 00 09100 EMERGEN		66, 063	0	8, 945, 644	0	2, 625, 355	
	TION BEDS (NON-DISTINCT PART) SABLE COST CENTERS						92.00
101.00 10100 HOME HE	ALTH AGENCY	36, 571	0	1, 839, 637	0	1, 770, 736	101. 00
SPECIAL PURPO 113. 00 11300 I NTERES	SE COST CENTERS T FYPENSE						113. 00
116. 00 11600 HOSPI CE		60, 803	0	793, 852	О	530, 482	
	LS (SUM OF LINES 1-117)	8, 573, 337	4, 752	197, 316, 424	-3, 104, 016	64, 700, 410	118. 00
	LE COST CENTERS LOWER, COFFEE SHOP & CANTEEN	0	0	С	ol	129, 291	190. 00
192. 00 19200 PHYSI CI	ANS' PRIVATE OFFICES	12, 358	0		0	493, 199	192. 00
192. 01 19201 PHYSI CI 192. 02 19202 LI FELI N		4, 292 88	0	0	0	162, 804 37, 105	192. 01 192. 02
192. 03 19203 CREDI T		0	0	ď	Ö		192. 03
192. 04 19204 BREAST 192. 05 19205 HOSPI TA		0 1, 373	0	C	0	0 1, 193, 352	192.04
194. 00 07950 COMMUNI		1, 3/3	0		0		194. 00
194. 01 07951 MARKETI	NG	5, 975	0	C	0	290, 569	194. 01
194. 02 07953 OCCUPAT 194. 03 07952 PATHS E		480 1, 233	0	0	0		194. 02 194. 03
200.00 Cross F	oot Adjustments	1,255	0			U, 124	200. 00
1 1	e Cost Centers be allocated (per Wkst. B,	534, 499	1, 059, 189	1, 648, 160		3, 104, 016	201. 00
202.00 Cost to Part I)	oc arrocateu (per WKSt. D,	554, 499	1,009,189	1, 040, 100		3, 104, 010	202.00
		<u> </u>			<u> </u>		

Health Financial Systems	DEARBORN COUNTY HOSPITAL			In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1		
				From 01/01/2014 To 12/31/2014		pared.	
					5/29/2015 8:5		
Cost Center Description	PURCHASI NG	ADMI TTI NG	CASHI ERI NG/AC	C Reconciliation	OTHER		
	RECEIVING AND	(ADMI SSI ONS)	OUNTS		ADMI NI STRATI VE		
	STORES		RECEI VABLE		AND GENERAL		
	(SUPPLY		(GROSS		(ACCUM.		
	EXPENSE)		CHARGES)		COST)		
	5. 03	5. 04	5. 05	5A. 06	5. 06		
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 062157	222. 893308	0.00835	3	0. 046242	203. 00	
204.00 Cost to be allocated (per Wkst. B,	126, 840	70, 709	71, 41	7	211, 787	204. 00	
Part II)							
205.00 Unit cost multiplier (Wkst. B, Part	0. 014750	14. 879840	0. 00036	2	0. 003155	205. 00	
)							

COST CALLOCATION STATISTICAL DIALS Provider CN: 150086 Period CN: 150086 Per		Financial Systems	DEARBORN COUN		00N 45000/ D		u of Form CMS-	
CALIFORNIA SHAPPICE COST CENTERS	COST AL	LOCATION - STATISTICAL BASIS		Provi der	F	rom 01/01/2014		pared:
Company Comp		Cost Center Description	PLANT (SQUARE	LINEN SERVICE (POUNDS OF	(SQUARE	(MEALS		
1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.000 1.00		OFNEDAL CERVI OF COST OFNITEDS	7. 00	8. 00	9. 00	10.00	11. 00	
5.02 00550 DATA PROCESSING	1. 00 2. 00 4. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
7.00	5. 02 5. 03 5. 04 5. 05	00550 DATA PROCESSING 00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING 00580 CASHIERING/ACCOUNTS RECEIVABLE						5. 02 5. 03 5. 04 5. 05
10.00 01000 01CTARY	7. 00 8. 00	00700 OPERATION OF PLANT	1					7. 00 8. 00
11.00 0 1100 CAFETERIA 2, 837 0 2, 837 0 888, 991 11.00 11.00 0 1000 CHITRAL SERVICE & SUPPLY 5, 888 1, 551 5, 568 0 18.82 14.00 14.00 0 1400 CENTRAL SERVICE & SUPPLY 5, 888 1, 551 5, 568 0 18.82 14.00 16.00 0 14.00 CENTRAL SERVICE & SUPPLY 5, 888 1, 551 5, 568 0 18.82 14.00 16.00 0 14.00 CENTRAL SERVICE & SUPPLY 6, 888 1.50 1, 16.86 0 14.00 15.10 10.00 16.00 0 14.00 0 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00			1					1
14.00 0 1400 CRITTAL SERVICE & SUPPLY		•	1				888, 991	1
15.00 01500 PHARMACY 1.08	13. 00	01300 NURSING ADMINISTRATION	600	0	600	0	23, 371	13. 00
1.00 01-000 MEDI CAR, RECORDS & LIBRARY 4, 807 0 49, 907 0 39, 399 10, 001 17. 00 170. 00 170. 001 170. 00 170. 001 170. 00 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001 170. 001								•
IMPATI ENT ROUTINE SERVICE COST CENTERS 34,258 297,920 54,258 45,293 30,00 30,00 3100 AURIS & PECHATRICS 7,400 50,884 7,400 3,998 45,004 31,00 31,00 31,00 31,00 31,00 MINERY CARE UNIT 7,400 50,884 7,400 3,998 45,004 31,00 31,00 31,00 31,00 31,00 MINERY CARE UNIT 7,400 50,884 7,400 3,998 45,004 31,000 31,717 31,000 30,000 MINERY CARE UNIT 7,400 50,884 7,400 3,978 40,000 50,000 60,000 CHEATING ROOM 1,163 37,621 1,163 1449 22,602 51,000 51,000 CHEATING ROOM 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504 0 504	16. 00	01600 MEDICAL RECORDS & LIBRARY				0		•
0.000 0.3000 ADULTS & PEDIATRICS 54,258 297,920 54,258 45,293 214,772 30,00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00	-		583	0	583	0	10, 210	17. 00
0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0			54, 258	297, 920	54, 258	45, 293	214, 772	30.00
MICLILARY SERVICE COST CENTERS			1					1
50.00			400	0	400	l O	13, /1/	43.00
52.00 05200 DELIVERY ROOM & LABOR ROOM 504 0 504 0 52.00	50. 00	05000 OPERATING ROOM	1					1
53.00 085300 ANESTHESI OLOGY 16				37, 621				
54.01				Ö				1
55.00 05500 05500 05500 05500 05500 057.00 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 05700 057		•						1
57.00 OS700 OSCAN O			1					1
59 00 OS900 CARDIAC CATHETER ZATION 0 0 0 0 55 00	57. 00	05700 CT SCAN	0	0	0	0	0	57. 00
60.00 0.0000 LABORATORY 6,720 105 6,720 0 104,560 60.00		1	803	0	1		-	
65. 00 06500 RESPI RATORY THERAPY 1, 164 10, 022 1, 164 0 28, 657 65. 00 05. 01 0350 SLEEP CLI NI C 0 3, 426 0 0 0 0 05. 01 0350 SLEEP CLI NI C 0 0 3, 426 0 0 0 0 05. 01 0350 SLEEP CLI NI C 0 0 0 0 05. 01 0350 SLEEP CLI NI C 0 0 0 0 0 0 0 0 05. 01 030 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000			6, 720	105			_	1
65. 01 03950 SLEEP CLI NIC 0 3, 426 0 0 0 65. 01		•	0			_		1
66.00 06600 PMSI CAL THERAPY 7, 564 11, 853 7, 564 0 33, 591 66, 00 06700 0CCUPATI ONAL THERAPY 794 808 794 0 6, 275 67, 00 68.00 06800 SPECEH PATHOLOGY 424 0 424 0 44, 466 68.00 06800 SPECEH PATHOLOGY 4, 761 3, 625 4, 761 0 19, 330 69, 00 71.00 71.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70			1, 164			0		1
68.00 06800 06800 06900 ELECTROCARDIOLOGY	66. 00	06600 PHYSI CAL THERAPY		11, 853	7, 564			1
69.00 06900 ELECTROCARDI OLOGY 4, 761 3, 625 4, 761 0 19, 330 69, 00 071.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 72.00 73.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0			1					•
17.2 00 07.200 IMPL DEV. CHARGED TO PATIENT 0 0 0 0 0 0 72. 00	69. 00	06900 ELECTROCARDI OLOGY						•
73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 73.00			0	0	0	0		
91. 00 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) 9, 684 144, 531 9, 684 693 63, 135 91. 00 92. 00 OTHER REI MBURSABLE COST CENTERS								
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 92. 00 0THER REIMBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY 3,085 0 3,085 0 0 101. 00 101. 00 1000 HOME HEALTH AGENCY 3,085 0 3,085 0 0 101. 00 1000 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 0			0.404	444 504	0.404	(00	(0.405	04 00
113. 00 11300 INTEREST EXPENSE	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	9, 684	144, 531	9, 684	693	63, 135	
113. 00			3, 085	0	3, 085	0	0	101. 00
116. 00 11600 HOSPI CE SUBTOTALS (SUM OF LINES 1-117) 160,500 845,550 157,730 50,133 871,191 118.00								113.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 2,440 0 2,440 0 7,106 190. 00 192. 00 19200 PHYSI CI ANS: PRI VATE OFFI CES 0 669 0 0 0 413 192. 00 192. 01 19201 PHYSI CI AN CLINI C 0 0 0 0 0 5,537 192. 01 192. 02 19202 LIFELI NE 0 0 0 0 0 0 192. 02 192. 02 19202 LIFELI NE 0 0 0 0 0 0 192. 02 192. 04 19204 BREAST MRI STUDY 0 0 0 0 0 0 192. 03 192. 05 19205 HOSPI TALI ST 0 0 0 0 0 0 192. 04 192. 05 COMMUNI TY MENTAL HEALTH 0 13,491 0 8,032 0 194. 00 194. 01 194. 01 107951 MARKETI NG 0 0 0 0 0 3,960 194. 01 194. 02 07953 OCCUPATI ONAL HEALTH 0 0 0 0 0 0 0 194. 03 194. 03 07952 PATHS EDUCATI ON 0 0 0 0 0 0 194. 03 200. 00 0 0 0 0 0 0 0 0	116. 00	11600 HOSPI CE						116. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 2, 440 0 0 7, 106 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 669 0 0 0 413 192. 00 192. 01 19201 PHYSI CI AN CLI NI C 0 0 0 0 0 5, 537 192. 01 19202 LI FELI NE 0 0 0 0 0 0 0 0 192. 02 19202 LI FELI NE 0 0 0 0 0 0 0 0 0 192. 03 19203 CREDI T UNI ON 1,046 0 1,046 0 1,046 0 0 192. 03 19203 CREDI T UNI ON 1,046 0 0 0 0 0 0 0 0 0 192. 03 192. 04 19204 BREAST MRI STUDY 0 0 0 0 0 0 0 0 0 192. 03 192. 05 19205 HOSPI TALI ST 0 0 0 0 0 0 0 0 0 192. 05 194. 00 07950 COMMUNI TY MENTAL HEALTH 0 13,491 0 8,032 0 194. 00 194. 01 194. 02 07953 OCCUPATI ONAL HEALTH 0 0 0 0 0 0 0 0 0 0 0 0 194. 01 194. 02 07953 OCCUPATI ONAL HEALTH 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			160, 500	845, 550	157, 730	50, 133	871, 191	118. 00
192. 01 19201 PHYSICIAN CLINIC 0 0 0 0 0 0 192. 01 192. 02 19202 LIFELINE 0 0 0 0 0 0 0 192. 02 192. 03 19203 CREDIT UNION 1,046 0 1,046 0 0 0 192. 03 192.04 19204 BREAST MRI STUDY 0 0 0 0 0 0 0 192. 04 192. 05 19205 19205 COMMUNITY MENTAL HEALTH 0 13,491 0 8,032 0 194. 00 194. 01 194. 01 07951 MARKETING 0 0 0 0 0 0 3,960 194. 01 194. 02 194. 03 07952 CCUPATIONAL HEALTH 0 0 0 0 0 0 0 0 0 0 0 0 0 194. 01 194. 02 194. 03 07952 PATHS EDUCATION 0 0 0 0 0 0 0 0 0 194. 03 200. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			2, 440	0	2, 440	0	7, 106	190. 00
192. 02 19202 LIFELINE 0 0 0 0 0 192. 02 19203 CREDIT UNION 1, 046 0 1, 046 0 0 1, 046 0 0 192. 03 19203 CREDIT UNION 1, 046 0 0 0 0 0 0 192. 03 19203 CREDIT UNION 0 0 0 0 0 0 192. 04 1920 BREAST MRI STUDY 0 0 0 0 0 0 0 192. 04 1920 BREAST MRI STUDY 0 0 0 0 0 0 0 0 192. 04 1920 BREAST MRI STUDY 0 0 0 0 0 0 0 0 192. 04 1920 BREAST MRI STUDY 0 0 0 0 0 0 0 0 192. 04 1920 BREAST MRI STUDY 0 0 0 0 0 0 0 0 192. 04 1920 BREAST MRI STUDY 0 0 0 0 0 0 0 0 192. 04 1920 BREAST MRI STUDY 0 0 0 0 0 0 0 0 192. 04 1920 BREAST MRI STUDY 0 0 0 0 0 0 0 0 192. 04 1920 BREAST MRI STUDY 0 0 0 0 0 0 0 0 192. 04 1920 BREAST MRI STUDY 0 0 0 0 0 0 0 0 192. 04 1920 BREAST MRI STUDY 0 0 0 0 0 0 0 192. 04 1920 BREAST MRI STUDY 0 0 0 0 0 0 0 192. 04 192. 05 1920 BREAST MRI STUDY 0 0 0 0 0 0 0 192. 05 1920 BREAST MRI STUDY 0 0 0 0 0 0 0 192. 05 1920 BREAST MRI STUDY 0 0 0 0 0 0 0 0 192. 05 1920 BREAST MRI STUDY 0 0 0 0 0 0 0 0 0 192. 05 1920 BREAST MRI STUDY 0 0 0 0 0 0 0 0 0 0 0 0 0 192. 05 1920 BREAST MRI STUDY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	669	1			
192. 03 19203 CREDIT UNION			0	0	0	0		
192. 05	192. 03	19203 CREDIT UNION	1, 046	O	1, 046	O	0	192. 03
194. 00 07950 COMMUNITY MENTAL HEALTH 0 13, 491 0 8, 032 0 194. 00 194. 01 07951 MARKETING 0 0 0 0 0 3, 960 194. 01 194. 02 07953 OCCUPATIONAL HEALTH 0 0 0 0 0 0 784 194. 02 194. 03 07952 PATHS EDUCATION 0 0 0 0 0 0 194. 03 200. 00 Cross Foot Adjustments 201. 00 Negative Cost Centers 202. 00 Cost to be allocated (per Wkst. B, Part I)			0	0	0	0		
194. 02 07953 OCCUPATIONAL HEALTH 0 0 0 0 0 784 194. 02 194. 03 07952 PATHS EDUCATION 0 0 0 0 194. 03 200. 00 201. 00 Negative Cost Centers 202. 00 Part I) 5, 466, 061 454, 328 1, 502, 666 999, 591 1, 538, 179 202. 00			0	13, 491	ő	8, 032		
194. 03 07952 PATHS EDUCATION 0 0 0 194. 03 200. 00 201. 00 Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) 5, 466, 061 454, 328 1, 502, 666 999, 591 1, 538, 179 202. 00			0	0	0	0		
200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 5,466,061 454,328 1,502,666 999,591 1,538,179 202.00			0	0	0	0		
202.00 Cost to be allocated (per Wkst. B, Part I) 5,466,061 454,328 1,502,666 999,591 1,538,179 202.00	200.00	Cross Foot Adjustments					0	200. 00
Part I)			5 166 O41	4E4 220	1 502 444	000 501	1 520 170	
203.00 Unit cost multiplier (Wkst. B, Part I) 33.332486 0.528467 9.320824 17.185438 1.730253 203.00	202.00	Part I)	3, 400, 061			777, 571	1, 558, 179	202.00
	203. 00	Unit cost multiplier (Wkst. B, Part I)	33. 332486	0. 528467	9. 320824	17. 185438	1. 730253	203. 00

Heal th Finar	ncial Systems	DEARBORN COUN	ITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der		Peri od: From 01/01/2014	Worksheet B-1	
					To 12/31/2014	Date/Time Pre 5/29/2015 8:5	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE	(SQUARE	(MEALS	(MAN HOURS)	
		(SQUARE	(POUNDS OF	FEET)	SERVED)		
		FEET)	LAUNDRY)				
		7. 00	8. 00	9. 00	10.00	11. 00	
204.00	Cost to be allocated (per Wkst. B, Part II)	1, 945, 881	52, 940	52, 71	4 135, 017	95, 616	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	11. 866141	0. 061579	0. 32697	7 2. 321276	0. 107556	205. 00

	Financial Systems	DEARBORN COUNT		CCN, 15000/ D		u of Form CMS-	
CUST AL	LOCATION - STATISTICAL BASIS		Provider		eriod: com 01/01/2014 o 12/31/2014	Worksheet B-1 Date/Time Pre 5/29/2015 8:5	pared:
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY		SOCIAL SERVICE	
		ADMI NI STRATI ON	SERVI CE & SUPPLY	(100%)	RECORDS & LI BRARY	(TIME	
		(GROSS HOURS)	(100%)		(ADJUSTED	SPENT)	
					CHARGES)		
	SENERAL SERVICE COST CENTERS	13. 00	14. 00	15. 00	16. 00	17. 00	
	00100 NEW CAP REL COSTS-BLDG & FLXT	T	T		I		1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2. 00
	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	01160 COMMUNI CATI ONS 00550 DATA PROCESSI NG		+				5. 01 5. 02
	00560 PURCHASING RECEIVING AND STORES						5. 03
	00570 ADMITTING						5. 04
	00580 CASHIERING/ACCOUNTS RECEIVABLE 00591 OTHER ADMINISTRATIVE AND GENERAL						5. 05 5. 06
	00700 OPERATION OF PLANT						7.00
	00800 LAUNDRY & LINEN SERVICE						8. 00
	00900 HOUSEKEEPI NG						9.00
	01000 DI ETARY 01100 CAFETERI A						10.00
	01300 NURSING ADMINISTRATION	448, 611					13.00
14. 00	01400 CENTRAL SERVICE & SUPPLY	18, 882	100				14. 00
	01500 PHARMACY	0	0	100	404 400 044		15.00
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0	0	0	191, 182, 916 0	2, 435	16. 00 17. 00
	NPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	<u> </u>	<u> </u>	<u> </u>	2, 433	17.00
	03000 ADULTS & PEDIATRICS	214, 772	0	0	12, 927, 424	2, 273	1
1	03100 INTENSIVE CARE UNIT	45, 064	0	0	3, 200, 438	88	1
-	04300 NURSERY NOCILLARY SERVICE COST CENTERS	13, 717	0	0	520, 552	0	43.00
	05000 OPERATING ROOM	63, 035	0	0	22, 795, 524	3	50.00
	D5100 RECOVERY ROOM	22, 602	0	0	3, 130, 829	36	
	D5200 DELIVERY ROOM & LABOR ROOM D5300 ANESTHESIOLOGY	7, 404	0	0	1, 487, 748 1, 516, 770	0	
	05400 RADI OLOGY-DI AGNOSTI C		0	0	19, 449, 590	0	1
54. 01	05401 ULTRASOUND	0	0	0	3, 894, 892	0	
1	D5500 RADI OLOGY-THERAPEUTI C	0	0	0	6, 754, 862	0	
	D5700 CT SCAN D5800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	20, 910, 286 6, 844, 203	0	
	05900 CARDI AC CATHETERI ZATI ON	o	Ö	Ö	0	0	1
	06000 LABORATORY	0	0	0	37, 463, 256	0	
	06001 BLOOD LABORATORY 06500 RESPI RATORY THERAPY	0	0	0	0 6, 486, 675	0	60. 01 65. 00
	03950 SLEEP CLINIC		0	0	816, 965	0	1
	06600 PHYSI CAL THERAPY	0	0	0	5, 036, 491	0	
	06700 OCCUPATI ONAL THERAPY	0	0	0	679, 873	0	
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY		0	0	549, 127 6, 874, 942	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	100	Ö	5, 505, 804	0	1
	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	2, 684, 942	0	
	07300 DRUGS CHARGED TO PATIENTS DUTPATIENT SERVICE COST CENTERS	0	O ₁	100	12, 707, 091	0	73. 00
91.00	09100 EMERGENCY	63, 135	0	0	8, 944, 632	34	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
_	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	0	0	0	o	0	101. 00
	SPECIAL PURPOSE COST CENTERS	<u> </u>	<u> </u>	<u> </u>	<u></u>		101.00
113.00	11300 NTEREST EXPENSE						113. 00
	11600 HOSPICE SUBTOTALS (SUM OF LINES 1-117)	0	0	0	101 102 014		116.00
118.00	IONREIMBURSABLE COST CENTERS	448, 611	100	100	191, 182, 916	2, 434	118. 00
-	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192. 00
	19201 PHYSICIAN CLINIC 19202 LIFELINE	0	0	0	0		192. 01 192. 02
	19203 CREDIT UNION		0	Ö	o		192. 03
	19204 BREAST MRI STUDY	0	0	0	o		192. 04
	19205 HOSPI TALI ST	0	0	0	0		192. 05 194. 00
	07950 COMMUNITY MENTAL HEALTH 07951 MARKETING		0	0	0		194. 00
194. 02 (07953 OCCUPATI ONAL HEALTH	0	o	O	o	0	194. 02
	07952 PATHS EDUCATION	0	O	0	o	0	194. 03
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers		-				200. 00 201. 00
201.00	Cost to be allocated (per Wkst. B,	1, 461, 044	1, 109, 046	2, 602, 372	1, 779, 188	495, 675	
	Part I)			· · ·			<u> </u>

Heal th Finar	ncial Systems	DEARBORN COUN	TY HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
					From 01/01/2014 To 12/31/2014		
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
		ADMI NI STRATI ON	SERVICE &	(100%)	RECORDS &		
			SUPPLY		LI BRARY	(TIME	
		(GROSS HOURS)	(100%)		(ADJUSTED	SPENT)	
					CHARGES)		
		13.00	14. 00	15. 00	16.00	17. 00	
203.00	Unit cost multiplier (Wkst. B, Part I)	3. 256817	11, 090. 460000	26, 023. 72000	0.009306	203. 562628	203. 00
204. 00	Cost to be allocated (per Wkst. B,	27, 684	194, 231	53, 52	2 165, 903	21, 823	204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	0. 061710	1, 942. 310000	535. 22000	0. 000868	8. 962218	205. 00
	11)						

Health Financial Systems	DEARBORN COUNTY HOSPITAL	In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 150086				
		From 01/01/2014 Part			

			T	o 12/31/2014	Date/Time Prep 5/29/2015 8:5	
		Ti †I	e XVIII	Hospi tal	PPS	7 dili
		11 (1	CAVIII	Costs	113	
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
oost senter beserretten	(from Wkst. B,	Adj.	10141 00313	Di sal I owance	10141 00313	
	Part I, col.	7.09		Di odi i olidiloo		
	26)					
	1.00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	15, 161, 728		15, 161, 728	ol	15, 161, 728	30.00
31. 00 03100 I NTENSI VE CARE UNI T	2, 873, 774		2, 873, 774			
43. 00 04300 NURSERY	847, 015	l e	847, 015		847, 015	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	5, 687, 237		5, 687, 237	0	5, 687, 237	50.00
51.00 05100 RECOVERY ROOM	1, 321, 060		1, 321, 060	o	1, 321, 060	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	449, 644		449, 644	o	449, 644	52. 00
53. 00 05300 ANESTHESI OLOGY	64, 350		64, 350	o	64, 350	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	5, 797, 546		5, 797, 546	o	5, 797, 546	54.00
54. 01 05401 ULTRASOUND	467, 727		467, 727	o	467, 727	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	1, 022, 847		1, 022, 847	o	1, 022, 847	55. 00
57. 00 05700 CT SCAN	744, 745		744, 745	o	744, 745	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	505, 014		505, 014	o	505, 014	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0		0	o	0	59. 00
60. 00 06000 LABORATORY	7, 801, 392		7, 801, 392	112, 738	7, 914, 130	60.00
60. 01 06001 BLOOD LABORATORY	0		0	o	0	60. 01
65. 00 06500 RESPI RATORY THERAPY	1, 488, 758	0	1, 488, 758	o	1, 488, 758	65. 00
65. 01 03950 SLEEP CLINIC	220, 801	0	220, 801	o	220, 801	65. 01
66. 00 06600 PHYSI CAL THERAPY	2, 056, 805	0	2, 056, 805	0	2, 056, 805	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	417, 734	0	417, 734	o	417, 734	67.00
68.00 06800 SPEECH PATHOLOGY	320, 258	0	320, 258	o	320, 258	68. 00
69. 00 06900 ELECTROCARDI OLOGY	1, 724, 444		1, 724, 444	o	1, 724, 444	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 984, 034		3, 984, 034	0	3, 984, 034	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	2, 767, 031		2, 767, 031	0	2, 767, 031	72.00
73.00 O7300 DRUGS CHARGED TO PATIENTS	5, 437, 382		5, 437, 382	0	5, 437, 382	73. 00
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	3, 653, 121		3, 653, 121	43, 179	3, 696, 300	91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 611, 788		1, 611, 788		1, 611, 788	92. 00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	1, 984, 204		1, 984, 204		1, 984, 204	101. 00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	568, 449		568, 449		568, 449	
200.00 Subtotal (see instructions)	68, 978, 888		68, 978, 888		69, 134, 805	
201.00 Less Observation Beds	1, 611, 788	l e	1, 611, 788		1, 611, 788	
202.00 Total (see instructions)	67, 367, 100	0	67, 367, 100	155, 917	67, 523, 017	202. 00

Health Financial Systems	DEARBORN COUNTY HOSPITAL	In Lieu of Form CMS-2552-1			
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 150086				
		From 01/01/2014 Part			

					Го 12/31/2014	Date/Time Pre 5/29/2015 8:5	
			Ti tl	e XVIII	Hospi tal	PPS	, <u>u</u>
			Charges		· ·		
	Cost Center Description	Inpati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	·	·	•	+ col. 7)	Rati o	I npati ent	
						Rati o	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	12, 927, 424		12, 927, 42	4		30. 00
31.00	03100 INTENSIVE CARE UNIT	3, 200, 438		3, 200, 43	3		31.00
43.00	04300 NURSERY	520, 552		520, 55	2		43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	5, 843, 695	16, 951, 829	22, 795, 52	0. 249489	0.000000	50.00
51.00	05100 RECOVERY ROOM	538, 236	2, 592, 593	3, 130, 82	9 0. 421952	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 396, 802	90, 946	1, 487, 74	0. 302231	0.000000	52. 00
53.00	05300 ANESTHESI OLOGY	496, 705	1, 020, 065	1, 516, 77	0. 042426	0.000000	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 362, 802	16, 086, 788	19, 449, 59	0. 298081	0.000000	54. 00
54. 01	05401 ULTRASOUND	748, 942	3, 145, 950	3, 894, 89	0. 120087	0.000000	54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	2, 871, 288	3, 883, 574	6, 754, 86	0. 151424	0.000000	55. 00
57.00	05700 CT SCAN	4, 961, 990	15, 948, 296	20, 910, 28	0. 035616	0.000000	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 020, 485	5, 823, 718		0. 073787	0. 000000	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0. 000000	0. 000000	59. 00
60.00	06000 LABORATORY	11, 348, 050	26, 115, 206	37, 463, 25	0. 208241	0. 000000	60.00
60. 01	06001 BLOOD LABORATORY	0	0		0. 000000	0. 000000	60. 01
65.00	06500 RESPIRATORY THERAPY	5, 398, 407	1, 088, 268	6, 486, 67	0. 229510	0. 000000	65. 00
65. 01	03950 SLEEP CLINIC	0	816, 965			0. 000000	65. 01
66.00	06600 PHYSI CAL THERAPY	1, 470, 934	3, 565, 557	5, 036, 49	0. 408381	0. 000000	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	333, 555	346, 318			0. 000000	
68. 00	06800 SPEECH PATHOLOGY	160, 223	388, 904			0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	2, 598, 724	4, 276, 218			0. 000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 732, 861	1, 772, 943			0.000000	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	1, 958, 162	726, 780			0. 000000	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	8, 852, 548	3, 854, 543			0. 000000	
	OUTPATIENT SERVICE COST CENTERS			, , , , ,			
91 00	09100 EMERGENCY	2, 144, 098	6, 800, 534	8, 944, 63	0. 408415	0. 000000	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	193, 931	1, 082, 304			0. 000000	
72.00	OTHER REIMBURSABLE COST CENTERS	170,701	1,002,001	1, 270, 20	1. 202721	0.000000	72.00
101 00	10100 HOME HEALTH AGENCY	0	1, 839, 637	1, 839, 63	7		101. 00
	SPECIAL PURPOSE COST CENTERS	<u> </u>	1,007,007	1,007,00	•		1.01.00
113 00	11300 I NTEREST EXPENSE						113. 00
	11600 HOSPI CE	0	793, 852	793, 85			116.00
200.00	· ·	76, 080, 852	119, 011, 788				200. 00
201.00		, 0, 000, 002	. 17, 011, 700	1,0,0,2,04			201.00
202.00	· ·	76, 080, 852	119, 011, 788	195, 092, 64			202.00
202.00	1.013. (300 111311 4011 0113)	, 0, 000, 002	, , , , , , , , , , , , , , , , , ,	1 70,072,04	~1		1202.00

Health Financial Systems	DEARBORN COUNTY HOSPITAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 150086	From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Prepared: 5/29/2015 8:57 am

			10 12/31/2014	5/29/2015 8:5	
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30. 00
31.00 03100 INTENSIVE CARE UNIT					31.00
43. 00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 249489				50.00
51.00 05100 RECOVERY ROOM	0. 421952				51. 00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0. 302231				52. 00
53. 00 05300 ANESTHESI OLOGY	0. 042426				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 298081				54.00
54. 01 05401 ULTRASOUND	0. 120087				54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 151424				55.00
57. 00 05700 CT SCAN	0. 035616				57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 073787				58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000				59. 00
60. 00 06000 LABORATORY	0. 211250				60.00
60. 01 06001 BLOOD LABORATORY	0. 000000				60. 01
65. 00 06500 RESPI RATORY THERAPY	0. 229510				65. 00
65. 01 03950 SLEEP CLINIC	0. 270270				65. 01
66. 00 06600 PHYSI CAL THERAPY	0. 408381				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 614429				67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 583213				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 250830				69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 723606				71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	1. 030574				72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 427901				73. 00
OUTPATIENT SERVICE COST CENTERS	0 440040				04 00
91. 00 09100 EMERGENCY	0. 413242				91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	1. 262924				92. 00
OTHER REIMBURSABLE COST CENTERS					101 00
101. 00 10100 HOME HEALTH AGENCY					101. 00
SPECIAL PURPOSE COST CENTERS					112 00
113. 00 11300 I NTEREST EXPENSE	1				113.00
116. 00 11600 HOSPI CE					116. 00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201. 00
202.00 Total (see instructions)					202. 00

Health Financial Systems	DEARBORN COUNTY HOSPITAL	In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 150086	Peri od: Worksheet C		
		From 01/01/2014 Part I		
		To 12/21/2014 Doto/Time December		

					o 12/31/2014	Date/Time Pre 5/29/2015 8:5	pared: 7 am
			Ti t	le XIX	Hospi tal	Cost	
					Costs		
Cost Center Description	n	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE CO	OST CENTERS				1		
30. 00 03000 ADULTS & PEDIATRICS		15, 161, 728		15, 161, 728		15, 161, 728	1
31.00 03100 INTENSIVE CARE UNIT		2, 873, 774		2, 873, 774		2, 873, 774	1
43. 00 04300 NURSERY		847, 015		847, 015	0	847, 015	43. 00
ANCILLARY SERVICE COST CENTE	ERS				,		
50. 00 05000 OPERATING ROOM		5, 687, 237		5, 687, 237		5, 687, 237	
51.00 05100 RECOVERY ROOM		1, 321, 060		1, 321, 060		1, 321, 060	
52. 00 05200 DELI VERY ROOM & LABOR	ROOM	449, 644		449, 644		449, 644	
53. 00 05300 ANESTHESI OLOGY		64, 350		64, 350		64, 350	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C		5, 797, 546		5, 797, 546		5, 797, 546	
54. 01 05401 ULTRASOUND		467, 727		467, 727		467, 727	
55. 00 05500 RADI OLOGY-THERAPEUTI C		1, 022, 847		1, 022, 847		1, 022, 847	
57. 00 05700 CT SCAN		744, 745		744, 745		744, 745	57. 00
58.00 05800 MAGNETIC RESONANCE I MA		505, 014		505, 014	0	505, 014	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI C	N	0		0	0	0	59. 00
60. 00 06000 LABORATORY		7, 801, 392		7, 801, 392	112, 738	7, 914, 130	60.00
60. 01 06001 BLOOD LABORATORY		0		0	0	0	60. 01
65. 00 06500 RESPI RATORY THERAPY		1, 488, 758	0	1, 488, 758	0	1, 488, 758	65. 00
65. 01 03950 SLEEP CLINIC		220, 801	0	220, 801	0	220, 801	65. 01
66. 00 06600 PHYSI CAL THERAPY		2, 056, 805	0	2, 056, 805	0	2, 056, 805	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		417, 734	0	417, 734	0	417, 734	67.00
68.00 06800 SPEECH PATHOLOGY		320, 258	0	320, 258	0	320, 258	68. 00
69. 00 06900 ELECTROCARDI OLOGY		1, 724, 444		1, 724, 444	0	1, 724, 444	69. 00
71.00 07100 MEDICAL SUPPLIES CHARG	SED TO PATLENTS	3, 984, 034		3, 984, 034	0	3, 984, 034	71. 00
72.00 07200 I MPL. DEV. CHARGED TO	PATI ENT	2, 767, 031		2, 767, 031	0	2, 767, 031	72. 00
73.00 07300 DRUGS CHARGED TO PATIE	INTS	5, 437, 382		5, 437, 382	0	5, 437, 382	73. 00
OUTPATIENT SERVICE COST CENT	TERS						
91. 00 09100 EMERGENCY		3, 653, 121		3, 653, 121	43, 179	3, 696, 300	91.00
92. 00 09200 OBSERVATION BEDS (NON-		1, 611, 788		1, 611, 788		1, 611, 788	92. 00
OTHER REIMBURSABLE COST CENT	TERS	1					
101.00 10100 HOME HEALTH AGENCY		1, 984, 204		1, 984, 204		1, 984, 204	101. 00
SPECIAL PURPOSE COST CENTERS	5						
113.00 11300 INTEREST EXPENSE							113. 00
116. 00 11600 HOSPI CE		568, 449		568, 449		568, 449	
200.00 Subtotal (see instruct	ions)	68, 978, 888	0	68, 978, 888		69, 134, 805	
201.00 Less Observation Beds		1, 611, 788		1, 611, 788		1, 611, 788	
202.00 Total (see instruction	ıs)	67, 367, 100	0	67, 367, 100	155, 917	67, 523, 017	202. 00

Health Financial Systems	DEARBORN COUNTY HOSPITAL	In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 150086	Peri od: Worksheet C		
		From 01/01/2014 Part I		
		To 12/21/2014 Doto/Time December		

					Γο 12/31/2014	Date/Time Pre 5/29/2015 8:5	pared: 7 am
			Ti t	le XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	12, 927, 424		12, 927, 42	4		30. 00
31. 00	03100 I NTENSI VE CARE UNI T	3, 200, 438		3, 200, 43			31. 00
43.00	04300 NURSERY	520, 552		520, 55	2		43.00
	ANCILLARY SERVICE COST CENTERS	,					
50. 00	05000 OPERATING ROOM	5, 843, 695	16, 951, 829				
51. 00	05100 RECOVERY ROOM	538, 236	2, 592, 593			l	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1, 396, 802	90, 946			0.000000	
53. 00	05300 ANESTHESI OLOGY	496, 705	1, 020, 065			0. 000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 362, 802	16, 086, 788			0. 000000	
54. 01	05401 ULTRASOUND	748, 942	3, 145, 950			0.000000	
55. 00	05500 RADI OLOGY-THERAPEUTI C	2, 871, 288	3, 883, 574			0.000000	
57. 00	05700 CT SCAN	4, 961, 990	15, 948, 296			0.000000	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 020, 485	5, 823, 718			0.000000	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0. 000000	0.000000	1
60.00	06000 LABORATORY	11, 348, 050	26, 115, 206	1		0.000000	
60. 01	06001 BLOOD LABORATORY	0	0		0.000000	0.000000	
65.00	06500 RESPIRATORY THERAPY	5, 398, 407	1, 088, 268			0.000000	1
65. 01	03950 SLEEP CLINIC	4 470 004	816, 965			0.000000	
66.00	06600 PHYSI CAL THERAPY	1, 470, 934	3, 565, 557			0.000000	
67.00	06700 OCCUPATIONAL THERAPY	333, 555	346, 318			l	
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	160, 223	388, 904			0. 000000 0. 000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 598, 724	4, 276, 218			0.00000	
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	3, 732, 861 1, 958, 162	1, 772, 943 726, 780				
73. 00	07300 DRUGS CHARGED TO PATIENTS	8, 852, 548	3, 854, 543			0.00000	
73.00	OUTPATIENT SERVICE COST CENTERS	0, 002, 040	3, 604, 043	12, 707, 09	0.427901	0.000000	73.00
91. 00	09100 EMERGENCY	2, 144, 098	6, 800, 534	8, 944, 63	0. 408415	0.000000	91. 00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	193, 931	1, 082, 304			0.00000	
92.00	OTHER REIMBURSABLE COST CENTERS	[173, 731]	1,002,304	1, 270, 23	1. 202724	0.000000	72.00
101 00	10100 HOME HEALTH AGENCY	l ol	1, 839, 637	1, 839, 63	7		101.00
101.00	SPECIAL PURPOSE COST CENTERS	<u>۱</u>	1,007,007	1,037,03	/		101.00
113 00	11300 I NTEREST EXPENSE						113. 00
	11600 H0SPI CE	0	793, 852	793, 85		1	116. 00
200.00		76, 080, 852	119, 011, 788			1	200. 00
201.00	, ,	, 5, 555, 662	, , 5 , , 700	.,,,,,,,,,,			201. 00
202. 00	1	76, 080, 852	119, 011, 788	195, 092, 64		l	202. 00

Health Financial Systems	DEARBORN COUNTY HOSPITAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 150086		Worksheet C Part I Date/Time Prepared: 5/29/2015 8:57 am

			10 12/31/2014	5/29/2015 8:57 am
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
43. 00 04300 NURSERY				43. 00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 000000			50.00
51.00 05100 RECOVERY ROOM	0. 000000			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52. 00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
54. 01 05401 ULTRASOUND	0. 000000			54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000			55. 00
57.00 05700 CT SCAN	0. 000000			57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59. 00
60. 00 06000 LABORATORY	0. 000000			60.00
60. 01 06001 BLOOD LABORATORY	0. 000000			60. 01
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65. 00
65. 01 03950 SLEEP CLINIC	0. 000000			65. 01
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000			72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
OUTPATIENT SERVICE COST CENTERS				
91. 00 09100 EMERGENCY	0. 000000			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92. 00
OTHER REIMBURSABLE COST CENTERS				
101.00 10100 HOME HEALTH AGENCY				101. 00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 INTEREST EXPENSE				113. 00
116. 00 11600 HOSPI CE				116. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00

Heal th	Financial Systems	DEARBORN COUN	ITY HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORT	IONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der		Peri od:	Worksheet D	
					From 01/01/2014 To 12/31/2014		narad.
					10 12/31/2014	5/29/2015 8:5	pareu. 7 am
			Ti tl	e XVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem (col.	
		Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
		(from Wkst. B,		Related Cost	•		
		Part II, col.		(col. 1 - col			
		26)		2)			
		1.00	2.00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2, 033, 771	0	2, 033, 77	1 14, 938	136. 15	30. 00
31.00	INTENSIVE CARE UNIT	277, 777		277, 77	7 2, 208	125. 80	31.00
43.00	NURSERY	24, 070		24, 07	0 704	34. 19	43.00
200.00	Total (lines 30-199)	2, 335, 618		2, 335, 61	8 17, 850		200. 00
	Cost Center Description	Inpati ent	I npati ent				
		Program days	Program				
			Capital Cost				
			(col. 5 x col.				
			6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	6, 693	911, 252	2			30. 00
31.00	INTENSIVE CARE UNIT	1, 140	143, 412	2			31.00
	NURSERY	0	0)			43. 00
200. 00	Total (lines 30-199)	7, 833	1, 054, 664				200. 00

Heal th Financial	Systems			DEARBORN COUNTY H	IOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTI ONMENT OF	I NPATI ENT	ANCILLARY SER	VICE CAPITAL	_ COSTS	Provi der CCN: 150086	Peri od:	Worksheet D

Health Financial Systems	DEARBORN COUN	ITY HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der		Peri od:	Worksheet D	
				From 01/01/2014	Part II	
				To 12/31/2014	Date/Time Pre	
		T: ±1	- \/\/	11: 4-1	5/29/2015 8: 5 PPS	<u>/ am</u>
C+ C+ D	0:+-1		e XVIII	Hospi tal		
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B, Part II, col.	8)	(col . 1 ÷ col	. Charges	column 4)	
	26)	0)	2)			
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
50. 00 05000 OPERATING ROOM	907, 230	22, 795, 524	0. 03979	9 3, 737, 787	148, 760	50.00
51. 00 05100 RECOVERY ROOM	52, 341	3, 130, 829	1			
52.00 05200 DELIVERY ROOM & LABOR ROOM	20, 539		1			
53. 00 05300 ANESTHESI OLOGY	3, 335		1			
54. 00 05400 RADI OLOGY-DI AGNOSTI C	429, 462	19, 449, 590	1			1
54. 01 05401 ULTRASOUND	28, 225	3, 894, 892	1			1
55. 00 05500 RADI OLOGY-THERAPEUTI C	53, 999		1			55. 00
57. 00 05700 CT SCAN	29, 771	20, 910, 286	1			
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	36, 088		1			
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	C	1		0	59.00
60. 00 06000 LABORATORY	321, 544	37, 463, 256	0. 00858	6, 056, 358	51, 982	60.00
60. 01 06001 BL00D LABORATORY	0		0. 00000		0	60. 01
65. 00 06500 RESPIRATORY THERAPY	55, 991	6, 486, 675	0. 00863	2 3, 651, 404	31, 519	65. 00
65. 01 03950 SLEEP CLINIC	1, 973	816, 965	0. 00241	5 0	0	65. 01
66. 00 06600 PHYSI CAL THERAPY	259, 014	5, 036, 491	0. 05142	7 974, 592	50, 120	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	28, 441	679, 873	0. 04183	3 209, 361	8, 758	67. 00
68. 00 06800 SPEECH PATHOLOGY	15, 971	549, 127	0. 02908	4 122, 775	3, 571	68. 00
69. 00 06900 ELECTROCARDI OLOGY	168, 288	6, 874, 942	0. 02447	8 2, 482, 170	60, 759	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	209, 518	5, 505, 804	0. 03805	4 1, 302, 874	49, 580	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	47, 636	2, 684, 942	0. 01774	2 10, 996	195	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	77, 345	12, 707, 091	0.00608	5, 056, 788	30, 781	73. 00
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	354, 001	8, 944, 632	0. 03957	7 1, 454, 750	57, 575	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	216, 202	1, 276, 235	0. 16940	121, 981	20, 664	92.00
200.00 Total (lines 50-199)	3, 316, 914	175, 810, 737	'	32, 647, 007	585, 623	200. 00

Health Financial Systems	DEARBORN COUN	ITY HOSPITAL		In Li€	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COST	TS Provi der		Peri od:	Worksheet D	
				From 01/01/2014		
				To 12/31/2014		
		T' 11	20/11/1		5/29/2015 8: 5	/ am
			e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School			Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos		1 through 3,	
					minus col. 4)	
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0)	0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0)	0	0	31.00
43. 00 04300 NURSERY	0	l o		0	0	43.00
200.00 Total (lines 30-199)	0	l c		o	0	200. 00
Cost Center Description	Total Patient	Per Diem (col.	Inpati ent	Inpatient		
· ·	Days	5 ÷ col. 6)	Program Days			
		ĺ		Pass-Through		
				Cost (col. 7 x		
				col. 8)		
	6. 00	7. 00	8. 00	9. 00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	14, 938	0.00	6, 69	3 0		30.00
31. 00 03100 INTENSIVE CARE UNIT	2, 208		1			31. 00
43. 00 04300 NURSERY	704			0		43. 00
200. 00 Total (lines 30-199)	17, 850		7, 83	3 0		200. 00

Health Financial Systems	DEARBORN COUN	ITY HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS		<u> </u>	Period: From 01/01/2014 To 12/31/2014	Date/Time Pre 5/29/2015 8:5	pared:
			e XVIII	Hospi tal	PPS	
Cost Center Description		Nursing School	Allied Health		Total Cost	
	Anesthetist			Medi cal	(sum of col 1	
	Cost			Education Cost	9	
					4)	
	1. 00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	()	0	0	
51.00 05100 RECOVERY ROOM	0	()	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	()	0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0	C)	0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C)	0	0	54. 00
54. 01 05401 ULTRASOUND	0	C) (0	0	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	C		0	0	55. 00
57. 00 05700 CT SCAN	0	C		0	0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	(0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	l c		0	0	59. 00
60. 00 06000 LABORATORY	0	l c		0	0	60.00
60. 01 06001 BLOOD LABORATORY	0	l c		0	0	60. 01
65. 00 06500 RESPIRATORY THERAPY	0	l c		0	0	65. 00
65. 01 03950 SLEEP CLINIC	0) (0	0	65. 01
66. 00 06600 PHYSI CAL THERAPY	0			0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0) (0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0			0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	1 0		0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	(0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0			0	0	73. 00
OUTPATIENT SERVICE COST CENTERS			1	<u>, </u>		1
91. 00 09100 EMERGENCY	0	(0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1 0		1	o o		
200. 00 Total (lines 50-199)				0		200. 00
	,	1	1	-ı		1-30.00

Heal th	Financial Systems	DEARBORN COUN	ITY HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORT	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS				Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Pre 5/29/2015 8:5	pared:
				e XVIII	Hospi tal	PPS	
	Cost Center Description	Cost (sum of	(from Wkst. C, Part I, col.	(col. 5 ÷ col	Ratio of Cost to Charges	Inpatient Program Charges	
		col . 2, 3 and 4)	8)	7)	(col. 6 ÷ col. 7)		
		6. 00	7. 00	8. 00	9. 00	10.00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	22, 795, 524				50. 00
	05100 RECOVERY ROOM	0	3, 130, 829	1			1
	05200 DELIVERY ROOM & LABOR ROOM	0	1, 487, 748	1			
	05300 ANESTHESI OLOGY	0	1, 516, 770				1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	19, 449, 590				
	05401 ULTRASOUND	0	3, 894, 892				1
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	6, 754, 862	1			1
	05700 CT SCAN	0	20, 910, 286	1			
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	6, 844, 203				
	05900 CARDI AC CATHETERI ZATI ON	0	(0.00000			59. 00
	06000 LABORATORY	0	37, 463, 256				
	06001 BLOOD LABORATORY	0	(40/ /7	0.00000			60. 01
	06500 RESPIRATORY THERAPY	0	6, 486, 675				
65. 01	03950 SLEEP CLINIC	0	816, 965				65. 01
	06600 PHYSI CAL THERAPY	0	5, 036, 491				
	06700 OCCUPATI ONAL THERAPY	0	679, 873	1			
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY		549, 127 6, 874, 942	1			
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5, 505, 804	1			
	07200 IMPL. DEV. CHARGED TO PATIENTS		2, 684, 942	1			
	07300 DRUGS CHARGED TO PATIENTS		12, 707, 091	1			1
73.00	U/300 DRUGS CHARGED TO PATTENTS		12, 707, 09	0.00000	0, 000000	3,030,766	1 /3.00

0.000000

0.000000

8, 944, 632 1, 276, 235 175, 810, 737

0 0 0

0. 000000

0.000000

1, 454, 750 91. 00 121, 981 92. 00

32, 647, 007 200. 00

OUTPATIENT SERVICE COST CENTERS
91. 00 09100 EMERGENCY

200.00

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

Total (lines 50-199)

Health Financial Systems	DEARBORN COUNTY H	OSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIEN	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 150086	Peri od:	Worksheet D
THROUGH COSTS			From 01/01/2014	Part IV

			To	12/31/2014	Date/Time Pro	
		Ti tl	e XVIII	Hospi tal	PPS	, <u> </u>
Cost Center Description	Inpati ent	Outpati ent	Outpati ent	<u> </u>		
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8		Costs (col. 9			
	x col. 10)		x col. 12)			
	11.00	12. 00	13.00			
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	5, 547, 658	0			50. 00
51.00 05100 RECOVERY ROOM	0	876, 591	0			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0			52.00
53. 00 05300 ANESTHESI OLOGY	0	170, 768	0			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	4, 799, 534	0			54.00
54. 01 05401 ULTRASOUND	0	608, 460	0			54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	1, 760, 702	0			55. 00
57. 00 05700 CT SCAN	0	4, 914, 161	0			57. 00
58.00 05800 MAGNETIC RESONANCE MAGING (MRI)	0	1, 591, 377	0			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0			59. 00
60. 00 06000 LABORATORY	0	2, 949, 950	0			60.00
60. 01 06001 BLOOD LABORATORY	0	0	0			60. 01
65. 00 06500 RESPIRATORY THERAPY	0	395, 213	0			65. 00
65. 01 03950 SLEEP CLI NI C	o	221, 922	0			65. 01
66. 00 06600 PHYSI CAL THERAPY	o	140, 920	0			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	o	1, 652	0			67. 00
68. 00 06800 SPEECH PATHOLOGY	o	0	0			68. 00
69. 00 06900 ELECTROCARDI OLOGY	o	1, 678, 978	0			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	63, 322	0			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	o	340, 293	0			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	o	1, 028, 449	0			73. 00
OUTPATIENT SERVICE COST CENTERS	'					1
91. 00 09100 EMERGENCY	0	1, 571, 563	0			91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	o	1, 003, 505	0			92.00
200.00 Total (lines 50-199)	o	29, 665, 018	0			200. 00
•						-

Health Financial Systems	DEARBORN COUN			In Lie	eu or Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der		Peri od:	Worksheet D	
				From 01/01/2014	Part V	
				To 12/31/2014		pared:
		T: +1	e XVIII	Hospi tal	5/29/2015 8: 5 PPS	<u>/ am</u>
		11 (1		ноѕрі таі		
		550 5 1 1	Charges	<u> </u>	Costs	
Cost Center Description	Cost to Charge			Cost	PPS Services	
		Services (see	Rei mbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.			
	4.00	0.00	(see inst.)	(see inst.)	F 00	
ANOLULA DV. OFDINI OF COOT OFFITEDO	1.00	2.00	3. 00	4. 00	5. 00	
ANCI LLARY SERVI CE COST CENTERS		1	1			
50. 00 05000 OPERATING ROOM	0. 249489			0	1, 384, 080	
51.00 05100 RECOVERY ROOM	0. 421952			0	369, 879	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 302231)	0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0. 042426			0	7, 245	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 298081			0	1, 430, 650	
54. 01 05401 ULTRASOUND	0. 120087	608, 460)	0	73, 068	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 151424	1, 760, 702		0 0	266, 613	55. 00
57. 00 05700 CT SCAN	0. 035616	4, 914, 161		0	175, 023	57.00
58.00 05800 MAGNETIC RESONANCE MAGING (MRI)	0. 073787	1, 591, 377	1	0	117, 423	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0)	0	0	59. 00
60. 00 06000 LABORATORY	0. 208241	2, 949, 950)	0	614, 301	60.00
60. 01 06001 BLOOD LABORATORY	0. 000000	0)	0	0	60. 01
65. 00 06500 RESPIRATORY THERAPY	0. 229510	395, 213	9, 32	3 0	90, 705	65. 00
65. 01 03950 SLEEP CLINIC	0. 270270	221, 922	. (0	59, 979	65. 01
66. 00 06600 PHYSI CAL THERAPY	0. 408381)	0	57, 549	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 614429			0	1, 015	
68.00 06800 SPEECH PATHOLOGY	0. 583213		,	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 250830			0	421, 138	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 723606		1	0	45, 820	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	1. 030574			0 0	350, 697	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 427901		1	2, 122		
OUTPATIENT SERVICE COST CENTERS	0. 427701	1,020,447	·	2, 122	440,074	73.00
91. 00 09100 EMERGENCY	0. 408415	1, 571, 563	1	0	641, 850	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 262924		1		1, 267, 351	
200.00 Subtotal (see instructions)	1. 202724	29, 665, 018	1	3 2, 122	7, 814, 460	
201.00 Less PBP Clinic Lab. Services-Program		27,000,010	7, 32,	2, 122		200.00
Only Charges			1			201.00
202.00 Net Charges (line 200 +/- line 201)		29, 665, 018	9, 32	3 2, 122	7, 814, 460	202 00
202.00	I	29,000,018	9, 32	۷, ۱۷۷	1,014,400	1202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 150086 Period: From 01/01/2014 To 12/31/2014 Part V Date/Time Prep. 5/29/2015 8: 57 PPS Cost Center Description Cost Rei mbursed Services Subject To Ded. & Coins. (see inst.) (see inst.)	ealth Financial Systems	DEARBORN COUN	NTY HOSPITAL		In Lie	u of Form CMS-2	2552-1
Costs Cost Center Description Cost Rei mbursed Servi ces Servi ces Not Subj ect To Ded. & Coi ns. Cost Rei mbursed Servi ces Not Subj ect To Ded. & Coi ns.	<u> </u>	AND VACCINE COST	Provi der	CCN: 150086	Peri od: From 01/01/2014	Worksheet D Part V Date/Time Pre	pared:
Cost Center Description Cost Cost Reimbursed Services Services Not Subject To Subject To Ded. & Coins. Cost Reimbursed Services Not Subject To Ded. & Coins.			Ti t	e XVIII	Hospi tal	PPS	
Rei mbursed Rei mbursed Servi ces Not Subj ect To Ded. & Coi ns.		Co:	sts				
6.00 7.00	Cost Center Description	Reimbursed Services Subject To Ded. & Coins. (see inst.)	Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	-			
				-			1

	Rei mbursed	Rei mbursed	
	Servi ces	Servi ces Not	
	Subject To	Subject To	
	Ded. & Coins.	Ded. & Coins.	
	(see inst.)	(see inst.)	
	6.00	7.00	
ANCILLARY SERVICE COST CENTERS			
50. 00 05000 OPERATING ROOM	0	0	50.00
51.00 05100 RECOVERY ROOM	0	o	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	O	52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	o	54.00
54. 01 05401 ULTRASOUND	0	o	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	o	55. 00
57. 00 05700 CT SCAN	0	O	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	O	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	O	59. 00
60. 00 06000 LABORATORY	0	o	60.00
60. 01 06001 BLOOD LABORATORY	0	o	60. 01
65. 00 06500 RESPIRATORY THERAPY	2, 140	o	65. 00
65. 01 03950 SLEEP CLINIC	0	o	65. 01
66. 00 06600 PHYSI CAL THERAPY	0	o	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	908	73. 00
OUTPATIENT SERVICE COST CENTERS			
91. 00 09100 EMERGENCY	0	0	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92. 00
200.00 Subtotal (see instructions)	2, 140	908	200. 00
201.00 Less PBP Clinic Lab. Services-Program	0		201. 00
Only Charges			
202.00 Net Charges (line 200 +/- line 201)	2, 140	908	202. 00

Health Financial Systems	DEARBORN COUNTY HOSE	PITAL	In Lie	u of Form CMS-:	2552-10
COMPUTATION OF INPATIENT OPERATING COST	P	Provi der CCN: 150086	Peri od: From 01/01/2014	Worksheet D-1	
				Date/Time Pre 5/29/2015 8:5	
		Title XVIII	Hospi tal	PPS	
Cook Cooker December 1					

Cost Center Description No. No.			Title XVIII	Hospi tal	5/29/2015 8: 5 PPS	7 am
PART 1 - ALL PROVIDER COMPONENTS NAME		Cost Center Description	THE AVITE	1103pi tai	113	
IMPARTER MAYS 1.0 Impartient days (including private room days and swing-bed days, excluding neoborn) 14,938 1.0 Impartient days (including private room days, excluding swing-bed and one-born days) 14,938 2.0 14,938 2.0 Impartient days (including private room days, sectualing swing-bed and observation bed days) 17 you have only private room days 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 3.0					1. 00	
Impatient days (including private room days and swing-bed days, excluding newborn)						
Impatient days (including private room days, excluding swing-bed and newborn days) 14,938 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000 2,000	1.00		excluding newborn)		14, 938	1. 00
do not complete this line. 4.00 Semi-private room days (excluding swing-bed and observation bed days) 5.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 7.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 7.00 Total swing-bed SNF type inpatient days (including private room days) through becember 31 of the cost reporting period (if callendar year, enter 0 on this line) 7.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 7.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (is line) 8.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 8.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 9.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 12.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 13.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 14.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 15.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 16.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 17.00 Swing-bed SWing-bed SNF services applicable to SNF type inpatient days applicable to SNF type inpatient days applicable to S		Inpatient days (including private room days, excluding swing-be	d and newborn days)			
5.00 Somil-private room days (excluding swing-bed and observation bed days) 1.3, 350 4.00	3. 00). If you have only pri	vate room days,	0	3. 00
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost operating period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including period period period (including private room days) after December 31 of the cost reporting period (including period period period (including period period period period period period (including period pe	4.00	· ·	days)		13, 350	4.00
Total swing-Bod SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total swing-Bod NF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total swing-Bod NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days april cable to the Program (excluding swing-Bod and neeborn days) Total patient days including private room days april cable to the Program (excluding swing-Bod and neeborn days) Total period (if calendar year, enter 0 on this line) Total period (if calendar year, enter 0 on this line) Total period (if calendar year, enter 0 on this line) Total period (if calendar year, enter 0 on this line) Total period (if calendar year, enter 0 on this line) Total period (if calendar year, enter 0 on this line) Total period (if calendar year, enter 0 on this line) Total period (if calendar year, enter 0 on this line) Total period (if calendar year, enter 0 on this line) Total period (if calendar year, enter 0 on this line) Total year, ente				r 31 of the cost		
reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed MF type inpatient days (including private room days) through December 31 of the cost 10 Total inpatient days including private room days after December 31 of the cost 10 Total inpatient days including private room days apricable to the Program (excluding swing-bed and 10 No March and Strippe inpatient days applicable to the Program (excluding swing-bed and 11 No March and Strippe inpatient days applicable to title XVIII only (including private room days) 11 No Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 12 No Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 12 No Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 13 No Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 14 No Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 15 No Swing-bed SNF type inpatient days applicable to title XV or XX only (including private room days) 16 No Swing-bed SNF type inpatient days applicable to title XV or XX only (including private room days) 17 No Swing-bed SNF type private room days applicable to title XV or XX only (including private room days) 18 No Swing-bed SNF type private room days applicable to title XV or XX only (including private room days) 19 No Swing-bed SNF type private room days applicable to title XV or XX only (including private room days) 19 No Swing-bed SNF type applicable to title XV or XX only (including private room days) 19 No Swing-bed SNF type services applicable to services through December 31 of the cost 19 No Swing-bed SNF type services applicable to services through December 31 of the cost 19 No Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line SNF type services through December 31 of the cost reporting period (line SNF type services th				24 6 11		, 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 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00	6.00		days) after December .	31 of the cost	0	6.00
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost on this line)	7.00		days) through December	31 of the cost	0	7. 00
reporting period (if calendar year, enter 0 on this line) 10.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 10.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SMF type inpatient days applicable to title XVIII only (cluding private room days) after through December 31 of the cost reporting period (see instructions) 12.00 Swing-bed SMF type inpatient days applicable to title XVIII only (cluding private room days) after otherwise through December 31 of the cost reporting period (see instructions) 13.00 Swing-bed NF type inpatient days applicable to title SV or XIX only (including private room days) of through December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) of through December 31 of the cost reporting period (including private room days) of 15.00 Total nursery days (title V or XIX only) of 15.00 Total nursery days (title V or XIX only) of 15.00 December 31 of the cost reporting period (including private room days) of 15.00 December 31 of the cost reporting period (including private room days) of 15.00 December 31 of the cost reporting period (including private room days) of 15.00 December 31 of the cost reporting period (including private room days) of 15.00 December 31 of the cost reporting period (including private room days) of 15.00 December 31 of the cost reporting period (including private room days) of 15.00 December 31 of the cost reporting period (including private room days) of 15.00 December 31 of the cost reporting period (including private room days) of 15.00 December 31 of the cost reporting period (including private room days) of 15.00 December 31 of the cost reporting period (including period period period period period (including period p						
10.00 Total Inpatient days Including private room days applicable to the Program (excluding swing-bed and newborn days) 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.	8.00		days) after December 3	of the cost	0	8.00
10.00 Swing-bed SNP type inpatient days applicable to title XVIII only (including private room days) 10.00	9. 00		the Program (excluding	swing-bed and	6, 693	9. 00
through December 31 of the cost reporting period (see instructions) 1.00 Swing-bed SNT 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) 1.00 Swing-bed NT type inpatient days applicable to titles V or XIX only (including private room days) 1.00 Swing-bed NT type inpatient days applicable to titles V or XIX only (including private room days) 1.00 Swing-bed NT type inpatient days applicable to titles V or XIX only (including private room days) 1.00 Swing-bed NT type inpatient days applicable to titles V or XIX only (including private room days) 1.00 Swing-bed NT type inpatient days applicable to the Program (excluding swing-bed days) 1.00 Swing-bed NT type inpatient days applicable to the Program (excluding swing-bed days) 1.00 Swing-bed NT type inpatient days applicable to the Program (excluding swing-bed days) 1.00 Swing-bed ADS Swing-bed Nr services applicable to services after December 31 of the cost 1.00 Medicare rate for swing-bed Nr services applicable to services after December 31 of the cost 1.00 Medicard rate for swing-bed Nr services applicable to services after December 31 of the cost 1.00 Program inpatient routine service cost (see instructions) 1.00 Medicard rate for swing-bed Nr services applicable to services after December 31 of the cost 1.00 Program inpatient routine service cost through December 31 of the cost reporting period (line 6 x line 18) 2.00 Swing-bed cost applicable to Swing-bed services after December 31 of the cost reporting period (line 6 x line 18) 2.01 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 28) 2.01 Swing-bed cost applicable to NF type service					_	
11.00 Swing-bed SNF type Inpatient days applicable to title XVIII only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 15.00 Total nursery days (title V or XIX only) 16.00 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 16.00 Nursery days (title V or XIX only) 17.00 Swing BED ADUSTNETT 18.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (life and and services) 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (life and are the for swing-bed SNF services applicable to services after December 31 of the cost reporting period (life and are the for swing-bed NF services applicable to services after December 31 of the cost period (life and are the for swing-bed NF services applicable to services after December 31 of the cost period (life and are the for swing-bed NF services applicable to services after December 31 of the cost period (life and are the for swing-bed NF services applicable to services after December 31 of the cost period (life and are the for swing-bed NF services after December 31 of the cost reporting period (life and are the for swing-bed NF services after December 31 of the cost reporting period (life and are the for swing-bed cost applicable to NF type services after December 31 of the cost reporting period (life and are the forest period (life and are the fore	10. 00			oom days)	0	10.00
12.00 Swing-bed NF type inpatient days applicable to titles \$\tilde{V}\$ or XIX only (including private room days) through December 31 of the cost reporting period (if call earled and period earled (if call earled and period earled (if call earled earled (if call earled earled (if call earle	11. 00			oom days) after	0	11. 00
through December 31 of the cost reporting period after December 31 of the cost reporting period (if calendar year, enter 0 on this line) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 15.00 16.00 17.00 18.00 18.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19						
13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) and refrome December 31 of the cost reporting period (if call endar year, enter 0 on this line) 14.00 15.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00	12. 00		only (including private	e room days)	0	12.00
after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14.00 Modically necessary private room days applicable to the Program (excluding swing-bed days) 15.00 16.00 Narsery days (title V or XIX only) 16.00 17.00 Modically necessary private room days applicable to the Program (excluding swing-bed days) 17.00 Modical rate rate for swing-bed SNF services applicable to services through December 31 of the cost 17.00 Modical rate for swing-bed SNF services applicable to services after December 31 of the cost 18.00 Modical rate for swing-bed SNF services applicable to services through December 31 of the cost 19.00 Modical rate for swing-bed NF services applicable to services through December 31 of the cost 19.00 Modical rate for swing-bed NF services applicable to services through December 31 of the cost 19.00 Modical drate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Modical drate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 20.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 6 x line 18) 21.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18) 22.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 19) 23.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 24.00 Total swing-bed cost (see instructions) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27. In 180 Swing-bed cost applicable to NF type service safter December 31 of the cost reporting period (line 8 x line 20) 28.00 Total swing-bed cost (see instructions) 29.00 Tot	13. 00		only (including private	e room days)	0	13. 00
15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Sill NG BED ADJUSTMENT 18.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period reporting reportin		after December 31 of the cost reporting period (if calendar yea	r, enter O on this line	e)		
16.00 Nursery days (title V or XIX only) SNING BED ADJUSTMENT 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period reporting reportin			(excluding swing-bed	days)		
SWING BED ADJUSTMENT 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost peporting period period medicare rate for swing-bed SNF services applicable to services after December 31 of the cost peporting period medicare rate for swing-bed NF services applicable to services through December 31 of the cost peporting period period medicare rate for swing-bed NF services applicable to services after December 31 of the cost peporting period peri						
reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost of the cost reporting period 21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 19) 25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost fer December 31 of the cost reporting period (line 8 x line 20) 28.00 Total swing-bed cost (see instructions) 29.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 29.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 29.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 29.00 Average perivate room charges (excluding swing-bed charges) 30.00 Average perivate room per diem charge (line 29 + line 3) 31.00 General inpatient routine service cost charges (excluding swing-bed charges) 32.00 Average perivate room per diem charge (line 30 + line 4) 33.00 Average perivate room cost differential (line 3 x line 35) 34.00 Average perivate room cost differential (line 3 x line 35) 35.00 Average perivate room cost differential (line 3 x line 35) 36.00 Private room cost differential and ustment (line 3 x line 38) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost per diem (see instructions) 39.00 Program gener		SWING BED ADJUSTMENT				
18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period of the cost stand the cost reporting period (line for x line 18) of the cost applicable to SNF type services through December 31 of the cost reporting period (line for x line 18) of x line 20) o	17. 00]	through December 31 or	f the cost	0. 00	17. 00
reporting period Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 17) 24.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) 28.00 Private room charges (excluding swing-bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Average perivate room per diem charge (line 29 + line 3) 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 33.00 Average per diem private room cost differential (line 34 x line 31) 34.00 Average per diem private room cost differential (line 34 x line 31) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 38) 37.00 Average general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost (east per	18 00		after December 31 of	the cost	0 00	18 00
reporting period 20. 00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 21. 00 Total general inpatient routine service cost (see instructions) 22. 00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18) 25. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18) 26. 00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 27. 00 General inpatient routine service cost enter December 31 of the cost reporting period (line 8 x line 20) 28. 00 Total swing-bed cost (see instructions) 29. 00 Total swing-bed cost (see instructions) 20. 00 Total swing-bed cost (see instructions) 20. 00 Total swing-bed cost (see instructions) 20. 00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 20. 00 General inpatient routine service cost enter of swing-bed and observation bed charges) 20. 00 Private room charges (excluding swing-bed charges) 20. 01 Semi-private room charges (excluding swing-bed charges) 20. 02 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 20. 01 Semi-private room per diem charge (line 29 + line 3) 20. 02 Average per diem private room per diem charge (line 29 + line 3) 20. 03 Average per diem private room cost differential (line 32 minus line 23) (see instructions) 20. 00 Average per diem private room cost differential (line 34 x line 31) 20. 01 Average per diem private room cost differential (line 34 x line 31) 20. 02 Average per diem private room cost differential (line 34 x line 35) 20. 03 Average per diem private room cost differential (line 34 x line 38) 20. 04 Average per diem private room cost differential (line 32 minus line					0.00	10.00
20. 00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 21. 00 Total general inpatient routine service cost (see instructions) 22. 00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18) 25. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 26. 00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28. 00 General inpatient routine service cost net of swing-bed and observation bed charges) 29. 00 Private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 31. 00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32. 00 Average private room per diem charge (line 29 + line 3) 33. 00 Average per diem private room charge differential (line 27 + line 28) 34. 00 Average per diem private room charge differential (line 3 x line 31) 35. 00 Average per diem private room charge differential (line 3 x line 31) 36. 00 Private room cost differential adjustment (line 3 x line 35) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3 x line 35) 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 39. 00 Adjusted general inpatient routine service cost per diem (see instructions) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40. 00 Medica	19. 00		through December 31 of	the cost	0. 00	19. 00
reporting period Total general inpatient routine service cost (see instructions) 21. 00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 22. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18) 25. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 26. 00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26. 00 Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 General inpatient routine service cost net of swing-bed and observation bed charges) O Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) O Concount of the cost reporting period (line 8 or 25.00 x line 20) D Private room charges (excluding swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 General inpatient routine service cost net of swing-bed and observation bed charges) O Private room charges (excluding swing-bed charges) O Concount of the cost reporting period (line 8 or 25.00 x line 27 s line 28) O Concount of the cost reporting period (line 8 or 25.00 x line 27 s line 26) D Private room charges (excluding swing-bed cost (line 21 minus line 26) D Private room charges (excluding swing-bed charges) O Concount of the cost reporting period (line 8 or 25.00 x line 27 s line 26) D Private room charges (excluding swing-bed charges) O Concount of the cost reporting period (line 8 or 25.00 x line 27 s line 28) O Concount of the cost reporting period (line 8 or 25.00 x line 27 s line 28) O Concount of the cost reporting period (line 8 or 25.00 x l	20. 00		after December 31 of th	ne cost	0.00	20.00
22. 00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26. 00 Total swing-bed cost (see instructions) 27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29. 00 Private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 31. 00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32. 00 Average private room per diem charge (line 29 + line 3) 33. 00 Average per ivate room per diem charge (line 30 + line 4) 34. 00 Average per diem private room cost differential (line 34 x line 31) 35. 00 Average per diem private room cost differential (line 34 x line 31) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) 38. 00 Aplasted general inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 39. 00 Program general inpatient routine service cost per diem (see instructions) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 3		reporting period				
5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 v line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 0 24.00 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25.00 x line 20) 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) 15, 161, 728 7.00 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 29.00 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 33.00 Average semi-private room per diem charge (line 30 * line 4) 0.00 34.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 0.00 35.00 Average per diem private room cost differential (line 34 x line 31) 0.00 36.00 Private room cost differential adjustment (line 3 x line 35) 0.00 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 15, 161, 728 7 minus line 36) 28.00 Adjusted general inpatient routine service cost per diem (see instructions) 1.014, 98 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1.014, 98 38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00			21 of the cost respond	ing popied (line		
23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ± line 28) 32.00 Average private room per diem charge (line 29 + line 3) 33.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Average per diem private room cost differential (line 34 x line 31) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 37 minus line 36) 27 minus line 36) 28.00 Program general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost (per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	22.00		31 of the cost report	ing period (iine	U	22.00
24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25.00 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 Deneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room per diem charge (line 27 + line 28) 30.00 Average per diem private room per diem charge (line 30 + line 4) 30.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 30.00 Average per diem private room cost differential (line 3 x line 31) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differ	23. 00	Swing-bed cost applicable to SNF type services after December 3	1 of the cost reporting	g period (line 6	0	23. 00
7 x line 19) 25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	24.00		21 of the cost reservit	ng poriod (lipo	0	24.00
x line 20) 26. 00 Total swing-bed cost (see instructions) 27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 30. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3) 30. 00 32. 00 Average semi-private room per diem charge (line 30 ÷ line 4) 34. 00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 35. 00 Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35) O 36. 00 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 15, 161, 728) Average per diem private room cost differential (see instructions) Average per diem cost differential adjustment (line 3 x line 35) Average per diem private room cost differential (see instructions) Average per diem private room cost differential (see instructions) Average per diem private room cost differential (see instructions) Average per diem cost differential (s	24.00		si di the cost reporti	ig perrou (Trile	U	24.00
Total swing-bed cost (see instructions) 26.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERNTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 + line 28) Average private room per diem charge (line 29 + line 3) Average semi-private room per diem charge (line 30 + line 4) Average per diem private room cost differential (line 32 minus line 33)(see instructions) Average per diem private room cost differential (line 34 x line 31) Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVI DERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35) O 26.00 15, 161, 728 27.00 28.00 28.00 29.00 28.00 29.00 29.00 20.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00	25. 00		of the cost reporting	period (line 8	0	25. 00
27. 00 Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 15, 161, 728 27. 00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	26 00				0	26.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) 9.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 31.00 General inpatient room per diem charge (line 29 + line 3) 32.00 Average private room per diem charge (line 30 + line 4) 33.00 Average semi-private room per diem charge (line 30 + line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 36.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 15, 161, 728) 37.00 General inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 28.00 28.00 29.00 30.00 30.00 30.00 31.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00		,	ine 21 minus line 26)			
29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 15, 161, 728) Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 29.00 29.00 30.00 0.00 30.00 0.00 31.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 0		PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 15, 161, 728) Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			and observation bed cha	arges)		
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 15, 161, 728) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 000 32.00 0.00 32.00 31.00 0.00 33.00 0.00 34.00 34.00 35.00 Oscillation (line 27 + line 28) 0.00 32.00 36.00 37.00 Oscillation (line 30) 37.00 Oscillation (line 30) 38.00 Oscillation (line 30) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)						
33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 15, 161, 728) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			line 28)			
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 15, 161, 728) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 34.00 34.00 15, 161, 728 37.00 15, 161, 728 37.00 40.00	32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32. 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 15, 161, 728 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, 014. 98 38. 00 39. 00 Program general inpatient routine service cost (line 9 x line 38) 6, 793, 261 39. 00 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40. 00	33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 15, 161, 728 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 36.00 15, 161, 728 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00	34.00	Average per diem private room charge differential (line 32 minu	s line 33)(see instruc [.]	tions)	0.00	
37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 15, 161, 728 16, 161, 728 37. 00 15, 161, 728 37. 00 15, 161, 728 37. 00 40. 00			31)			
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,014.98 38.00 Program general inpatient routine service cost (line 9 x line 38) 6,793,261 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,014.98 38.00 Program general inpatient routine service cost (line 9 x line 38) 6,793,261 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	37. 00		d private room cost di	fferential (line	15, 161, 728	37. 00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,014.98 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 6,793,261 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,014.98 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 1,014.98 38.00 6,793,261 39.00			TMENTS			
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 6,793,261 39.00 40.00	38. 00				1, 014. 98	38. 00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	39. 00					
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 6,793,261 41.00	40.00					
	41. 00	Total Program general inpatient routine service cost (line 39 +	line 40)		6, 793, 261	41.00

<u>Heal</u> th	Financial Systems	DEARBORN COUN	TY HOSPITAL		In Lie	eu of Form CMS-2	<u>255</u> 2-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der		Period: From 01/01/2014	Worksheet D-1	
					Γο 12/31/2014	Date/Time Pre	
			Ti +I	e XVIII	Hospi tal	5/29/2015 8: 5 PPS	7 am
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
	<u>'</u>	Inpatient Cost	Inpatient Days	Diem (col. 1		(col. 3 x col.	
		1.00	2.00	col . 2) 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)	1.00					42. 00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2, 873, 774	2, 208	1, 301. 5	1, 140	1, 483, 744	
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
46. 00	1						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	3, line 200)			9, 263, 319	48. 00
	Total Program inpatient costs (sum of lines			ons)		17, 540, 324	
	PASS THROUGH COST ADJUSTMENTS					1 054 ((4	
50. 00	Pass through costs applicable to Program inp.	atient routine	services (Tron	n WKST. D, SUM	or Parts I and	1, 054, 664	50.00
51.00	Pass through costs applicable to Program inp	atient ancillar	y services (fr	om Wkst. D, su	um of Parts II	585, 623	51.00
F0 00	and IV)	FO F43				4 (40 05=	F0 00
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu-		lated non-phy	sician anosth	atist and	1, 640, 287 15, 900, 037	
33.00	medical education costs (line 49 minus line		erated, non-pris	731 Clair allestin	etist, and	15, 700, 037	33.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
	Program discharges Target amount per discharge					0.00	
56. 00	Target amount (line 54 x line 55)					0.00	1
57. 00	,	ing cost and ta	arget amount (I	ine 56 minus I	ine 53)	0	1
58. 00	Bonus payment (see instructions)		l' 4007			0	
59. 00	Lesser of lines 53/54 or 55 from the cost re market basket	porting period	ending 1996, L	updated and cor	npounaea by the	0.00	59. 00
60.00	Lesser of lines 53/54 or 55 from prior year	cost report, up	dated by the m	narket basket		0.00	60.00
61. 00	If line 53/54 is less than the lower of line					0	61. 00
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		s (lines 54 x	60), or 1% of	the target		
62. 00	Relief payment (see instructions)	matractions)				0	62. 00
63. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	ıcti ons)			0	63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	mher 31 of the	cost reporti	na neriod (See	0	64. 00
0 1. 00	instructions)(title XVIII only)	to thi odgir book	Simbol of or the	cost reportir	ig perrod (see		01.00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the o	cost reporting	period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 nlus line 6	55)(title XVIII	only) For	0	66. 00
00.00	CAH (see instructions)	10 00313 (11110	or prus rine c	,0)(((((() //((() //((() //((() //((() //((() //((() //((() //((() //((() //((() //((() //((() //((() //((() //((() //((() //(() //((() //((() //((() //((() //((() //(() //((() //(() //((() //(() //((() //(() //((() //(() //(() //((() //(() //(() //((() //(() //(() //(() //((() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(() //(()	0111 97. 101		00.00
67. 00	Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 c	of the cost rep	porting period	0	67. 00
68 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after D	ecember 31 of	the cost repoi	rting period	0	68. 00
	(line 13 x line 20)				arrig parria		
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil		•				70.00
71. 00	Adjusted general inpatient routine service of	•					71. 00
72.00	Program routine service cost (line 9 x line		. (1:= 4: ::	25)			72.00
73. 00 74. 00	Medically necessary private room cost application. Total Program general inpatient routine serv						73. 00 74. 00
75. 00	Capital -related cost allocated to inpatient	,			art II, column		75. 00
	26, line 45)		-				
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line	. *					76. 00 77. 00
	Inpatient routine service cost (line 74 minu						78.00
79. 00	Aggregate charges to beneficiaries for exces	s costs (from p					79. 00
	Total Program routine service costs for comp		cost limitation	n (line 78 minu	us line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I)				81. 00 82. 00
83. 00	Reasonable inpatient routine service costs (* .				83. 00
84.00	Program inpatient ancillary services (see in		`				84. 00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
00.00	PART IV - COMPUTATION OF OBSERVATION BED PASS		n ough 65)				, 55. 55
87. 00	Total observation bed days (see instructions)				1, 588	
88.00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	•				1, 014. 98 1, 611, 788	
U 7. UU	Topsorvation bed cost (Time of X Time od) (Se	c manuchons)				1,011,768	J 07.00

Health Financial Systems	DEARBORN COUN	ITY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2014		
				To 12/31/2014		
					5/29/2015 8: 5	/ am
		Ti tle	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	2, 033, 771	15, 161, 728	0. 13413	8 1, 611, 788	216, 202	90.00
91.00 Nursing School cost	0	15, 161, 728	0.00000	0 1, 611, 788	0	91.00
92.00 Allied health cost	0	15, 161, 728	0.00000	0 1, 611, 788	0	92.00
93.00 All other Medical Education	0	15, 161, 728	0.00000	0 1, 611, 788	0	93. 00

Health Financial Systems DEARBORN COUNTY HOSPITAL In Lieu of Form CMS-2	
	552-10
COMPUTATION OF INPATIENT OPERATING COST Provider CCN: 150086 Period: Worksheet D-1	
From 01/01/2014	
To 12/31/2014 Date/Time Pre	
5/29/2015 8:5	am
Title XLX Hospital Cost	
Cost Center Description	
1.00	

		Title XIX	Hospi tal	Cost	7 alli
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS		· ·		
	I NPATI ENT DAYS			44.000	
1. 00 2. 00	Inpatient days (including private room days and swing-bed days, Inpatient days (including private room days, excluding swing-be			14, 938 14, 938	•
3.00	Private room days (excluding swing-bed and observation bed days		vate room days.	14, 730	3.00
0.00	do not complete this line.	y. It you have omly pro	rate reem dayer	· ·	0.00
4.00	Semi-private room days (excluding swing-bed and observation bed			13, 350	
5. 00	Total swing-bed SNF type inpatient days (including private room	days) through December	r 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room	days) after December	31 of the cost	0	6. 00
7.00	reporting period (if calendar year, enter 0 on this line)		21 -6	0	7 00
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	days) through becember	31 Of the Cost	U	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after December 3	1 of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	1, 093	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII onl	y (including private r	oom days)	0	10.00
	through December 31 of the cost reporting period (see instruction	ons)	,	0	
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl December 31 of the cost reporting period (if calendar year, ent		oom days) after	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	only (including private	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar yea Medically necessary private room days applicable to the Program	r, enter O on this lind (excluding swing-bed)	e) davs)	0	14. 00
15. 00	Total nursery days (title V or XIX only)	(exercaring eming gear		704	
16. 00	Nursery days (title V or XIX only)			0	16. 00
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services	through December 31 o	f the cost	0.00	17. 00
10.00	reporting period	often December 21 of	the cost	0.00	10.00
18. 00	Medicare rate for swing-bed SNF services applicable to services reporting period	arter December 31 or	the cost	0.00	18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	through December 31 of	the cost	0. 00	19. 00
20. 00	Medicald rate for swing-bed NF services applicable to services reporting period	after December 31 of t	ne cost	0. 00	20. 00
21. 00	Total general inpatient routine service cost (see instructions)			15, 161, 728	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	31 of the cost report	ing period (line	0	22. 00
23. 00	$5 ext{ x line 17}$ Swing-bed cost applicable to SNF type services after December 3	1 of the cost reporting	g period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December	31 of the cost reportio	na period (line	0	24. 00
	7 x line 19)	•		_	
25. 00	Swing-bed cost applicable to NF type services after December 31 \times line 20)	of the cost reporting	period (line 8	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 (I PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	ine 21 minus line 26)		15, 161, 728	27. 00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28. 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	
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0. 00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34. 00	Average per diem private room charge differential (line 32 minu		tions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x line	31)		0.00	ı
36. 00	Private room cost differential adjustment (line 3 x line 35)	d privata room cost di	Eforantial (1:	15 141 720	36.00
37. 00	General inpatient routine service cost net of swing-bed cost an 27 minus line 36)	u private room cost di	rrerentiai (IINe	15, 161, 728	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		l l		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS				
38. 00	Adjusted general inpatient routine service cost per diem (see i			1, 014. 98	1
39. 00	Program general inpatient routine service cost (line 9 x line 3	-		1, 109, 373	1
40.00	Medically necessary private room cost applicable to the Program	,		1 100 272	
41.00	Total Program general inpatient routine service cost (line 39 +	11110 40)		1, 109, 373	41.00

Heal th	Financial Systems DEARBORN COUNTY HOSPITAL In Lie	eu of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST Provider CCN: 150086 Period: From 01/01/2014	Worksheet D-1	
	To 12/31/2014	Date/Time Prep	
	Title XIX Hospital	5/29/2015 8: 5 ⁷ Cost	<u>/ am</u>
	Cost Center Description Total Total Average Per Program Days	Program Cost	
	Inpatient Cost Inpatient Days Diem (col. 1 ÷ col. 2)	(col. 3 x col. 4)	
	1.00 2.00 3.00 4.00	5. 00	
42. 00	NURSERY (title V & XIX only) 847,015 704 1,203.15 Content of the Nurser	0	42. 00
43.00	INTENSIVE CARE UNIT 2, 873, 774 2, 208 1, 301. 53	0	43. 00
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT		44. 00 45. 00
46. 00			46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)		47. 00
	Cost Center Description	1.00	
48. 00		1, 210, 597	
49. 00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions) PASS THROUGH COST ADJUSTMENTS	2, 319, 970	49. 00
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and	0	50. 00
51. 00	III Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II	o	51. 00
31.00	and IV)	l	31.00
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)		53. 00
F.4.00	TARGET AMOUNT AND LIMIT COMPUTATION		E4 00
54. 00 55. 00	Program discharges Target amount per discharge	0, 00	54. 00 55. 00
56. 00	Target amount (line 54 x line 55)	0	56. 00
57. 00 58. 00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) Bonus payment (see instructions)	0 0	57. 00 58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the		59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60. 00
61. 00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by	0.00	61. 00
	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		
62.00	Relief payment (see instructions)	0	62. 00
63. 00	Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST	0	63. 00
64. 00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See	0	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See	0	65. 00
03.00	instructions)(title XVIII only)	١	03.00
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	o	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period		68. 00
00.00	(line 13 x line 20)		
69. 00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY	0	69. 00
70. 00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70. 00
71. 00 72. 00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
73. 00	Program routine service cost (line 9 x line 71) Medically necessary private room cost applicable to Program (line 14 x line 35)		72. 00 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 78. 00	Program capital-related costs (line 9 x line 76) Inpatient routine service cost (line 74 minus line 77)		77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for excess costs (from provider records)		79. 00
80. 00 81. 00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) Inpatient routine service cost per diem limitation		80. 00 81. 00
82. 00	Inpatient routine service cost limitation (line 9 x line 81)		82. 00
83. 00 84. 00	Reasonable inpatient routine service costs (see instructions) Program inpatient ancillary services (see instructions)		83. 00 84. 00
85. 00	Utilization review - physician compensation (see instructions)		85. 00
86. 00			86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions)	1, 588	87. 00
88.00		1, 014. 98	
υ 9 . UU	Observation bed cost (line 87 x line 88) (see instructions)	1, 611, 788	U7. UU

Health Financial Systems	DEARBORN COUN	ITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2014 To 12/31/2014	Date/Time Prep 5/29/2015 8:5	
		Ti t	le XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	2, 033, 771	15, 161, 728	0. 13413	1, 611, 788	216, 202	90.00
91.00 Nursing School cost	0	15, 161, 728	0.00000	1, 611, 788	0	91.00
92.00 Allied health cost	0	15, 161, 728	0.00000	1, 611, 788	0	92.00
93.00 All other Medical Education	0	15, 161, 728	0.00000	1, 611, 788	0	93.00

ealth Financial Systems	DEARBORN COUNTY HOSPITAL			eu of Form CMS-	
NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150086	Peri od: From 01/01/2014	Worksheet D-3	3
			To 12/31/2014	Date/Time Pre	nared
			10 12/31/2014	5/29/2015 8: 5	
	Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	0.00	2)	
I NIDATI ENT. DOUTI NE. CEDVI CE. COCT. CENTEDO		1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 0. 00 03000 ADULTS & PEDI ATRI CS		1	4, 257, 259		30.0
1.00 03100 NTENSI VE CARE UNI T			1, 528, 334		31.0
3. 00 04300 NURSERY			1, 520, 554		43. 0
ANCI LLARY SERVI CE COST CENTERS					43.0
0. 00 O5000 OPERATING ROOM		0. 24948	3, 737, 787	932, 537	50.0
1. 00 05100 RECOVERY ROOM		0. 4219!			1
2. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 30223			
3. 00 05300 ANESTHESI OLOGY		0. 04242			
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 29808	2, 202, 836	656, 624	54. (
4. 01 05401 ULTRASOUND		0. 12008	37 277, 876	33, 369	54. (
5. 00 05500 RADI OLOGY-THERAPEUTI C		0. 15142	24 1, 144, 239	173, 265	55.0
7. 00 05700 CT SCAN		0. 0356	16 2, 840, 799	101, 178	57. (
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 07378		39, 499	58. (
9. 00 05900 CARDI AC CATHETERI ZATI ON		0.00000			
0. 00 06000 LABORATORY		0. 2112			
0. 01 06001 BLOOD LABORATORY		0.00000		0	
5. 00 06500 RESPI RATORY THERAPY		0. 2295			
5. 01 03950 SLEEP CLINIC		0. 2702		0	
6. 00 06600 PHYSI CAL THERAPY		0. 40838			
7. 00 06700 OCCUPATI ONAL THERAPY		0. 61442			
8. 00 06800 SPEECH PATHOLOGY 9. 00 06900 ELECTROCARDI OLOGY		0. 5832			
9.00 06900 ELECTROCARDIOLOGY 1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 25083 0. 72360			
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS		1. 0305			
3. 00 07300 DRUGS CHARGED TO PATIENTS		0. 42790			
OUTPATIENT SERVICE COST CENTERS		0.42/90	3,030,760	2, 103, 603	73.
1. 00 09100 EMERGENCY		0. 41324	1, 454, 750	601, 164	91.
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 26292			
00.00 Total (sum of lines 50-94 and 96-98)		2027	32, 647, 007		
01.00 Less PBP Clinic Laboratory Services-Pr	rogram only charges (line 61)		02,017,007		201.
02.00 Net Charges (line 200 minus line 201)	1.5 1.1.5 1.1.5 grz (1.1.10 gr)		32, 647, 007	ł	202. (

Heal th Fi	nancial Systems	DEARBORN COUNTY HOSPITAL		In Li€	eu of Form CMS-2	2552-10
I NPATI EN	T ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150086	Peri od:	Worksheet D-3	
				From 01/01/2014 To 12/31/2014		narodi
				10 12/31/2014	5/29/2015 8:5	
-		Ti ·	tle XIX	Hospi tal	Cost	, <u>u</u>
	Cost Center Description		Ratio of Cos		Inpatient	
	'		To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2. 00	3. 00	
	IPATIENT ROUTINE SERVICE COST CENTERS					
	3000 ADULTS & PEDIATRICS			866, 996		30. 00
	3100 INTENSIVE CARE UNIT			224, 321		31.00
	300 NURSERY			155, 487		43. 00
	CILLARY SERVICE COST CENTERS		0.0404	00 040 045	70.40/	F0 00
	OOOO OPERATI NG ROOM		0. 2494			
	S100 RECOVERY ROOM		0. 4219			1
	5200 DELIVERY ROOM & LABOR ROOM 5300 ANESTHESIOLOGY		0. 3022 0. 0424			•
	6400 RADI OLOGY-DI AGNOSTI C		0. 0424			
	401 ULTRASOUND		0. 2980			
	5500 RADI OLOGY-THERAPEUTI C		0. 1200			1
	5700 CT SCAN		0. 0356			
	5800 MAGNETIC RESONANCE IMAGING (MRI)		0. 0737			1
	5900 CARDI AC CATHETERI ZATI ON		0.0000			59. 00
	0000 LABORATORY		0. 2082			
60. 01 06	001 BLOOD LABORATORY		0.0000		0	60. 01
65. 00 06	500 RESPI RATORY THERAPY		0. 2295	10 276, 750	63, 517	65. 00
65. 01 03	3950 SLEEP CLINIC		0. 2702	70 0	0	65. 01
	600 PHYSI CAL THERAPY		0. 4083	81 40, 540	16, 556	66. 00
	700 OCCUPATI ONAL THERAPY		0. 6144	·		67. 00
	800 SPEECH PATHOLOGY		0. 5832			68. 00
	900 ELECTROCARDI OLOGY		0. 2508			
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 7236	·		
	200 IMPL. DEV. CHARGED TO PATIENT		1. 0305	·		l .
	300 DRUGS CHARGED TO PATIENTS		0. 4279	01 643, 656	275, 421	73. 00
	ITPATIENT SERVICE COST CENTERS		0.400.	45 407 247	F4 057	04.00
	2100 EMERGENCY		0. 4084			
1	O200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 2629	·		
200.00	Total (sum of lines 50-94 and 96-98)	regreem only changes (1) == (1)		4, 009, 758		
201. 00 202. 00	Less PBP Clinic Laboratory Services-Pr Net Charges (line 200 minus line 201)	ogram only charges (Tine 61)		4, 009, 758		201. 00 202. 00
202.00	INGL Glidiges (TITIE 200 IIII lius TITIE 201)		I	4,007,730	I	1202.00

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der	CCN: 150086	Peri od: From 01/01/2014	Worksheet E Part A	
				To 12/31/2014	Date/Time Pre 5/29/2015 8:5	pared: 7 am
		Titl	e XVIII	Hospi tal	PPS	
	DADT A INDATIENT HOSDITAL SERVICES LINDED LDDS		0	1. 00	2. 00	
1.00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS DRG Amounts Other than Outlier Payments			0		1.00
1. 01	DRG amounts other than outlier payments for discharges occurring	g prior		0		1. 01
1. 02	to October 1 (see instructions) DRG amounts other than outlier payments for discharges occurring	g on or		13, 282, 160		1. 02
1. 03	after October 1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for			0		1. 03
	discharges occurring prior to October 1 (see instructions)					
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)			218, 652		2. 00
2. 01 2. 02	Outlier reconciliation amount Outlier payment for discharges for Model 4 BPCI (see instruction	ns)		0		2. 01 2. 02
3.00	Managed Care Simulated Payments	,		0		3.00
4. 00	Bed days available divided by number of days in the cost report period (see instructions)	i ng		73. 65		4. 00
	Indirect Medical Education Adjustment					1
5. 00	FTE count for allopathic and osteopathic programs for the most 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 which meet the	e		0.00		6. 00
	criteria for an add-on to the cap for new programs in accordance CFR 413.79(e)	e with 42				
7. 00	MMA Section 422 reduction amount to the IME cap as specified un	der 42		0.00		7. 00
7. 01	CFR $\S412.105(f)(1)(iv)(B)(1)$ ACA Section 5503 reduction amount to the IME cap as specified u	nder 42		0.00		7. 01
	CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July	1, 2011				
8.00	then see instructions. Adjustment (increase or decrease) to the FTE count for allopath	ic and		0.00		8. 00
	osteopathic programs for affiliated programs in accordance with 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67					
	(August 1, 2002).					
8. 01	The amount of increase if the hospital was awarded FTE cap slot- section 5503 of the ACA. If the cost report straddles July 1, 2			0.00		8. 01
	i nstructi ons.					
8. 02	The amount of increase if the hospital was awarded FTE cap slots closed teaching hospital under section 5506 of ACA. (see instru			0.00		8. 02
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines			0.00		9. 00
10. 00	land 8,02) (see instructions) FTE count for allopathic and osteopathic programs in the curren	t year		0.00		10.00
11 00	from your records FTE count for residents in dental and podiatric programs.			0.00		11. 00
	Current year allowable FTE (see instructions)			0.00		12. 00
13.00	' '			0.00		13.00
14. 00	Total allowable FTE count for the penultimate year if that year or after September 30, 1997, otherwise enter zero.	enaea on		0.00		14. 00
15. 00	Sum of lines 12 through 14 divided by 3.			0.00		15. 00
	Adjustment for residents in initial years of the program			0.00		16.00
17.00	Adjusted rolling average FTE count	е		0. 00 0. 00		17. 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)	2 122 of t	ha MMA	0		22. 01
23. 00	Indirect Medical Education Adjustment for the Add-on for Section Number of additional allopathic and osteopathic IME FTE residen		THE MIMA	0.00		23. 00
0.4.00	slots under 42 Sec. 412.105 (f)(1)(iv)(C).			0.00		04.00
24. 00 25. 00	IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -0-, then enter the lo	wer of		0. 00 0. 00		24. 00 25. 00
	line 23 or line 24 (see instructions)					
26. 00 27. 00	Resident to bed ratio (divide line 25 by line 4) IME payments adjustment factor. (see instructions)			0. 000000 0. 000000		26. 00 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 29. 01	Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0		29. 00 29. 01
29.01	Disproportionate Share Adjustment					27.01
30. 00	Percentage of SSI recipient patient days to Medicare Part A pat (see instructions)	ient days		3. 20		30. 00
31. 00	Percentage of Medicaid patient days (see instructions)			18. 59		31. 00
32. 00 33. 00	Sum of lines 30 and 31 Allowable disproportionate share percentage (see instructions)			21. 79 7. 19		32. 00 33. 00
	Disproportionate share adjustment (see instructions)			238, 747		34.00

Title XVIII	4, 885 88065 3, 486 35. 02 9, 756 36. 00 40. 00 41. 00 42. 00
Uncompensated Care Adjustment	9, 756 35. 00 40. 00 41. 00 42. 00
Uncompensated Care Adjustment	4, 885 88065 3, 486 35. 02 9, 756 36. 00 40. 00 41. 00 42. 00
Uncompensated Care Adjustment 35. 00 Total uncompensated care amount (see instructions) 36. 01 Factor 3 (see instructions) 35. 02 Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions) 35. 03 Pro rata share of the hospital uncompensated care payment amount (see instructions) 36. 00 Total uncompensated care (sum of columns 1 and 2 on line 35. 03) Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46) 40. 00 Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions) 41. 01 Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions) 41. 01 Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions) 42. 00 Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment) 43. 00 Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions) 44. 00 Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days) 45. 00 Average weekly cost for dialysis treatments (see instructions)	4, 885 35. 00 88065 35. 01 3, 486 35. 02 9, 756 35. 03 36. 00 40. 00 41. 00 42. 00
35. 00 Total uncompensated care amount (see instructions) 35. 01 Factor 3 (see instructions) 35. 02 Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions) 35. 03 Pro rata share of the hospital uncompensated care payment amount (see instructions) 36. 00 Total uncompensated care (sum of columns 1 and 2 on line 35. 03) Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46) 40. 00 Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions) 41. 00 Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions) 42. 00 Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment) 43. 00 Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions) 44. 00 Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days) 45. 00 Average weekly cost for dialysis treatments (see instructions)	88065 35. 01 3, 486 35. 02 9, 756 35. 03 36. 00 40. 00 41. 00 42. 00
35.01 Factor 3 (see instructions) Hospi tal uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions) 35.03 Pro rata share of the hospital uncompensated care payment amount (see instructions) 36.00 Total uncompensated care (sum of columns 1 and 2 on line 35.03) Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46) 40.00 Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions) 41.00 Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions) 41.01 Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions) Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment) Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions) At.00 Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days) 45.00 Average weekly cost for dialysis treatments (see instructions)	88065 35. 01 3, 486 35. 02 9, 756 35. 03 36. 00 40. 00 41. 00 42. 00
35. 02 Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions) 35. 03 Pro rata share of the hospital uncompensated care payment amount (see instructions) 36. 00 Total uncompensated care (sum of columns 1 and 2 on line 35. 03) Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46) 40. 00 Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions) 41. 00 Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions) 41. 01 Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 682, 683, 684 an 685. (see instructions) 42. 00 Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment) 43. 00 Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions) 44. 00 Ratio of average length of stay to one week (line 43 divided by I ine 41 divided by 7 days) 45. 00 Average weekly cost for dialysis treatments (see instructions)	3, 486 35. 02 9, 756 35. 03 36. 00 40. 00 41. 00 42. 00
enter zero on this line) (see instructions) 35. 03 Pro rata share of the hospital uncompensated care payment amount (see instructions) 36. 00 Total uncompensated care (sum of columns 1 and 2 on line 35. 03) Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46) 40. 00 Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions) 41. 00 Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions) 41. 01 Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions) 42. 00 Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment) 43. 00 Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions) 44. 00 Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days) 45. 00 Average weekly cost for dialysis treatments (see instructions)	9, 756 35. 03 36. 00 40. 00 41. 00 41. 01 42. 00
35. 03 Pro rata share of the hospital uncompensated care payment amount (see instructions) 36. 00 Total uncompensated care (sum of columns 1 and 2 on line 35. 03) Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46) 40. 00 Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions) 41. 00 Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions) 41. 01 Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions) 42. 00 Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment) 43. 00 Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions) 44. 00 Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days) 45. 00 Average weekly cost for dialysis treatments (see instructions)	36. 00 40. 00 41. 00 41. 01 42. 00
Total uncompensated care (sum of columns 1 and 2 on line 35.03) Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46) 40.00 Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions) Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions) Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions) Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment) Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions) Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days) Average weekly cost for dialysis treatments (see instructions)	40. 00 41. 00 41. 01 42. 00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46) 40.00 Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions) 41.00 Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions) 41.01 Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions) 42.00 Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment) 43.00 Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions) 44.00 Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days) 45.00 Average weekly cost for dialysis treatments (see instructions)	40. 00 41. 00 41. 01 42. 00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46) 40.00 Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions) 41.00 Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions) 41.01 Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions) Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment) 43.00 Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions) 44.00 Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days) 45.00 Average weekly cost for dialysis treatments (see instructions)	41. 00 41. 01 42. 00
40.00 Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions) 41.00 Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions) 41.01 Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions) 42.00 Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment) 43.00 Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions) 44.00 Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days) 45.00 Average weekly cost for dialysis treatments (see instructions)	41. 00 41. 01 42. 00
excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions) 41.00 Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions) 41.01 Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions) 42.00 Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment) 43.00 Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions) 44.00 Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days) 45.00 Average weekly cost for dialysis treatments (see instructions)	41. 00 41. 01 42. 00
41.00 Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions) 41.01 Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions) 42.00 Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment) 43.00 Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions) 44.00 Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days) 45.00 Average weekly cost for dialysis treatments (see instructions)	41. 01
682, 683, 684 an 685. (see instructions) 41.01 Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions) 42.00 Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment) 43.00 Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions) 44.00 Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days) 45.00 Average weekly cost for dialysis treatments (see instructions)	41. 01
41.01 Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions) 42.00 Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment) 43.00 Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions) 44.00 Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days) 45.00 Average weekly cost for dialysis treatments (see instructions)	42.00
MS-DRGs 652, 682, 683, 684 an 685. (see instructions) 42.00 Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment) 43.00 Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions) 44.00 Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days) 45.00 Average weekly cost for dialysis treatments (see instructions)	42.00
42.00 Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment) 43.00 Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions) 44.00 Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days) 45.00 Average weekly cost for dialysis treatments (see instructions)	
43.00 Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions) 44.00 Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days) 45.00 Average weekly cost for dialysis treatments (see instructions) 0.000000	40.00
682, 683, 684 an 685. (see instructions) 44.00 Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days) 45.00 Average weekly cost for dialysis treatments (see instructions) 0.000000 0.0000000000000000000000000	
44.00 Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days) 45.00 Average weekly cost for dialysis treatments (see instructions) 0.000000	43.00
divided by line 41 divided by 7 days) 45.00 Average weekly cost for dialysis treatments (see instructions) 0.00	44.00
45.00 Average weekly cost for dialysis treatments (see instructions) 0.00	11.00
	45. 00
44 00 IT 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
46.00 Total additional payment (line 45 times line 44 times line 41.01)	46. 00
47. 00 Subtotal (see instructions) 14, 553, 250	47. 00
48.00 Hospital specific payments (to be completed by SCH and	48. 00
MDH, small rural hospitals only. (see instructions)	
49.00 Total payment for inpatient operating costs (see 14,553,250	49. 00
instructions) 50.00 Payment for inpatient program capital (from Wkst. L, Pt. I 1,098,448	50.00
and Pt. II, as applicable)	30.00
51.00 Exception payment for inpatient program capital (Wkst. L,	51.00
Pt. III, see instructions)	
52.00 Direct graduate medical education payment (from Wkst. E-4,	52.00
line 49 see instructions). 53.00 Nursing and Allied Health Managed Care payment	53.00
54. 00 Special add-on payments for new technologies	54.00
55.00 Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1,	55. 00
line 69)	-, -,
56.00 Cost of physicians' services in a teaching hospital (see intructions)	56. 00
57.00 Routine service other pass through costs (from Wkst. D,	57.00
Pt. III, column 9, lines 30 through 35).	
58.00 Ancillary service other pass through costs from Wkst. D, 0	58. 00
Pt. IV, col. 11 line 200)	F0.00
59.00 Total (sum of amounts on lines 49 through 58) 15,651,698 60.00 Primary payer payments 26,332	59. 00 60. 00
61.00 Total amount payable for program beneficiaries (line 59	61. 00
minus line 60)	
62.00 Deductibles billed to program beneficiaries 1,580,288	62.00
63.00 Coinsurance billed to program beneficiaries 34,048	63.00
64.00 Allowable bad debts (see instructions) 40,678 65.00 Adjusted reimbursable bad debts (see instructions) 26,441	64. 00 65. 00
66.00 Allowable bad debts for dual eligible beneficiaries (see -61, 151	66.00
instructions)	33.33
67.00 Subtotal (line 61 plus line 65 minus lines 62 and 63) 14,037,471	67. 00
68.00 Credits received from manufacturers for replaced devices 0	68. 00
for applicable to MS-DRGs (see instructions) 69.00 Outlier payments reconciliation (sum of lines 93, 95 and 0	69. 00
96). (For SCH see instructions)	37.00
70.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0	70.00
70. 50 RURAL DEMONSTRATION PROJECT	70. 50
70. 89 Pioneer ACO demonstration payment adjustment amount (see	70. 89
instructions) 70.90 HSP bonus payment HVBP adjustment amount (see	70. 90
instructions)	70.90
70. 91 HSP bonus payment HRR adjustment amount (see instructions)	70. 91
70.92 Bundled Model 1 discount amount (see instructions)	70. 92
70. 93 HVBP payment adjustment amount (see instructions) 13, 558	70. 93
70. 94 HRR adjustment amount (see instructions) 70. 95 Recovery of accelerated depreciation -51, 339 0	70. 94 70. 95
1.5.75 1.55515. 3 OF GOOD OF GOOD GOOD OF GO	1 70. 90

	Financial Systems DEARBORN COUNT			u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150086	Peri od: From 01/01/2014 To 12/31/2014		pared: 7 am
		Title XVIII	Hospi tal	PPS	
			Prior to	On/After	
			October 1	October 1	
		0	1. 00	2. 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)		13, 999, 690		71. 00
71. 01	Sequestration adjustment (see instructions)		279, 994		71. 01
72.00	Interim payments		13, 835, 625		72. 00
73.00	3,		0		73.00
74. 00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)		-115, 929		74.00
75. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		2, 956, 042		75. 00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90. 00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0		90.00
91. 00	Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
92. 00	Operating outlier reconciliation adjustment amount (see instructions)		0		92. 00
93. 00	Capital outlier reconciliation adjustment amount (see instructions)		0		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)		0		95. 00
96. 00	Time value of money for capital related expenses (see instructions)		0		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	0 100. 00
HVBP Adjustment for HSP Bonus Payment		
101.00 HVBP adjustment factor (see instructions)	0	0 101. 00
102.00 HVBP adjustment amount for HSP bonus payment (see instructions)	0	0 102. 00
HRR Adjustment for HSP Bonus Payment		
103.00 HRR adjustment factor (see instructions)	0.0000	0. 0000 103. 00
104.00 HRR adjustment amount for HSP bonus payment (see instructions)	0	0 104. 00

Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Provi der CCN: 150086

1.00 RR aemails other than cuttier 1.00 1.00 2.00 3.00 4.00 5.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.0					Ti +I	e XVIII	Hospi tal	5/29/2015 8: 5 PPS	7 am
1.00 Bids amounts other than outiller 0.0 1.00 2.00 3.00 4.00 5.00 1.01			W/S E, Part A	Amounts (from			Peri od		
1.00 DKG anounts other than outlier 1.00 0 0 0 0 0 0 0 0 0									
1. Displayments for discharges 1.01 Displayments for discharges 1.02 13.282.160 0 0 13.282.160 13.282.160 1.02	1 00	DRG amounts other than outlier			2.00	3.00	4.00		1 00
Experience For discharges	1.00		1.00	Ĭ		0			1.00
1.00 200 13,282,160 10,282,160 10 13,282,160 10 13,282,160 10 13,282,160 10 13,282,160 10 13,282,160 10 13,282,160 10 13,282,160 10 10 13,282,160 10 10 10 10 10 10 10	1. 01		1. 01	0	0	0	0	0	1. 01
1.02 BRC amounts other than outlier 1.02 13,282,160 0 15,282,160 13,282,160 1.02									
Cocurring on or after October 1.03 Cocurring promot for Nodel 4 1.03 Cocurring promot for Nodel 4 SPCI operating payment for Nodel 4 SPCI operating payments for	1.02		1. 02	13, 282, 160	0	0	13, 282, 160	13, 282, 160	1. 02
1.03 10 10 10 10 10 10 10									
1.04 SPCI Occurring prior to a botchart 1.04 SPCI Occurring on or after October 1.04 SPCI Occurring outlier 1.04 SPCI		occurring on or after October							
1.04 SPCI Occurring prior to a botchart 1.04 SPCI Occurring on or after October 1.04 SPCI Occurring outlier 1.04 SPCI	1. 03	DRG for Federal specific	1. 03	0	0	0	0	0	1. 03
Cotober 1		operating payment for Model 4							
1.04 0 0 0 0 0 0 0 0 0									
Operating payment for Model 4 RPCI occurring on ordifor Circler Colored Circler Colored Circler Colored Circler	1 04		1 04	0	0	0	0	0	1 04
October 1					J	· ·			
2.00									
discharges (see instructions) 2.01 0 0 0 0 0 0 0 0 0	2 00	4	2 00	218 652	0	0	218 652	218 652	2 00
discharges for Model 4 BPCI 0 0 0 0 0 0 0 0 0	2.00		2.00	210, 032	J	O	210, 032	210,032	2.00
3.00 Operating outline 2.01 0 0 0 0 0 0 0 0 0	2. 01		2. 02	0	0	0	0	0	2. 01
Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil Peconcil P	2 00		2 01	0	0	0	0	_	2 00
Managed care slmulated 3.00 0 0 0 0 0 0 4.00	3.00		2.01	U	U	U	U	0	3.00
Indirect Medical Education Adjustment 21.00	4.00	Managed care simulated	3. 00	0	0	0	0	0	4. 00
Anount From Worksheet E, Part 21.00		1 7	+ +						
A, I Ine 21 (see instructions) 6. 01 IME payment adjustment (see 22.00 0 0 0 0 0 0 0 0 0	5 00			0 000000	0 000000	0.000000	0.000000		5 00
Instructions Color Instructions Color Color	0.00		21.00	0.00000	0.00000	0.00000	0.00000		0.00
MMC payment adjustment for managed care (see instructions) More payment adjustment feator (soe instructions) More payment adjustment add on for managed care (see instructions) More payment adjustment add on for managed care (see instructions) More payment (sum of lines 6 and 8) More payment (sum of lines 6 and 8) More payment (sum of lines 6 and 8) More payment for managed care (sum of lines 6 and 8) More payment for managed care (sum of lines 6 and 8) More payment for managed care (sum of lines 6 and 8) More payment for managed care (sum of lines 6 and 8) More payment for managed care (sum of lines 6 and 8) More payment for managed care (sum of lines 6 and 8) More payment for managed care (sum of lines 6 and 8) More payment for managed care (sum of lines 6 and 8) More payment for managed care (sum of lines 6 and 8) More payment for managed care payment for managed care payment for managed care payments More payment for managed	6.00		22. 00	0	0	0	0	0	6. 00
nanaged care (see Instructions) Indirect Medical Education Adjustment For the Add-on For Section 422 of the MMA	6 01		22 01	0	0	0	0	0	6.01
Instructions Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA Total Improvement adjustment factor (See instructions) 27.00 (0.000000 (0.000000 0.000000 0.000000 0.000000 0.000000	0.01		22.01		0	0	0	0	0.01
ME payment adjustment factor (See instructions) 27.00 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.000000 0.00000000		instructions)							
See instructions See See	7 00						0.000000		7 00
1.00 NE adjustment (see 28.00 0 0 0 0 0 0 0 0 0	7.00		27.00	0.000000	0.000000	0.000000	0.00000		7.00
ME payment adjustment add on 28.01	8.00	IME adjustment (see	28. 00	0	0	0	0	0	8. 00
For managed caire (see instructions) 9.00 Total IME payment (sum of 29.00 0 0 0 0 0 0 0 0 0	0.01		20.01	0	0	0	0		0.01
Instructions	8.01		28.01	U	U	Ü	0	0	8.01
1									
Total IME payment for managed 29.01	9. 00		29. 00	0	0	0	0	0	9. 00
Care (Sum of Fines 6.01 and 8.01) Suppositionate Share Adjustment Suppositionate Share Adjustment Suppositionate Share Adjustment Suppositionate Share Adjustment Suppositionate Share percentage (see instructions) Suppositionate Share percentage (see instructions) Suppositionate Share Suppositionate Sha	9 01		29 01	0	0	0	0	0	9 01
Disproportionate Share Adjustment 33.00 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.0719 0.	7. 01		27.01		J	O	J		7.01
10.00									
Share percentage (see instructions) 11.00 15 proportionate share 34.00 238,747 0 0 0 238,747 238,747 11.00 15 proportionate share 34.00 813,691 0 643,935 169,756 813,691 11.01 11.01 12.00 14.00 14.00 14.553,250 14.553,250 15.00 14.00 14.553,250 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00	10 00			0.0710	0.0710	0 0710	0.0710		10 00
11.00 Disproportionate share 34.00 238,747 0 0 0 238,747 238,747 11.00 238,747 238,747 11.00 238,747 238,747 11.00 238,747 238,747 11.00 238,747 238,747 11.00 238,747 238,747 11.00 238,747 238,747 11.00 238,747 238,747 11.00 238,747 238,747 11.00 238,747 238,747 238,747 11.00 238,747 238,747 238,747 11.00 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238,747 238	10.00		33.00	0.0717	0.0719	0.0717	0.0717		10.00
11. 01 Uncompensated care payments 36. 00 813, 691 0 643, 935 169, 756 813, 691 11. 01 Additional payment for high percentage of ESRD beneficiary discharges 12. 00 Total ESRD additional payment 46. 00 0 0 0 0 0 0 0 0 0		instructions)							
11. 01 Uncompensated care payments 36. 00 813, 691 0 643, 935 169, 756 813, 691 11. 01	11. 00		34.00	238, 747	0	0	238, 747	238, 747	11. 00
Additional payment for high percentage of ESRD beneficiary discharges	11. 01	,	36, 00	813, 691	0	643, 935	169, 756	813. 691	11. 01
13.00 Subtotal (see instructions) 47.00 14,553,250 0 643,935 13,909,315 14,553,250 13.00 14.00 Hospital specific payments 48.00 0 0 0 0 0 14.00 (completed by SCH and MDH, small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient operating costs (see instructions) 16.00 Payment for inpatient program capital 17.00 Special add-on payments for new technologies 17.01 Net organ aquisition cost 55.00 0 0 0 0 0 0 17.00 17.01 Net organ aquisition cost 55.00 0 0 0 0 0 0 0 17.02 Capital received from manufacturers for replaced devices for applicable MS-DRGs 23.00 0 0 0 0 0 0 0 18.00 18.00 Subtotal (see instructions) 14,553,250 0 643,935 13,909,315 14,553,250 15.00 14.00 643,935 13,909,315 14,553,250 15.00 15.00 643,935 13,909,315 14,553,250 15.00 15.00 643,935 13,909,315 14,553,250 15.00 15.00 0 0 0 0 0 0 0 0 17.01 0 0 0 0 0 0 0 0 17.02 0 0 0 0 0 0 0 17.03 0 0 0 0 0 0 0 18.00 0 0 0 0 0 0 18.00 0 0 0 0 0 0 18.00 0 0 0 0 0 18.00 0 0 0 0 0 18.00 0 0 0 0 0 18.00 0 0 0 0 18.00 0 0 0 0 18.00 0 0 0 0 18.00 0 0 0 0 18.00 0 0 0 0 18.00 0 0 0 18.00 0 0 0 18.00 0 0 0 18.00 0 0 0 18.00 0 0 0 18.00 0 0 0 18.00 0 0 0 18.00 0 0 0 18.00 0 0 0 18.00 0 0 18.00 0 0 18.00 0 0 0 18.00 0 0 0 18.00 0 0 18.00 0 0 0 18.00 0 0 0 18.00 0 0 0 18.00 0 0 0 18.00 0 0 0 18.00 0 0 0 18.00 0 0 0 18.00 0 0 0 18.00 0 0 0 18.00 0 0 0 18.00 0 0 0 18.00 0 0 0 18.00 0 0 0 18.00 0 0 0		Additional payment for high per	centage of ESF			·			
13.00 Subtotal (see instructions) 47.00	12.00		46. 00	0	0	0	0	0	12. 00
14.00 (completed by SCH and MDH, small rural hospitals only.) (see instructions) 48.00 0 0 0 0 0 0 14.00 15.00 Total payment for inpatient operating costs (see instructions) 49.00 14,553,250 0 643,935 13,909,315 14,553,250 15.00 16.00 Payment for inpatient program capital 50.00 1,098,448 0 0 1,098,448 1,098,448 1,098,448 1,098,448 16.00 17.00 Special add-on payments for new technologies 54.00 0 0 0 0 0 0 0 17.00 17.01 Net organ aquisition cost devices for applicable MS-DRGs 68.00 0 0 0 0 0 0 0 0 0 17.02 18.00 daystment amount (see 93.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 18.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	13 00	(see Instructions)	47 00	14 553 250	0	643 935	13 909 315	14 553 250	13 00
Small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient 49.00 14,553,250 0 643,935 13,909,315 14,553,250 15.00 operating costs (see instructions) 16.00 Payment for inpatient program 50.00 1,098,448 0 0 1,098,448 1,098,448 16.00 capital 17.00 Special add-on payments for new technologies 17.01 Net organ aquisition cost 55.00 0 0 0 0 0 0 17.01 17.02 Capital received from 68.00 0 0 0 0 0 17.02 manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation 93.00 0 0 0 0 0 18.00 0 0 0 0 0 0 0 0 0				0	Ö	0 10, 700	0		1
(see instructions) Total payment for inpatient operating costs (see instructions) 16.00 Payment for inpatient program capital 17.00 Special add-on payments for new technologies 18.00 Capital received from manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment amount (see									
15.00 Total payment for inpatient operating costs (see instructions) 16.00 Payment for inpatient program capital 17.00 Special add-on payments for new technologies 17.01 Net organ aquisition cost capital received from manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment amount (see		, ,							
16.00 Payment for inpatient program 50.00 1,098,448 0 0 1,098,448 1,098,448 16.00 17.00 17.00 17.00 17.01 17.02 17.02 17.02 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00	15. 00		49. 00	14, 553, 250	0	643, 935	13, 909, 315	14, 553, 250	15. 00
16.00 Payment for inpatient program capital 50.00 1,098,448 0 0 1,098,448 1,098,448 16.00 17.00 Special add-on payments for new technologies 54.00 0 0 0 0 0 0 0 0 17.01 17.01 Net organ aquisition cost manufacturers for replaced devices for applicable MS-DRGs 68.00 0 0 0 0 0 0 0 0 17.02 18.00 Capital outlier reconciliation adjustment amount (see 93.00 0 0 0 0 0 0 0 0 0 18.00		operating costs (see							
Capital	1/ 00		FO 00	1 000 440	0	0	1 000 440	1 000 440	14 00
17. 00 Special add-on payments for new technologies 54.00 0 0 0 0 0 0 0 0 17.00 17. 01 Net organ aquisition cost 55.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 <td>10.00</td> <td></td> <td>50.00</td> <td>1, 098, 448</td> <td>0</td> <td>0</td> <td>1, 098, 448</td> <td>i, 098, 448</td> <td>10.00</td>	10.00		50.00	1, 098, 448	0	0	1, 098, 448	i, 098, 448	10.00
17. 01 Net organ aquisition cost 55. 00 0 0 0 0 0 0 17. 01 17. 02 Capital received from manufacturers for replaced devices for applicable MS-DRGs 68. 00 0 0 0 0 0 0 0 0 18. 00 0 0 0 0 0 0 0 0 0 18. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	17. 00		54. 00	o	0	0	o	О	17. 00
17.02 Capital received from manufacturers for replaced devices for applicable MS-DRGs Capital outlier reconciliation adjustment amount (see	4=	new technologies							
manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment amount (see					0	0	0		
devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment amount (see	17.02		00.00			Ü			17.02
adjustment amount (see		devices for applicable MS-DRGs							
	18. 00		93. 00	0	0	0	0	0	18. 00
		adjustment amount (see instructions)							
					ı .			•	•

							o 12/31/2014		pared:
					Ti tl	e XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from	Pre/	Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Enti tl	lement	to 10/01	On/After 10/01	through 4)	
		0	1.00	2.	00	3.00	4. 00	5. 00	
19.00	SUBTOTAL				0	643, 935	15, 007, 763	15, 651, 698	19. 00
		W/S L, line	(Amounts from						
			L)						
		0	1.00		00	3.00	4. 00	5. 00	
20.00	Capital DRG other than outlier	1. 00	1, 055, 996		0	(1, 055, 996	1, 055, 996	20. 00
20. 01	Model 4 BPCI Capital DRG other	1. 01	0		0	(0	0	20. 01
	than outlier								
	Capital DRG outlier payments	2. 00	42, 452		0	(42, 452	42, 452	21. 00
21. 01	Model 4 BPCI Capital DRG	2. 01	0		0	(0	0	21. 01
	outlier payments								
22.00	Indirect medical education	5. 00	0.0000		0.0000	0.0000	0. 0000		22. 00
	percentage (see instructions)								
23. 00	Indirect medical education	6. 00	0		0	(0	0	23. 00
	adjustment (see instructions)								
24.00	Allowable disproportionate	10. 00	0. 0000		0.0000	0.0000	0.0000		24. 00
	share percentage (see								
	instructions)								
25. 00	Di sproporti onate share	11. 00	0		0	(0	0	25. 00
	adjustment (see instructions)				_				
26. 00	Total prospective capital	12. 00	1, 098, 448		0	(1, 098, 448	1, 098, 448	26. 00
	payments (see instructions)								
			(Amounts to E,						
		line 0	Part A) 1.00	_	00	3.00	4. 00	5. 00	
27.00		U	1.00	2.	00			5.00	27.00
27. 00	Low volume adjustment factor	70.0/				0.000000	0. 000000	•	27. 00
28. 00	Low volume adjustment	70. 96				()	0	28. 00
	(transfer amount to Wkst. E,								
20.00	Pt. A, line)	70.07					0	0	20.00
29. 00	Low volume adjustment	70. 97					0	U	29. 00
	(transfer amount to Wkst. E,								
100.00	Pt. A, line)		Y						100. 00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		ļ ^Ÿ						100.00
	aujustiiietits to wkst. E, Pt. A.	I	1	I		I	1		I

HOSPI T	TAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provi der	F	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Exhibi Date/Time Pre 5/29/2015 8:5	pared:
			Titl	e XVIII	Hospi tal	PPS	/ aiii
		Wkst. E, Pt.	Amt. from	Period to	Peri od on	Total (cols. 2	
		A, line	Wkst. E, Pt. A)	10/01	after 10/01	and 3)	
		0	1.00	2.00	3. 00	4. 00	
1.00	DRG amounts other than outlier payments	1.00					1. 00
1.01	DRG amounts other than outlier payments for	1. 01	0	C)	0	1. 01
	discharges occurring prior to October 1						
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	13, 282, 160		13, 282, 160	13, 282, 160	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1.03	0	C)	0	1. 03
1. 04	1 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after	1. 04	0		0	0	1. 04
0.00	October 1	0.00	040 (50		040 (50	040 (50	0.00
2. 00	Outlier payments for discharges (see instructions)	2.00	218, 652	(218, 652		
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	(0	0	2. 01
3.00	Operating outlier reconciliation	2. 01	0	C	0	0	3. 00
4.00	Managed care simulated payments	3.00	0	(0	0	4. 00
г оо	Indirect Medical Education Adjustment	21.00	0.000000	0.00000	0.00000		F 00
5. 00	Amount from Worksheet E, Part A, line 21 (see instructions)	21. 00	0. 000000	0. 000000	0.000000		5. 00
6. 00	IME payment adjustment (see instructions)	22. 00	0	C	0	0	6. 00
6. 01	IME payment adjustment for managed care (see	22. 01	0	Ċ	0	0	6. 01
	instructions)						
	Indirect Medical Education Adjustment for the						
7. 00	IME payment adjustment factor (see instructions)	27. 00	0. 000000	0. 000000	0. 000000		7. 00
8.00	IME adjustment (see instructions)	28. 00	0	C	0	0	8. 00
8. 01	IME payment adjustment add on for managed care (see instructions)	28. 01	0	(0	0	8. 01
9.00	Total IME payment (sum of lines 6 and 8)	29. 00	0	C	0	0	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	0	(0	0	9. 01
	Di sproporti onate Share Adjustment						
10. 00	1 1 1 1 3	33. 00	0. 0719	0. 0719	0. 0719		10. 00
11. 00	(see instructions) Disproportionate share adjustment (see	34. 00	238, 747	(238, 747	238, 747	11. 00
	instructions)						
11. 01	Uncompensated care payments	36.00	813, 691	643, 935	169, 756	813, 691	11. 01
10.00	Additional payment for high percentage of ESR		discharges				10.00
12. 00	Total ESRD additional payment (see instructions)	46. 00	0	C	0	0	12. 00
13. 00	Subtotal (see instructions)	47. 00	14, 553, 250	643, 935	13, 909, 315	14, 553, 250	13. 00
14. 00	Hospital specific payments (completed by SCH	48. 00	0	0 10, 700	0	0	14. 00
	and MDH, small rural hospitals only.) (see						
15 00	instructions)	40.00	14 552 250	643, 935	13, 909, 315	14 552 250	15 00
15. 00	(see instructions)	49. 00	14, 553, 250	043, 935			
16.00	Payment for inpatient program capital	50.00	1, 098, 448	(1, 098, 448	l	
17. 00	Special add-on payments for new technologies	54.00	0		0	0	
17. 01 17. 02	Net organ aquisition cost	55. 00 68. 00	0	(0	
17.02	Capital received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0			0	17. 02
18. 00	Capital outlier reconciliation adjustment	93. 00	0	C	0	0	18. 00
19 00	amount (see instructions) SUBTOTAL			643, 935	15, 007, 763	15, 651, 698	19.00
00	1	1	1	3.5,700			

Heal th	Financial Systems	DEARBORN COUN	ITY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	ATION EXHIBIT 5	Provi der		Period: From 01/01/2014 Fo 12/31/2014	Worksheet E Part A Exhibi Date/Time Pre 5/29/2015 8:5	pared:
			Ti tl	e XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2. 00	3. 00	4. 00	
20.00	Capital DRG other than outlier	1.00	1, 055, 996	(1, 055, 996	1, 055, 996	20. 00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	(0	0	20. 01
21.00	Capital DRG outlier payments	2.00	42, 452	(42, 452	42, 452	21. 00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	(0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0.0000	0.0000	0.0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	(0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0. 0000	0.0000		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11.00	0	(0	0	25. 00
26. 00	Total prospective capital payments (see instructions)	12.00	1, 098, 448	(1, 098, 448	1, 098, 448	26. 00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3. 00	4. 00	
27. 00							27. 00
28. 00	Low volume adjustment prior to October 1	70. 96	0	()	0	28. 00
29.00	Low volume adjustment on or after October 1	70. 97	0		0	0	29. 00
30.00	HVBP payment adjustment (see instructions)	70. 93	13, 558	(13, 558	13, 558	30. 00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0		0	0	30. 01
31.00	HRR adjustment (see instructions)	70. 94	-51, 339		-51, 339	-51, 339	31. 00
31. 01	HRR adjustment for HSP bonus payment (see	70. 91	0	(0	0	31. 01

0

70. 99

100.00

0 32. 00

(Amt. to Wkst. E, Pt. A) 4.00

3. 00

2.00

1.00

Ν

instructions)

32.00 HAC Reduction Program adjustment (see

instructions)

100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.

Health Financial Systems	DEARBORN COUNTY HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150086	Peri od: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 5/29/2015 8:57 am

			10 12/31/2014	5/29/2015 8:5	
		Title XVIII	Hospi tal	PPS	/ alli
		THE XVIII	nospi tui	113	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			3, 048	1. 00
2.00	Medical and other services reimbursed under OPPS (see instructi	ons)		7, 814, 460	2. 00
3.00	PPS payments			6, 510, 869	3. 00
4.00	Outlier payment (see instructions)			9, 860	4. 00
5.00	Enter the hospital specific payment to cost ratio (see instruct	i ons)		0.000	5. 00
6.00	Line 2 times line 5			0	6. 00
7.00	Sum of line 3 plus line 4 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 acqui si ti ons			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			3, 048	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e charges				
12. 00	Ancillary service charges			11, 445	1
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, co	1. 4)		0	
14. 00	Total reasonable charges (sum of lines 12 and 13)			11, 445	14.00
45.00	Customary charges				1 45 00
15. 00	Aggregate amount actually collected from patients liable for pa			0	
16. 00	Amounts that would have been realized from patients liable for		a chargebasis	0	16. 00
17 00	had such payment been made in accordance with 42 CFR §413.13(e)			0.000000	17.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	•
18. 00 19. 00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete only	if line 10 evenede line	. 11) (000	11, 445	1
19.00	instructions)	IT TITLE TO EXCEEDS TITLE	; II) (See	8, 397	19. 00
20. 00	Excess of reasonable cost over customary charges (complete only	if line 11 evceeds line	18) (500	0	20. 00
20.00	instructions)	TI TITLE TI EXCECUS TITLE	, 10) (300		20.00
21. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		3, 048	21. 00
22. 00	Interns and residents (see instructions)	,		0	1
23. 00	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)	,		6, 520, 729	•
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			.,	
25.00	Deductibles and coinsurance (for CAH, see instructions)			1, 864	25. 00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for	CAH, see instructions)		1, 450, 838	26. 00
27. 00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) pl	us the sum of lines 22 a	and 23} (for	5, 071, 075	27. 00
	CAH, see instructions)				
28. 00	Direct graduate medical education payments (from Wkst. E-4, lin	e 50)		0	
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
30.00	Subtotal (sum of lines 27 through 29)			5, 071, 075	1
31. 00	Primary payer payments			7, 357	1
32. 00	Subtotal (line 30 minus line 31)	6)		5, 063, 718	32. 00
33. 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE: Composite rate ESRD (from Wkst. I-5, line 11)	3)		0	33. 00
34. 00	Allowable bad debts (see instructions)			150, 392	ł
35. 00	Adjusted reimbursable bad debts (see instructions)			97, 755	1
36. 00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		58, 842	ł
37. 00	Subtotal (see instructions)	011 0113)		5, 161, 473	
	MSP-LCC reconciliation amount from PS&R				38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	•
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			Ö	
39. 98	Partial or full credits received from manufacturers for replace	d devices (see instructi	ons)	Ö	
39. 99	RECOVERY OF ACCELERATED DEPRECIATION		,	0	1
40. 00	Subtotal (see instructions)			5, 161, 667	1
40. 01	Seguestration adjustment (see instructions)			103, 233	•
41.00	Interim payments			5, 084, 454	
42.00	Tentative settlement (for contractors use only)			0	
43.00	Balance due provider/program (see instructions)			-26, 020	43. 00
44.00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2, ch	napter 1,	0	1
	§115. 2				
	TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0	•
91. 00	Outlier reconciliation adjustment amount (see instructions)			0	•
	The rate used to calculate the Time Value of Money				92.00
93. 00	Time Value of Money (see instructions)			0	•
94.00	Total (sum of lines 91 and 93)		I	ا (ا	94. 00

Health Financial Systems DEA ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Peri od: Worksheet E-1
From 01/01/2014 Part I
To 12/31/2014 Date/Time Prepared: 5/29/2015 8:57 am Provi der CCN: 150086

					5/29/2015 8:5	7 am
			e XVIII	Hospi tal	PPS	
		·	nt Part A	Par	⁻t 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		13, 752, 989		4, 964, 061	1.00
2.00	Interim payments payable on individual bills, either		0		0	2. 00
	submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
3.00	amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	12/31/2014	82, 636	12/31/2014	120, 393	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 3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		~		0 120, 393	3. 54 3. 99
3. 99	3. 50-3. 98)		82, 636		120, 393	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		13, 835, 625		5, 084, 454	4. 00
1. 00	(transfer to Wkst. E or Wkst. E-3, line and column as		10,000,020		0,001,101	1. 00
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider		_		T	
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02			0		0	5. 02
5. 03	Dravi dan ta Dragram		0		0	5. 03
5. 50	Provider to Program TENTATIVE TO PROGRAM		1 0		0	5. 50
5. 50	TENTATI VE TO FROGRAM		0			5. 50
5. 52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		0		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		115, 929		26, 020	6. 02
7. 00	Total Medicare program liability (see instructions)		13, 719, 696	_	5, 058, 434	7. 00
				Contractor	NPR Date	
			0	Number	(Mo/Day/Yr)	
8. 00	Name of Contractor		U	1. 00	2. 00	8. 00
0.00	Inalie of Contractor				1 1	0.00

Heal th	Financial Systems DEARBORN COUNTY H	HOSPI TAL	In Lie	u of Form CMS-2	2552-10			
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 150086	Peri od: From 01/01/2014	Worksheet E-1 Part II				
			To 12/31/2014		pared:			
				5/29/2015 8:5	7 am			
		Title XVIII	Hospi tal	PPS				
				1. 00				
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD 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 4,364							
2.00	00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12 7,833							
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			1, 633	3.00			
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-	12		15, 558	4. 00			
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			195, 092, 640	5. 00			
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 lin	ne 20		2, 012, 704	6. 00			
7.00	CAH only - The reasonable cost incurred for the purchase of cel	rtified HIT technology	Wkst. S-2, Pt. I	0	7. 00			
	line 168	-						
8.00	Calculation of the HIT incentive payment (see instructions)			812, 458	8. 00			
9.00	Sequestration adjustment amount (see instructions)			16, 249	9. 00			
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		796, 209	10.00			
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH	-						
30.00	Initial/interim HIT payment adjustment (see instructions)			742, 025	30.00			
	Other Adjustment (specify)			0	31. 00			
22.00	20 Delegans due provider (Line 9 (ex line 10) minus line 20 and line 21) (cos instructions)							

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

742, 025 30. 00 0 31. 00 54, 184 32. 00 742, 025

Health Financial Systems	DEARBORN COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150086	Peri od: Worksheet E-3 From 01/01/2014 Part VII To 12/31/2014 Date/Time Prepared:

			10 12/31/2014	5/29/2015 8:5	
		Title XIX	Hospi tal	Cost	
			Inpati ent	Outpati ent	
			1. 00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	ICES FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		2, 319, 970		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		o		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		2, 319, 970	0	4.00
5.00	Inpatient primary payer payments		0		5. 00
6.00	Outpatient primary payer payments			0	6. 00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		2, 319, 970	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
8.00	Routine service charges		1, 246, 804		8. 00
9.00	Ancillary service charges		4, 009, 758	0	
10. 00	Organ acquisition charges, net of revenue		0		10.00
11. 00	Incentive from target amount computation		0		11. 00
12. 00	Total reasonable charges (sum of lines 8 through 11)		5, 256, 562	0	12. 00
	CUSTOMARY CHARGES	 			
13. 00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
14 00	basis			0	14 00
14. 00	Amounts that would have been realized from patients liable for		0	0	14. 00
15. 00	a charge basis had such payment been made in accordance with 42 Ratio of line 13 to line 14 (not to exceed 1.000000)	CFR 9413. 13(e)	0. 000000	0. 000000	15. 00
16. 00	Total customary charges (see instructions)		5, 256, 562	0.000000	1
17. 00	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds	2, 936, 592	0	
17.00	line 4) (see instructions)	IT TITLE TO EXCEEDS	2, 730, 372	O	17.00
18. 00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds line	0	0	18.00
.0.00	16) (see instructions)	The readed tries		ŭ	
19.00	Interns and Residents (see instructions)		o	0	19.00
20.00		ctions)	o	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	2, 319, 970	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co	ompleted for PPS provid	ers.		
22.00	Other than outlier payments		0	0	22. 00
23.00	Outlier payments		0	0	23. 00
24. 00			0		24. 00
	Capital exception payments (see instructions)		0		25. 00
	Routine and Ancillary service other pass through costs		0	0	
	Subtotal (sum of lines 22 through 26)		0	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	
29. 00	Titles V or XIX (sum of lines 21 and 27)		2, 319, 970	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		1		
30.00	Excess of reasonable cost (from line 18)		0 010 070	0	
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		2, 319, 970	0	
32.00	Deducti bl es		١	0	
33.00			0	0	
35.00	Allowable bad debts (see instructions) Utilization review		0	U	34. 00 35. 00
36. 00		22)	2, 319, 970	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	2, 317, 770	0		
	Subtotal (line 36 ± line 37)	2, 319, 970	0		
	Direct graduate medical education payments (from Wkst. E-4)	2, 317, 770	O	39.00	
	Total amount payable to the provider (sum of lines 38 and 39)	2, 319, 970	0	1	
41. 00	Interim payments	3, 318, 240	0	1	
42. 00	Balance due provider/program (line 40 minus line 41)	-998, 270	0		
43. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub 15-2.	0	0	
	chapter 1, §115.2			ŭ	
	1 1		'		•

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

Provi der CCN: 150086

Peri od: Worksheet G From 01/01/2014 To 12/31/2014 Date/Time Prepared: 5/29/2015 8:57 am

			''	0 12/31/2014	5/29/2015 8:5	
		General Fund	Speci fi c	Endowment Fund	Plant Fund	
			Purpose Fund			
	AUDDENT ACCETO	1.00	2.00	3. 00	4. 00	
1. 00	CURRENT ASSETS Cash on hand in banks	4 710 E24	0	O	0	1. 00
2.00	Temporary investments	6, 718, 536	_	0	0	2. 00
3. 00	Notes receivable	0		0	0	3. 00
4. 00	Accounts receivable	13, 755, 142	1	o	0	4. 00
5. 00	Other recei vable	0	Ō	0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6. 00
7.00	Inventory	1, 387, 698	0	0	0	7. 00
8.00	Prepai d expenses	0	0	0	0	8. 00
9.00	Other current assets	56, 277, 089		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)	78, 138, 465	0	0	0	11. 00
12 00	FI XED ASSETS Land	75, 208	0	O	0	12. 00
12. 00 13. 00	Land improvements	1, 514, 521		0	0	13. 00
14. 00	Accumulated depreciation	-1, 099, 588		0	0	14. 00
15. 00	Buildings	64, 207, 670		ő	0	15. 00
16. 00	Accumulated depreciation	-35, 972, 270		0	0	16. 00
17. 00	Leasehold improvements	0	0	0	0	17. 00
18.00	Accumul ated depreciation	0	0	0	0	18.00
19. 00	Fi xed equi pment	0	0	0	0	19. 00
20. 00	Accumulated depreciation	0	0	0	0	20. 00
21. 00	Automobiles and trucks	0	0	0	0	21. 00
22. 00	Accumulated depreciation	0	0	0	0	22. 00
23. 00	Maj or movable equipment	47, 002, 013		0	0	23. 00
24. 00	Accumulated depreciation Minor equipment depreciable	-37, 672, 024	0	0	0	24. 00 25. 00
25. 00 26. 00	Accumulated depreciation	0		0	0	26. 00
27. 00	HIT designated Assets		0	0	0	27. 00
28. 00	Accumulated depreciation	0	Ö	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	Ö	Ö	o	0	29. 00
30.00	Total fixed assets (sum of lines 12-29)	38, 055, 530	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	10, 675, 553		0	0	34. 00
35. 00	Total other assets (sum of lines 31-34)	10, 675, 553		0	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	126, 869, 548	0	U U	0	36. 00
37. 00	Accounts payable	1, 743, 582	0	0	0	37. 00
38. 00	Salaries, wages, and fees payable	5, 388, 004		0	0	38. 00
39. 00	Payroll taxes payable	0,000,001	0	Ö	0	39. 00
40. 00	Notes and Loans payable (short term)	500, 000	Ō	0	0	40. 00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accel erated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44. 00	Other current liabilities	1, 674, 223			0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	9, 305, 809	0	0	0	45. 00
47 00	LONG TERM LIABILITIES		1 0	ام	0	47.00
46. 00	Mortgage payable Notes payable	0		0	0	46. 00 47. 00
47. 00 48. 00	Unsecured Loans			0	0	48. 00
49. 00	Other long term liabilities	27, 000, 000	1	0	0	49. 00
50. 00	Total long term liabilities (sum of lines 46 thru 49	27, 000, 000		o	0	50.00
51. 00	Total liabilites (sum of lines 45 and 50)	36, 305, 809		· ·	0	51. 00
	CAPITAL ACCOUNTS	,		-,		
52.00	General fund balance	90, 563, 739				52. 00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56. 00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant				0	57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
59. 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	90, 563, 739	0	0	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	126, 869, 548		0	0	
55. 55	59)	.23,007,040			O	55. 55
				'		

In Lieu of Form CMS-2552-10 Health Financial Systems DEARBORN COUNTY HOSPITAL STATEMENT OF CHANGES IN FUND BALANCES Provider CCN: 150086 Peri od: Worksheet G-1 From 01/01/2014 12/31/2014 Date/Time Prepared: 5/29/2015 8:57 am 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 89, 846, 025 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 717, 714 2.00 3.00 Total (sum of line 1 and line 2) 90, 563, 739 0 3.00 4.00 0 Additions (credit adjustments) (specify) 0 4.00 0 0 0 0 5.00 0 5.00 6.00 6.00 0 7.00 0 7.00 0 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 10.00 90, 563, 739 Subtotal (line 3 plus line 10) 11.00 0 11.00 12.00 Deductions (debit adjustments) (specify) 12.00 00000 13.00 13.00 14.00 14.00 0 15.00 0 15.00 16.00 16.00 17.00 17.00 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance 90, 563, 739 19.00 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 Total (sum of line 1 and line 2) 3.00 0 0 3.00 4.00 Additions (credit adjustments) (specify) 4.00 5.00 0 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 10.00 11.00 0 Subtotal (line 3 plus line 10) 0 11.00 12.00 Deductions (debit adjustments) (specify) 12.00 13.00 13.00

0

0

0 0 14.00

15.00

16.00

17.00

18.00

19.00

14.00

15.00 16.00

17.00

18.00

19.00

Total deductions (sum of lines 12-17)

sheet (line 11 minus line 18)

Fund balance at end of period per balance

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provi der CCN: 150086

Cost Center Description Inpatient Outpatient	/29/2015 8: 57 Total	diii
1.00 2.00	3. 00	
PART I - PATIENT REVENUES		
General Inpatient Routine Services		
1.00 Hospi tal 15, 363, 308	15, 363, 308	1.00
2. 00 SUBPROVI DER - I PF		2.00
3.00 SUBPROVI DER - I RF		3.00
4. 00 SUBPROVI DER		4.00
5.00 Swing bed - SNF 0	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) 15,363,308	15, 363, 308	10.00
Intensive Care Type Inpatient Hospital Services		
11. 00 I NTENSI VE CARE UNI T 3, 224, 652	3, 224, 652	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 3,224,652	3, 224, 652	16. 00
[11-15]		
17.00 Total inpatient routine care services (sum of lines 10 and 16)	18, 587, 960	17. 00
	167, 149, 331	18. 00
19.00 Outpati ent_services	8, 945, 644	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 1, 839, 637	1, 839, 637	22. 00
23. 00 AMBULANCE SERVICES		23. 00
24. 00 CMHC		24. 00
25. 00 AMBULATORY SURGICAL CENTER (D. P.) 26. 00 HOSPICE 0 793, 852	793. 852	25. 00 26. 00
26. 00 HOSPI CE 27. 00 PRO FEES 0 793, 852 46, 418 150, 544	196, 962	26.00
	197, 513, 386	28. 00
G-3, line 1)	197, 313, 300	20.00
PART II - OPERATING EXPENSES		
29.00 Operating expenses (per Wkst. A, column 3, line 200) 84,356,961		29. 00
30. 00 ADD (SPECIFY)		30.00
31.00		31. 00
32.00		32. 00
33.00		33. 00
34.00		34. 00
35. 00		35. 00
36.00 Total additions (sum of lines 30-35)		36. 00
37. 00 DEDUCT (SPECIFY)		37. 00
38.00		38. 00
39.00		39.00
40.00		40.00
41. 00		41.00
42.00 Total deductions (sum of lines 37-41)		42.00
43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 84,356,961		43.00
to Wkst. G-3, line 4)		

	Financial Systems	DEARBORN COUNTY HO			u of Form CMS-2	
STATE	MENT OF REVENUES AND EXPENSES		Provider CCN: 150086	Peri od:	Worksheet G-3	
				From 01/01/2014 To 12/31/2014	Date/Time Pre	nared:
				10 12/31/2014	5/29/2015 8: 5	
					1.00	
1.00	Total patient revenues (from Wkst. G-2, Par		8)		197, 513, 386	
2.00	Less contractual allowances and discounts of	n patients' accounts			118, 155, 500	
3.00	Net patient revenues (line 1 minus line 2)				79, 357, 886	
4.00	Less total operating expenses (from Wkst. G	-2, Part II, line 43)			84, 356, 961	4.00
5.00	Net income from service to patients (line 3	minus line 4)			-4, 999, 075	5.00
	OTHER INCOME					
6.00	Contributions, donations, bequests, etc				0	
7.00	Income from investments				0	
8.00	Revenues from telephone and other miscelland	eous communication se	rvi ces		0	
9.00	Revenue from television and radio service				0	
10.00	Purchase di scounts				0	10.00
	Rebates and refunds of expenses				0	
					0	12. 00
13.00	Revenue from Laundry and Linen service				0	
14.00	Revenue from meals sold to employees and gue	ests			0	14. 00
15.00	Revenue from rental of living quarters				0	15. 00
16.00	Revenue from sale of medical and surgical sa	upplies to other than	pati ents		0	16. 00
17.00	Revenue from sale of drugs to other than par	tients			0	17. 00
18.00	Revenue from sale of medical records and abs	stracts			0	18. 00
19.00	Tuition (fees, sale of textbooks, uniforms,	etc.)			0	19. 00
20.00	Revenue from gifts, flowers, coffee shops, a	and canteen			0	20.00
21.00	Rental of vending machines				0	21. 00
22.00	Rental of hospital space				0	22. 00
23.00	Governmental appropriations				0	23. 00
24.00	OTHER INCOME				3, 136, 338	24.00
24.01	INVESTMENT INCOME				2, 641, 833	24. 01
24.02	GAIN ON DISPOSAL				5, 894	24. 02
24.03	MISC INCOME				2, 401	24. 03
25.00	Total other income (sum of lines 6-24)				5, 786, 466	25. 00
26.00	Total (line 5 plus line 25)				787, 391	26. 00
27.00	OTHER LOSS				69, 677	27. 00
28 00	Total other expenses (sum of line 27 and sul	hscrints)			69 677	28 00

69, 677 28. 00 717, 714 29. 00

28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

	HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	0	662, 936	0	662, 936	6. (00
7.00	Physi cal Therapy	0	109, 109	0	109, 109	7. (00
8.00	Occupational Therapy	0	39, 740	0	39, 740	8.0	00
9.00	Speech Pathology	0	16, 236	0	16, 236	9. (00
10.00	Medical Social Services	0	19, 717	0	19, 717	10.0	00
11.00	Home Health Aide	0	56, 784	0	56, 784	11. (00
12.00	Supplies (see instructions)	0	0	0	0	12. (00
13.00	Drugs	0	0	0	0	13.0	00
14.00	DME	0	0	0	0	14. (00
	HHA NONREI MBURSABLE SERVI CES						
15.00	Home Dialysis Aide Services	0	0	0	0	15. (00
16. 00	Respiratory Therapy	0	0	0	0	16. (
17. 00	Private Duty Nursing	0	0	0	0	17. (
18. 00	Clinic	0	0	0	0	18. (
19. 00	Health Promotion Activities	0	0	0	0	19. (00
20.00	Day Care Program	0	0	0	0	20.0	00
21. 00	1	0	0	0	0	21. (
22. 00	Homemaker Service	0	339	0	339	22.0	00
23.00	All Others (specify)	0	0	0	0	23.0	00
24.00	Total (sum of lines 1-23)	-13, 231	1, 218, 522	0	1, 218, 522	24.0	00

		for Cost Allocation (from Wkst. H, col. 10)	BI dgs & Fi xtures	Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1. 00	2. 00	3.00	4. 00	4A. 00	
1. 00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &	0	0				0	1.00
2. 00	Fixtures Capital Related - Movable			0			0	2. 00
2.00	Equipment			0			U	2.00
3.00	Plant Operation & Maintenance	0	0	0			0	3.00
4. 00 5. 00	Transportation Administrative and General	313, 661	0	0		_	313, 661	4. 00 5. 00
	HHA REIMBURSABLE SERVICES							
6. 00 7. 00	Skilled Nursing Care Physical Therapy	662, 936 109, 109	0	0		_	662, 936 109, 109	1
8.00	Occupati onal Therapy	39, 740	0	0			39, 740	1
9.00	Speech Pathology	16, 236	0	0	0	0	16, 236	1
10.00	Medical Social Services	19, 717	0	0		0	19, 717	
11.00	Home Heal th Aide	56, 784	0	0		0	56, 784	1
12. 00 13. 00	Supplies (see instructions) Drugs	0	0	0			0	
14. 00	DME		0	0			0	1
	HHA NONREIMBURSABLE SERVICES	-	-			-1	·	
15. 00	Home Dialysis Aide Services	0	0	0			0	
16.00	Respiratory Therapy	0	0	0			0	
17.00	Private Duty Nursing Clinic		0	0	_		0	
19. 00	Health Promotion Activities		0	0		_	0	
20. 00	Day Care Program	O	0	0	Ō	0	0	1
21. 00	Home Delivered Meals Program	0	0	0	0	0	0	
22. 00	Homemaker Service	339	0	0	0	0	339	1
23. 00	All Others (specify)	1 210 522	0	0	•	_	1 210 522	23. 00
24. 00	Total (sum of lines 1-23)	1, 218, 522 Admi ni strati ve	Total (cols	0	0	U	1, 218, 522	24. 00
		& General	4A + 5)					
	GENERAL SERVICE COST CENTERS	5. 00	6. 00					
1.00	Capi tal Related - Bldg. &							1.00
	Fixtures							
2. 00	Capital Related - Movable Equipment							2. 00
3.00	Plant Operation & Maintenance							3. 00
4.00	Transportation							4. 00
5.00	Administrative and General HHA REIMBURSABLE SERVICES	313, 661						5. 00
6.00	Skilled Nursing Care	229, 799	892, 735					6.00
7. 00	Physical Therapy	37, 822	146, 931					7. 00
8.00	Occupational Therapy	13, 775	53, 515					8. 00
9.00	Speech Pathology	5, 628	21, 864					9. 00
10.00	Medical Social Services	6, 835	26, 552 74, 449					10.00
11.00	Home Health Aide Supplies (see instructions)	19, 684 0	76, 468 0					11. 00 12. 00
13. 00	Drugs	l ő	o					13. 00
14.00	DME	0	0					14. 00
	HHA NONREI MBURSABLE SERVI CES							
15. 00	1	0	0					15. 00
16. 00 17. 00	Respiratory Therapy Private Duty Nursing	0	0					16. 00 17. 00
	Clinic		Ö					18. 00
19. 00	Health Promotion Activities		0					19. 00
	Day Care Program	0	0					20. 00
	Home Delivered Meals Program	0	0					21. 00
	Homemaker Service	118	457					22. 00
	All Others (specify) Total (sum of lines 1-23)	0	0 1, 218, 522					23. 00 24. 00
_ 1. 00	1.1.1.2. (34 3	1	., 210, 022					

Health Financial Systems		DEARBORN COUN	TY HOSPITAL		In Lie	eu of Form CMS-:	2552-10
COST ALLOCATION - HHA STATISTICAL BAS	SI S		Provi de	er CCN: 150086	Peri od: From 01/01/2014	Worksheet H-1	
			HHA CCI	I: 157055	To 12/31/2014	Date/Time Pre 5/29/2015 8:5	
					Home Health Agency I	PPS	
	Capital Re	ated Costs					
	BI dgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance	(MI LEAGE)	onReconciliation	Admi ni strati ve & General (ACCUM. COST)	
			(SQUARE FEE)			

		Capital Rel	ated Costs					
		DI dese 0	Marralala	DI+	T	D!!!-#!	A -l:: + + :	
		BIdgs & Fixtures	Movable Equi pment	Plant Operation &	(MI LEAGE)	Reconciliation	Administrative & General	
			(DOLLAR VALUE)	Maintenance	(MI LEAGE)		(ACCUM. COST)	
		(SQUARE TELT)	(DOLLAR VALUE)	(SQUARE FEET)			(ACCOM. COST)	
		1.00	2. 00	3.00	4. 00	5A. 00	5. 00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. &	0				0		1. 00
	Fixtures							
2.00	Capital Related - Movable		0			0		2. 00
	Equi pment							
3.00	Plant Operation & Maintenance	0	0	0		0		3. 00
4.00	Transportation (see	0	0	0	0			4.00
	instructions)							
5.00	Administrative and General	0	0	0	0	-313, 661	904, 861	5. 00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	662, 936	6. 00
7.00	Physi cal Therapy	0	0	0	0	0	109, 109	7. 00
8.00	Occupati onal Therapy	0	0	0	0	0	39, 740	8. 00
9.00	Speech Pathology	0	0	0	0	0	16, 236	9. 00
10.00	Medical Social Services	0	0	0	0	0	19, 717	
11. 00	Home Health Aide	0	0	0	0	0	56, 784	11. 00
12. 00	Supplies (see instructions)	0	0	0	0	0	0	
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15. 00	Home Dialysis Aide Services	0	0	0	0	0	0	
16. 00	Respiratory Therapy	0	0	0	0	0	0	16. 00
17. 00	Private Duty Nursing	0	0	0	0	0	0	17. 00
18. 00	Clinic	0	0	0	0	0	0	18. 00
19. 00	Health Promotion Activities	0	0	0	0	0	0	19. 00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21. 00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22. 00	Homemaker Service	0	0	0	0	0	339	22. 00
	All Others (specify)	0	0	0	0	0	0	23. 00
24.00	Total (sum of lines 1-23)	0	0	0	0	-313, 661	904, 861	24.00
25. 00	Cost To Be Allocated (per	0	0	0	0		313, 661	25. 00
	Worksheet H-1, Part I)							
26. 00	Unit Cost Multiplier	0. 000000	0. 000000	0. 000000	0. 000000		0. 346640	26. 00

Peri od: Worksheet H-2
From 01/01/2014 Part I
To 12/31/2014 Date/Time Prepared: 5/29/2015 8:57 am HHA CCN: 157055

							5/29/2015 8:5	7 am
						Home Health Agency I	PPS	
			CAPITAL REL	ATED COSTS				
	Cost Center Description	HHA Trial Balance (1)	NEW BLDG & FIXT	NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	COMMUNI CATI ONS	DATA PROCESSI NG	
		0	1.00	2. 00	4.00	5. 01	5. 02	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 000 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00	Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) (2)	0 892, 735 146, 931 53, 515 21, 864 26, 552 76, 468 0 0 0 0 0 0 0 0 0 0 0 0 0	35, 301 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25, 562 25, 562	388, 018 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2,062 0 0 0 0 0 0 0 0 0 0 0 0 0 0	83, 632 83, 632 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00
	6 decimal places. Cost Center Description	PURCHASI NG	ADMI TTI NG	CASHI ERI NG/ACC	Subtotal	OTHER	OPERATION OF	
		RECEIVING AND STORES		OUNTS RECEI VABLE		ADMINISTRATIVE AND GENERAL	PLANT	
		5. 03	5. 04	5. 05	5A. 05	5. 06	7. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 20. 00 21. 00	Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) (2)	2, 273 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	15, 366	892, 735 146, 931 53, 515 21, 864 26, 552 76, 468 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	41, 282 6, 794 2, 475 1, 011 1, 228 3, 536 0 0 0 0 0 0 0 0 0 0 0	102, 831 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00 20. 00 21. 00

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

From 01/01/2014 Part I HHA CCN: 157055 12/31/2014 Date/Time Prepared: 5/29/2015 8:57 am Home Health PPS Agency I LAUNDRY & NURSI NG CENTRAL Cost Center Description HOUSEKEEPI NG DI ETARY CAFETERI A LINEN SERVICE ADMI NI STRATI ON SERVICE & SUPPLY 8.00 9.00 10.00 13.00 11.00 14.00 Administrative and General 28, 755 1.00 0 0 2.00 Skilled Nursing Care 0 0 2.00 0 Physical Therapy 0 0 3.00 0 3.00 0 0 4.00 Occupational Therapy 4.00 Speech Pathology 0 0 0 5.00 000000000000 0 0 0 0 0 0 0 0 0 0 0 0 5.00 Medical Social Services 0 0 6.00 6.00 0 0 7.00 0 Home Health Aide 7.00 8.00 Supplies (see instructions) 0 0 8.00 9.00 Drugs 9.00 0 0 0 0 0 10 00 DMF 10 00 Home Dialysis Aide Services 0 0 11.00 11.00 12.00 Respiratory Therapy 12.00 0 13.00 Private Duty Nursing 0 13.00 0 Ω 14 00 Clinic 14 00 15.00 Health Promotion Activities 0 15.00 0 16.00 Day Care Program 0 0 16.00 0 17 00 Home Delivered Meals Program 17 00 18.00 Homemaker Service 18.00 19.00 All Others (specify) 0 19.00 20.00 Total (sum of lines 1-19) (2) 28, 755 20.00 Unit Cost Multiplier: column 21.00 21.00 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places Cost Center Description MEDI CAL PHARMACY SOCIAL SERVICE Subtotal Intern & Subtotal RECORDS & Residents Cost LI BRARY & Post Stepdown Adjustments 15. 00 16.00 17. 00 24. 00 25. 00 26. 00 1.00 Administrative and General 0 0 709, 335 709, 335 1.00 0 0 0 2.00 Skilled Nursing Care 934, 017 934, 017 2.00 0 3.00 Physical Therapy 00000000000000000 0 153, 725 0 153, 725 3.00 Occupational Therapy 0 4.00 0 55, 990 0 0 0 0 0 0 0 0 0 0 0 0 55, 990 4.00 0 22, 875 Speech Pathology 22, 875 5 00 Ω 5 00 6.00 Medical Social Services 0 27, 780 27, 780 6.00 7.00 Home Health Aide 80,004 80,004 7.00 0 0 0 8.00 Supplies (see instructions) 0 0 8.00 9.00 9.00 Drugs 0 0 10.00 DMF 0 10.00 0 11.00 Home Dialysis Aide Services 11.00

0

0

0

0

0

Ω

0

0

O

478

1, 984, 204

12.00

13.00

14.00

15.00

16.00

17 00

18.00

19.00

20.00

21.00

478

1, 984, 204

0 0 0

0

0

12.00

13.00

14.00

15.00

16.00

17.00

19.00

20.00

Clinic

Respiratory Therapy

Private Duty Nursing

Day Care Program

Homemaker Service

6 decimal places.

All Others (specify)

Health Promotion Activities

Home Delivered Meals Program

Total (sum of lines 1-19) (2)

Unit Cost Multiplier: column

26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to

⁽¹⁾ Column O, line 20 must agree with Wkst. A, column 7, line 101.

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

HHA CCN: 157055 То 12/31/2014 Date/Time Prepared: 5/29/2015 8:57 am

Home Health PPS Agency I Total HHA Cost Center Description Allocated HHA A&G (see Part Costs II) 27. 00 28. 00 1.00 Administrative and General 1.00 519, 685 1, 453, 702 2.00 Skilled Nursing Care 2.00 Physical Therapy 85, 532 239, 257 3.00 3.00 87, 143 4.00 Occupational Therapy 31, 153 4.00 5.00 Speech Pathology 12, 728 35, 603 5.00 6.00 Medical Social Services 15, 457 43, 237 6.00 124, 518 7.00 Home Health Aide 44, 514 7.00 8.00 Supplies (see instructions) 0 0 8.00 9.00 Drugs 0 000000 9.00 0 10.00 10.00 DMF 0 Home Dialysis Aide Services 11.00 11.00 12.00 Respiratory Therapy 12.00 Private Duty Nursing 13.00 13.00 0 14.00 14 00 Clinic 15.00 Health Promotion Activities 15.00 0 16.00 Day Care Program 0 16.00 0 Home Delivered Meals Program 17.00 17 00 18.00 Homemaker Service 266 744 18.00 19.00 All Others (specify) 0 19.00 Total (sum of lines 1-19) (2) 709, 335 20.00 20.00 1, 984, 204 Unit Cost Multiplier: column 21.00 21.00 0. 556398 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.

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

Peri od: Worksheet H-2
From 01/01/2014 Part II
To 12/31/2014 Date/Time Prepared: 5/29/2015 8:57 am

Home Heal th PPS HHA CCN: 157055

						Home Health Agency I	PPS	
		CAPITAL REL	ATED COSTS			Agency 1		
	Cost Center Description	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS	COMMUNI CATI ONS (PHONES)	DATA PROCESSING (DP EQUIPMENT)	PURCHASING RECEIVING AND STORES (SUPPLY	
				SALARI ES)			EXPENSE)	
1 00	Administrative and Consumb	1.00	2.00	4.00	5. 01	5. 02	5. 03	1 00
1. 00 2. 00	Administrative and General Skilled Nursing Care	3, 085 0	3, 085 0	1, 083, 422 0	•	40 0	36, 571 0	1. 00 2. 00
3.00	Physical Therapy	0	0	o o			0	3. 00
4. 00	Occupational Therapy	0	0	O			0	4. 00
5.00	Speech Pathology	0	0	O	1	_	0	5.00
6.00	Medical Social Services	0	0	0	1		0	6. 00
7.00	Home Heal th Aide	0	0	0	1		0	7. 00
8. 00 9. 00	Supplies (see instructions) Drugs	0	0	0	1		0	8. 00 9. 00
10. 00	DME	0	0	0	1	_	0	10. 00
11. 00	Home Dialysis Aide Services	o o	0	O			0	11. 00
12.00	Respiratory Therapy	0	0	O	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0			0	13.00
14.00	Clinic	0	0	0	1		0	14.00
15. 00 16. 00	Health Promotion Activities Day Care Program	0	0	0			0	15. 00 16. 00
17. 00	Home Delivered Meals Program	0	0	0		0	0	17. 00
18. 00	Homemaker Service	Ö	0	O	Ö	0	o	18. 00
19. 00	All Others (specify)	0	0	O	0	0	0	19.00
20. 00	Total (sum of lines 1-19)	3, 085	3, 085	1, 083, 422		40	36, 571	20. 00
21. 00 22. 00	Total cost to be allocated Unit cost multiplier	35, 301 11. 442788	25, 562 8. 285900	388, 018 0. 358141			2, 273 0. 062153	21. 00 22. 00
22.00	Cost Center Description		CASHI ERI NG/ACC			OPERATION OF	LAUNDRY &	22.00
		(ADMISSIONS)	OUNTS		ADMI NI STRATI VE	PLANT	LINEN SERVICE	
			RECEI VABLE		AND GENERAL	(SQUARE	(POUNDS OF	
			(GROSS CHARGES)		(ACCUM. COST)	FEET)	LAUNDRY)	
		5. 04	5. 05	5A. 06	5. 06	7. 00	8. 00	
1. 00	Administrative and General	0	1, 839, 637	C	552, 214	3, 085	0	1. 00
2.00	Skilled Nursing Care	0	0	0			0	2. 00
3. 00 4. 00	Physical Therapy Occupational Therapy	0	0	0	1,	0	0	3. 00 4. 00
5.00	Speech Pathology	0	0	0		0	0	5. 00
6. 00	Medical Social Services	o o	0	O	· ·	0	0	6. 00
7.00	Home Health Aide	0	0	0		0	0	7. 00
8.00	Supplies (see instructions)	0	0	0	1	0	0	8. 00
9.00	Drugs	0	0	0	1	_	0	9.00
10. 00 11. 00	DME Home Dialysis Aide Services	I 0	0	0	1	_	0	10. 00 11. 00
12. 00	Respiratory Therapy	0	0	0			0	12. 00
13. 00	Private Duty Nursing	O	0	0	•		0	13.00
14.00	Clinic	0	0	0			0	14. 00
15.00	Health Promotion Activities	0	0	0		0	0	15. 00
16. 00 17. 00	Day Care Program Home Delivered Meals Program	0	0	0	0	0	0	16. 00 17. 00
18. 00	Homemaker Service	0	0	0	1		0	18. 00
19. 00	All Others (specify)	0	0	0	1	0	0	19. 00
20. 00	Total (sum of lines 1-19)	0	1, 839, 637		1, 770, 736	•	0	20. 00
21. 00	Total cost to be allocated	0 000000	15, 366		81, 882	102, 831	0 000000	21. 00
22.00	Unit cost multiplier	0. 000000	0. 008353		0. 046242	33. 332577	0. 000000	ZZ. UU

Health Financial Systems DEARBORN COUNTY HOSPITAL ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL Provide Provi der CCN: 150086 BASIS 157055 HHA CCN:

Cost Center Description								3/29/2013 0.3	/ alli
Cost Center Description								PPS	
		Cost Center Description	HUISEKEEDI NG	DIFTADV	CAFETERIA	MITEST NC		DHADMACV	
Text SERVED CGROSS HOURS CGROSS HOURS CGROSS HOURS CGROSS HOURS CTOMB		cost center bescription							
1.00 Administrative and General 3, 085 0.0 0 11.00 13.00 14.00 15.00 1.00 10.00 14.00 15.00 1.00 10.00 14.00 15.00 1.00 10.00 14.00 15.00 1.00 10.00 14.00 15.00 1.00 10.00 14.00 15.00 1.00 10.00 14.00 15.00 10.00 14.00 15.00 10.00 14.00 15.00 10.00 14.00 15.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.				,	(WAN HOURS)	ADMINI STRATTO		(100%)	
1.00				SERVED)		(CDOCC HOUDE)			
1.00 Administrative and General 3.085 0 0 0 0 0 0 0 0 0			0.00	10.00	11 00			15 00	
2.00 Skilled Mursing Care	1 00	Administrative and Ceneral				_			1 00
2.00 Physical Therapy				- 1					
0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00			1	- 1					
5.00 Speech Pathology				U					
0.00 Medical Social Services 0 0 0 0 0 0 0 0 0				0					
1.00 Home Health Aide			"	0					1
Supplies (see Instructions)				0					
0,00 Drugs		l .		0					1
10.00 DME		1	0	0					
11. 00 Home Dial ysis Aide Services 0 0 0 0 0 0 0 1. 00			0	0				0	
12 00 Respiratory Therapy 0 0 0 0 0 0 0 12 00	10.00		0	0	(0 (10. 00
13. 00 Private Duty Nursing	11. 00	Home Dialysis Aide Services	0	0	(0 (0	0	11.00
14. 00 Clinic C	12.00	Respiratory Therapy	0	0	(0 (0	0	12.00
15.00 Heal th Promotion Activities 0 0 0 0 0 0 0 15.00	13.00	Private Duty Nursing	0	0	(0	0	0	13. 00
16.00 Day Care Program	14.00	Clinic	O	0	(0	0	0	14. 00
17.00 Home Del I vered Meals Program 0 0 0 0 0 0 0 17.00 18.00 Homemaker Service 0 0 0 0 0 0 0 0 18.00 19.00 Ali Others (specify) 3.885 0 0 0 0 0 0 0 19.00 20.00 Total (sum of lines 1-19) 3.885 0 0 0 0 0 0 0 20.00 22.00 Unit cost multiplier 9.329098 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 22.00 Unit cost multiplier 9.329098 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 20.00 Skilled Nursing Care 16.00 17.00 17.00 3.00 Physical Therapy 0 0 0 0 0 0 3.00 Physical Therapy 0 0 0 0 0 5.00 Speech Pathology 0 0 0 0 6.00 Medical Social Services 0 0 0 0 8.00 Supplies (see instructions) 0 0 0 0 8.00 DME 0 0 0 0 8.00 DME 0 0 0 0 8.00 Physical Therapy 0 0 0 0 8.00 O 0 0 0 0 8.00 0 0 0 0 8.00 0 0 0 0 8.00 0 0 0 0 8.00 0 0 0 0 8.00 0 0 0 0 8.00 0 0 0 0 8.00 0 0 0 0 8.00 0 0 0 0 8.00 0 0 0 0 8.00 0 0 0 8.00 0 0 0 0 8.00 0 0 0 0 8.00 0 0 0 0 8.00 0 0 0 0 8.00 0 0 0 0 8.00 0 0 0 0 8.00 0 0 0 0 8.00 0 0 0 0 8.00 0 0 0 0 8.00 0 0 0 0 8.00 0 0 0 0 8.00 0 0 0 0 8.00 0 0 0 0 8.00 0 0 0 0 8.00 0 0 0 0 8.00 0 0 0 0 8.00 0 0 0 0 8.00 0 0 0 0 8.00 0 0 0 0 8.00 0 0 0 0 8.00 0 0 0 0 8.00 0 0 0 0 8.00 0 0 0 0 8.00 0 0 0 0 8.00 0 0 0 0 8.00 0 0 0 0 8.00 0 0 0 0 8.00 0 0 0 0 8.00 0 0 0 0 8.00 0 0 0 0 8.00 0 0 0 0 8.00 0 0 0 0 8.00 0 0 0 0 8.00	15.00	Health Promotion Activities	O	0	(0	0	0	15. 00
1.00 Administrative and General 1.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00	16.00	Day Care Program	O	0	(0	0	0	16. 00
19.00 All Others (specify) 0 0 0 0 0 0 0 0 0	17.00	Home Delivered Meals Program	0	0	(o o	0	0	17. 00
20.00 Total (sum of lines 1-19) 3.085 0 0 0 0 0 0 20.00	18.00	Homemaker Service	o	0	(ol (0	0	18. 00
20.00 Total (sum of lines 1-19) 3.085 0 0 0 0 0 0 20.00	19.00	All Others (specify)	o	0	(ol (0	l o	19. 00
21.00			3, 085	0	(0	0	20.00
22.00 Unit cost multiplier				0	(0	0	
Cost Center Description REDICAL RECORDS & LIBRARY (ADJUSTED DESCRIPTION CHARGES) CTIME SPENT)				0. 000000	0. 00000	0. 000000	0.00000	0. 000000	
RECORDS & LIBRARY (ADJUSTED CHARGES)									
CAJUSTED CHARGES CHA		•	RECORDS &						
CHARGES 16.00 17.00			LI BRARY	(TIME					
16.00			(ADJUSTED	SPENT)					
1.00 Administrative and General 0 0 1.00 2.00 Skilled Nursing Care 0 0 2.00 3.00 Physical Therapy 0 0 3.00 4.00 Occupational Therapy 0 0 4.00 5.00 Speech Pathology 0 0 5.00 6.00 Medical Social Services 0 0 6.00 7.00 Home Health Aide 0 0 7.00 8.00 Supplies (see instructions) 0 0 8.00 9.00 Drugs 0 0 9.00 10.00 DME 0 0 10.00 11.00 Home Dialysis Aide Services 0 0 11.00 12.00 Respiratory Therapy 0 0 11.00 12.00 Respiratory Therapy 0 0 12.00 13.00 14.00 13.00 14.00 15.00 Heal th Promotion Activities 0 0 15.00 16.00 Day Care Program 0 0 15.00			CHARGES)						
2.00 Skilled Nursing Care 0 0 3.00 Physical Therapy 0 0 4.00 Occupati onal Therapy 0 0 5.00 Speech Pathol ogy 0 0 6.00 Medi cal Social Services 0 0 7.00 Home Heal th Ai de 0 0 8.00 Suppli es (see instructions) 0 0 9.00 Drugs 0 0 10.00 DME 0 0 12.00 Respiratory Therapy 0 0 13.00 Private Duty Nursing 0 0 14.00 Clinic 0 0 15.00 Heal th Promotion Activities 0 0 16.00 Day Care Program 0 0 17.00 Home Delivered Meals Program 0 0 17.00 Homeaker Service 0 0 19.00 All Others (specify) 0 0 10.00 Total (sum of lines 1-19) 0 0 10.00 Total cost to be allocated 0	1 00								1 00
3.00 Physical Therapy 0 0 0 0 0 0 0 0 0		l .	1	-					
4.00 Occupational Therapy			-	9					
5. 00 Speech Pathology 0 0 5.00 6. 00 Medical Social Services 0 0 6.00 7. 00 Home Heal th Aide 0 0 7.00 8. 00 Supplies (see instructions) 0 0 9.00 9. 00 Drugs 0 0 9.00 10. 00 DME 0 0 10.00 11. 00 Home Dialysis Aide Services 0 0 11.00 12. 00 Respiratory Therapy 0 0 12.00 13. 00 Private Duty Nursing 0 0 12.00 14. 00 Clinic 0 0 13.00 14. 00 Clinic 0 0 15.00 15. 00 Health Promotion Activities 0 0 15.00 16. 00 Day Care Program 0 0 17.00 18. 00 Homemaker Service 0 0 17.00 19. 00 All Others (specify) 0 0 19.00 20. 00 Total (sum of lines 1-19) 0 0 <td< td=""><td></td><td></td><td>-</td><td>0</td><td></td><td></td><td></td><td></td><td></td></td<>			-	0					
6.00 Medical Social Services 0 0 0 0 6.00 7.00 Home Health Aide 0 0 0 7.00 8.00 Supplies (see instructions) 0 0 0 8.00 9.00 Drugs 0 0 0 0 9.00 DME 0 0 0 0 11.00 Home Dialysis Aide Services 0 0 0 11.00 Respiratory Therapy 0 0 12.00 Respiratory Therapy 0 0 0 12.00 Private Duty Nursing 0 0 0 13.00 Private Duty Nursing 0 0 0 14.00 Clinic 0 0 15.00 Health Promotion Activities 0 0 0 15.00 Health Promotion Activities 0 0 0 17.00 Home Delivered Meals Program 0 0 0 17.00 Home Delivered Meals Program 0 0 0 17.00 Home Delivered Service 0 0 0 17.00 Home Delivered Meals Program 0 0 0 0 17.00 Total (sum of lines 1-19) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0					
7.00 Home Health Aide				0					
8.00 Supplies (see instructions) 0 0 0 9.00 10.00 10.00 DME 0 0 10.00 11.00 Home Dialysis Aide Services 0 0 12.00 Respiratory Therapy 0 0 12.00 Private Duty Nursing 0 0 14.00 15.00 Health Promotion Activities 0 0 15.00 Day Care Program 0 0 15.00 Home Delivered Meals Program 0 0 17.00 Home Delivered Meals Program 0 0 0 18.00 Homemaker Service 0 19.00 All Others (specify) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0					1
9.00 Drugs 0 0 0 9.00 10.00 DME 0 10.00 11.00 11.00 Home Dialysis Aide Services 0 0 11.00 12.00 Respiratory Therapy 0 0 12.00 13.00 Private Duty Nursing 0 0 13.00 14.00 Clinic 0 0 14.00 15.00 Health Promotion Activities 0 0 15.00 16.00 Day Care Program 0 0 15.00 17.00 Home Delivered Meals Program 0 0 16.00 17.00 Homemaker Service 0 17.00 18.00 Homemaker Service 0 0 18.00 19.00 All Others (specify) 0 0 0 19.00 20.00 Total (sum of lines 1-19) 0 0 0 20.00 21.00 Total cost to be allocated 0 0 0 0 10.00		1	0	0					
10.00 DME 0 0 10.00 11.00 Home Dialysis Aide Services 0 0 11.00 12.00 Respiratory Therapy 0 0 12.00 13.00 Private Duty Nursing 0 0 13.00 14.00 Clinic 0 0 14.00 15.00 Heal th Promotion Activities 0 0 15.00 16.00 Day Care Program 0 0 16.00 17.00 Home Delivered Meals Program 0 0 17.00 18.00 Homemaker Service 0 0 18.00 19.00 All Others (specify) 0 0 19.00 20.00 Total (sum of lines 1-19) 0 0 20.00 21.00 Total cost to be allocated 0 0 21.00		1	0	0					
11. 00 Home Dialysis Aide Services 0 0 12. 00 Respiratory Therapy 0 0 13. 00 Private Duty Nursing 0 0 14. 00 Clinic 0 0 15. 00 Heal th Promotion Activities 0 0 16. 00 Day Care Program 0 0 17. 00 Home Delivered Meals Program 0 0 18. 00 Homemaker Service 0 0 19. 00 All Others (specify) 0 0 20. 00 Total (sum of lines 1-19) 0 0 21. 00 Total cost to be allocated 0 0				0					
12.00 Respiratory Therapy 0 0 12.00 13.00 Private Duty Nursing 0 0 13.00 14.00 Clinic 0 0 14.00 15.00 Heal th Promotion Activities 0 0 15.00 16.00 Day Care Program 0 0 16.00 17.00 Home Delivered Meals Program 0 0 17.00 18.00 Homemaker Service 0 0 18.00 19.00 All Others (specify) 0 0 19.00 20.00 Total (sum of lines 1-19) 0 0 20.00 21.00 Total cost to be allocated 0 0 21.00	10. 00	1	0	0					
13.00 Private Duty Nursing 0 0 14.00 Clinic 0 0 15.00 Health Promotion Activities 0 0 16.00 Day Care Program 0 0 17.00 Home Delivered Meals Program 0 0 18.00 Homemaker Service 0 0 19.00 All Others (specify) 0 0 20.00 Total (sum of lines 1-19) 0 0 21.00 Total cost to be allocated 0 0			0	0					
14.00 Clinic 0 0 15.00 Health Promotion Activities 0 0 16.00 Day Care Program 0 0 17.00 Home Delivered Meals Program 0 0 18.00 Homemaker Service 0 0 19.00 All Others (specify) 0 0 20.00 Total (sum of lines 1-19) 0 0 21.00 Total cost to be allocated 0 0	12.00	Respiratory Therapy	0	0					12. 00
15.00 Health Promotion Activities 0 0 0 15.00 16.00 Day Care Program 0 0 16.00 17.00 Home Delivered Meals Program 0 0 0 17.00 18.00 Homemaker Service 0 0 18.00 19.00 All Others (specify) 0 0 0 19.00 20.00 Total (sum of lines 1-19) 0 0 0 21.00 21.00 Total cost to be allocated 0 0 0 0 21.00	13.00	Private Duty Nursing	0	0					13. 00
16.00 Day Care Program 0 0 17.00 Home Delivered Meals Program 0 0 18.00 Homemaker Service 0 0 19.00 All Others (specify) 0 0 20.00 Total (sum of lines 1-19) 0 0 21.00 Total cost to be allocated 0 0	14.00	Clinic	0	0					14.00
17.00 Home Delivered Meals Program 0 0 18.00 Homemaker Service 0 0 19.00 All Others (specify) 0 0 20.00 Total (sum of lines 1-19) 0 0 21.00 Total cost to be allocated 0 0			0	0					
18.00 Homemaker Service 0 0 19.00 All Others (specify) 0 0 20.00 Total (sum of lines 1-19) 0 0 21.00 Total cost to be allocated 0 0	16. 00	Day Care Program	0	0					
19.00 All Others (specify) 0 0 19.00 20.00 Total (sum of lines 1-19) 0 0 20.00 21.00 Total cost to be allocated 0 0 21.00		Home Delivered Meals Program	0	0					17. 00
20.00 Total (sum of lines 1-19) 0 0 21.00 Total cost to be allocated 0 0	18. 00	Homemaker Service	0	0					18. 00
21.00 Total cost to be allocated 0 0 21.00	19.00	All Others (specify)	o	O					19. 00
	20.00	Total (sum of lines 1-19)	0	o					20.00
22.00 Unit cost multiplier 0.000000 0.000000 22.00	21.00	Total cost to be allocated	o	o					21.00
	22. 00	Unit cost multiplier	0. 000000	0. 000000					22. 00

	Financial Systems	-0	DEARBORN CO			0011 450007		In Lie	u of Form CMS-2	
PORI	FIONMENT OF PATIENT SERVICE COST	5			rovi der	CCN: 150086	Period: From 01/0	1/2014	Worksheet H-3 Part I	
				F	HA CCN:	157055		1/2014	Date/Time Prep 5/29/2015 8:57	
					Ti tl	e XVIII	Home He		PPS	
	Cost Center Description		Facility Cos		red	Total HHA	Total V		Average Cost	
		H-2, Part I, col. 28, line	(from Wkst.		llary (from	Costs (cols. + 2)	1		Per Visit (col. 3 ÷ col.	
		COI. 20, TITIE	η-2, Pait i		: 11)	+ 2)			4)	
		0	1.00		00	3.00	4. 0	0	5. 00	
	PART I - COMPUTATION OF LESSER	OF AGGREGATE F	PROGRAM COST,	AGGREGA	E OF TH	HE PROGRAM LII	MITATION CO	OST, OF	?	
	BENEFICIARY COST LIMITATION									
00	Cost Per Visit Computation Skilled Nursing Care	2. 00	1, 453, 70	าวไ		1, 453, 7	n2	4, 613	315. 13	1.
00	Physical Therapy	3. 00			(1		1, 842	129. 89	2.
00	Occupational Therapy	4. 00		1	(1		467	186. 60	
00	Speech Pathology	5. 00	35, 60	03	(35, 6	03	180	197. 79	4. (
00	Medical Social Services	6. 00		1		43, 2		52	831. 48	
00	Home Heal th Ai de	7. 00		1	_	124, 5		1, 811	68. 76	
00	Total (sum of lines 1-6)		1, 983, 4	60	(.,		8, 965		7.
			1			Program Visi	art B			
	Cost Center Description	Cost Limits	CBSA No. (1)) Pa	t A	Not Subject		t to		
						Deducti bl es	& Deducti			
		0	1.00	1	00	Coi nsurance		0	F 00	
	Limitation Cost Computation	0	1. 00		00	3.00	4. 0	U	5. 00	
00	Skilled Nursing Care		17140		(0			8.
01	Skilled Nursing Care		50031		(3, 0	09			8.
02	Skilled Nursing Care		50034		(1	56			8.
03	Skilled Nursing Care		99915		(1	0			8.
00	Physical Therapy		17140		(1	0			9.
01 02	Physical Therapy Physical Therapy		50031 50034		(58 54			9. 9.
03	Physical Therapy		99915		(1	0			9.
0.00	Occupational Therapy		17140		Ċ	1	o			10.
0. 01	Occupational Therapy		50031		(2	55			10.
0. 02	Occupational Therapy		50034		(36			10.
0. 03	Occupational Therapy		99915		(0			10.
. 00	Speech Pathology		17140		(0			11.
. 01	Speech Pathology		50031 50034		(1	63 56			11.
. 02	Speech Pathology Speech Pathology		99915		(1	0			11. 11.
2. 00	Medical Social Services		17140		(1	o			12.
2. 01	Medical Social Services		50031		(1	32			12.
2. 02	Medical Social Services		50034		(3			12.
2. 03	Medical Social Services		99915		(0			12.
3. 00	Home Heal th Aide		17140		(1	0			13.
. 01			50031		(72			13.
	Home Health Aide Home Health Aide		50034 99915	ŀ	(36 0			13. 13.
	Total (sum of lines 8-13)		99913		(14.
50		From Wkst. H-2	Facility Cos	ts Sh	ared	Total HHA		narges	Ratio (col. 3	17.
		Part I, col.	(from Wkst.		llary	Costs (cols.			÷ col . 4)	
		28, line	H-2, Part I) Costs	(from	+ 2)	Recor	rd)		
		0	1.00		: 11)	2.00	4.0	0	E 00	
	Supplies and Drugs Cost Computa		1. 00		00	3.00	4. 0	U	5. 00	
i. 00	Cost of Medical Supplies	8. 00		0	(0	0	0. 000000	15.
	Cost of Drugs	9. 00		o	Č		o	0		

	Financial Systems	<u> </u>	DEARBORN COUN		CCN: 15000/	In Lie	eu of Form CMS-2 Worksheet H-3	
PPURT	TIONMENT OF PATIENT SERVICE COSTS	5		HHA CCN:	CCN: 150086 157055	From 01/01/2014 To 12/31/2014	Part I	pared:
				Ti tl	e XVIII	Home Health Agency I	PPS	7 aiii
			Program Visits		Cost of Services	Agency I		
			Par	t B	Jei vi ces	Part B		
	Cost Center Description	Part A	Not Subject to Deductibles & Coinsurance	Subject to	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6. 00	7. 00	8. 00	9. 00	10. 00	11. 00	
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION		PROGRAM COST, A				₹	
	Cost Per Visit Computation							1
. 00	Skilled Nursing Care	C	3, 365			0 1, 060, 412		1.0
. 00	Physi cal Therapy	Ċ				0 157, 427		2.0
. 00	Occupational Therapy	C	291			0 54, 301		3.0
. 00	Speech Pathology	C	119			0 23, 537		4. C
. 00	Medical Social Services	C	35			0 29, 102		5.0
. 00	Home Health Aide	C	1, 008			0 69, 310		6.0
. 00	Total (sum of lines 1-6)		6, 030			0 1, 394, 089		7. C
	Cost Center Description	6. 00	7.00	8. 00	9. 00	10.00	11.00	
	Limitation Cost Computation	6.00	7.00	0.00	9.00	10.00	11.00	
00	Skilled Nursing Care							8.0
01	Skilled Nursing Care							8.
02	Skilled Nursing Care							8.
03	Skilled Nursing Care							8.
00	Physical Therapy							9.
01	Physical Therapy							9.
02	Physical Therapy							9.
03	Physical Therapy							9.
0. 00	Occupati onal Therapy							10.
). 01	Occupati onal Therapy							10.
). 02	Occupati onal Therapy							10.
0. 03	Occupati onal Therapy							10.
. 00	Speech Pathology							11.
. 01	Speech Pathology							11.
. 02	1 '							11.
. 03	Speech Pathology							11.
2. 00	Medical Social Services							12.
2. 01	Medical Social Services							12.
2. 02	Medical Social Services							12.
2. 03	Medical Social Services							12.
3. 00	Home Health Aide							13.
3. 01	Home Heal th Aide							13.
3. 02	Home Health Aide Home Health Aide							13.
3. 03	Total (sum of lines 8-13)							13. (
+. 00	Total (Sull of Titles 6-13)	Prog	ram Covered Cha	l	Cost of			14.
		1109	rain covered che	n ges	Servi ces			
			Par	† R		Part B		
	Cost Center Description	Part A	Not Subject to		Part A	Not Subject to	Subject to	
	cost center bescription	Tai t A	Deductibles &		Tart A	Deductibles &	Deductibles &	
			Coi nsurance	Coi nsurance		Coi nsurance	Coi nsurance	
		6. 00	7. 00	8. 00	9. 00	10.00	11.00	
	Supplies and Drugs Cost Computa							
5. 00	Cost of Medical Supplies	С						15. (
	Cost of Drugs		86	0		0	0	16.

PP0R1	TIONMENT OF PATIENT SERVICE COST	S	Pro	vider CCN:	150086	Period: From 01/01/2014	Worksheet H-: Part I	3
			ННА	CCN:	157055	To 12/31/2014	Date/Time Pro 5/29/2015 8:	epare 57 am
				Title XVI	11	Home Health Agency I	PPS	
	Cost Center Description	Total Program				.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
		Cost (sum of						
		col s. 9-10)				-		4
	PART I - COMPUTATION OF LESSER	12.00	A COST ACCDECATE	OF THE DDG	CDAM III	MITATION COST OD		_
	BENEFICIARY COST LIMITATION	OF AGGREGATE PROGRAM	USI, AGGREGATE	OF THE PRO	JGKAW LI	WITATION COST, OR		
	Cost Per Visit Computation							-
00	Skilled Nursing Care	1, 060, 412						1.
00	Physical Therapy	157, 427						2
00	Occupational Therapy	54, 301						3
00	Speech Pathology	23, 537						4
00	Medical Social Services	29, 102						5
00	Home Health Aide	69, 310						6
00	Total (sum of lines 1-6)	1, 394, 089						7.
	Cost Center Description							
		12. 00						
	Limitation Cost Computation							
00	Skilled Nursing Care							8
01	Skilled Nursing Care							8
02	Skilled Nursing Care							8
03	Skilled Nursing Care							8
00	Physi cal Therapy							9
01	Physical Therapy							9
02	Physical Therapy							9
03	Physical Therapy							10
. 00	Occupational Therapy Occupational Therapy							10
. 02	Occupational Therapy							10
. 03	Occupational Therapy							10
. 00	Speech Pathology							11
. 01	Speech Pathology							11
. 02	Speech Pathology							11
. 03	Speech Pathology							11
. 00	Medical Social Services							12
. 01	Medical Social Services							12
. 02	Medical Social Services							12
2. 03	Medical Social Services							12
. 00	Home Health Aide							13
3. 01	Home Health Aide							13
3. 02	Home Health Aide							13
3. 03	Home Health Aide							13
1.00	Total (sum of lines 8-13)							14

Health Financial Systems		DEARBORN COUN	ITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF PATIENT SERVICE	COSTS		Provi der	CCN: 150086	Peri od:	Worksheet H-3	
			HHA CCN:	157055	From 01/01/2014 To 12/31/2014	Part II Date/Time Pre	narod:
			TITIA CCN.	157055	10 12/31/2014	5/29/2015 8:5	
			Ti tl	e XVIII	Home Health	PPS	
					Agency I		
Cost Center Descrip	ion From Wkst. C,	Cost to Charge	Total HHA	HHA Shared	Transfer to		
	Part I, col.	Ratio	Charge (from	Ancillary	Part I as		
	9, line		provi der	Costs (col.	1 Indicated		
			records)	x col. 2)			
	0	1.00	2.00	3.00	4. 00		
PART II - APPORTIONMENT O	COST OF HHA SERVI	CES FURNISHED B	BY SHARED HOSPI	TAL DEPARTMEN	ITS		
1.00 Physical Therapy	66. 00	0. 408381			0 col. 2, line 2	. 00	1. 00
2.00 Occupational Therapy	67. 00	0. 614429	C		0 col. 2, line 3	. 00	2. 00
3.00 Speech Pathology	68. 00	0. 583213	C		Ocol. 2, line 4	. 00	3. 00
4.00 Cost of Medical Supplies	71. 00	0. 723606	(0 col. 2, line 1	5. 00	4.00
5.00 Cost of Drugs	73. 00	0. 427901	c)	0 col. 2, line 1	6. 00	5. 00

	inancial Systems DEARBORN COUNTY HO		CCN: 150086	Peri od:	eu of Form CMS- Worksheet H-4	
		HHA CCN:	157055	From 01/01/2014 To 12/31/2014		
		Ti tl	e XVIII	Home Health Agency I	PPS	, ,
					rt B	
			Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
			1. 00	2. 00	3. 00	
	ART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOM/	ARY CHARGE			1	
	easonable Cost of Part A & Part B Services		ı			
- 1	Reasonable cost of services (see instructions)			0		
	otal charges ustomary Charges			0 0	0	2
	ustomary charges mount actually collected from patients liable for payment for:	servi ces	I	0 0	0	3
	on a charge basis (from your records)	oci vi ceo			1	`
00 A	umount that would have been realized from patients liable for partients on a charge basis had such payment been made in account of the parties of the payment been made in account of the payment been made in account of the payment been made in account of the payment of the payment been made in account of the payment of t			0 0	0	4
00 R	Patio of line 3 to line 4 (not to exceed 1.000000)		0. 00000	0. 000000	0. 000000	5
	otal customary charges (see instructions)			0	0	
	excess of total customary charges over total reasonable cost (control of the cost (control of the cost (control of the cost (cost of the cost (cost of the cost of	omplete		0	0	7
0 E	only if line 6 exceeds line 1) Excess of reasonable cost over customary charges (complete only exceeds line 6)	ifline		0 0	0	8
0 P	rimary payer amounts			0 0		-
				Part A	Part B	
				Servi ces 1.00	Servi ces 2.00	
P	ART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			11.00		
00 T	otal reasonable cost (see instructions)			0	0] 10
	otal PPS Reimbursement - Full Episodes without Outliers			0	1	
	otal PPS Reimbursement - Full Episodes with Outliers			0	24, 670	
	otal PPS Reimbursement - LUPA Episodes			0	36, 504	
	otal PPS Reimbursement - PEP Episodes otal PPS Outlier Reimbursement - Full Episodes with Outliers			0	7, 930 15, 769	
	otal PPS Outlier Reimbursement - PEP Episodes				0	1
	otal Other Payments				ol o	
1	ME Payments			0	0	18
00 T				0	0	
00 T 00 D 00 0	Dxygen Payments			0	ή	
00 T 00 D 00 0 00 P	Prosthetic and Orthotic Payments	,			1 0	
00 T 00 D 00 0 00 P 00 P	Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsura	ance)			004 224	1 2
00 T 00 D 00 0 00 P 00 P 00 S	Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsura Subtotal (sum of lines 10 thru 20 minus line 21)	ance)		0	1 000, 22.	
00 T 00 D 00 0 00 P 00 P 00 S 00 E	Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsurable Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8)	ance)		0	0	23
00 T 00 D 00 0 00 P 00 P 00 S 00 E 00 S	Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsurable to the subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Excess reasonable cost (from line 8)	ance)		0000	0	23
00 T 00 D 00 O 00 P 00 P 00 S 00 E 00 S	Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsurable Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8)	ance)		0	0 886, 224 0	23 24 25
00 T 00 D 00 O 00 P 00 P 00 S 00 E 00 S 00 C 00 N	Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsur- Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Excess reasonable cost (from line 8) Exceptional (line 22 minus line 23) Exceptional (line 22 minus line 23) Exceptional (line 24 minus line 25) Exemption (line 24 minus line 25) Exemption (line 24 minus line 25) Exemption (line 24 minus line 26)	ŕ		0	0 886, 224 0	23 24 25 26 27
00 T 00 D 00 O 00 P 00 P 00 S 00 E 00 S 00 C 00 N 00 R	Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsur- Bubtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Excess reaso	tructi ons)		0	0 886, 224 0 886, 224	23 24 25 26 27 28
00 T 00 D 00 O 00 P 00 P 00 S 00 E 00 S 00 C 00 N 00 R 00 R	Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsur- Bubtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Eubtotal (line 22 minus line 23) Euclines and billed to program patients (from your records) Elet cost (line 24 minus line 25) Elet imbursable bad debts (from your records) Elet imbursable bad debts for dual eligible beneficiaries (see ins Eletation of the second of	tructi ons)		0	0 886, 224 0 886, 224	23 24 25 26 27 28 29
00 T 00 D 00 O 00 P 00 P 00 S 00 C 00 N 00 R 00 R 00 R	Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsurable to Bedicare patients) Part B deductibles billed to Medicare patients (exclude coinsurable to billed to the Solution of Line 21) Part B deductible Cost (from Line 8) Part B deductible Cost (from Line 23) Part B deduction of Line 22 minus Line 23) Part B deductible Cost (Line 24 minus Line 25) Part B deductible Cost (From Your records) Part B deductible Cost (From Line 25) Part B deductibl	tructi ons)		0	0 886, 224 0 886, 224 0 886, 224	23 24 25 26 27 28 29 30
00 T 00 D 00 O 00 P 00 P 00 S 00 E 00 S 00 C 00 N 00 R 00 R 00 T 00 M 50 P	Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsur- Bibbotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Exploration (line 22 minus line 23) Exploration (line 22 minus line 23) Exploration (line 24 minus line 25) Exploration (line 26 plus line 26) Exploration (line 26 plus line 26) Exploration (line 26) Exploration (lin	tructi ons)		0	0 886, 224 0 886, 224 0 886, 224 0 886, 224	23 24 25 26 27 28 29 30
00 T 00 D 00 O 00 P 00 P 00 S 00 E 00 S 00 C 00 N 00 R 00 R 00 T 00 M 50 P	Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsur- Broad Broa	tructi ons)		000000000000000000000000000000000000000	0 886, 224 0 886, 224 0 886, 224 0 886, 308	23 24 25 26 27 28 29 30 30 31
00 T 00 D 00 O 00 P 00 P 00 S 00 E 00 C 00 N 00 R 00 R 00 T 00 M 50 P 00 S	Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsur- Bibbotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Exploration (line 22 minus line 23) Exploration (line 22 minus line 23) Exploration (line 24 minus line 25) Exploration (line 26 plus line 26) Exploration (line 26 plus line 26) Exploration (line 26) Exploration (lin	tructi ons)		000000000000000000000000000000000000000	0 886, 224 0 886, 224 0 886, 224 0 886, 308	23 24 25 26 27 28 29 30 30 31
. 00	Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsur- Part B deductibles billed to Medicare patients (exclude coinsur- Part B deductibles billed to Medicare patients (exclude coinsur- Part B deductibles billed to thru 20 minus line 21) Part B description of the 22 minus line 23 Part B description of the 24 minus line 25 Part B description of the 24 minus line 25 Part B description of the 25 Part B description of the 26 plus line 26 Part B description of the 26 plus line 27 Part B description of the 26 plus line 28 Part B description of the 26 plus line 29 Part B description of the 26 plus line 29 Part B description of the 26 plus line 29 Part B description of the 26 plus line 29 Part B description of the 26 plus line 29 Part B description of the 27 Part B deduction of the 21 P	tructi ons) 27)		000000000000000000000000000000000000000	0 886, 224 0 886, 224 0 886, 224 0 886, 308 0 886, 308 0 87, 724	23 24 25 26 27 28 29 30 31 31 32
. 00 T . 00 D . 00 P . 00 S . 00 C . 00 R . 00 M . 00 M . 50 P . 00 S . 01 S . 00 B . 00 S . 01 S . 00 B .	Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsur- Part B deductibles billed to Medicare patients (exclude coinsur- Part B deductibles billed to Medicare patients (exclude coinsur- Part B deductibles billed to program line 8) Proposed B deduction	tructions) 27) d 33)		000000000000000000000000000000000000000	0 886, 224 0 886, 224 0 886, 224 0 886, 324 0 886, 308 0 886, 308 0 17, 724 0 868, 584	23 24 25 26 27 28 29 30 31 31 32 33 34

In Lieu of Form CMS-2552-10

Health Financial Systems DEARBORN COUNTY HOSPITAL ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAS FOR SERVICES RENDERED TO Provide 150086 | Peri od: | Worksneet ii 5 | From 01/01/2014 | Date/Time Prepared: 5/29/2015 8:57 am | PPS Provi der CCN: 150086 PROGRAM BENEFICIARIES HHA CCN:

				Home Health Agency I	PPS	
		I npati en	t Part A		-t 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			0	868, 584	1. 00
2.00	Interim payments payable on individual bills, either			0	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none, write "NONE" or enter a zero					
3. 00	List separately each retroactive lump sum adjustment					3. 00
0.00	amount based on subsequent revision of the interim rate					0.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider	T		T	1	
3. 01				0	0	3. 01
3. 02				0	0 0	3. 02 3. 03
3. 03 3. 04				0		3. 03
3. 05				0		3. 04
3.03	Provider to Program			O _I		3. 03
3.50				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)			0	868, 584	4. 00
1. 00	(transfer to Wkst. H-4, Part II, column as appropriate,				000,001	1. 00
	line 32)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1) Program to Provider					
5. 01	1 rogram to 11 ovi dei			0	0	5. 01
5. 02				0	0	5. 02
5.03				0	0	5. 03
	Provider to Program					
5. 50				0	0	5. 50
5. 51				0	0	5. 51
5. 52 5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 52 5. 99
5. 99	5. 50-5. 98)			O O		3. 99
6. 00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVI DER			0	0	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	0	6. 02
7. 00	Total Medicare program liability (see instructions)			0	868, 584	7. 00
				Contractor	NPR Date	
)	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor			1.00	2.00	8. 00
	I the state of the	ı		1	1 1	0

Health Financial Systems	DEARBORN COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
ANALYSIS OF PROVIDER-BASED HOSPICE COSTS	Provi der CCN: 150086	Period: Worksheet K

Hospi ce CCN: 151531 To 12/31/2014 Date/Ti me Prepared:

			1.00p. 00			5/29/2015 8:5	7 am
					Hospi ce I		
		Salaries (from	Empl oyee	Transportati o	n Contracted	Other	
		Wkst. K-1)	Benefits (from	(see inst.)	Services (from		
			Wkst. K-2)		Wkst. K-3)		
		1.00	2. 00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.				O	0	1. 00
2.00	Capital Related Costs-Movable Equip.				O	0	2. 00
3.00	Plant Operation and Maintenance	0	0		0	0	3. 00
4.00	Transportation - Staff	0	0		0	0	4. 00
5.00	Volunteer Service Coordination	0	0		0	0	5. 00
6.00	Administrative and General	135, 511	0)	0	190, 451	6. 00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0		0	0	7. 00
8.00	Inpatient - Respite Care	0	0		0	0	8. 00
	VISITING SERVICES						
9.00	Physi ci an Servi ces	0	0		0	0	9. 00
10.00	Nursi ng Care	81, 783	0		0 0	0	10. 00
11. 00	Nursing Care-Continuous Home Care	0	0		0	0	11. 00
12.00	Physi cal Therapy	0	0		0 0	0	12. 00
13.00	Occupational Therapy	0	0		0	0	13.00
14.00	Speech/ Language Pathology	0	0		0	0	14. 00
15.00	Medical Social Services	46, 290	0		0 0	0	15. 00
16.00	Spiritual Counseling	7, 433	0		0	0	16. 00
17. 00	Di etary Counsel i ng	0	0		0	0	17. 00
18.00	Counseling - Other	0	0		0	0	18. 00
19. 00	Home Health Aide and Homemaker	12, 323	0		0	0	19. 00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		0		20. 00
21. 00	Other	0	0)	0 (C	0	21. 00
	OTHER HOSPICE SERVICE COSTS	_					
22. 00	Drugs, Biological and Infusion Therapy	0	0		0		22. 00
23. 00	Anal gesi cs	0	0	1	0	1	23. 00
24. 00	Sedatives / Hypnotics	0	0		0	0	24. 00
25. 00	Other - Specify	0	0		0	0	25. 00
26. 00	Durable Medical Equipment/Oxygen	0	0		0	0	26. 00
27. 00	Patient Transportation	0	0		0	0	27. 00
28. 00	I maging Services	0	0		0	0	28. 00
29. 00	Labs and Diagnostics	0	0		0	0	29. 00
30.00	Medical Supplies	0	0		0	0	30. 00
31. 00	Outpatient Services (including E/R Dept.)	0	0		0	0	31. 00
32.00	Radiation Therapy	0	0		0	0	32. 00
33.00	Chemotherapy	0	0		0	1	33. 00
34.00	Other	0	0)	0	0	34. 00
	HOSPICE NONREIMBURSABLE SERVICE						
35. 00	Bereavement Program Costs	0	l ~		0		35. 00
36. 00	Volunteer Program Costs	0	0	1	0	1	36. 00
37. 00	Fundrai si ng	0	0	•	0	0	37. 00
38. 00	Other Program Costs	0	0	•	0	0	38. 00
39. 00	Total (sum of lines 1 thru 38)	283, 340	0)	0	190, 451	39.00

Heal th I	Financial Systems	DEARBORN COUN	ITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
ANALYSI	S OF PROVIDER-BASED HOSPICE COSTS		Provi der	CCN: 150086	Peri od: From 01/01/2014	Worksheet K	
			Hospi ce	CCN: 151531	To 12/31/2014	Date/Time Prep 5/29/2015 8:5	pared: 7 am
					Hospi ce I		
		Total (cols.	Reclassi fi cati	i Subtotal (co	I. Adjustments	Total (col. 8	
		1-5)	on	6 ± col. 7)		± col. 9)	
		6. 00	7. 00	8. 00	9. 00	10.00	
C	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0		0	0 0	0	1. 00
2.00	Capital Related Costs-Movable Equip.	0	(0	0	0	2. 00
3. 00 I	Plant Operation and Maintenance	0	(0	0	0	3. 00
4.00	Transportation - Staff	0	(0	0	0	4. 00

			Reclassificati		Adjustments	lotal (col. 8	
		1-5)	on	6 ± col . 7)	0.00	± col. 9) 10.00	
	GENERAL SERVICE COST CENTERS	6. 00	7. 00	8. 00	9. 00	10.00	
1 00	Capital Related Costs-Bldg and Fixt.		1 0		٥	0	1 00
1. 00 2. 00				0	0	0	
3.00	Capital Related Costs-Movable Equip.			0	0	0	
	Plant Operation and Maintenance			0	U	ľ	0.00
4.00	Transportation - Staff			0	0	0	
5.00	Volunteer Service Coordination	225 0/2	U F / 207	0/0 155	4 (00	0	5. 00
6.00	Administrative and General	325, 962	-56, 807	269, 155	-4, 602	264, 553	6. 00
7 00	I NPATI ENT CARE SERVI CE		0	0	0	0	7. 00
7.00	Inpatient - General Care	0	1		0		
8. 00	Inpatient - Respite Care		<u> </u>	U	U	0	8. 00
9. 00	VI SI TI NG SERVI CES Physi ci an Servi ces		0		٥	0	9.00
10.00	Nursi ng Care	81, 783	1		0	81, 783	
11. 00	Nursing Care-Continuous Home Care	81, 783		81, 783	0	81, 783	1
				0	0	0	
12.00	Physical Therapy	0		0	U	1	1
13.00	Occupational Therapy	0		0	0	1	13.00
14. 00	Speech/ Language Pathology	4/ 200		47 200	0	47 200	14.00
15.00	Medical Social Services	46, 290	ł	46, 290	0	46, 290	1
	Spiritual Counseling	7, 433	0	7, 433	0	7, 433	
	Di etary Counsel i ng	0	0	0	0	0	
	Counseling - Other	10.000	0	40.000	0	0	1
19.00	Home Health Aide and Homemaker	12, 323		12, 323	0	12, 323	1
	HH Aide & Homemaker - Cont. Home Care	0	· -	0	0	0	
21. 00	Other	0	0	0	0	0	21. 00
22.00	OTHER HOSPICE SERVICE COSTS		0	0	O		22.00
	Drugs, Biological and Infusion Therapy Analgesics		0		0	1	22. 00
23. 00	Sedatives / Hypnotics			0	0	1	23. 00 24. 00
				0	0	1	
25. 00	Other - Specify			0	0	1	25. 00
	Durable Medical Equipment/Oxygen			0	0	0	26. 00 27. 00
28. 00	Patient Transportation			0	0	1	1
	I maging Services			0	0	1	28. 00
	Labs and Diagnostics			0	U		29. 00
30.00	Medical Supplies			0	0	1	30.00
31.00	Outpatient Services (including E/R Dept.)	0		0	0	1	31.00
32.00	Radi ati on Therapy	0	0	0	0	0	32. 00
33. 00	Chemotherapy	0	0	0	0	0	33. 00
34. 00	Other	0	0	0	0	0	34. 00
25 00	HOSPI CE NONREI MBURSABLE SERVI CE	1	1 0		ما		25 00
35. 00	Bereavement Program Costs	0	0	0	0	0	
	Volunteer Program Costs			0	0	0	36.00
37. 00	Fundrai si ng			0	0	0	07.00
38. 00	Other Program Costs	472 701	1 5, 207	41, 004	4 (22)	0	
39.00	Total (sum of lines 1 thru 38)	473, 791	-56, 807	416, 984	-4, 602	412, 382	39.00

Health Financial Systems	DEARBORN COUNTY HOSPITAL	In Lieu of	f Form CMS-2552-10
HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES	Provi der CCN: 150086	Peri od: Wo	rksheet K-1

Hospi ce CCN: 151531 To 12/31/2014 Date/Time Prepared:

Administrator Director Social Supervisors Nurses				nospi ce c	JON. 131331	10 12/31/2014	5/29/2015 8:5	
Administrator Director Social Supervisors Nurses						Hospi ce I		
1.00 2.00 3.00 4.00 5.00			Admi ni strator	Di rector			Nurses	
1.00 Capital Related Costs-Bldg and Fixt.			1.00	2.00		4. 00	5. 00	
2.00 Capital Related Costs-Movable Equip. 2.00 3.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.0		GENERAL SERVICE COST CENTERS						
3.00 Plant Operation and Maintenance 0 0 0 0 0 0 0 3.00 4.00 Transportation - Staff 0 0 0 0 0 0 0 4.00 5.00 Volunteer Service Coordination 0 0 0 0 0 0 0 5.00 6.00 Administrative and General 55, 299 80, 212 0 0 0 0 5.00 INPATIENT CARE SERVICE 7.00 Inpatient - General Care 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1.00	Capital Related Costs-Bldg and Fixt.						1.00
4.00 Transportation - Staff 0 0 0 0 0 4.00 5.00 Volunteer Service Coordination 0 0 0 0 5.00 6.00 Administrative and General 55,299 80,212 0 0 0 6.00 INPATIENT CARE SERVICE 7.00 Inpatient - General Care 0 0 0 0 0 0 0 0 0 0 8.00 VISITING SERVICES 9.00 Physician Services 0 0 0 0 0 9.00 10.00 Nursing Care 0 0 0 0 0 9.00 11.00 Nursing Care-Continuous Home Care 0 0 0 0 0 0 11.00 12.00 Physical Therapy 0 0 0 0 0 0 0 0 12.00 13.00 Occupational Therapy 0 0 0 0 0 0 0 0 14.00 15.00<	2.00	Capital Related Costs-Movable Equip.						2. 00
S. 00 Volunteer Service Coordination 0 0 0 0 0 0 0 0 0	3.00	Plant Operation and Maintenance	0	0		0	0	3. 00
6.00 Administrative and General 55, 299 80, 212 0 0 0 0 6.00 INPATIENT CARE SERVICE	4.00	Transportation - Staff	0	0		0	0	4. 00
INPATIENT CARE SERVICE	5.00	Volunteer Service Coordination	0	0		0	0	5. 00
7.00 Inpatient - General Care 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	6.00	Administrative and General	55, 299	80, 212		0	0	6. 00
8.00 Inpatient - Respite Care 0 0 0 0 0 8.00		INPATIENT CARE SERVICE						
VISITING SERVICES 9.00 Physician Services 0 0 0 0 9.00 10.00 Nursing Care 0 0 0 0 81,783 10.00 11.00 Nursing Care-Continuous Home Care 0 0 0 0 0 11.00 12.00 Physical Therapy 0 0 0 0 0 12.00 13.00 Occupational Therapy 0 0 0 0 0 13.00 14.00 Speech/ Language Pathology 0 0 0 0 0 14.00 15.00 Medical Social Services 0 0 46,290 0 0 15.00 16.00 Spiritual Counseling 0 0 0 0 0 16.00	7.00		0	0		0	0	7. 00
9.00 Physician Services 0 0 0 0 0 9.00 10.00 Nursing Care 0 0 0 0 0 81,783 10.00 11.00 Nursing Care-Continuous Home Care 0 0 0 0 0 11.00 12.00 Physical Therapy 0 0 0 0 0 0 12.00 13.00 Occupational Therapy 0 0 0 0 0 0 13.00 0 0 0 14.00 0 15.00 Medical Social Services 0 0 46,290 0 0 15.00 16.00 Spiritual Counseling 0 0 0 0 0 16.00	8.00		0	0		0	0	8. 00
10.00 Nursing Care 0 0 0 0 81, 783 10.00 11.00 Nursing Care-Continuous Home Care 0 0 0 0 0 11.00 12.00 Physical Therapy 0 0 0 0 0 0 12.00 13.00 Occupational Therapy 0 0 0 0 0 13.00 14.00 Speech/ Language Pathology 0 0 0 0 14.00 15.00 Medical Social Services 0 0 46,290 0 0 15.00 16.00 Spiritual Counseling 0 0 0 0 0 16.00								
11. 00 Nursi ng Care-Conti nuous Home Care 0 0 0 0 0 11. 00 12. 00 Physi cal Therapy 0 0 0 0 0 12. 00 13. 00 Occupati onal Therapy 0 0 0 0 0 0 13. 00 14. 00 Speech/ Language Pathol ogy 0 0 0 0 0 14. 00 15. 00 Medi cal Soci al Servi ces 0 0 46, 290 0 0 15. 00 16. 00 Spi ri tual Counsel i ng 0 0 0 0 0 16. 00	9.00	Physi ci an Servi ces	0	0		0	0	9. 00
12.00 Physical Therapy 0 0 0 0 0 12.00 13.00 Occupational Therapy 0 0 0 0 0 13.00 14.00 Speech/ Language Pathology 0 0 0 0 0 14.00 15.00 Medical Social Services 0 0 46,290 0 0 15.00 16.00 Spiritual Counseling 0 0 0 0 0 16.00	10.00		0	0		0	81, 783	10.00
13. 00 Occupational Therapy 0 0 0 0 0 13. 00 14. 00 Speech/ Language Pathology 0 0 0 0 0 14. 00 15. 00 Medical Social Services 0 0 46, 290 0 0 15. 00 16. 00 Spiritual Counseling 0 0 0 0 0 16. 00	11. 00		0	0		0	0	11.00
14.00 Speech/ Language Pathology 0 0 0 0 14.00 15.00 Medical Social Services 0 0 46,290 0 0 15.00 16.00 Spiritual Counseling 0 0 0 0 0 16.00	12.00	Physi cal Therapy	0	0		0	0	12.00
15.00 Medical Social Services 0 0 46,290 0 0 15.00 16.00 Spiritual Counseling 0 0 0 0 0 16.00	13.00	Occupational Therapy	0	0		0	0	13. 00
16.00 Spiritual Counseling 0 0 0 16.00	14.00	Speech/ Language Pathology	0	0		0	0	14. 00
	15. 00		0	0	46, 29	0	0	15. 00
17 00 Di etary Councel i ng 0 0 0 0 0 0 0 17 00	16.00		0	0		0	0	16. 00
	17.00	Di etary Counseling	0	0		0	0	17. 00
18.00 Counseling - Other 0 0 0 0 18.00	18.00	Counseling - Other	0	0		0	0	18. 00
19.00 Home Health Aide and Homemaker 0 0 0 0 0 19.00			0	0		0		
20.00 HH Aide & Homemaker - Cont. Home Care 0 0 0 0 20.00			0	-	l .	-	_	1
21. 00 Other O O O O 21. 00	21. 00		0	0		0 0	0	21. 00
OTHER HOSPICE SERVICE COSTS			,					1
22.00 Drugs, Biological and Infusion Therapy 22.00								
23. 00 Anal gesi cs								
24.00 Sedatives / Hypnotics								1
25. 00 Other - Speci fy 25. 00								
26.00 Durable Medical Equipment/Oxygen 26.00								
27.00 Patient Transportation 0 0 0 0 0 27.00			0	0		0		
28. 00 I maging Services 0 0 0 0 0 28. 00			0	0		0		
29.00 Labs and Diagnostics 0 0 0 0 0 29.00		1	0	0		0		
30.00 Medical Supplies 0 0 0 0 0 30.00			0	0		0		
31.00 Outpatient Services (including E/R Dept.) 0 0 0 0 31.00		, , , , , , , , , , , , , , , , , , , ,	0	0		-	_	
32.00 Radiation Therapy 0 0 0 0 0 32.00		1	0	0		-		
33.00 Chemotherapy 0 0 0 0 0 33.00		1	0	0		-		
34.00 Other 0 0 0 0 34.00	34.00		0	0		0 0	0	34.00
HOSPI CE NONREI MBURSABLE SERVI CE			1					
35.00 Bereavement Program Costs 0 0 0 0 35.00			0	0			_	
36.00 Volunteer Program Costs 0 0 0 0 36.00			0	0		-	_	
37. 00 Fundrai si ng 0 0 0 0 37. 00				0		<u> </u>	_	
38.00 Other Program Costs 0 0 0 0 38.00			55 200	00.010	47.00	-	_	
39.00 Total (sum of lines 1 thru 38) 55,299 80,212 46,290 0 81,783 39.00	39.00	Tiotal (Sum of Titles I thru 38)	55, 299	δU, 212	40, 29	υ 0	δι, /83	J 39. 00

Heal th	Financial Systems	DEARBORN COUNT	Y HOSPITAL		In Lie	u of Form CMS-2552-10
HOSPI C	CE COMPENSATION ANALYSIS SALARIES AND WAGES		Provi der	CCN: 150086	Peri od:	Worksheet K-1
			Hospi ce C	CN: 151531	From 01/01/2014 To 12/31/2014	Date/Time Prepared:
			nospi ce o			5/29/2015 8:57 am
					Hospi ce I	
		Total	Ai des	All-Other	Total (1)	
		Therapists 6.00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS	6.00	7.00	8.00	9.00	
1. 00	Capital Related Costs-Bldg and Fixt.					1. 00
2. 00	Capital Related Costs-Brug and Trxt.					2. 00
3. 00	Plant Operation and Maintenance		0		0	3. 00
4. 00	Transportation - Staff		0			4.00
5. 00	Volunteer Service Coordination		ő		0 0	5. 00
6.00	Administrative and General		ő		0 135, 511	6.00
0.00	INPATIENT CARE SERVICE		<u>~</u>		0 1007011	0.00
7.00	Inpatient - General Care		0		0 0	7. 00
8.00	Inpatient - Respite Care		o		0 0	8. 00
	VI SI TI NG SERVI CES	'				
9.00	Physi ci an Servi ces		0		0 0	9. 00
	Nursi ng Care		0		0 81, 783	10. 00
	Nursing Care-Continuous Home Care		0		0 0	11. 00
	Physi cal Therapy	0	0		0 0	12. 00
	Occupational Therapy	0	0		0 0	13. 00
	Speech/ Language Pathology	0	0		0 0	14. 00
	Medical Social Services		0		0 46, 290	15. 00
	Spiritual Counseling		0	7, 4		16. 00
	Di etary Counsel i ng		0		0 0	17. 00
	Counseling - Other		0		0 0	18. 00
	Home Health Aide and Homemaker		12, 323		0 12, 323	19. 00
	HH Aide & Homemaker - Cont. Home Care		0		0 0	20. 00
21. 00	Other		0		0 0	21. 00
22.00	OTHER HOSPICE SERVICE COSTS					22.00
	Drugs, Biological and Infusion Therapy					22. 00
	Anal gesi cs					23. 00 24. 00
	Sedatives / Hypnotics Other - Specify					24.00
	Durable Medical Equipment/Oxygen					26. 00
	Patient Transportation		0		0	27. 00
	Imaging Services		0			28. 00
	Labs and Diagnostics		0			29. 00
	Medical Supplies		0			30.00
	Outpatient Services (including E/R Dept.)		ol O			31. 00
	Radiation Therapy		0		0	32.00

0

0

12, 323

0 0 0

7, 433

0 0 0

283, 340

32.00

33.00

34.00

35.00

36.00 37. 00

38.00

39. 00

32.00 Radiation Therapy

Other

37.00 Fundrai si ng

Chemotherapy

HOSPICE NONREIMBURSABLE SERVICE
Bereavement Program Costs

Volunteer Program Costs

38.00 Other Program Costs 39.00 Total (sum of lines 1 thru 38)

33.00

34.00

35.00

36.00

| In Lieu of Form CMS-2552-10 | Provider CCN: 150086 | Period: | Worksheet K-4 | From 01/01/2014 | Part | To 12/31/2014 | Date/Time Prepared: | 5/79/2015 8:57 am

					5/29/2015 8: 5		7 am
					Hospi ce I		
	·		CAPITAL RE	LATED COST			
		NET EXPENSES	BUI LDI NGS &	MOVABLE	PLANT	TRANSPORTATI ON	
		FOR COST	FI XTURES	EQUI PMENT	OPERATION &		
		ALLOCATI ON			MAI NT.		
		0	1. 00	2.00	3. 00	4. 00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1.00
2.00	Capital Related Costs-Movable Equip.	0			0		2. 00
3.00	Plant Operation and Maintenance	0	0		0		3. 00
4.00	Transportation - Staff	0	0		0	0	4. 00
5.00	Volunteer Service Coordination	0	0		0	0	5. 00
6.00	Administrative and General	264, 553	0		0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0		0 0	0	7. 00
8.00	Inpatient - Respite Care	0	0		0	0	8. 00
	VISITING SERVICES						
9.00	Physi ci an Servi ces	0	0		0 0	0	9. 00
10.00	Nursing Care	81, 783	0		0	0	10.00
11.00	Nursing Care-Continuous Home Care	o	0		0	0	11. 00
12.00	Physical Therapy	o	0		0 0	0	12.00
13.00	Occupational Therapy	o	0		0 0	0	13. 00
14.00	Speech/ Language Pathology	o	0		0 0	0	14. 00
15.00	Medical Social Services	46, 290	0		0 0	0	15. 00
16.00	Spiritual Counseling	7, 433	0		0 0	0	16. 00
17.00	Di etary Counsel i ng	o	0		0 0	0	17. 00
18.00	Counseling - Other	o	0		0 0	0	18. 00
19.00	Home Health Aide and Homemaker	12, 323	0		0 0	0	19. 00
20.00	HH Aide & Homemaker - Cont. Home Care	o	0		0 0	0	20. 00
21.00	Other	o	0		0 0	0	21. 00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0		0 0	0	22. 00
23.00	Anal gesi cs	o	0		0 0	0	23. 00
24.00	Sedatives / Hypnotics	o	0		0 0	0	24.00
25.00	Other - Specify	o	0		0 0	0	25. 00
26.00	Durable Medical Equipment/Oxygen	o	0		0 0	0	26. 00
27.00	Patient Transportation	o	0		0 0	0	27. 00
28.00	Imaging Services	o	0		0 0	0	28. 00
29.00	Labs and Diagnostics	o	0		0 0	0	29. 00
30.00	Medical Supplies	o	0		0 0	0	30.00
31. 00	Outpatient Services (including E/R Dept.)	o	0		0	0	31.00
32. 00	Radi ati on Therapy	o	0		0	0	32.00
33. 00	Chemotherapy	o	0		0 0	0	33. 00
34.00	Other	o	0		0		34.00
	HOSPICE NONREIMBURSABLE SERVICE	-					
35. 00	Bereavement Program Costs	O	0		0 0	0	35. 00
36. 00	Volunteer Program Costs		0		0 0		36. 00
37. 00	Fundrai si ng		0		0 0	ő	37. 00
38. 00	Other Program Costs		0		0 0		38. 00
	Total (sum of lines 1 thru 38)	412, 382	0		0 0		1
	/		ŭ	'	,	'	

Health Financial Systems	DEARBORN COUNTY HOSPITAL	In Lieu of Form CMS-2552-10		
COST ALLOCATION - HOSPICE GENERAL SERVICE COST	Provi der CCN: 150086	Period: Worksheet K From 01/01/2014 Part I	7-4	

Hospi ce CCN: 151531 To 12/31/2014 Part 1 Date/Time Prepared:

			1103	spice c	CN. 131331 1	0 12/31/2014	5/29/2015 8:5	
						Hospi ce I	3, 2, , 20, 0	
		VOLUNTEER	SUBTO	TAL /	ADMI NI STRATI VE	TOTAL (col. 5A		
		SERVI CES	(cols. (& GENERAL	± col. 6)		
		COORDI NATOR				,		
		5. 00	5A		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS		•			'		
1.00	Capital Related Costs-Bldg and Fixt.							1.00
2.00	Capital Related Costs-Movable Equip.							2.00
3.00	Plant Operation and Maintenance							3.00
4. 00	Transportation - Staff							4. 00
5. 00	Volunteer Service Coordination							5. 00
6. 00	Administrative and General		1	64, 553	264, 553			6.00
0.00	INPATIENT CARE SERVICE			0 17 000	201,000	1		- 0.00
7. 00	Inpatient - General Care	C		0	(0		7.00
8. 00	Inpatient - Respite Care		1	o	(8.00
0.00	VI SI TI NG SERVI CES		1	۳,		,		- 0.00
9. 00	Physician Services	C		0	(0		9.00
10. 00	Nursing Care			81, 783	146, 358	-		10.00
11. 00	Nursing Care-Continuous Home Care			0.7,700	,	0		11.00
12. 00	Physical Therapy			0	Č			12.00
13. 00	Occupational Therapy			0	Č			13. 00
14. 00				0	Č			14. 00
	Medical Social Services		ál	46, 290	82, 840	129, 130		15. 00
	Spiritual Counseling			7, 433	13, 302			16.00
17. 00	Di etary Counsel i ng		ál	7, 100	10, 002	20, 700		17. 00
18. 00	Counseling - Other		ál	0	(18. 00
19. 00	Home Health Aide and Homemaker		ál	12, 323	22, 053	34, 376		19. 00
20. 00	HH Ai de & Homemaker - Cont. Home Care		II.	12, 323	22,000	0 34, 370		20.00
21. 00	Other		1	0		o o		21.00
21.00	OTHER HOSPICE SERVICE COSTS		4	<u> </u>		7		21.00
22. 00	Drugs, Biological and Infusion Therapy	C		O	(0		22. 00
			l .	0	(23. 00
	Sedatives / Hypnotics			0	(ή		24. 00
25. 00	Other - Specify			0				25. 00
26. 00	Durable Medical Equipment/Oxygen		3	0				26. 00
27. 00	Patient Transportation		3	0				27. 00
28. 00	Imaging Services		3	0				28. 00
29. 00	Labs and Diagnostics			0	(29.00
30. 00				0	(30.00
31. 00	Medical Supplies			0	(31.00
32.00	Outpatient Services (including E/R Dept.)			0	(31.00
32.00	Radiation Therapy			0	(32.00
34. 00	Chemotherapy Other			0	(34.00
34.00			7	U)		34.00
25 00	HOSPICE NONREIMBURSABLE SERVICE Bereavement Program Costs		1	O	() 0		35. 00
				0	(
36. 00	Volunteer Program Costs		(U	(36.00
37. 00	Fundrai si ng			O	(37. 00
38. 00	Other Program Costs		() .	12 202	C	412 202		38. 00
39.00	Total (sum of lines 1 thru 38)	(C	기 4	12, 382		412, 382		39. 00

						5/29/2015 8:5	7 am
					Hospi ce I		
		CAPITAL RE	LATED COST				
		BUILDINGS &	MOVABLE	PLANT	TRANSPORTATI ON	VOLUNTEER	
		FIXTURES (SQ.	EQUIPMENT (\$	OPERATION &	(MI LEAGE)	SERVI CES	
		FT.)	VALUE)	MAINT. (SQ.		COORDI NATOR	
		,	ĺ	FT.)		(HOURS)	
		1.00	2. 00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS				•		
1.00	Capital Related Costs-Bldg and Fixt.	0					1.00
2.00	Capital Related Costs-Movable Equip.	0	0				2.00
3.00	Plant Operation and Maintenance	i o	0				3. 00
4. 00	Transportation - Staff	0	0		o o		4. 00
5. 00	Volunteer Service Coordination		0			0	5. 00
			0			0	•
6. 00	Administrative and General	0	0	1	J U	0	6. 00
7.00	I NPATI ENT CARE SERVI CE	1	_	1		0	7 00
7.00	Inpatient - General Care	0			0		7. 00
8.00	Inpatient - Respite Care	0	0	1	0	0	8. 00
	VI SI TI NG SERVI CES	ı		ı	1		
9.00	Physi ci an Servi ces	0	0		0	0	9. 00
10. 00	Nursing Care	0	0		0	0	10. 00
11. 00	Nursing Care-Continuous Home Care	0	0		0	0	11. 00
12.00	Physi cal Therapy	0	0		0	0	12. 00
13.00	Occupational Therapy	0	0		0	0	13.00
14.00	Speech/ Language Pathology	0	0		0	0	14. 00
15.00	Medical Social Services	0	0		0	0	15. 00
16.00	Spiritual Counseling	0	0		0	0	16. 00
17. 00	Di etary Counsel i ng	0	0		0	0	17. 00
18. 00	Counseling - Other	0	0		0	0	18. 00
19. 00	Home Health Aide and Homemaker	0	0		0	0	19. 00
20. 00	HH Aide & Homemaker - Cont. Home Care	i o	Ö	•	0	0	20. 00
21. 00	Other	l o	0		o o	Ö	21. 00
21.00	OTHER HOSPICE SERVICE COSTS	J			<u> </u>		21.00
22. 00	Drugs, Biological and Infusion Therapy	0	0	1	0	0	22. 00
23. 00	Anal gesi cs		0	•		0	23. 00
24. 00	Sedatives / Hypnotics	0	0			0	24.00
		0	0			0	
25. 00	Other - Specify	0	_				25. 00
26. 00	Durable Medical Equipment/Oxygen	0	0		0	0	26. 00
27. 00	Patient Transportation	0	0		0	0	27. 00
28. 00	I maging Services	0	0		0	0	28. 00
29. 00	Labs and Diagnostics	0	0		0	0	29. 00
30.00	Medical Supplies	0	0		0	0	30. 00
31.00	Outpatient Services (including E/R Dept.)	0	0		0	0	31.00
32.00	Radiation Therapy	0	0		0	0	32. 00
33.00	Chemotherapy	0	0		0	0	33. 00
34.00	Other	0	0		0	0	34. 00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0		0	0	35. 00
36.00	Volunteer Program Costs	0	0		0	0	36. 00
37. 00	Fundrai si ng	0	0		0	0	37. 00
38. 00	Other Program Costs	0	0	1	0	0	38. 00
39. 00	Cost to be Allocated (per Wkst. K-4, Part I)	l n	n		o n	0	39. 00
	Unit Cost Multiplier	0. 000000	0. 000000	0. 00000	0. 000000	_	
10.00	Join C 3550 mar crprror	0.00000	0.00000	0.00000	3. 333000	0.00000	1 .0.00

From 01/01/2014 Part II Date/Time Prepared: Hospi ce CCN: 151531 То 12/31/2014 5/29/2015 8:57 am Hospi ce I RECONCI LI ATI ON ADMI NI STRATI VE & GENERAL (ACC. COST) 6A 6.00 GENERAL SERVICE COST CENTERS Capital Related Costs-Bldg and Fixt. 1.00 0 Capital Related Costs-Movable Equip. 2.00 Plant Operation and Maintenance 0 3.00 Transportation - Staff 0 4.00 Volunteer Service Coordination 5.00 -264, 553 Administrative and General 147, 829 6.00 INPATIENT CARE SERVICE Inpatient - General Care Inpatient - Respite Care 0 7.00 0 0 8.00 VISITING SERVICES Physician Services 0 9.00 Nursing Care 81, 783 10.00 Nursing Care-Continuous Home Care 11.00 0 Physical Therapy 0 12.00 Occupational Therapy 13.00 0 Speech/ Language Pathology Medical Social Services 0 14.00 46, 290 15.00 Spiritual Counseling 7, 433 16.00 Dietary Counseling 0 17.00 Counseling - Other 18.00 0

						5/29/2015 8:5	/ am
					Hospi ce I		
			CAPI TAL REI	_ATED_COSTS			
	Cost Center Description	Hospi ce Tri al	NEW BLDG &	NEW MVBLE	EMPLOYEE	COMMUNI CATI ONS	
		Bal ance (1)	FLXT	EQUI P	BENEFITS		
					DEPARTMENT		
		0	1.00	2.00	4. 00	5. 01	
1.00	Administrative and General		3, 604	2, 610	101, 476	0	1. 00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	O	0	0	0	0	3. 00
4.00	Physi ci an Servi ces	O	0	0	0	0	4. 00
5.00	Nursing Care	228, 141	0	0	0	0	5. 00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6. 00
7.00	Physical Therapy	0	0	0	0	0	7. 00
8.00	Occupational Therapy	0	0	0	0	0	8. 00
9.00	Speech/ Language Pathology	0	0	0	0	0	9. 00
10.00	Medical Social Services	129, 130	0	0	0	0	10.00
11. 00	Spiritual Counseling	20, 735	0	0	0	0	11. 00
12.00	Di etary Counseling	0	0	0	0	0	12. 00
13.00		0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	34, 376	0	0	0	0	14. 00
15. 00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15. 00
16. 00		O	0	0	0	0	16. 00
17. 00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17. 00
18. 00		0	0	0	0	0	18. 00
19. 00	Sedatives / Hypnotics	0	0	0	0	0	19. 00
20. 00	Other - Specify	o	0	0	0	0	20.00
21. 00	Durable Medical Equipment/Oxygen	o	0	0	0	0	21. 00
22. 00		o	0	0	0	0	22. 00
23. 00		o	0	0	0	0	23. 00
24.00	Labs and Diagnostics	0	0	0	0	0	24. 00
25. 00		o	0	0	0	0	25. 00
26. 00		o	0	0	0	0	26. 00
27. 00	Radi ati on Therapy	o	0	0	0	o	27. 00
28. 00	Chemotherapy	o	0	0	0	0	28. 00
29. 00		o	0	0	0	0	29. 00
30. 00		o	0	0	0	0	30.00
31. 00	9	o	0	0	0	0	31.00
32. 00	Fundrai si ng	o	0	0	0	0	32. 00
33. 00		o	0	0	0	0	1
34.00		412, 382	3, 604	2, 610	101, 476	0	34.00
35. 00				·			35. 00

							5/29/2015 8: 5	7 am
						Hospi ce I		
	Cost Center Description	DATA	PURCHASI N	IG ADMITTIN	IG (CASHI ERI NG/ACC	Subtotal	
		PROCESSI NG	RECEIVING A	AND		OUNTS		
			STORES			RECEI VABLE		
		5. 02	5. 03	5. 04		5. 05	5A. 05	
1.00	Administrative and General	C	3,	779	0	6, 631	118, 100	1. 00
2.00	Inpatient - General Care	C)	0	0	0	0	2. 00
3.00	Inpatient - Respite Care	C)	0	0	0	0	3. 00
4.00	Physi ci an Servi ces	C)	0	0	0	0	4. 00
5.00	Nursi ng Care	C)	0	0	0	228, 141	5. 00
6.00	Nursing Care-Continuous Home Care	C)	0	0	0	0	6. 00
7.00	Physi cal Therapy	C)	0	0	0	0	7. 00
8.00	Occupational Therapy	C)	0	0	0	0	8. 00
9.00	Speech/ Language Pathology	C)	0	0	0	0	9. 00
10.00	Medical Social Services	C)	0	0	0	129, 130	10.00
11. 00	Spiritual Counseling	C)	0	0	0	20, 735	11. 00
12.00	Di etary Counsel i ng	C)	0	0	0	0	12. 00
13.00	Counseling - Other	C)	0	0	0	0	13. 00
14.00	Home Health Aide and Homemaker	C)	0	0	0	34, 376	14. 00
15. 00	HH Aide & Homemaker - Cont. Home Care	C)	0	0	0	0	15. 00
16.00	Other	C)	0	0	0	0	16. 00
17. 00	Drugs, Biological and Infusion Therapy	C)	0	0	0	0	17. 00
18.00	Anal gesi cs	C)	0	0	0	0	18. 00
19. 00	Sedatives / Hypnotics	C)	0	0	0	0	19. 00
20.00	Other - Specify	C)	0	0	0	0	20. 00
21.00	Durable Medical Equipment/Oxygen	C)	0	0	0	0	21. 00
22. 00	Patient Transportation	C)	0	0	0	0	22. 00
23.00	I maging Services	C)	0	0	0	0	23. 00
24.00	Labs and Diagnostics	C)	0	0	0	0	24. 00
25. 00	Medical Supplies	C)	0	0	0	0	25. 00
26.00	Outpatient Services (including E/R Dept.)	C)	0	0	0	0	26. 00
27. 00	Radiation Therapy	C)	0	0	0	0	27. 00
28. 00	Chemotherapy	C)	0	0	0	0	28. 00
29. 00	Other	C)	0	0	0	0	29. 00
30.00	Bereavement Program Costs	C)	0	0	0	0	30. 00
31.00	Volunteer Program Costs	C)	0	0	0	0	31. 00
32.00	Fundrai si ng	C)	0	0	0	0	32. 00
33.00	Other Program Costs	C)	0	0	0	0	33. 00
34.00	Total (sum of lines 1 thru 33) (2)	C	3,	779	0	6, 631	530, 482	34. 00
35. 00	Unit Cost Multiplier (see instructions)						0.000000	35. 00

						5/29/2015 8:5	7 am
					Hospi ce I		
	Cost Center Description	OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		ADMI NI STRATI VE	PLANT	LINEN SERVICE			
		AND GENERAL					
		5. 06	7. 00	8. 00	9. 00	10.00	
1.00	Administrative and General	5, 461	10, 500	0	2, 936	0	1. 00
2.00	Inpatient - General Care	0	0	0	0	0	2. 00
3.00	Inpatient - Respite Care	0	0	0	0	0	3. 00
4.00	Physi ci an Servi ces	0	0	0	0	0	4. 00
5.00	Nursi ng Care	10, 550	0	0	0	0	5. 00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6. 00
7.00	Physi cal Therapy	0	0	0	0	0	7. 00
8.00	Occupational Therapy	0	0	0	0	0	8. 00
9.00	Speech/ Language Pathology	0	0	0	0	0	9. 00
10.00	Medical Social Services	5, 971	0	0	0	0	10. 00
11. 00	Spiritual Counseling	959	0	0	0	0	11. 00
12.00	Di etary Counsel i ng	0	0	0	0	0	12. 00
13.00	Counseling - Other	0	0	0	0	0	13. 00
14.00	Home Health Aide and Homemaker	1, 590	0	0	0	0	14. 00
15. 00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15. 00
16.00	Other	0	0	0	0	0	16. 00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17. 00
18.00	Anal gesi cs	0	0	0	0	0	18. 00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19. 00
20.00	Other - Specify	0	0	0	0	0	20. 00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21. 00
22. 00	Patient Transportation	0	0	0	0	0	22. 00
23.00	I maging Services	0	0	0	0	0	23. 00
24.00	Labs and Diagnostics	0	0	0	0	0	24. 00
25.00	Medical Supplies	0	0	0	0	0	25. 00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26. 00
27.00	Radi ati on Therapy	0	0	0	0	0	27. 00
28. 00	Chemotherapy	0	0	0	0	0	28. 00
29. 00	Other	0	0	0	0	0	29. 00
30.00	Bereavement Program Costs	0	0	0	0	0	30. 00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundrai si ng	0	0	0	0	0	32. 00
33.00	Other Program Costs	0	0	0	0	0	33. 00
34.00	Total (sum of lines 1 thru 33) (2)	24, 531	10, 500	0	2, 936	0	34. 00
35.00	Unit Cost Multiplier (see instructions)						35. 00

						5/29/2015 8:5	<u> 7 am</u>
					Hospi ce I		
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
			ADMI NI STRATI ON	SERVICE &		RECORDS &	
				SUPPLY		LI BRARY	
		11. 00	13. 00	14.00	15. 00	16. 00	
1.00	Administrative and General	0	0		0	0	1. 00
2.00	Inpatient - General Care	0	0		0	0	2. 00
3.00	Inpatient - Respite Care	0	0		0	0	3. 00
4.00	Physi ci an Servi ces	0	0		0 0	0	4. 00
5.00	Nursi ng Care	0	0		0 0	0	5. 00
6.00	Nursing Care-Continuous Home Care	0	0		0 0	0	6. 00
7.00	Physi cal Therapy	0	0		0 0	0	7. 00
8.00	Occupational Therapy	0	0		0 0	0	8. 00
9.00	Speech/ Language Pathology	0	0		0 0	0	9. 00
10.00	Medical Social Services	0	0		0	0	10.00
11.00	Spiritual Counseling	0	0		0 0	0	11. 00
12.00	Di etary Counsel i ng	0	0		0	0	12.00
13.00	Counseling - Other	0	0		0	0	13.00
14.00	Home Health Aide and Homemaker	0	0		0	0	14. 00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0		0	0	15. 00
16.00	Other	0	0		0	0	16. 00
17.00	Drugs, Biological and Infusion Therapy	0	0		0	0	17. 00
18.00	Anal gesi cs	0	0		0	0	18. 00
19.00	Sedatives / Hypnotics	0	0		0 0	0	19. 00
20.00	Other - Specify	0	0		0 0	0	20. 00
21.00	Durable Medical Equipment/Oxygen	0	0		0	0	21. 00
22. 00	Patient Transportation	0	0		0 0	0	22. 00
23.00	I maging Services	0	0		0 0	0	23. 00
24.00	Labs and Diagnostics	0	0		0 0	0	24. 00
25.00	Medical Supplies	0	0		0 0	0	25. 00
26.00	Outpatient Services (including E/R Dept.)	0	0		0 0	0	26. 00
27.00	Radiation Therapy	0	0		0 0	0	27. 00
28. 00	Chemotherapy	0	0		0 0	0	28. 00
29.00	Other	0	0		0 0	0	29. 00
30.00	Bereavement Program Costs	0	o		0 0	0	30. 00
31.00	Volunteer Program Costs	0	0		0	0	31. 00
32.00	Fundrai si ng	0	0		0	0	32. 00
33.00	Other Program Costs	0	0		0	0	33. 00
34.00	Total (sum of lines 1 thru 33) (2)	0	0		0	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35. 00

						5/29/2015 8:5	/ am
					Hospi ce I		
	Cost Center Description	SOCIAL SERVICE	Subtotal	Intern &	Subtotal	Allocated	
	·		(cols. 4A-23)	Residents Cost	(cols. 24 ±	Hospice A&G	
				& Post	25)	(See Part II)	
				Stepdown	·	,	
				Adjustments			
		17. 00	24. 00	25.00	26.00	27. 00	
1.00	Administrative and General	0	136, 99	7			1.00
2.00	Inpatient - General Care	0			0	0	2.00
3.00	Inpatient - Respite Care	0			0	0	3. 00
4.00	Physi ci an Servi ces	0			0	0	4. 00
5.00	Nursing Care	0	238, 69	1 (238, 691	75, 791	5. 00
6.00	Nursing Care-Continuous Home Care	0			0	0	6.00
7.00	Physi cal Therapy	0			0	0	7. 00
8.00	Occupational Therapy	0			0	0	8. 00
9.00	Speech/ Language Pathology	0			0	0	9. 00
10.00	Medi cal Soci al Servi ces	0	135, 10	1 (135, 101	42, 898	10.00
11. 00	Spiritual Counseling	0	21, 69	4 0	21, 694	6, 888	11. 00
12.00	Di etary Counsel i ng	0			0	0	12.00
13.00	Counseling - Other	0			0	0	13. 00
14.00	Home Health Aide and Homemaker	0	35, 96	6 0	35, 966	11, 420	14. 00
15.00	HH Aide & Homemaker - Cont. Home Care	0			0	0	15. 00
16.00	0ther	0			0	0	16. 00
17. 00	Drugs, Biological and Infusion Therapy	0			0	0	17. 00
18.00	Anal gesi cs	0			0	0	18. 00
19.00	Sedatives / Hypnotics	0			0	0	19. 00
20.00	Other - Specify	0			0	0	20. 00
21. 00	Durable Medical Equipment/Oxygen	0			0	0	21. 00
22. 00	Patient Transportation	0			0	0	22. 00
23.00	I maging Services	0			0	0	23. 00
24.00	Labs and Diagnostics	0			0	0	24. 00
25.00	Medical Supplies	0			0	0	25. 00
26.00	Outpatient Services (including E/R Dept.)	0			0	0	26. 00
27.00	Radi ati on Therapy	0			0	0	27. 00
28.00	Chemotherapy	0			0	0	28. 00
29.00	Other	0			0	0	29. 00
30.00	Bereavement Program Costs	0			0	0	30.00
31.00	Volunteer Program Costs	0			0	0	31.00
32.00	Fundrai si ng	0			0	0	32. 00
33.00	Other Program Costs	0			0	0	33. 00
34.00	Total (sum of lines 1 thru 33) (2)	0	568, 44	9 0	568, 449		34.00
35.00	Unit Cost Multiplier (see instructions)					0. 317525	35. 00
		•	•	•	•	•	•

Health Financial Systems	DEARBORN COUNTY HO	OSPI TAL	In Lie	u of Form CMS-2552-10
ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST	CENTERS	Provi der CCN: 150086	Period: From 01/01/2014	Worksheet K-5 Part I

Hospi ce CCN: 151531 From 01/01/2014 Part I Date/Time Prepared: 5/29/2015 8:57 am

				37 2 77 20 13 0. 37 dill
		1	Hospi ce I	
	Cost Center Description	Total Hospice		
		Costs (cols.		
		26 ± 27) 28.00		
1.00	Administrative and General	28.00		1, 00
2. 00	Inpatient - General Care	0		2.00
3.00	Inpatient - Respite Care	0		3. 00
4.00	Physician Services			4. 00
5.00	Nursing Care	314, 482		5. 00
6. 00	Nursing Care-Continuous Home Care	314, 462		6. 00
7. 00	Physical Therapy	0		7.00
8. 00	Occupational Therapy			8.00
9. 00	Speech/ Language Pathology			9. 00
10.00		177, 999		10.00
11. 00		28, 582		11. 00
12. 00	1 .	20, 302		12. 00
13. 00				13. 00
14. 00	Home Health Aide and Homemaker	47, 386		14. 00
15. 00	HH Aide & Homemaker - Cont. Home Care	47, 300		15. 00
16. 00				16. 00
17. 00				17. 00
18. 00				18. 00
19. 00				19. 00
20. 00	31	0		20.00
21. 00		0		21.00
22. 00		0		22. 00
	Imaging Services	0		23. 00
24. 00		o		24. 00
25. 00		O		25. 00
26. 00	Outpatient Services (including E/R Dept.)	O		26. 00
27. 00		O		27. 00
28. 00		O		28. 00
29. 00	1	O		29. 00
30.00	Bereavement Program Costs	O		30.00
31.00		O		31.00
32.00	9	O		32. 00
33. 00	Other Program Costs	0		33. 00
34.00		568, 449		34. 00
35.00	Unit Cost Multiplier (see instructions)			35. 00
		. '		•

						5/29/2015 8: 5	7 am
					Hospi ce I		
	·	CAPITAL RELA	ATED COSTS				
	Cost Center Description	NEW BLDG &	NEW MVBLE	EMPLOYEE	COMMUNI CATI ONS	DATA	
	'	FLXT	EQUI P	BENEFITS		PROCESSI NG	
		(SQUARE	(SQUARE	DEPARTMENT	(PHONES)	(DP EQUIPMENT)	
		FEET)	FEET)	(GROSS	(**************************************	(
		,	. ==.,	SALARI ES)			
		1.00	2. 00	4. 00	5. 01	5. 02	
1. 00	Administrative and General	315	315	283, 340	0	0	1. 00
2.00	Inpatient - General Care	o	0	0	0	0	2. 00
3.00	Inpatient - Respite Care	o	0	0	0	0	3. 00
4.00	Physi ci an Servi ces	o	0	0	0	o	4. 00
5.00	Nursing Care	o	0	0	0	0	5. 00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6. 00
7. 00	Physical Therapy	o	0	0	0	0	7. 00
8.00	Occupational Therapy	o	0	0	0	0	8. 00
9. 00	Speech/ Language Pathology	0	0	0	0	0	9. 00
10.00	Medical Social Services	0	0	0	0	0	10.00
11. 00	Spiritual Counseling	o	0	0	0		11. 00
12. 00	Di etary Counsel i ng	o	0	0	_	-	12. 00
13. 00	Counseling - Other		0	0	0	0	13. 00
14. 00	Home Health Aide and Homemaker	o	0	0	_	0	14. 00
15. 00	HH Ai de & Homemaker - Cont. Home Care	Ö	0	0	0	_	15. 00
16. 00	Other	Ö	0	0	0	0	16. 00
17. 00	Drugs, Biological and Infusion Therapy		0	0	0	0	17. 00
18. 00	Anal gesi cs		0	0	_	o	18. 00
19. 00	Sedatives / Hypnotics		0	0	0		19. 00
20. 00	Other - Specify		0	0	_	0	20. 00
21. 00	Durable Medical Equipment/Oxygen		0	0	0	Ö	21. 00
22. 00	Patient Transportation		0	0	_	0	22. 00
23. 00	Imaging Services		0	0	_	- 1	23. 00
24. 00	Labs and Diagnostics		0	0	0	0	24. 00
25. 00	Medical Supplies		0	0	0	0	25. 00
26. 00	Outpatient Services (including E/R Dept.)		0	0	0	ŭ	26. 00
27. 00	Radi ati on Therapy		0	0	0	0	27. 00
28. 00	Chemotherapy		0	0	0	0	28. 00
29. 00	Other		0	0	0	0	29. 00
30. 00	Bereavement Program Costs		0	0	0	0	30.00
31. 00	Volunteer Program Costs		0	0	0	0	31. 00
32. 00	Fundrai si ng		0	0	0	0	32. 00
33. 00	Other Program Costs		0	0		0	33. 00
34. 00	Total (sum of lines 1 thru 33) (2)	315	315	283, 340		0	34. 00
35. 00	Total cost to be allocated	3, 604	2, 610	•		0	35. 00
	Unit Cost Multiplier (see instructions)	11. 441270	2, 610 8. 285714				
30.00	Junit Cost Multiplier (See Instructions)	11.441270	ö. 2ö5/14	0.358142	0.000000	0.000000	30.00

150086 | Period: | Worksheet K-5 | From 01/01/2014 | Part II | To 12/31/2014 | Date/Time Prepared: 5/29/2015 8:57 am Provi der CCN: 150086 STATISTICAL BASIS Hospi ce CCN:

						5/29/2015 8:5	/ am
					Hospi ce I		
	Cost Center Description	PURCHASI NG	ADMI TTI NG	CASHI ERI NG/ACC	Reconciliation	OTHER	
		RECEIVING AND	(ADMI SSI ONS)	OUNTS		ADMI NI STRATI VE	
		STORES		RECEI VABLE		AND GENERAL	
		(SUPPLY		(GROSS		(ACCUM.	
		EXPENSE)		CHARGES)		COST)	
		5. 03	5. 04	5. 05	5A. 06	5. 06	
1.00	Administrative and General	60, 803	0	793, 852	0	118, 100	1. 00
2.00	Inpatient - General Care	0	0	0	0	0	
3.00	Inpatient - Respite Care	0	0	0	0	0	3. 00
4.00	Physi ci an Servi ces	0	0	0	0	0	4. 00
5.00	Nursi ng Care	0	0	0	0	228, 141	5. 00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6. 00
7.00	Physi cal Therapy	0	0	0	0	0	7. 00
8.00	Occupational Therapy	0	0	0	0	0	8. 00
9.00	Speech/ Language Pathology	0	0	0	0	0	9. 00
10.00	Medical Social Services	0	0	0	0	129, 130	10.00
11. 00	Spiritual Counseling	0	0	0	0	20, 735	11. 00
12.00	Di etary Counsel i ng	0	0	0	0	0	12. 00
13.00	Counseling - Other	0	0	0	0	0	13. 00
14.00	Home Health Aide and Homemaker	0	0	0	0	34, 376	14. 00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15. 00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17. 00
18.00	Anal gesi cs	0	0	0	0	0	18. 00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19. 00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21. 00
22.00	Patient Transportation	0	0	0	0	0	22. 00
23.00	I maging Services	0	0	0	0	0	23. 00
24.00	Labs and Diagnostics	0	0	0	0	0	24. 00
25.00	Medical Supplies	0	0	0	0	0	25. 00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26. 00
27.00	Radi ati on Therapy	0	0	0	0	0	27. 00
28.00	Chemotherapy	0	0	0	0	0	28. 00
29.00	Other	0	0	0	0	0	29. 00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31. 00
32.00	Fundrai si ng	0	0	0	0	0	32. 00
33.00	Other Program Costs	0	0	0	0	0	33. 00
34.00	Total (sum of lines 1 thru 33) (2)	60, 803	0	793, 852		530, 482	34. 00
35.00	Total cost to be allocated	3, 779	0	6, 631		24, 531	35. 00
36. 00	Unit Cost Multiplier (see instructions)	0. 062152	0. 000000	0. 008353		0. 046243	36. 00

STATISTICAL BASIS

						5/29/2015 8:5	7 am
					Hospi ce I		
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NO	DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE	(SQUARE	(MEALS	(MAN HOURS)	
		(SQUARE	(POUNDS OF	FEET)	SERVED)		
		FEET)	LAUNDRY)				
		7. 00	8. 00	9. 00	10.00	11. 00	
1.00	Administrative and General	315	0	31	5 0	0	1. 00
2.00	Inpatient - General Care	0	0		0 0	0	2. 00
3.00	Inpatient - Respite Care	0	0		0 0	0	3. 00
4.00	Physi ci an Servi ces	0	0		0 0	0	4. 00
5.00	Nursi ng Care	0	0		0 0	0	5. 00
6.00	Nursing Care-Continuous Home Care	0	0		0 0	0	6. 00
7.00	Physi cal Therapy	0	0		0 0	0	7. 00
8.00	Occupational Therapy	0	0		0 0	0	8. 00
9.00	Speech/ Language Pathology	o	0		0 0	0	9. 00
10.00	Medical Social Services	o	0		0 0	0	10. 00
11.00	Spiritual Counseling	o	0		0 0	0	11. 00
12.00	Di etary Counseling	0	0		0 0	0	12. 00
13.00	Counseling - Other	0	0		0 0	0	13. 00
14.00	Home Health Aide and Homemaker	O	0		0 0	0	14. 00
15.00	HH Aide & Homemaker - Cont. Home Care	o	0		0 0	0	15. 00
16.00	Other	o	0		0 0	0	16. 00
17. 00	Drugs, Biological and Infusion Therapy	o	0		0 0	0	17. 00
18.00	Anal gesi cs	o	0		0 0	0	18. 00
19.00	Sedatives / Hypnotics	0	0		0 0	0	19. 00
20.00	Other - Specify	0	0		0 0	0	20. 00
21.00	Durable Medical Equipment/Oxygen	0	0		0 0	0	21. 00
22. 00	Patient Transportation	0	0		0 0	0	22. 00
23. 00	I maging Services	0	0		0 0	0	23. 00
24. 00	Labs and Diagnostics	0	0		0 0	0	24. 00
25. 00	Medical Supplies	0	0		0 0	0	25. 00
26. 00	Outpatient Services (including E/R Dept.)	0	0		0 0	0	26. 00
27. 00	Radiation Therapy	0	0		0 0	0	27. 00
28. 00	Chemotherapy	0	0		0 0	0	28. 00
29. 00	Other	0	0		0 0	0	29. 00
30. 00	Bereavement Program Costs	0	0		0 0	l o	30.00
31. 00	Volunteer Program Costs	0	0		0 0	0	31. 00
32. 00	Fundrai si ng	0	0		0 0	0	32. 00
33. 00	Other Program Costs		n		0 0	Ö	33. 00
34. 00	Total (sum of lines 1 thru 33) (2)	315	n	31	5 0	0	34. 00
35. 00	Total cost to be allocated	10, 500	0	2, 93		0	35. 00
	Unit Cost Multiplier (see instructions)	33. 333333	0. 000000			-	
30.00	John C 303 C Mai ti pi rei (300 i listi deti 0113)	33. 333333	0.000000	7. 52000	0.00000	0.00000	1 30.00

			1.000		0 12,01,201.	5/29/2015 8: 5	7 am
					Hospi ce I		
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
		ADMI NI STRATI ON	SERVICE &	(100%)	RECORDS &		
			SUPPLY	, ,	LI BRARY	(TIME	
		(GROSS HOURS)	(100%)		(ADJUSTED	SPENT)	
		(` ′		CHARGES)	ĺ	
		13.00	14.00	15.00	16.00	17. 00	
1.00	Administrative and General	0	0	0	C	0	1. 00
2.00	Inpatient - General Care	O	0	0	C	0	2. 00
3.00	Inpatient - Respite Care	O	0	0	C	0	3. 00
4.00	Physi ci an Servi ces	O	0	0	C	0	4. 00
5.00	Nursing Care	O	0	0	C	0	5. 00
6.00	Nursing Care-Continuous Home Care	o	0	0	0	0	6. 00
7.00	Physical Therapy	o	0	0	0	0	7. 00
8.00	Occupational Therapy	ol	0) 0	C	0	8. 00
9.00	Speech/ Language Pathology	o	0		C	0	9. 00
10.00	Medical Social Services	o	0		C	0	10.00
11. 00	Spiritual Counseling	o	0		C	0	11. 00
12. 00	Di etary Counsel i ng	o	0		C	0	12. 00
13.00	Counseling - Other	o	0		C	0	13. 00
14. 00	Home Health Aide and Homemaker	o	0		C	0	14. 00
15. 00	HH Aide & Homemaker - Cont. Home Care	0	0		o c	0	15. 00
16. 00	Other	o	0		o c	0	16. 00
17. 00	Drugs, Biological and Infusion Therapy	o	0		o c	0	17. 00
18. 00	Anal gesi cs	o	0		C	0	18. 00
19. 00	Sedatives / Hypnotics	o	0		C	0	19. 00
20.00	Other - Specify	o	0	0	0	0	20. 00
21.00	Durable Medical Equipment/Oxygen	o	0	0	0	0	21. 00
22. 00	Patient Transportation	o	0	0) C	0	22. 00
23.00	I maging Services	o	0	0) C	0	23. 00
24.00	Labs and Diagnostics	o	0	ol o) C	0	24. 00
25.00	Medical Supplies	o	0	ol o) C	0	25. 00
26.00	Outpatient Services (including E/R Dept.)	o	0	ol o) C	0	26. 00
27.00	Radiation Therapy	l	0	ol o	C	0	27. 00
28. 00	Chemotherapy	l	0	ol o	C	0	28. 00
29. 00	Other	o	0		C	0	29. 00
30.00	Bereavement Program Costs	o	0		C	0	30.00
31. 00	Volunteer Program Costs	o	0		C	0	31. 00
32. 00	Fundrai si ng	o	0		C	0	32. 00
33. 00	Other Program Costs		0	Ö	o c	Ō	33. 00
34. 00	Total (sum of lines 1 thru 33) (2)		0	Ö	o c	o o	34. 00
35. 00	Total cost to be allocated	o	0	0) C	0	35. 00
	Unit Cost Multiplier (see instructions)	0. 000000	0. 000000	0. 000000	0. 000000	0.00000	

Heal th	Financial Systems DEAR	BORN COUNTY H	SPI TAL		In Lie	eu of Form CMS-2	2552-10
COMPUT	TATION OF TOTAL HOSPICE SHARED COSTS		Provi der	CCN: 150086	Peri od:	Worksheet K-5	
			Hospi ce (CCN: 151531	From 01/01/2014 To 12/31/2014		nared:
			позрі се с	JOIN. 131331	10 12/31/2014	5/29/2015 8: 5	
					Hospi ce I		
	Cost Center Description				ge Total Hospice		
		1,	col . 11	Ratio	Charges	Ancillary	
			line			Costs (cols. 1	
					Records)	x 2)	
	I		0	1.00	2. 00	3. 00	
	ANCILLARY SERVICE COST CENTERS						
1. 00	PHYSI CAL THERAPY		66. 00			0	1. 00
2.00	OCCUPATI ONAL THERAPY		67. 00	0. 6144	29 0	0	2. 00
3.00	SPEECH PATHOLOGY		68. 00	0. 5832	13 0	0	3. 00
4.00	DRUGS CHARGED TO PATIENTS		73.00	0. 4279	01 0	0	4. 00
5.00	DURABLE MEDICAL EQUIP-RENTED		96.00				5. 00
6.00	LABORATORY		60.00	0. 2112	50 0	0	6. 00
6. 01	BLOOD LABORATORY		60. 01	0.0000	00 0	0	6. 01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		71.00	0. 7236	06 0	0	7. 00
8.00	OTHER OUTPATIENT SERVICE COST CENTER		93.00				8. 00
9.00	RADI OLOGY-THERAPEUTI C		55.00	0. 1514	24 0	0	9. 00
10.00	OTHER ANCILLARY SERVICE COST CENTERS		76. 00				10.00
11.00	Totals (sum of lines 1-10)					0	11. 00

Heal th	Financial Systems DEARBORN COUN	ITY HO	OSPI TAL		ı	n Lie	u of Form CMS-2	2552-10
CALCULATION OF HOSPICE PER DIEM COST			Provi der	Provider CCN: 150086		/2014	Worksheet K-6	
			Hospi ce (CCN: 151531	To 12/31.	/2014	Date/Time Prep 5/29/2015 8:5	
					Hospi ce	1		
		Ti t	le XVIII	Title XIX	0ther	r	Total	
			1.00	2.00	3. 00		4. 00	
1.00	Total cost (see instructions)						568, 449	1. 00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)						4, 987	2. 00
3.00	Average cost per diem (line 1 divided by line 2)						113. 99	3. 00

		litle XVIII	litle XIX	Other	lotal	
		1. 00	2.00	3. 00	4. 00	
1.00	Total cost (see instructions)				568, 449	1. 00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				4, 987	2.00
3.00	Average cost per diem (line 1 divided by line 2)				113. 99	3.00
4. 00	Upduplicated Medicare Days (Worksheet S-9, column 1, line 5)	3, 424				4. 00
5.00	Aggregate Medicare cost (line 3 time line 4)	390, 302				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line		748			6.00
	5)					
7.00	Aggregate Medicaid cost (line 3 time line 60)		85, 265			7.00
8.00	Upduplicated SNF Days (Worksheet S-9, column 3, line 5)	0				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	0				9. 00
10.0	Unduplicated NF Days (Worksheet S-9, column 4, line 5)		0			10.00
11. 0	Aggregate NF cost (line 3 times line 10)		0			11.00
12.0	Other Unduplicated days (Worksheet S-9, column 5, line 5)			815		12.00
13.0	Aggregate cost for other days (line 3 times line 12)			92, 902		13.00

Health Financial Systems DEARBORN COUNTY F CALCULATION OF CAPITAL PAYMENT		Provi der CCN: 150086	Peri od:	u of Form CMS-2 Worksheet L	
			From 01/01/2014 To 12/31/2014	Parts I-III Date/Time Pre 5/29/2015 8:5	
		Title XVIII	Hospi tal	PPS	7 dili
				1 00	
	PART I - FULLY PROSPECTIVE METHOD			1. 00	
	CAPITAL FEDERAL AMOUNT				1
. 00	Capital DRG other than outlier	1, 055, 996			
. 01	Model 4 BPCI Capital DRG other than outlier			0	
. 00 . 01	Capital DRG outlier payments Model 4 BPCI Capital DRG outlier payments			42, 452 0	
. 00	Total inpatient days divided by number of days in the cost re	enorting period (see inst	ructions)	42. 86	
. 00	Number of interns & residents (see instructions)	oper tring period (see riist	1 40 (1 0113)	0.00	•
. 00	Indirect medical education percentage (see instructions)			0.00	5.0
. 00	Indirect medical education adjustment (multiply line 5 by the			0.00	
. 00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)				
. 00	Percentage of Medicaid patient days to total days (see instructions)				8. C
. 00 0. 00	Sum of lines 7 and 8 Allowable disproportionate share percentage (see instructions)				10.0
1. 00					11.0
2. 00					12. (
	DADT III DAWIENT INDED DEACONADIE GOOT			1. 00	
. 00	PART II - PAYMENT UNDER REASONABLE COST Program inpatient routine capital cost (see instructions)			0	1.0
. 00	Program inpatient ancillary capital cost (see instructions)				2. 0
. 00	Total inpatient program capital cost (line 1 plus line 2)				3. (
. 00					4. (
. 00	Total inpatient program capital cost (line 3 x line 4)			0	5. (
				1. 00	
00	PART III - COMPUTATION OF EXCEPTION PAYMENTS			0	
00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances (see instructions)				1. (
00	Net program inpatient capital costs (line 1 minus line 2)				3. (
00	Applicable exception percentage (see instructions)			0.00	4. (
00	Capital cost for comparison to payments (line 3 x line 4)			0	
00	Percentage adjustment for extraordinary circumstances (see i			0.00	1
00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) Capital minimum payment level (line 5 plus line 7)			0	1
00	Current year capital payments (from Part I, line 12, as applicable)			0	
). 00	Current year comparison of capital minimum payment level to		less line 9)	0	
1. 00	Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14)			0	11. (
2. 00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)			0	1
	Current year exception payment (if line 12 is positive, ente		·	0	
	Carryover of accumulated capital minimum payment level over	ollowing period	0	14.	
	l(if line 1) is possible optor the amount on this line)				
3. 00 4. 00 5. 00	(if line 12 is negative, enter the amount on this line) Current year allowable operating and capital payment (see in	structions)		Ō	15
4. 00 5. 00	,	structions)		0	