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 DECATUR CO. MEMORIAL HOSPITAL (151332) 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.

Officer or Administrator of Provider(s)

Title

			Title XVIII				
	Cost Center Description		Part A	Part B	HI T	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
PART III - SETTLEMENT SUMMARY							
1.00	Hospi tal	0	325, 982	-710, 206	0	0	1.00
2.00	Subprovi der - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	-11, 005	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
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	314, 977	-710, 206	0	0	200.00

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

Health Financial Systems DECATUR CO. MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 151332 Peri od: Worksheet S-2 From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/22/2015 1:38 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 702 NORTH LINCOLN STREET 1.00 PO Box: 1.00 State: IN Zip Code: 47240-1398 County: DECATUR 2.00 Ci ty: GREENSBURG 2.00 Component Name CCN CBSA Provi der Date Payment System (P, Certi fi ed T, 0, or N) Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 DECATUR CO. MEMORIAL 151332 99915 12/01/2005 Ν 0 3.00 HOSPI TAI Subprovi der - IPF 4.00 4.00 5.00 Subprovi der - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF DECATUR CO SWING BED 99915 157332 12/01/2005 0 N 7 00 7 00 N Swing Beds - NF 8.00 8.00 9.00 Hospital-Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospital -Based OLTC 11.00 12.00 Hospital -Based HHA DECATUR CO. HHA 157153 99915 03/01/1985 Ν Ρ Ν 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital -Based Health Clinic - RHC 15 00 15 00 Hospital-Based Health Clinic - FQHC 16.00 Hospital -Based (CMHC) I 17.00 17.00 Renal Dialysis 18.00 18.00 19.00 Other 19.00 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2014 12/31/2014 20.00 Type of Control (see instructions) 21.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for disproportionate Ν 22.00 share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting Ν Ν 22.01 period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires final uncompensated care payments to be Ν N 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result Ν 22.03 of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 0 23.00 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no. In-State In-State Out-of Out-of Medi cai d Other Medi cai d Medi cai d HMO days State Medi cai d State Medi cai d Medi cai d paid days el i gi bl e days unpai d paid days el i gi bl e days unpai d 1.00 4.00 5.00 6.00 2.00 3.00 24.00 If this provider is an IPPS hospital, enter the 0 24.00 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. If this provider is an IRF, enter the in-state 0 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.

care or general surgery. (see instructions)

	ı Financial Systems FAL AND HOSPITAL HEALTH CARE COMP		O. MEMORIAL ATA		1	In Lie Period: From 01/01/2014 To 12/31/2014	u of Form CMS-2 Worksheet S-2 Part I Date/Time Pre 5/22/2015 1:3	pared:
			Progran	n Name	Program Code	Unweighted IME FTE Count	Unwei ghted	S piii
			1. (00	2.00	3. 00	4. 00	
	Of the FTEs in line 61.05, speci specialty, if any, and the number for each new program. (see instruction of the special type in the special type	er of FTE residents ructions) Enter in er in column 2, the the IME FTE olumn 4, direct GME fy each expanded the number of FTE gram. (see the program name, code, enter in column and enter in column				0. 00		61. 10
	4, direct GME FTE unweighted cou	int.						
							1.00	
62.00	ACA Provisions Affecting the Hea Enter the number of FTE resident	al th Resources and Se	rvices Admi	nistration	n (HRSA)	ried for which	0.00	62.00
	your hospital received HRSA PCRE Enter the number of FTE resident during in this cost reporting pe			62.01				
42.00	Teaching Hospitals that Claim Re Has your facility trained reside	esidents in Nonprovid	er Settings			noriad? Entar	T N	42.00
63.00	"Y" for yes or "N" for no in col						N	63.00
Unweighted Unweighted FTES FTEs in Nonprovider Hospital								
					Si te 1. 00	2.00	3. 00	
	Section 5504 of the ACA Base Yea	ar FTE Residents in N	lonprovi der	Setti nas				
	period that begins on or after a	July 1, 2009 and befo	re June 30,	2010.	,			
64. 00	Enter in column 1, if line 63 is in the base year period, the nun resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in you of (column 1 divided by (column	nber of unweighted no otations occurring in on number of unweighte our hospital. Enter i	n-primary c all nonpro d non-prima n column 3	are vider ry care the ratio	0.0	0.00	0. 000000	64.00
		Program Name	Progran		Unwei ghted FTEs Nonprovi der	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1 00	2.4	20	Si te	4.00	F 00	
65. 00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	1.00	2.0		3.00	4.00 0 0.00	5. 00 0. 000000	65.00

Health Financial Systems DECATUR CO. MEMO HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider	CCN: 151332	In L Period:	ieu of Form CMS Worksheet S	
TIOST FAE AND TIOST FAE HEALTH CARE COMMERCE TOENTH TOATTON DATA	11 ovi dei		From 01/01/20 To 12/31/20	114 Part I	repared:
			V	XI X	. 50 piii
Title V and XIX Services			1.00	2. 00	
90.00 Does this facility have title V and/or XIX inpatient hospit yes or "N" for no in the applicable column.			N	Y	90.00
91.00 Is this hospital reimbursed for title V and/or XIX through full or in part? Enter "Y" for yes or "N" for no in the app			N	N	91.00
92.00 Are title XIX NF patients occupying title XVIII SNF beds (d instructions) Enter "Y" for yes or "N" for no in the applic	able column.			N	92.00
93.00 Does this facility operate an ICF/MR facility for purposes "Y" for yes or "N" for no in the applicable column.	of title V and	I XIX? Enter	N	N	93.00
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, applicable column.	and "N" for n	no in the	N	N	94.00
95.00 If line 94 is "Y", enter the reduction percentage in the ap 96.00 Does title V or XIX reduce operating cost? Enter "Y" for ye applicable column.			N O.	0. 0 N	95. 00 96. 00
97.00 If line 96 is "Y", enter the reduction percentage in the ap	plicable colum	nn.	0.	0.0	97.00
105.00 Does this hospital qualify as a Critical Access Hospital (C 106.00 of this facility qualifies as a CAH, has it elected the all	nt Y		105. 00 106. 00		
for outpatient services? (see instructions) 107.00 Column 1: If this facility qualifies as a CAH, is it eligi for I &R training programs? Enter "Y" for yes or "N" for n instructions) If yes, the GME elimination would not be on W the program would be cost reimbursed. If yes complete Wkst. this facility is a CAH, do I &Rs in an approved medical educ CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or	o in column 1. kst. B, Pt. I, D-2, Pt. II. ation program	(see col. 25 and Column 2: If train in the	f		107. 00
instructions) 108.00 s this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		•			108. 00
CIN Section 9412. 113(c). Litter 1 101 yes of N 101 110.	Physi cal	Occupati ona		Respi ratory	/
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	1. 00 N	2. 00 N	3. 00 Y	4.00 N	109. 00
				1.00	
110.00 Did this hospital participate in the Rural Community Hospit the current cost reporting period? Enter "Y" for yes or "N"		on project (4	410A Demo)for	N	110.00
			1	. 00 2. 00 3. 00	0
Miscellaneous Cost Reporting Information 115.00 s this an all-inclusive rate provider? Enter "Y" for yes o is yes, enter the method used (A, B, or E only) in column 2 a either "93" percent for short term hospital or "98" perce psychiatric, rehabilitation and long term hospitals provide Pub. 15-1, §2208.1. 116.00 s this facility classified as a referral center? Enter "Y" 117.00 s this facility legally-required to carry malpractice insu	. If column 2 nt for long te rs) based on t	is "E", enter erm care (incl :he definition " for no.	rin column udes nin CMS	N O	115. 00 116. 00 117. 00
no. 118.00 Is the mal practice insurance a claims-made or occurrence po	licy? Enter 1	if the policy	y is	1	118. 00
claim-made. Enter 2 if the policy is occurrence.		Premi ums	Losses	Insurance	
118.01 List amounts of malpractice premiums and paid losses:		1. 00 307, 35	2.00	3.00	0118.01
			1.00	2. 00	
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sche and amounts contained therein.			N		118. 02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that q Hold Harmless provises 10 ACA §3121 and applicable amendments?	n column 1, "Y ualifies for t	" for yes or he Outpatient		N	119. 00 120. 00
Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost imples patients? Enter "Y" for yes or "N" for no.	antabl e devi ce	es charged to	Y		121. 00
Transplant Contar Informatica					125 00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" f	or yes and "N"	for no. If	N		125. 00
	nter the certi				126. 00

Health Financial Systems	DECATUR CO. MEMO	ORIAL HOSPITAL		In Lie	u of Form CMS	-2552-10		
HOSPITAL AND HOSPITAL HEALTH CARE COMPL	EX IDENTIFICATION DATA	Provi der		Period: From 01/01/2014	Worksheet S- Part I	-2		
				o 12/31/2014	Date/Time Pr			
					5/22/2015 1:	38 pm		
120 0015 this is a Madisara contified L	luor transplant contar or	ton the contif	i ooti on doto	1. 00	2. 00	120.00		
128.00 If this is a Medicare certified I in column 1 and termination date,	•		ication date			128. 00		
129.00 If this is a Medicare certified I column 1 and termination date, if		ter the certifi	cation date ir	ו		129. 00		
130.00 If this is a Medicare certified p		enter the cer	ti fi cati on			130. 00		
date in column 1 and termination 131.00 of this is a Medicare certified i			ertification			131.00		
date in column 1 and termination	date, if applicable, in co	olumn 2.						
132.00 If this is a Medicare certified i in column 1 and termination date,			ication date			132. 00		
133.00 If this is a Medicare certified o			ication date			133. 00		
in column 1 and termination date, if applicable, in column 2. 134.00 f this is an organ procurement organization (0PO), enter the OPO number in column 1								
and termination date, if applicab	le, in column 2.							
140.00 Are there any related organization				Y		140. 00		
chapter 10? Enter "Y" for yes or are claimed, enter in column 2 th								
1.00	2. (00		3.00	·			
If this facility is part of a cha office and enter the home office			ough 143 the n	ame and address	of the home			
141.00 Name:	Contractor's Name:		Contracto	r's Number:		141.00		
142.00 Street: 143.00 Ci ty:	PO Box: State:		Zi p Code:			142. 00 143. 00		
					1.00			
144.00 Are provider based physicians' co	sts included in Worksheet	A?			1. 00 Y	144.00		
145.00 If costs for renal services are c	laimed on Worksheet A, lir		costs for inpa	atient services	N	145. 00		
only? Enter "Y" for yes or "N" fo	i iio.							
146.00 Has the cost allocation methodolo	ay changed from the provide	nucly filed cos	t roport?	1.00 N	2. 00	146. 00		
Enter "Y" for yes or "N" for no i	n column 1. (See CMS Pub.			IV.		140.00		
the approval date (mm/dd/yyyy) in 147.00Was there a change in the statist		ves or "N" for	no	N		147. 00		
148.00 Was there a change in the order o	f allocation? Enter "Y" fo	or yes or "N" f	or no.	N		148. 00		
149.00 Was there a change to the simplif	ied cost finding method? E	Enter "Y" for y	es or "N" for	N		149. 00		
		Part A	Part B	Title V	Title XIX			
Does this facility contain a prov	ider that qualifies for a	1.00 n exemption fro	2.00 om the applica	3.00 tion of the low	4.00 er of costs			
or charges? Enter "Y" for yes or	"N" for no for each compo					155.00		
155.00 Hospi tal 156.00 Subprovi der - TPF		N N	N N	N N	N N	155. 00 156. 00		
157. 00 Subprovi der – I RF 158. 00 SUBPROVI DER		N	N	N	N	157.00		
158. 00 S0BPROVI DER 159. 00 SNF		N	N	N	N	158. 00 159. 00		
160.00 HOME HEALTH AGENCY 161.00 CMHC		N	N	N	N	160.00		
TO L. OO OWITO			N N	N N	N	161. 00		
Mul ti campus					1. 00			
165.00 Is this hospital part of a Multic	ampus hospital that has or	ne or more camp	uses in differ	rent CBSAs?	N	165. 00		
Enter "Y" for yes or "N" for no.	Name	County	State Zip	Code CBSA	FTE/Campus			
	0	1. 00		. 00 4. 00	5. 00			
166.00 If line 165 is yes, for each campus enter the name in column					0. 0	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		
167.00 s this provider a meaningful use 168.00 of this provider is a CAH (line 1					Y	167. 00 0168. 00		
reasonable cost incurred for the 169.00 If this provider is a meaningful	HIT assets (see instructio	ons)			0.4	00169.00		
transition factor. (see instructi		aranuta CAH	(1116 100 15	w), enter the	0.1	59107.00		

Health Financial Systems	DECATUR CO. MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDE	RE COMPLEX IDENTIFICATION DATA Provider CCN: 151332 Period:					
			To 12/31/2014	Date/Time Pre 5/22/2015 1:3		
	Begi nni ng	Endi ng				
	1. 00	2. 00				
170.00 Enter in columns 1 and 2 the EHR beginn period respectively (mm/dd/yyyy)	12/31/2014	170. 00				
				1. 00		
171.00 If line 167 is "Y", does this provider Medicare cost plans reported on Wkst. S (see instructions)	N	171. 00				

STITKL F	nancial Systems D AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	ECATUR CO. MEMORIAL E ESTIONNAIRE F			Period: From 01/01/2014	worksheet S- Part II	2
						Date/Time Pr 5/22/2015 1:	
					Y/N 1.00	2.00	
mm/o	eral Instruction: Enter Y for all YES res dd/yyyy format.	ponses. Enter N for a	nll NO re	esponses. Ente	er all dates in	the	
	PLETED BY ALL HOSPITALS vider Organization and Operation						
	s the provider changed ownership immediate porting period? If yes, enter the date of				N		1
Ti eb	of trig perrou: 11 yes, enter the date of	the change in corumn	2. (366	Y/N	Date	V/I	
	s the provider terminated participation in			1. 00 N	2. 00	3. 00	2
vol	s, enter in column 2 the date of terminati untary or "I" for involuntary.						
con or off of	the provider involved in business transac ntracts, with individuals or entities (e.g medical supply companies) that are relate ficers, medical staff, management personne directors through ownership, control, or	., chain home offices d to the provider or d, or members of the	s, drug its board	N			3
rei	ationships? (see instructions)			Y/N	Type	Date	
Fir	ancial Data and Penorts			1. 00	2.00	3. 00	
Col	ancial Data and Reports umn 1: Were the financial statements pre countant? Column 2: If yes, enter "A" for			Y	A		4
or	"R" for Reviewed. Submit complete copy or umn 3. (see instructions) If no, see inst	enter date available					
) Are	e the cost report total expenses and total	revenues different		N			5
Tino	ose on the filed financial statements? If	yes, submit reconcili	ation.		Y/N	Legal Oper.	
	roved Educational Activities				1.00	2. 00	
	umn 1: Are costs claimed for nursing schelegal operator of the program?	ool? Column 2: If ye	es, is th	ne provider is	N N		6
Are Wer	Are costs claimed for Allied Health Programs? If "Y" see instructions. No Were nursing school and/or allied health programs approved and/or renewed during the North No						8
) Are	st reporting period? If yes, see instructi e costs claimed for Intern-Resident progra		rent cos	st report? If	N		9
12	s, see instructions. s an Intern-Resident program been initiate	d or renewed in the d	current c	cost reporting	, N		10
	riod? If yes, see instructions. e GME cost directly assigned to cost cente	ers other than I & R i	n an Apr	proved	N		11
	aching Program on Worksheet A? If yes, see					Y/N	
Dod	Dobto					1.00	
00 Is	<u>Debts</u> the provider seeking reimbursement for ba					Y	12
	line 12 is yes, did the provider's bad de riod? If yes, submit copy.	bt collection policy	change o	during this co	ost reporting	N	13
	line 12 is yes, were patient deductibles Complement	and/or co-payments wa	aived? If	yes, see ins	structi ons.	N N	_ 14
500	I total beds available change from the pri	or cost reporting per	iod? If			N Devet D	15
00 Did		Description		Y/N	rt A Date	Part B Y/N	
00 Dia	R Data	0		1. 00	2. 00	3. 00	
				Υ	03/26/2015	Y	16
PS&I 00 Was	s the cost report prepared using the PS&R		I				
PS&I Was Rep	port only? If either column 1 or 3 is yes, ser the paid-through date of the PS&R						
PS&I Was Rep ent Rep	port only? If either column 1 or 3 is yes,						
PS&I Was Rep ent Rep ins	port only? If either column 1 or 3 is yes, ter the paid-through date of the PS&R port used in columns 2 and 4 (see structions) at the cost report prepared using the PS&R			N		N	17
PS&II 00 Was Rep ent Rep i ns 00 Was	port only? If either column 1 or 3 is yes, the the paid-through date of the PS&R port used in columns 2 and 4 (see structions) as the cost report prepared using the PS&R port for totals and the provider's records allocation? If either column 1 or 3 is			N		N	17
PS&I 00 Was Rep ent Rep i ns 00 Was Rep for yes	port only? If either column 1 or 3 is yes, the the paid-through date of the PS&R port used in columns 2 and 4 (see structions) at the cost report prepared using the PS&R port for totals and the provider's records			N		N	17
PS&I Was Rep ent Rep i ns Was Rep for yes 2 a	port only? If either column 1 or 3 is yes, the the paid-through date of the PS&R port used in columns 2 and 4 (see structions) at the cost report prepared using the PS&R port for totals and the provider's records allocation? If either column 1 or 3 is allocation and 4 (see instructions). In a line 16 or 17 is yes, were adjustments			N N		N N	
PS&I Wass Rep ent Rep i ns Was Rep for yes 2 a 00 If mad cl a	cort only? If either column 1 or 3 is yes, cer the paid-through date of the PS&R cort used in columns 2 and 4 (see structions) is the cost report prepared using the PS&R cort for totals and the provider's records allocation? If either column 1 or 3 is senter the paid-through date in columns and 4 (see instructions) line 16 or 17 is yes, were adjustments the to PS&R Report data for additional aims that have been billed but are not						
PS&M 00 Wass Rep ent Rep ins 00 Wass Rep for yes 2 a 00 If mad cla inc	port only? If either column 1 or 3 is yes, the the paid-through date of the PS&R port used in columns 2 and 4 (see structions) as the cost report prepared using the PS&R port for totals and the provider's records allocation? If either column 1 or 3 is and 4 (see instructions) line 16 or 17 is yes, were adjustments de to PS&R Report data for additional						18
PS&I 00 Was Reppent ins 00 Was Repfor yes 2 a 00 If mad cla inc thi 00 If	cort only? If either column 1 or 3 is yes, ter the paid-through date of the PS&R cort used in columns 2 and 4 (see structions) is the cost report prepared using the PS&R cort for totals and the provider's records allocation? If either column 1 or 3 is and 4 (see instructions) line 16 or 17 is yes, were adjustments de to PS&R Report data for additional aims that have been billed but are not cluded on the PS&R Report used to file s cost report? If yes, see instructions. Iine 16 or 17 is yes, were adjustments						18
PS&M Wass Rep ent Rep ins Wass Rep for yes 2 a inc thi DO If mad oth	cort only? If either column 1 or 3 is yes, cer the paid-through date of the PS&R cort used in columns 2 and 4 (see structions) is the cost report prepared using the PS&R cort for totals and the provider's records allocation? If either column 1 or 3 is seenter the paid-through date in columns and 4 (see instructions). Iine 16 or 17 is yes, were adjustments de to PS&R Report data for additional aims that have been billed but are not cluded on the PS&R Report used to file s cost report? If yes, see instructions. Iine 16 or 17 is yes, were adjustments de to PS&R Report data for corrections of the PS&R Report data for corrections of the PS&R Report information? If yes, see			N		N	18
PS&M OO Wass Rep ent Rep ins OO Rep for yes 2 a OO If mad cla inc thi OO If mad oth ins	cort only? If either column 1 or 3 is yes, the the paid-through date of the PS&R cort used in columns 2 and 4 (see structions) is the cost report prepared using the PS&R cort for totals and the provider's records allocation? If either column 1 or 3 is either the paid-through date in columns and 4. (see instructions) Iine 16 or 17 is yes, were adjustments allocation of either the ps&R Report data for corrections of			N		N	18

Health Financial Systems	DECATUR CO. MEMORIAL	HOSPI TAL	In Li	eu of Form CMS-2552-10
HOODITAL AND HOODITAL HEALTH CADE DE	LUBURGENEUT CUECTI CARLAL DE	D 1 1 00N 454000	5	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 151332 Worksheet S-2 Peri od: From 01/01/2014 Part II Date/Time Prepared: 12/31/2014 5/22/2015 1:38 pm Part A Part B Description Y/N Date Y/N 0 1.00 2.00 3.00 21.00 Was the cost report prepared only using the N 21 00 Ν provider's records? If yes, see instructions. 1 00 COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related Cost 22.00 Have assets been relifed for Medicare purposes? If yes, see instructions 22.00 Ν 23.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost Ν 23.00 reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases entered into during this cost reporting period? Ν 24.00 If ves. see instructions 25.00 25 00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see Ν instructions. 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see Ν 26.00 i nstructi ons. 27 00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit Ν 27.00 сору. Interest Expense 28.00 Were new Loans, mortgage agreements or Letters of credit entered into during the cost reporting Ν 28.00 period? If yes, see instructions. 29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) Υ 29.00 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 30.00 Ν 30.00 instructions. Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see 31.00 Ν 31.00 instructions. Purchased Services 32.00 Have changes or new agreements occurred in patient care services furnished through contractual Ν 32.00 arrangements with suppliers of services? If yes, see instructions. 33.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If 33.00 no, see instructions. Provi der-Based Physicians 34.00 Are services furnished at the provider facility under an arrangement with provider-based physicians? Υ 34.00 If yes, see instructions. If line 34 is yes, were there new agreements or amended existing agreements with the provider-based Ν 35.00 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? N 36, 00 36,00 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? 37.00 If yes, see instructions. If line 36 is yes, was the fiscal year end of the home office different from that of 38.00 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, 39.00 see instructions. If line 36 is yes, did the provider render services to the home office? If yes, see 40 00 40.00 instructions. 1.00 2.00 Cost Report Preparer Contact Information ESSLINGER 41.00 Enter the first name, last name and the title/position RENEE 41.00 held by the cost report preparer in columns 1, 2, and 3, respectively. 42 00 BKD, LLP 42 00 Enter the employer/company name of the cost report preparer. 43.00 Enter the telephone number and email address of the cost 3173834253 RESSLI NGER@BKD. COM 43.00 report preparer in columns 1 and 2, respectively.

Provi der CCN: 151332 Worksheet S-2 From 01/01/2014 To 12/31/2014 Part II Date/Time Prepared: 5/22/2015 1:38 pm Part B Date 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R 03/26/2015 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 instructions) 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 2 and 4. (see instructions) 18.00 If line 16 or 17 is yes, were adjustments 18.00 made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. 19.00 | If line 16 or 17 is yes, were adjustments 19.00 made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions. 20.00 | If line 16 or 17 is yes, were adjustments 20.00 made to PS&R Report data for Other? Describe the other adjustments: 21.00 Was the cost report prepared only using the provider's records? If yes, see 21.00 instructions. 3.00 Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position MANAGING CONSULTANT 41.00 held by the cost report preparer in columns 1, 2, and 3, respecti vel y. 42.00 Enter the employer/company name of the cost report 42.00

43.00

preparer.

Enter the telephone number and email address of the cost

report preparer in columns 1 and 2, respectively.

43.00

Heal th Fi nancial SystemsDECATUR CO.MEMORIAL HOSPITALHOSPITAL HOSPITALHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATAProvider

					Т	o 12/31/2014	Date/Time Pre 5/22/2015 1:3	
							1/P Days /	O DIII
							0/P Visits /	
							Trips	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V	
	·	Line Number			Avai I abl e			
		1. 00		2. 00	3.00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00		22	8, 030	80, 904. 00	0	1.00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2. 00	HMO and other (see instructions)							2.00
3. 00	HMO IPF Subprovi der							3.00
4.00	HMO I RF Subprovi der							4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					00 004 00	0	6.00
7. 00	Total Adults and Peds. (exclude observation			22	8, 030	80, 904. 00	0	7. 00
0.00	beds) (see instructions)	04.00			4 005	0.740.00	0	0.00
8. 00	INTENSIVE CARE UNIT	31. 00		3	1, 095	2, 712. 00	0	8.00
9.00	CORONARY CARE UNIT							9.00
10.00	BURN INTENSIVE CARE UNIT							10.00
11.00	SURGICAL INTENSIVE CARE UNIT							11. 00 12. 00
12. 00 13. 00	OTHER SPECIAL CARE (SPECIFY) NURSERY	43.00					0	12.00
		43.00		25	9, 125	83, 616. 00	0	14.00
14. 00 15. 00	Total (see instructions) CAH visits			23	9, 123	63, 616. 00	0	15.00
16. 00	SUBPROVIDER - IPF						U	16.00
17. 00	SUBPROVIDER - 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	101.00					0	22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	101.00					O	23. 00
24. 00	HOSPI CE							24.00
24. 10	HOSPICE (non-distinct part)	30.00						24. 10
25. 00	CMHC - CMHC	99. 00					0	25. 00
26. 00	RURAL HEALTH CLINIC	77.00					O	26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER							26. 25
27. 00	Total (sum of lines 14-26)			25				27. 00
28. 00	Observation Bed Days			20			0	
29. 00	Ambul ance Trips						_	29.00
30.00	Employee discount days (see instruction)							30.00
31.00	Employee discount days - IRF							31.00
32.00	Labor & delivery days (see instructions)			0	0			32.00
32. 01	Total ancillary labor & delivery room							32.01
	outpatient days (see instructions)							
33.00	LTCH non-covered days							33.00

Provi der CCN: 151332

Peri od: Worksheet S-3 From 01/01/2014 Part I To 12/31/2014 Date/Time Prepared: 5/22/2015 1:38 pm

Title XVIII							5/22/2015 1:3	8 pm
1.00 Hospital Adults & Peds. (columns 5 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions) 276 0 3, 371 2 2 2 2 2 2 2 2 2			I/P Days	s / O/P Visits	/ Tri ps	Full Time I	Equi val ents	
No. Hospital Adults & Peds. (columns 5 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 For the portion of LDP room available beds) 1,000								
No. Hospital Adults & Peds. (columns 5 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 For the portion of LDP room available beds) 1,000								
1.00		Component	Title XVIII	Title XIX				
1.00 Hospi tal Adult ts & Peds. (col umns 5, 6, 7 and 8 1,693 282 3,371 2 2.00 2 2.00 2 2.00 2 2.00 2 2.00 2 2.00 2 2.00 2 2.00 2 2.00 2 2.00								
8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 276						9. 00	10.00	
Hospice days)(see instructions for col. 2 For the portion of LDP room available beds) 2.00 HMU and other (see instructions) 2.76 0 0 0 3.00 0 0 0 0 0 0 0 0 0	1.00		1, 693	282	3, 371			1.00
For the portion of LDP room avail able beds) 2.00 Mo and other (see Instructions) 2.76 0 0 0 0 0 0 0 0 0								
2.00 HM0 and other (see instructions)								
3. 00								
4. 00			276	_				
5.00			0	_				ł
6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 BURN INTENSIVE CARE UNIT 10.00 SURRI INTENSIVE CARE UNIT 11.00 OTHER SPECIAL CARE (SPECIFY) 13.00 INTENSIVE CARE UNIT 14.00 Total (see instructions) 15.00 CAH visits 16.00 CAH visits 17.00 SUBPROVIDER - IFF 18.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER FACILITY 19.00 SKILLED NURSING FACILITY 20.00 HOME HEALTH AGENCY 23.00 HOME HEALTH AGENCY 24.10 HOSPICE (non-distinct part) 25.00 CAB RURAL HEALTH CLINIC 26.10 SUBPROVIDER SET ON	4.00		0	0				4.00
7.00			274	0	274			5.00
Deds) (see instructions) Reds R	6.00			_				6.00
8. 00 INTENSIVE CARE UNIT 80 2 113 8. 00 9. 00 CORONARY CARE UNIT 10. 00 11. 00 SURGI CAL INTENSIVE CARE UNIT 11. 00 11. 00 11. 00 SURGI CAL INTENSIVE CARE UNIT 12. 00 12. 00 12. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 14. 00 14. 00 15. 00 14. 00 15. 00 1	7.00	Total Adults and Peds. (exclude observation	1, 967	282	3, 799			7.00
9. 00 CORONARY CARE UNIT 10. 00 BURN INTENSIVE CARE UNIT 11. 00 SURGICAL INTENSIVE CARE UNIT 12. 00 OTHER SPECIAL CARE (SPECIFY) 13. 00 NURSERY 16. 00 Total (see instructions) 17. 00 CAH visits 18. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		beds) (see instructions)						
10. 00 BURN INTENSIVE CARE UNIT 10. 00 11. 00 11. 00 SURGICAL INTENSIVE CARE UNIT 11. 00 12. 00 01HER SPECIAL CARE (SPECIFY) 0 342 12. 00 13. 00 14. 00 15. 00 1	8.00	INTENSIVE CARE UNIT	80	2	113			8.00
11. 00 SURGICAL INTENSIVE CARE UNIT 12. 00 OTHER SPECIAL CARE (SPECIFY) 13. 00 NURSERY 0 342 13. 00 13. 00 14. 00 Total (see instructions) 2, 047 284 4, 254 0. 00 371. 70 14. 00 15. 00 CAH visits 0 0 0 0 0 0 0 0 0	9.00							9. 00
12. 00 OTHER SPECIAL CARE (SPECIFY) 13. 00 NURSERY 14. 00 Total (see instructions) 2, 047 284 4, 254 0. 00 371. 70 14. 00 15. 00 CAH visits 0 CAH visits 0 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 19. 00 SKILLED NURSING FACILITY 19. 00 SKILLED NURSING FACILITY 20. 00 NURSING FACILITY 20. 00 ON URSING FACILITY 20. 00 OTHER LONG TERM CARE 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 10 HOSPICE 24. 10 HOSPICE (non-distinct part) 26. 00 CMIRC - CMIC 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 0 Demployee discount days (see instruction) 32. 00 Labor & delivery days (see instructions) 0 Total ancillary labor & delivery room outpatient days (see instructions) 0 Total ancillary labor & delivery room outpatient days (see instructions) 0 University of the control of th	10.00	BURN INTENSIVE CARE UNIT						10.00
13. 00 NURSERY 0 342 0.00 371. 70 14. 00 15. 00 2.0 4. 254 0.00 371. 70 14. 00 15. 00 2.0	11.00	SURGICAL INTENSIVE CARE UNIT						11.00
14.00	12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
15. 00 CAH visits	13.00	NURSERY		0	342			13.00
16.00 SUBPROVIDER - I PF 17.00 SUBPROVIDER - I RF 18.00 SUBPROVIDER - I RF 18.00 SUBPROVIDER 19.00 SKILLED NURSING FACILITY 19.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPI CE 24.10 HOSPI CE 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.20 Total (sum of lines 14-26) 27.00 Observation Bed Days 29.00 Ambul ance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - I RF 32.00 Total ancillary labor & delivery room outpatient days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 31.00 Uservation Bed Days Age instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions)	14.00	Total (see instructions)	2, 047	284	4, 254	0.00	371. 70	14.00
17. 00 SUBPROVIDER - IRF 17. 00 18. 00 SUBPROVIDER 18. 00 18. 00 18. 00 19. 00 SVILLED NURSING FACILITY 19. 00 20. 00 NURSING FACILITY 20. 00 NURSING FACILITY 20. 00 NURSING FACILITY 20. 00 21. 00 22. 00 HOME HEALTH AGENCY 3, 899 4, 622 9, 525 0. 00 15. 62 22. 00 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 23. 00 24. 10 HOSPICE (non-distinct part) 0 0 0 0 0 24. 10 25. 00 CMHC C CMHC C CMHC C CMHC C C C C C C C C C	15.00	CAH visits	0	0	0			15.00
18.00 SUBPROVI DER 18.00 19.00 SKI LLED NURSI NG FACI LI TY 19.00 20.00 NURSI NG FACI LI TY 21.00 OTHER LONG TERM CARE 21.00 22.00 HOME HEALTH AGENCY 3,899 4,622 9,525 0.00 15.62 22.00 23.00 AMBULATORY SURGI CAL CENTER (D. P.) 23.00 24.00 HOSPI CE 24.00 24.10 HOSPI CE 24.10 HOSPI CE 26.00 24.10 25.00 CMHC - CMHC 0 0 0 0 0 0 0 0 0	16.00	SUBPROVIDER - IPF						16.00
19.00 SKILLED NURSING FACILITY 20.00 20.00 20.00 21.00 21.00 22.00 22.00 23.00 24.00 25.00 24.00 25.00 26.25 26.25 27.00 27.00 28.	17.00	SUBPROVIDER - IRF						17.00
20.00 NURSING FACILITY 20.00 21.00 21.00 22.00 21.00 22.00 22.00 23.00 4.622 9.525 0.00 15.62 22.00 23.00 24.00 4.602 25.00 24.10 4.605 26.00 24.10 4.600 25.00 26.00 26.00 26.00 26.25 27.00 26.00 26.25 27.00 26.00 26.25 27.00 26.0	18.00	SUBPROVI DER						18.00
21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 3,899 4,622 9,525 0.00 15.62 22.00 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 4.10 HOSPICE (non-distinct part) 0 0 0 0 24.10 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER 27.00 Total (sum of lines 14-26) 0 0 0 0 0 0 387.32 27.00 28.00 Observation Bed Days 4,622 9,525 0.00 15.62 22.00 24.10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	19.00	SKILLED NURSING FACILITY						19.00
22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 00 HOSPICE 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 27. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 29. 00 Employee discount days (see instructions) 20. 01 Total ancillary labor & delivery room outpatient days (see instructions) 20. 00 HOME HEALTH AGENCY 3, 899 4, 622 9, 525 0. 00 15. 62 22. 00 23. 00 24. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	20.00	NURSING FACILITY						20.00
23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.25 FEDERALLY QUALIFIED HEALTH CENTER 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions)	21.00	OTHER LONG TERM CARE						21.00
24.00	22.00	HOME HEALTH AGENCY	3, 899	4, 622	9, 525	0.00	15. 62	22.00
24. 10 HOSPICE (non-distinct part) 0 0 0 0 0 0 0.00 25.00 26.00 CMHC - CMHC 0 0 0 0 0 0 0.00 25.00 26.00 RURAL HEALTH CLINIC 26.00 26.25 FEDERALLY QUALIFIED HEALTH CENTER 27.00 Observation Bed Days 0 0 1,137 28.00 Ambulance Trips 0 29.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 0 1 Cabor & delivery days (see instructions) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
25. 00 CMHC - CMHC	24.00	HOSPI CE						24.00
26.00 RURAL HEALTH CLINIC 26.25 FEDERALLY QUALIFIED HEALTH CENTER 27.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 26.00 26.25 27.00 26.00 387.32 27.00 28.00 29.00 29.00 30.00 31.00 31.00 32.01	24. 10	HOSPICE (non-distinct part)	0	0	0			24. 10
26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 32. 01	25.00	CMHC - CMHC	0	0	0	0.00	0.00	25. 00
27.00 Total (sum of lines 14-26) 0.00 387.32 27.00 28.00 0 0 0 29.00	26.00	RURAL HEALTH CLINIC						26.00
27.00 Total (sum of lines 14-26) 0.00 387.32 27.00 28.00 0bservation Bed Days 0 1,137 28.00 28.00 29.00 30.00 Employee discount days (see instruction) 0 30.00 29.00 31.00 29.00 29.00 31.00 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 0 0 0 32.01 32.01 32.01 33.00 32.01 34.00	26. 25	FEDERALLY QUALIFIED HEALTH CENTER						26. 25
28.00 Observation Bed Days 0 1,137 28.00 29.00 30.00 Employee discount days (see instruction) 0 30.00 31.00 29.00 32.00 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 0 0 32.01 3	27.00	1				0.00	387. 32	27. 00
29.00 Ambulance Trips 0 29.00 30.00 Employee discount days (see instruction) 0 30.00 31.00 Employee discount days - IRF 0 31.00 32.00 Labor & delivery days (see instructions) 0 0 0 32.00 Total ancillary labor & delivery room outpatient days (see instructions)	28.00	1 '		0	1, 137			1
30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 30.00 O O O O O O O O O O O O O O O O O O	29.00		o		,			29. 00
31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 31.00 32.00 32.01	30.00				0			30.00
32.00 Labor & delivery days (see instructions) 0 0 0 0 32.00 32.01 Total ancillary labor & delivery room outpatient days (see instructions)					0			1
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			o	0				1
outpatient days (see instructions)]					•
]			
33.00 LTCH non-covered days 0 33.00	33.00	LTCH non-covered days	0					33.00

| Peri od: | Worksheet S-3 | From 01/01/2014 | Part | To 12/31/2014 | Date/Time Prepared: | Part | P Heal th Fi nancial SystemsDECATUR CO. MEMORIAL HOSPITALHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATAProvider Provi der CCN: 151332

					5/22/2015 1:38		
		Full Time	'	Di sch	arges	072272010 1.0	5 рііі
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers	12.00	12.00	14.00	Pati ents	
1 00	Henrital Adulta 9 Dada (asluma 5 / 7 and	11. 00	12. 00	13. 00 512	14.00	15.00	1 00
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and		U	512	164	1, 130	1. 00
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2. 00	HMO and other (see instructions)			78	0		2.00
3. 00	HMO IPF Subprovider			, 0	J		3. 00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation						7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE 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	0.00		540	4.4	4 400	13.00
14.00	Total (see instructions)	0. 00	0	512	164	1, 130	14.00
15. 00 16. 00	CAH visits SUBPROVIDER - IPF						15. 00 16. 00
17. 00	SUBPROVIDER - IPF						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						24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC	0. 00					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 30. 00	Ambulance Trips Employee discount days (see instruction)						29. 00 30. 00
31. 00	Employee discount days (see firsti detroit)						31.00
32.00	Labor & delivery days (see instructions)						32.00
32. 00	Total ancillary labor & delivery room						32. 00
JZ. U1	outpatient days (see instructions)						52.01
33.00	LTCH non-covered days					ļ	33.00
	•			. '	,	'	

Heal th	Financial Systems D	ECATUR CO. MEM	ORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOME H	IEALTH AGENCY STATISTICAL DATA			F	eriod: rom 01/01/2014		
			Componen	t CCN: 157153 T	o 12/31/2014	5/22/2015 1:3	
					Home Health Agency I	PPS	
					1.	00	
0.00	County	T: +1 - \/	T: +1 - V/// 1 1	T: +1 - VIV	0+1	Tabal	0.00
		1.00	Title XVIII 2.00	Title XIX 3.00	0ther 4.00	Total 5. 00	
1. 00	HOME HEALTH AGENCY STATISTICAL DATA Home Health Aide Hours	0	С	0	0	0	1.00
2. 00	Unduplicated Census Count (see instructions)			0.00	0. 00	0. 00	
				Number of Empl	oyees (Full Ti	me Equivalent)	
		Enter the numb		Staff	Contract	Total	
		your normal	work week				
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES	()	1.00	2. 00	3. 00	
3. 00	Administrator and Assistant Administrator(s)		0.00	•		l	1
4. 00 5. 00	Director(s) and Assistant Director(s) Other Administrative Personnel			0.00		•	1
6.00	Direct Nursing Service			7. 49	0. 00	7. 49	6.00
7. 00 8. 00	Nursing Supervisor Physical Therapy Service			0. 00 3. 52			1
9. 00	Physical Therapy Supervisor			0.00		l	1
10.00	Occupational Therapy Service			1. 05		l	1
11. 00 12. 00	Occupational Therapy Supervisor Speech Pathology Service			0. 00 0. 33		1	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. 17 0. 00		1	14. 00 15. 00
16. 00	Home Heal th Ai de			1. 17	0. 00	1. 17	1
17.00	Home Heal th Ai de Supervi sor			0. 00 0. 00			17. 00 18. 00
18. 00	Other (specify) HOME HEALTH AGENCY CBSA CODES			0.00	0.00	0.00	18.00
19. 00	Enter in column 1 the number of CBSAs where you provided services during the cost			4			19. 00
20.00	reporting period.			17140			20.00
20. 00	during this cost reporting period (line 20			17140			20.00
20. 01	contains the first code).			18020			20. 01
20. 01				26900			20. 01
20. 03		Full Fr	oi sodes	99915			20. 03
		Wi thout		LUPA Epi sodes	PEP Only	Total (cols.	
		0utliers 1.00	2.00	3.00	Epi sodes 4.00	1-4) 5. 00	
21 00	PPS ACTIVITY DATA	2 240	1 4	122	40	2 517	21.00
21. 00 22. 00	Skilled Nursing Visits Skilled Nursing Visit Charges	2, 340 412, 448					
23. 00	Physical Therapy Visits	1, 311	21	3	36	1, 371	23. 00
24. 00 25. 00	Physical Therapy Visit Charges Occupational Therapy Visits	241, 813 278		1	· ·	253, 318 292	
26.00	Occupational Therapy Visit Charges	53, 628	2, 145	•		56, 358	26. 00
27. 00 28. 00	Speech Pathology Visits Speech Pathology Visit Charges	28 5, 460		0	0	28 5, 460	27. 00 28. 00
29. 00	Medical Social Service Visits	36		1	4	43	ı
30.00	Medical Social Service Visit Charges	6, 825		1		i .	
31. 00 32. 00	Home Health Aide Visits Home Health Aide Visit Charges	823 93, 951			17 2, 004	842 96, 191	31. 00 32. 00
33.00	Total visits (sum of lines 21, 23, 25, 27,	4, 816	48	129	100	5, 093	33. 00
34. 00	29, and 31) Other Charges	0	1	0		0	34.00
35. 00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	814, 125	9, 165	18, 372	17, 214	858, 876	35.00
36. 00		304		34	5	343	36. 00
37.00	Total Number of Outlier Episodes	42.045	1	1 004	0	1	
აზ. 00	Total Non-Routine Medical Supply Charges	63, 845	60	1, 884	2, 934	Ι οδ, /23	38. 00

Heal th	Financial Systems DECATUR CO. MEMORIAL H	OSPI TAL		In Lie	u of Form CMS-2	2552-10	
		rovider CCN: 15°		eri od:	Worksheet S-1		
				rom 01/01/2014			
			T	o 12/31/2014	Date/Time Pre 5/22/2015 1:3		
					3/22/2013 1.30	o piii	
					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	col umn	8)	0. 425562	1. 00	
	Medicaid (see instructions for each line)				0.404.007		
2.00	Net revenue from Medicaid				3, 124, 937	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid? If line 3 is "yes", does line 2 include all DSH or supplemental p	2	Y N	3. 00 4. 00			
4. 00 5. 00	If line 4 is "no", then enter DSH or supplemental payments from N	,	eai cai a		2, 453, 667	4. 00 5. 00	
6. 00	Medicaid charges	leui cai u			15, 145, 852	6.00	
7. 00	Medicald cost (line 1 times line 6)				6, 445, 499	7.00	
8. 00	Difference between net revenue and costs for Medicaid program (li	ne 7 minus sum	of Lin	es 2 and 5 if	866, 895	8.00	
0.00	<pre>< zero then enter zero)</pre>	ne / iii nas saiii	01 1111	23 2 dild 5, 11	000, 073	0.00	
	State Children's Health Insurance Program (SCHIP) (see instruction	ns for each lir	ne)				
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 li	i ne 9;	f < zero then	0	12.00	
	enter zero)						
40.00	Other state or local government indigent care program (see instru					40.00	
13.00	Net revenue from state or local indigent care program (Not included)				0		
14. 00	Charges for patients covered under state or local indigent care p	rogram (Not ind	ci uaea	n 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 indic	ent care progra	am (lin	- 15 minus line		16.00	
.0.00	13; if < zero then enter zero)	one oar o progre	u (5 10 mm 1 do 1 1 m			
	Uncompensated care (see instructions for each line)						
17.00	Private grants, donations, or endowment income restricted to fund	ing charity can	re		0	17.00	
18.00	Government grants, appropriations or transfers for support of hos				0	18.00	
19. 00	Total unreimbursed cost for Medicaid , SCHIP and state and local	indigent care p	program	s (sum of lines	866, 895	19. 00	
	8, 12 and 16)	l lint n		Lassussal	T-+-1 /1 1		
			sured ents	Insured patients	Total (col. 1 + col. 2)		
			00	2. 00	3. 00		
20. 00	Total initial obligation of patients approved for charity care (a		738, 430	0	2, 738, 430	20.00	
	charges excluding non-reimbursable cost centers) for the entire f				_,		
21.00	Cost of initial obligation of patients approved for charity care	(line 1 1,	165, 372	0	1, 165, 372	21.00	
	times line 20)						
22. 00	Partial payment by patients approved for charity care		0	0	0		
23. 00	Cost of charity care (line 21 minus line 22)		165, 372	0	1, 165, 372	23. 00	
					1. 00		
24. 00	Does the amount in line 20 column 2 include charges for patient of	ays beyond a le	ength o	f stay limit	N N	24. 00	
	imposed on patients covered by Medicaid or other indigent care pr	ogram?	Ü	•			
25.00	If line 24 is "yes," charges for patient days beyond an indigent	n of stay limit	0	25. 00 26. 00			
	.00 Total bad debt expense for the entire hospital complex (see instructions) 5,86						
27. 00	Medicare bad debts for the entire hospital complex (see instructi				398, 198		
28. 00	Non-Medicare and non-reimbursable Medicare bad debt expense (line		,		5, 463, 986		
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt exper	se (line 1 time	es line	28)	2, 325, 265		
30.00		20)			3, 490, 637		
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line	30)			4, 357, 532	31.00	

CLASSIFICATION AND ADJUSTMENTS OF TRIA	AL BALANCE OF EXPENSES	Provi der		Peri od:	Worksheet A	
				From 01/01/2014 To 12/31/2014		
Cost Center Description	Sal ari es	0ther	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)		
	1. 00	2.00	3.00	4. 00	5. 00	
GENERAL SERVICE COST CENTERS				_		
00 00100 CAP REL COSTS-BLDG & FIXT		3, 293, 425				
00 00200 CAP REL COSTS-MVBLE EQUIP		0)	0		
00 00300 OTHER CAP REL COSTS	112 071	(150 700	()72 77	0	_	
00 00400 EMPLOYEE BENEFITS DEPARTMEN 00 00500 ADMINISTRATIVE & GENERAL	T 113, 071 2, 392, 382	6, 159, 700			-,,	
00 00600 MAINTENANCE & REPAIRS	351, 071	4, 195, 535 322, 942				
00 00700 OPERATION OF PLANT	331,071	680, 283			1	
00 00800 LAUNDRY & LINEN SERVICE	49, 145	28, 425			77, 570	
00 00900 HOUSEKEEPI NG	380, 313	144, 878			1	
. 00 01000 DI ETARY	443, 033	309, 337				
. 00 01100 CAFETERI A	O	0)	511, 945		1
. 00 01300 NURSING ADMINISTRATION	600, 788	22, 766	623, 55	4 0	623, 554	1:
. 00 01400 CENTRAL SERVICES & SUPPLY	31, 737	2, 185			,	
.00 01600 MEDICAL RECORDS & LIBRARY	421, 173	89, 905				
. 00 01700 SOCIAL SERVICE	297, 647	11, 114	308, 76	1 0	308, 761	1
INPATIENT ROUTINE SERVICE COST CE		110.00/	0 000 00	000 400	0.007.054	١.,
. 00 03000 ADULTS & PEDIATRICS	2, 190, 233	140, 006				
. 00 03100 I NTENSI VE CARE UNI T . 00 04300 NURSERY	328, 273	7, 188 0		1 0 0 120, 607		1 -
ANCI LLARY SERVI CE COST CENTERS	I OI		'	120, 607	120, 607	- 4
OO OSOOO OPERATING ROOM	983, 979	439, 847	1, 423, 82	6 0	1, 423, 826	5 50
. 00 05200 DELIVERY ROOM & LABOR ROOM	0	437, 047		0 112, 581		
. 00 05300 ANESTHESI OLOGY	479, 217	559, 582	1	·		
. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 159, 250	600, 203				
. 00 03630 ULTRA SOUND	o	43, 416	43, 41	6 74, 861	118, 277	5
. 00 06000 LABORATORY	1, 066, 259	512, 360	1, 578, 61	9 0	1, 578, 619	6
.00 06200 WHOLE BLOOD & PACKED RED BL	OOD CELL 0	94, 788	94, 78	8 0	94, 788	6
. 00 06500 RESPI RATORY THERAPY	732, 938	73, 034		·		
. 00 06600 PHYSI CAL THERAPY	550, 433	14, 562				
. 00 06700 OCCUPATI ONAL THERAPY	179, 355	5, 917			,	
. 00 06800 SPEECH PATHOLOGY	155, 863	28, 145			,	
. 00 06900 ELECTROCARDI OLOGY	98, 389	14, 476				
.00 O7100 MEDICAL SUPPLIES CHARGED TO .00 O7200 IMPL. DEV. CHARGED TO PATIE		2, 530, 160		0 -84, 629 0 23, 965		
. 00 07300 DRUGS CHARGED TO PATIENTS	766, 863	2, 581, 904	1			
OUTPATIENT SERVICE COST CENTERS	700,000	2,301,704	3, 340, 70	,, ,	3, 340, 707	1 "
. 00 09000 CLI NI C	555, 337	429, 055	984, 39	2 0	984, 392	9
. 01 09001 ONCOLOGY	196, 668	223, 452			1	
. 02 09002 OUTPATIENT CLINIC	61, 678	7, 654	69, 33	2 0	69, 332	9
.03 09003 PROVIDER BASED CLINIC - TCM		1, 683, 038				
. 04 09004 PROVIDER BASED CLINIC - DCP	C 1, 470, 791	121, 337	1, 592, 12			
.05 09005 PROVIDER BASED CLINIC - WES		9, 961				
. 06 09006 CLI NI C	223, 507	333, 596			,	
. 07 09007 WOMEN' S HEALTH SERVICES	553, 940	413, 321				
. 00 09100 EMERGENCY	1, 945, 077	702, 025	2, 647, 10	2 0	2, 647, 102	
00 09200 0BSERVATION BEDS (NON-DISTI		102 ///	062.44	2 0	0/2 442	9
. 00 09500 AMBULANCE SERVICES . 00 09900 CMHC	858, 777	103, 666	962, 44	0	962, 443 0	
1.00 10100 HOME HEALTH AGENCY	872, 151	159, 102	1, 031, 25	3 -68, 365	_	
SPECIAL PURPOSE COST CENTERS	872, 131	157, 102	. 1,031,25	3 -00, 303	702, 888	110
8. 00 SUBTOTALS (SUM OF LINES 1-1 NONREI MBURSABLE COST CENTERS	17) 21, 193, 883	27, 092, 290	48, 286, 17	3 423	48, 286, 596	1118
0. 00 19000 GIFT, FLOWER, COFFEE SHOP &	CANTEEN O	0		0 0	0	19
2.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	l	0 0		19:
4. 00 07950 MARKETI NG	83, 460	267, 722		-		
4. 02 07952 OTHER NONREI MBURSABLE	24, 412	4, 206				
0.00 TOTAL (SUM OF LINES 118-199) 21, 301, 755	27, 364, 218	48, 665, 97	3 0	48, 665, 973	200

In Lieu of Form CMS-2552-10

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES Provider CCN: 151332 Peri od: Worksheet A From 01/01/2014 12/31/2014 Date/Time Prepared: 5/22/2015 1:38 pm Cost Center Description Adjustments Net Expenses (See A-8) For Allocation 6. 00 7.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT -544, 127 2, 749, 298 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 0 2.00 3.00 00300 OTHER CAP REL COSTS 3 00 0 0 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT -765, 254 5, 507, 517 4.00 00500 ADMINISTRATIVE & GENERAL 6, 670, 927 5.00 -286, 240 5.00 6.00 00600 MAINTENANCE & REPAIRS 674, 013 6.00 0 00700 OPERATION OF PLANT 680, 283 7.00 0 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 0 77, 570 8.00 9 00 00900 HOUSEKEEPI NG 0 525, 191 9 00 01000 DI ETARY 240, 425 10.00 10.00 0 01100 CAFETERI A -135, 485 11.00 376, 460 11.00 13.00 01300 NURSING ADMINISTRATION 623, 554 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY -609 33, 313 14.00 16.00 01600 MEDICAL RECORDS & LIBRARY -4, 275 560, 052 16.00 17.00 01700 SOCIAL SERVICE 308, 761 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 2, 096, 985 30.00 -66 03100 INTENSIVE CARE UNIT 31.00 0 335, 461 31 00 04300 NURSERY 43.00 120, 607 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 1, 295, 432 50.00 -128,39450.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 112, 581 52.00 108, 664 53.00 05300 ANESTHESI OLOGY -990, 799 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 684, 379 -213 54.00 03630 ULTRA SOUND 55 00 0 118, 277 55 00 60.00 06000 LABORATORY -465 1, 578, 154 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 94, 788 62.00 62.00 06500 RESPIRATORY THERAPY -7. 280 628. 257 65.00 65.00 06600 PHYSI CAL THERAPY 66.00 -21, 142 543, 853 66.00 -1, 000 67.00 06700 OCCUPATIONAL THERAPY 184, 272 67.00 06800 SPEECH PATHOLOGY 68.00 184,008 68.00 69 00 06900 ELECTROCARDI OLOGY -85, 093 198 207 69 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 -106, 128 2, 339, 403 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 23, 965 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 -3,4283, 345, 339 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C -540, 897 443, 495 90.00 09001 ONCOLOGY 267, 370 90.01 -152, 750 90.01 90 02 09002 OUTPATIENT CLINIC 69, 332 90.02 0 09003 PROVIDER BASED CLINIC - TCMP 90.03 -1, 473, 793 771, 438 90.03 09004 PROVIDER BASED CLINIC - DCPC -913, 632 351, 507 90.04 90.04 90.05 09005 PROVIDER BASED CLINIC - WESTPORT -1, 092 105, 186 90.05 90.06 09006 CLINIC -64, 800 492, 303 90.06 90.07 09007 WOMEN'S HEALTH SERVICES -855, 832 110, 742 90.07 91.00 09100 EMERGENCY -1, 290, 267 1, 356, 835 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 962, 443 95.00 99. 00 09900 CMHC 99.00 101.00 10100 HOME HEALTH AGENCY 101.00 962,888 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) -8, 373, 061 39, 913, 535 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 Λ 192.00 194. 00 07950 MARKETI NG 0 350, 759 194.00

28, 618

40, 292, 912

-8, 373, 061

194.02

200.00

200.00

194. 02 07952 OTHER NONREI MBURSABLE

TOTAL (SUM OF LINES 118-199)

Health Financial Systems	DECATUR CO. MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
RECLASSI FI CATI ONS		Provi der CCN: 151332	Peri od:	Worksheet A-6

(LOL) (OC	STITCATIONS			11 OVI dei	CCN. 131332	From 01/01/2014	WOI KSHEET A-0
						To 12/31/2014	Date/Time Prepare 5/22/2015 1:38 pm
		Increases		·			
	Cost Center	Li ne #	Sal ary	0ther			
	2. 00	3. 00	4. 00	5. 00			
	A - ULTRASOUND SALARY RECLASS						
. 00	ULTRA SOUND	<u>55.</u> 00	7 <u>4, 8</u> 61	0			1.
	0		74, 861	0			
	B - L&D AND NURSERY RECLASS						
. 00	NURSERY	43.00	105, 250	15, 357			1.
. 00	DELIVERY ROOM & LABOR ROOM	52. 00	98, 246	14, 335			2.
	0		203, 496	29, 692			
	C - EKG SALARY RECLASS						
. 00	ELECTROCARDI OLOGY	69. 00	73, 342	0			1.
			73, 342				
	D - CAFETERIA RECLASS		•				
. 00	CAFETERI A	11. 00	301, 459	210, 486			1.
			301, 459	210, 486			
	E - ANESTHESIA GAS EXPENSE						
. 00	ANESTHESI OLOGY	53.00	0	60, 664			1.
				60, 664			İ
	F - DIRECT EXPENSE ALLOCATION		-1				
00	ADMINISTRATIVE & GENERAL	5. 00	300, 462	0			1.
00	MEDICAL RECORDS & LIBRARY	16. 00	53, 249	0			2.
00	I I I I I I I I I I I I I I I I I I I	0.00	0	0			3.
00		— — 	353, 711	- — — <u>ö</u>			0.
	H - MARKETING EXPENSE RECLASS		000,711				
00	ADMINISTRATIVE & GENERAL	5. 00	0	423			1.
00	n delicated a delicated a			$- \frac{423}{423}$			''
	I - IMPLANTABLE DEVICES		<u> </u>	423			
00	I MPL. DEV. CHARGED TO	72.00	0	23, 965			1.
00	PATIENTS	72.00	٥	23, 703			1.
		+		23, 965			
	J - EKG PHYSICIAN FEES RECLAS	.c	<u> </u>	23, 703			
00	ELECTROCARDI OLOGY	69. 00	٥	97, 093			1.
00	o IROCARDI OLOGI		— — — }	9 <u>7, 093</u> 97, 093			1.
	K - HOME HEALTH COSTS RECLASS		U _I	97,093			
00	ADMINISTRATIVE & GENERAL		40 245	^			1
00	ADWINISIKATIVE & GENERAL		6 <u>8, 3</u> 65 68, 365	5			1.
00 00	Const Tataly Laurence			422, 222			500
00.00	Grand Total: Increases		1, 075, 234	422, 323			500.

Provider CCN: 151332 | Period: | Worksheet A-6 | From 01/01/2014 | To 12/31/2014 | Date/Time Prep

						To 12/31/2014	Date/Time Prepared: 5/22/2015 1:38 pm
		Decreases					
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref	.	
	6. 00	7.00	8. 00	9. 00	10.00		
	A - ULTRASOUND SALARY RECLASS						
1.00	RADI OLOGY-DI AGNOSTI C	54.00	74, 861	0)	0	1.00
	0		74, 861	0			
	B - L&D AND NURSERY RECLASS						
1.00	ADULTS & PEDIATRICS	30. 00	203, 496	29, 692	2	0	1.00
2.00		0.00	0	0) (ol	2. 00
	0		203, 496	29, 692			
	C - EKG SALARY RECLASS						
1.00	RESPIRATORY THERAPY	<u>65.</u> 00	7 <u>3, 3</u> 42	0)	<u>o</u>	1.00
	0		73, 342	0)		
	D - CAFETERIA RECLASS						
1.00	DI ETARY	1000	30 <u>1, 4</u> 59	21 <u>0, 4</u> 86		ol	1.00
	0		301, 459	210, 486			
	E - ANESTHESIA GAS EXPENSE						
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	60, 664		0	1.00
	PATI ENT						
	0		0	60, 664			
	F - DIRECT EXPENSE ALLOCATION						
1.00	PROVIDER BASED CLINIC - DCPC	90. 04	326, 989	0		0	1.00
2.00	PROVIDER BASED CLINIC -	90. 05	26, 035	0)	0	2. 00
	WESTPORT						
3.00	WOMEN'S HEALTH SERVICES	<u>90.</u> 07	687	0		<u>o</u> l	3. 00
	0		353, 711	0)		
	H - MARKETING EXPENSE RECLASS						
1. 00	MARKETI NG	1 <u>94.</u> 00	•	423		0	1.00
	0		0	423	3		
	I - IMPLANTABLE DEVICES						
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	23, 965	1	0	1.00
	PATI ENT					_	
	0		0	23, 965			
	J - EKG PHYSICIAN FEES RECLASS					_	
1.00	RESPIRATORY THERAPY	6500	0	97, 093		<u>o</u>	1.00
	0		0	97, 093	8		
	K - HOME HEALTH COSTS RECLASS					_	
1. 00	HOME HEALTH AGENCY	1 <u>01.</u> 00	6 <u>8, 3</u> 65	0	<u> </u>	Ō	1.00
	0		68, 365	0)		
500.00	Grand Total: Decreases		1, 075, 234	422, 323	i		500.00

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 151332 Peri od: Worksheet A-7 From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/22/2015 1:38 pm Acqui si ti ons Begi nni ng Purchases Disposals and Donati on Total Bal ances Retirements 2.00 3.00 4.00 1.00 5.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 1, 127, 637 Land 0 1.00 0 390, 797 2.00 Land Improvements 37, 682 37, 682 0 2.00 3.00 Buildings and Fixtures 27, 136, 593 1, 223, 390 3.00 1, 223, 390 1, 550, 023 0 4.00 Building Improvements 8, 630, 651 0 4.00 Fi xed Equi pment 2, 128, 830 155, 550 0 155, 550 5.00 156, 083 5.00 0 6.00 Movable Equipment 15, 858, 973 246, 288 6.00 1, 742, 822 1, 742, 822 0 7.00 HIT designated Assets 4, 518, 930 0 7.00 8.00 Subtotal (sum of lines 1-7) 59, 792, 411 3, 159, 444 0 3, 159, 444 1, 952, 394 8.00 9.00 Reconciling Items 0 0 9.00 Total (line 8 minus line 9) 59, 792, 411 3, 159, 444 3, 159, 444 1, 952, 394 10.00 O 10.00 Endi ng Ful I y Bal ance Depreciated Assets 6. 00 7. 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 1, 127, 637 0 1.00 0 2.00 Land Improvements 428, 479 2.00 26, 809, 960 3.00 Buildings and Fixtures 0 3.00 4.00 Building Improvements 8, 630, 651 0 4.00 5.00 Fixed Equipment 2, 128, 297 0 5.00 0 6.00 Movable Equipment 17, 355, 507 6.00 HIT designated Assets 4, 518, 930 0 7.00 7.00 8.00 Subtotal (sum of lines 1-7) 60, 999, 461 0 8.00

60, 999, 461

0

0

9.00

Reconciling Items

10.00 Total (line 8 minus line 9)

Heal th	Financial Systems	DECATUR CO. MEMO	ORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10		
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der		Peri od:	Worksheet A-7			
					From 01/01/2014 To 12/31/2014	Part II Date/Time Pre	nared·		
					10 12/01/2011	5/22/2015 1: 3			
			SU	JMMARY OF CAPI	TAL				
	0	D				T			
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see			
					(see instructions)	instructions)			
		9. 00	10. 00	11. 00	12. 00	13.00			
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2									
1.00	CAP REL COSTS-BLDG & FLXT	2, 836, 755			6 0	0	1.00		
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	(0	0	2.00		
3.00	Total (sum of lines 1-2)	2, 836, 755	166, 414	290, 25	6 0	0	3.00		
		SUMMARY 0	F CAPITAL						
	Cost Center Description	0ther	Total (1)						
			(sum of cols.						
			9 through 14)						
		instructions)							
		14. 00	15. 00						
	PART II - RECONCILIATION OF AMOUNTS FROM WO	<u>RKSHEET A, COLUI</u>	· · · · · · · · · · · · · · · · · · ·						
1. 00	CAP REL COSTS-BLDG & FIXT	0	3, 293, 425				1.00		
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00		

0 0 0

3, 293, 425

2.00

3.00 Total (sum of lines 1-2)

Heal tl	n Financial Systems D	ECATUR CO. MEMO	ORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 01/01/2014 To 12/31/2014		
		COMI	PUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	S Capitalized Gross Assets Leases for Ratio (col. 1 - col. 2)		Ratio (see instructions)	Insurance	
	DART III DECONOLILIATION OF CARLTAL COCTO	1. 00	2. 00	3.00	4. 00	5. 00	
1. 00 2. 00 3. 00	PART III - RECONCILIATION OF CAPITAL COSTS C CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP Total (sum of lines 1-2)	43, 643, 944 17, 355, 507 60, 999, 451		43, 643, 94 17, 355, 50 60, 999, 45	0. 284519	0	1.00 2.00 3.00
		ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY C	F CAPITAL	
	Cost Center Description	Taxes	Other Capital-Relat ed Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6. 00	7. 00	8.00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C						
1. 00 2. 00 3. 00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP Total (sum of lines 1-2)	0			2, 560, 789 0 0 2, 560, 789	0	1.00 2.00 3.00
0.00	Total (Sam of Times 12)	0	Sl	JMMARY OF CAPI		100, 111	0.00
	Cost Center Description	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)		
		11. 00	12. 00	13.00	14. 00	15. 00	
1 00	PART III - RECONCILIATION OF CAPITAL COSTS C		1 ~			2.740.000	1 00
1. 00 2. 00 3. 00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP Total (sum of lines 1-2)	22, 095 0 22, 095	0		0 0 0 0	2, 749, 298 0 2, 749, 298	1.00 2.00 3.00

	Financial Systems	D	ECATUR CO. MEMO			u of Form CMS-2	
ADJUST	MENTS TO EXPENSES				Period: From 01/01/2014 To 12/31/2014	Worksheet A-8 Date/Time Pre 5/22/2015 1:3	pared:
				Expense Classification or To/From Which the Amount is			
					j		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
1 00	Investment income CAD DEL	1. 00	2. 00	3.00 CAP REL COSTS-BLDG & FLXT	4.00	5. 00 0	1.00
1. 00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			CAP REL CUSIS-BLDG & FIXI	1.00	U	1.00
2. 00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2.00
3.00	Investment income - other		O		0.00	0	3.00
4. 00	(chapter 2) Trade, quantity, and time		О		0.00	0	4.00
5. 00	discounts (chapter 8) Refunds and rebates of		0		0. 00	0	5. 00
	expenses (chapter 8)					_	
6. 00	Rental of provider space by suppliers (chapter 8)		0		0. 00	0	6.00
7. 00	Telephone services (pay stations excluded) (chapter		0		0. 00	0	7. 00
	21)						
8. 00	Television and radio service (chapter 21)		0		0. 00	0	8.00
9.00	Parking Lot (chapter 21)	4.0.2	0		0. 00	0	
10. 00	Provi der-based physician adjustment	A-8-2	-6, 022, 515			0	10.00
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0. 00	0	11.00
12. 00	Related organization	A-8-1	7, 200			0	12. 00
13. 00	transactions (chapter 10) Laundry and Linen service		О		0.00	0	13.00
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee		0		0. 00 0. 00	0	
	and others					_	
16. 00	Sale of medical and surgical supplies to other than		0		0. 00	0	16.00
17 00	patients Sale of drugs to other than		0		0. 00	0	17. 00
	patients						
18. 00	Sale of medical records and abstracts		0		0.00	0	18. 00
19. 00	Nursing school (tuition, fees, books, etc.)		0		0. 00	0	19.00
	Vending machines		0		0.00		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				0.00	0	22.00
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65. 00		23.00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25.00
04.00	(chapter 21)			OAD DEL COSTO DIDO A FLVT	1 00		0, 00
	Depreciation - CAP REL COSTS-BLDG & FIXT			CAP REL COSTS-BLDG & FIXT	1.00	0	26. 00
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
	Non-physician Anesthetist		O	*** Cost Center Deleted ***		_	28.00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	0. 00 67. 00	0	29. 00 30. 00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	instructions) Adjustment for speech	A-8-3	O	SPEECH PATHOLOGY	68. 00		31.00
	pathology costs in excess of limitation (chapter 14)						
	1 tation (Gnapter 14)	I	I I				I

Health Financial Systems
ADJUSTMENTS TO EXPENSES Provi der CCN: 151332 Peri od: Worksheet A-8 From 01/01/2014 To 12/31/2014 Date/Time Prepared: 5/22/2015 1:38 pm

					5/22/2015 1:3	8 pm
			Expense Classification on	Worksheet A		
			To/From Which the Amount is			
				,		
Cost Center Description	Basis/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
cost center bescription		Alliourt	COST CONTEN	LITIC #	Ref.	
	(2)	2.00	3. 00	4.00		
20. 20. 1044 44. 7. 4. 4. 6.	1.00	2. 00		4. 00	5. 00	00.00
32.00 CAH HIT Adjustment for	A	-304, 326	CAP REL COSTS-BLDG & FIXT	1. 00	9	32.00
Depreciation and Interest						
33.00 CAFETERIA MEALS-EMPLOYEE	В	-98, 766	CAFETERI A	11. 00	0	33.00
33. 01 RADI OLOGY	В	-213	RADI OLOGY-DI AGNOSTI C	54. 00	0	33. 01
33. 02 CENTRAL SUPPLY	В	1	CENTRAL SERVICES & SUPPLY	14. 00	0	33. 02
33. 03 LABORATORY	B		LABORATORY	60.00	0	33. 03
					0	
33. 04 PHYSI CAL THERAPY	В		PHYSI CAL THERAPY	66. 00	0	33. 04
33. 05 OCCUPATI ONAL THERAPY	В	-1, 000	OCCUPATI ONAL THERAPY	67. 00	0	33. 05
33.06 PROVIDER BASED CLINIC	В	-244	PROVIDER BASED CLINIC - DCPC	90. 04	0	33.06
33.07 WESTPORT CLINIC	В	-1.092	PROVIDER BASED CLINIC -	90. 05	0	33. 07
	_	.,	WESTPORT		_	
33. 08 IT	В	20 024	ADMINISTRATIVE & GENERAL	5. 00	0	33. 08
					0	
33.09 STAFF DEVELOPMENT	В		ADMINISTRATIVE & GENERAL	5. 00	0	33. 09
34.00 CAFETERIA MEALS-VISITOR	В		CAFETERI A	11. 00	0	34.00
35.00 MEDICAL RECORD TRANSCRIPTS	В	-4, 275	MEDICAL RECORDS & LIBRARY	16.00	0	35.00
FEES						
36. 00 CLASS FEES	В	-66	ADULTS & PEDIATRICS	30. 00	0	36.00
37. 00 OTHER INCOME	B		ADMINISTRATIVE & GENERAL	5. 00	0	37.00
4					-	
38. 00 NON-OPERATING INCOME	В		ADMINISTRATIVE & GENERAL	5. 00	0	38. 00
39.00 BABY PICTURE COMMISSIONS	В	-3, 179	ADMINISTRATIVE & GENERAL	5. 00	0	39.00
40.00 CASH OVER/SHORT	В	-50	ADMINISTRATIVE & GENERAL	5. 00	0	40.00
41.00 REFUNDS & REIMBURSEMENTS	В		MEDICAL SUPPLIES CHARGED TO	71. 00	0	41.00
TT. 00 REF 0NDO & REF INDOROEMENTO		71,200	PATI ENT	71.00	O	11.00
42.00 OTHER DONATIONS	В	450		F 00	0	42.00
			ADMI NI STRATI VE & GENERAL	5. 00	0	42.00
43. 00 REBATES	В	-14, 922	MEDICAL SUPPLIES CHARGED TO	71. 00	0	43.00
			PATI ENT			
45.00 REBATES - PHARMACY	В	-95	DRUGS CHARGED TO PATIENTS	73.00	0	45.00
45. 01 PHYSICIAN RECRUITMENT	В	-104, 502	ADMINISTRATIVE & GENERAL	5. 00	0	45. 01
45. 02 I NTEREST EXPENSE	A		CAP REL COSTS-BLDG & FIXT	1. 00	11	45. 02
45. 03 EMPLOYEE DRUG SALES	A				0	45. 02
			DRUGS CHARGED TO PATIENTS	73. 00	-	
45. 04 PATIENT TELEPHONE EXPENSE	A		ADMINISTRATIVE & GENERAL	5. 00	0	45. 04
45.05 PATIENT TELEPHONE BENEFITS	A	-2, 606	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	45. 05
45. 06 TELEVI SI ON	A	-2, 073	CAP REL COSTS-BLDG & FLXT	1. 00	9	45.06
45.07 PHYSICIAN BENEFITS	A		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	45. 07
45. 08 AHA/I HA LOBBYI NG EXPENSE	A	1	ADMINISTRATIVE & GENERAL	5. 00	0	45. 08
45. 09 CHARI TABLE CONTRIBUTION	A	- 10, 160	ADMINISTRATIVE & GENERAL	5. 00	0	45. 09
EXPENSE						
45. 10 BOND ISSUE COSTS AMORTIZATION	A	23, 233	CAP REL COSTS-BLDG & FIXT	1. 00	9	45. 10
45. 11 CRNA OFFSET	Α	-480, 875	ANESTHESI OLOGY	53. 00	0	45. 11
45. 12 BILLINGS COST OFFSET	A	1	ADMINISTRATIVE & GENERAL	5. 00	0	45. 12
45. 13 BILLINGS COST OFFSET	A		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	45. 13
1	1	1		4.00	U	
50.00 TOTAL (sum of lines 1 thru 49	기	-8, 373, 061				50.00
(Transfer to Worksheet A,						
column 6, line 200.)						
(1) Description - all chapter refere	ences in this co	lumn pertain t	o CMS Pub 15-1			

⁽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.

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

			Related Organization(s) and/or Home Office			
Symbol (1)	Name	Percentage of	Name	Percentage of		
		Ownershi p		Ownershi p		
1. 00	2. 00	3. 00	4. 00	5. 00		
B. INTERRELATIONSHIP TO RELA	FED ORGANIZATION(S) AND/OR HO	ME OFFICE:				

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

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

6. 00	G	COUNTY	100. 00 COUNTY	100.00	6. 00
7.00			0.00	0.00	7. 00
8.00			0.00	0.00	8. 00
9.00			0.00	0.00	9. 00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or	COUNTY			100.00
	non-financial) specify:				

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

Worksheet A-8, column 2,

line 12.

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

Heal th	Financial Syste	ems		DEC	CATUR CO.	MEMORI A	L HOSPITAL					In Lieu	u of Form CM:	S-2552-10
	ENT OF COSTS OF	SERVICES FROM	RELATED	ORGANI ZA	TIONS AN	D HOME	Provi der	CCN:	151332	Peri		1 /201 4	Worksheet A	-8-1
OFFI CE	COSTS									To		1/2014 1/2014		repared: :38 pm
	Net Adjustments (col. 4 minus col. 5)* 6.00	Wkst. A-7 Ref. 7.00												
	A. COSTS INCURPOFFICE COSTS:	RED AND ADJUSTI	MENTS RE	QUI RED AS	A RESUL	T OF TRAI	NSACTIONS N	WI TH	RELATED	ORGAN	VI ZATI (ONS OR	CLAIMED HOM	
1. 00 2. 00 3. 00 4. 00	7, 200 0 0 0	9 0 0 0												1.00 2.00 3.00 4.00
5.00	7, 200													5.00
appropr	amounts on line late.Positive a been posted to	amounts increas	se cost a	and negati	ive amou	nts decre	ase cost. F	or r	elated o	rgani	zati or	or ho	me office co	st which
nas no	Related Orga and/or Hor	ni zati on(s)	COT CHILITS	T dilay of	2, the	amourt ar	Towable 3	lour u	be man	carca	711 66	T CHILLY T	or this par	
	Type of I													

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

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

6.00	COUNTY		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00		1	10.00
7. 00 8. 00 9. 00 10. 00 100. 00		10	00.00

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

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

 D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in

Provi der CCN: 151332

Peri od:

From 01/01/2014

PROVI DER BASED PHYSI CI AN ADJUSTMENT

12/31/2014 Date/Time Prepared: 5/22/2015 1:38 pm Wkst. A Line # Cost Center/Physician Total Professi onal Provi der RCE Amount Physi ci an/Prov I denti fi er der Component Remuneration Component Component Hours 1.00 2.00 5.00 3 00 4 00 6 00 7 00 50. 00 AGGREGATE-OPERATING ROOM 1.00 128, 394 128, 394 0 0 1.00 2.00 53. 00 AGGREGATE-ANESTHESI OLOGY 509, 924 509, 924 0 0 0 2.00 0 60. 00 AGGREGATE-LABORATORY 3.00 97 0 0 3.00 0 65. 00 AGGREGATE-RESPI RATORY 0 7.280 7.280 4.00 4.00 THERAPY 5.00 69. 00 AGGREGATE-ELECTROCARDI OLOGY 85, 093 85,093 0 5.00 90. 00 AGGREGATE-CLI NI C 0 6.00 540, 897 540, 897 0 0 6.00 90. 01 AGGREGATE-ONCOLOGY 0 152, 750 152, 750 0 C 7.00 7.00 90. 03 AGGREGATE-PROVI DER BASED 8.00 1, 473, 793 1, 473, 793 0 8.00 CLINIC - TC 9.00 90. 04 AGGREGATE-PROVI DER BASED 913, 388 913, 388 0 9.00 CLINIC - DC 90. 06 AGGREGATE-CLINIC 10 00 0 64,800 64,800 0 0 10.00 11.00 90. 07 AGGREGATE-WOMEN' S HEALTH 855, 832 855, 832 0 11.00 SERVI CES 12.00 91. 00 AGGREGATE-EMERGENCY 1, 519, 480 1, 290, 267 229, 213 12.00 6, 251, 728 200.00 6, 022, 515 229, 213 0 200.00 Physician Cost Wkst. A Line # Cost Center/Physician Unadjusted RCE 5 Percent of Cost of Provi der I denti fi er Unadjusted RCE Memberships & of Malpractice Li mi t Component Limit Continuing Share of col Insurance Educati on 12 1.00 14. 00 2.00 9.00 8. 00 12.00 13.00 1.00 50. 00 AGGREGATE-OPERATING ROOM 0 0 1.00 2.00 53. 00 AGGREGATE-ANESTHESI OLOGY o 0 0 2.00 0 3.00 60. 00 AGGREGATE-LABORATORY 0 0 0 0 3.00 65. 00 AGGREGATE-RESPI RATORY 0 4.00 0 0 4.00 THERAPY 5.00 69. 00 AGGREGATE-ELECTROCARDI OLOGY 0 5.00 90. 00 AGGREGATE-CLI NI C 0 6.00 6.00 90. 01 AGGREGATE-ONCOLOGY 0 7.00 0 0 C 7.00 90. 03 AGGREGATE-PROVI DER BASED 8.00 C 8.00 CLINIC - TC 9.00 90. 04 AGGREGATE-PROVI DER BASED 0 0 9.00 CLINIC - DC 90. 06 AGGREGATE-CLI NI C 10 00 0 10.00 11.00 90. 07 AGGREGATE-WOMEN' S HEALTH 0 11.00 SERVI CES 91. 00 AGGREGATE-EMERGENCY 12.00 12.00 0 200.00 200.00 Wkst. A Line # Cost Center/Physician Provi der Adjusted RCE RCF Adjustment I denti fi er Component Di sal I owance Li mi t Share of col 14 16.00 17.00 1 00 2 00 15 00 18 00 1.00 50. 00 AGGREGATE-OPERATING ROOM 128, 394 1.00 0 2.00 53. 00 AGGREGATE-ANESTHESI OLOGY 0 509, 924 2.00 0 0 60. 00 AGGREGATE-LABORATORY 0 3.00 0 0 3.00 65. 00 AGGREGATE-RESPI RATORY 0 0 4.00 7.2804.00 THERAPY 5.00 69. 00 AGGREGATE-ELECTROCARDI OLOGY 5.00 85, 093 90. 00 AGGREGATE-CLI NI C 6.00 o 0 540, 897 6.00 90. 01 AGGREGATE-ONCOLOGY 7.00 0 0 0 152, 750 7.00 90. 03 AGGREGATE-PROVI DER BASED 8.00 O 0 1, 473, 793 8.00 CLINIC - TC 9.00 90. 04 AGGREGATE-PROVI DER BASED 0 0 913, 388 9.00 CLINIC - DC 90. 06 AGGREGATE-CLI NI C 10 00 64,800 10.00 0 0 11.00 90. 07 AGGREGATE-WOMEN' S HEALTH 0 0 855, 832 11.00 SERVI CES 12.00 91. 00 AGGREGATE-EMERGENCY 0 0 1, 290, 267 12.00 200.00 0 6, 022, 515 200.00

Health Financial Systems	DECATUR CO.	MEMORI AL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
REASONABLE COST DETERMINATION FOR THERAPY OUTSIDE SUPPLIERS	SERVICES FURNISHED	ВУ	Provi der	CCN: 151332	From 01/01/2014	Worksheet A-8 Parts I-VI Date/Time Pre 5/22/2015 1:3	pared:
	Cost						
						1. 00	
PART I - GENERAL INFORMATION							
1.00 Total number of weeks worked (excl	51	1.00					

100 Line 1 multiplied by 15 hours per week 100							1. 00			
1.00 Number of unduplicated days in which supervisor or therapist was on provider site (see instructions) 104 3.0 3.0 Number of unduplicated days in which supervisor or therapists (see instructions) 104 3.0		PART I - GENERAL INFORMATION								
Mumber of multiplicated days in which therapy assistant was on provider at let (see instructions) 0.4 3.0	1.00	Total number of weeks worked (excluding aide		1.00						
1.00 Number of unduplicated days in which thorapy assistants was on provider site to but not ther supervisor 0 4.0	2.00									
0	3.00	Number of unduplicated days in which supervi	104	3.00						
5.00 Number of undupil cated offsi fe visits - supervisors or therapts (see Instructions) 5.00 Number of undupil cated offsi fe visits - therapy assistants (include only visits made by therapy) 0.60 0.80 0	4.00	Number of unduplicated days in which therapy	0	4.00						
2.00 Marber of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see 2.00 3.00		nor therapist was on provider site (see inst								
assistant and on which supervisor and/or therapist was not present during the visit(s)) (see 3.75 1.5	5.00	Number of unduplicated offsite visits - supe	0	5.00						
Standard travel expense rate per mile	6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy								
1.00 Optional travel expense rate per mile Supervisors Therapists Assistants Aidos Trainees		assistant and on which supervisor and/or the								
Optional travel expense rate per mile		instructions)								
Supervisors Therapists Assistants Alides Trainees	7.00	Standard travel expense rate					3. 25	7.00		
1.00 10tal hours worked 1.00 2.00 3.00 4.00 5.00 0.00	8.00	Optional travel expense rate per mile		0.00	8.00					
1.00 Collar hours worked 0.00 712.00 0.00			Supervi sors	Therapi sts	Assi stants	Ai des	Trai nees			
			1.00	2.00	3.00	4. 00	5. 00			
11.00 Standard travel allowance (column 3 and 2,	9. 00	Total hours worked	0.00	712. 00	0.00	0.00	0.00	9.00		
0.00 0.00	10.00	AHSEA (see instructions)	0.00	68. 99	0.00	0.00	0.00	10.00		
0.00 0.00	11.00	Standard travel allowance (columns 1 and 2,	34. 50	34. 50	0.00		!	11.00		
12.00 Number of travel hours (provider site) 0 0 0 0 12.0										
12.01 Number of travel hours (offsite) 0 0 0 0 13.0 Number of miles driven (provider site) 0 0 0 0 13.0 Number of miles driven (provider site) 0 0 0 0 0 0 13.0										
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Part II - SALARY EQUIVALENCY COMPUTATION 1.00		1 "	1	-			!			
Part II - SALARY EQUIVALENCY COMPUTATION 1, 100 11.00 14.00 14.00 15.00 16.00 15.00 16.00	13.01	Number of mires arriver (orrarte)	١		<u> </u>			13.0		
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		Part II - SALARY FOLLIVALENCY COMPLITATION					1.00			
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16.00 Assistants (column 3, line 9 times column 3, line 10) 49,121		1 .					1			
17.00 Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others) 17.00 17.00 18.00 1										
Others Othe			,							
Aldes (column 4, line 9 times column 5, line 10)	17.00	· ·	nd 15 for respi	ratory therapy	y or lines 14-1	6 for all	49, 1211	17.00		
19.00 Trainees (column 5, line 9 times column 5, line 10) 19.0 1		1	40)							
Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others) 49,121			,							
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.										
occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23. 21.00 Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others) 22.00 Weighted allowance excluding aides and trainees (line 2 times line 21) 23.00 Total salary equivalency (see instructions) 24.01 Total salary equivalency (see instructions) 25.777 27.02 PART III - STANDARD AND DFIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE Standard Travel Allowance 24.00 Therapists (line 3 times column 2, line 11) 25.00 Assistants (line 4 times column 3, line 11) 26.00 Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others) 27.00 Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 3, 926 and 27) 28.00 Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 3, 926 and 3) 29.00 Total standard travel allowance and optional Travel Expense Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12) 30.00 Assistants (column 3, line 10 times column 3, line 12) 30.00 Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others) 30.00 Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others) 30.00 Assistants (column 3, line 10 times columns 1 and 2, line 12) 30.00 Total travel allowance and standard travel expense (sum of lines 27 and 31) 30.00 Total standard travel allowance and standard travel expense (sum of lines 27 and 31) 30.00 Total standard travel allowance and optional travel expense (sum of lines 27 and 31) 30.00 Total standard travel allowance and optional travel expense (sum of lines 27 and 31) 30.00 Total standard travel allowance and optional standard travel expense (sum of lines 27 and 31) 30.00 Total standard travel e	20. 00							20.00		
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	44 00		L ovnonco (cum	of Lines 20 as	ad 20 coo i ac	tructions)		14 00		
+3.00 Optional travel allowance and standard travel expense (sull 01 11 lies 39 and 42 - see illistructions)						,				
	45.00	Toper onal travel arrowance and Standard trave	a exherise (2011)	OI IIIICS 37 dl	14 42 - SEE 1115	oti ucti olis)	1	1 45.0		

	ABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS	FURNI SHED BY	Provi der	CCN: 151332	Period: From 01/01/2014 To 12/31/2014	Date/Time Pre 5/22/2015 1:3	pared:	
					Speech Pathology	/ Cost		
						1. 00		
6. 00	Optional travel allowance and optional travel			1			46.00	
		Therapi sts 1.00	Assi stants 2.00	Ai des 3.00	Trai nees 4.00	Total 5. 00		
	PART V - OVERTIME COMPUTATION	1.00	2.00	3.00	4.00	3.00		
7. 00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0. 00	0. 00	0. 0	0. 00	0.00	47.00	
8. 00	Overtime rate (see instructions)	0. 00	0.00	1			48.00	
9. 00	Total overtime (including base and overtime	0. 00	0.00	0.0	0.00		49.00	
	allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT							
0. 00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0. 00	0.0	0. 00	0.00	50.00	
. 00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0. 00	0. 00	0.0	0. 00	0.00	51.00	
2. 00	DETERMINATION OF OVERTIME ALLOWANCE	68. 99	0.00	0.0	0.00		 52. 00	
. 00	Adjusted hourly salary equivalency amount (see instructions)	00. 99	0.00	0.0	0.00		32.0	
. 00	Overtime cost limitation (line 51 times line 52)	0	С		0 0		53.00	
1. 00	Maximum overtime cost (enter the lesser of	0	C)	0		54.00	
. 00	line 49 or line 53) Portion of overtime already included in hourly computation at the AHSEA (multiply	0	C		0 0		55.00	
5. 00	line 47 times line 52) Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	C		0 0	0	56.00	
						1. 00		
	Part VI - COMPUTATION OF THERAPY LIMITATION A	AND EXCESS COST	Γ ADJUSTMENT					
8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00	Salary equivalency amount (from line 23) Travel allowance and expense - provider site Travel allowance and expense - Offsite servid Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 65)	ces (from lines	s 44, 45, or 4	6)		52, 777 3, 926 0 0 0 0 56, 703 0	59. 00 60. 00 61. 00 62. 00 63. 00 64. 00	
00. 01	LINE 33 CALCULATION 0.00 Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others 0.01 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 0.02 Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION 3,							
01. 01 01. 02	Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION	sum of lines 2	29 and 30 for	all others	others	0 338	101. 00 101. 01 101. 02	
	Line 31 = line 29 for respiratory therapy or Line 32 = line 8 times columns 1 and 2, line 13 for all others				umns 1-3, line		102. 00 102. 0	

0 102.02

13 for all others 102.02 Line 35 = sum of lines 31 and 32

Provi der CCN: 151332

Peri od:

COST ALLOCATION - GENERAL SERVICE COSTS

From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/22/2015 1:38 pm CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Subtotal for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 0 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 2, 749, 298 2, 749, 298 1 00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 0 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5, 507, 517 0 5, 509, 908 4.00 4.00 2.391 00500 ADMINISTRATIVE & GENERAL 5.00 6, 670, 927 0 807, 491 8,002,035 5.00 523, 617 6.00 00600 MAINTENANCE & REPAIRS 674,013 44, 335 0 102, 668 821, 016 6.00 7.00 00700 OPERATION OF PLANT 680, 283 210, 887 891, 170 7.00 116, 770 00800 LAUNDRY & LINEN SERVICE 24, 828 0 14.372 8.00 8 00 77.570 00900 HOUSEKEEPI NG 525, 191 0 9.00 111, 219 636, 410 9.00 10.00 01000 DI ETARY 240, 425 36, 452 41, 402 318, 279 10.00 11.00 01100 CAFETERI A 376, 460 5, 665 0 88, 159 470, 284 11.00 01300 NURSING ADMINISTRATION 0 623, 554 812, 553 13 00 13 00 13, 303 175 696 0 14.00 01400 CENTRAL SERVICES & SUPPLY 33, 313 C 9, 281 42, 594 14.00 01600 MEDICAL RECORDS & LIBRARY 560, 052 99, 203 0 138, 741 797, 996 16.00 16.00 01700 SOCIAL SERVICE 308, 761 0 87, 044 398, 502 17.00 17.00 2,697 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 2, 096, 985 263, 953 0 581, 005 2, 941, 943 30.00 03100 INTENSIVE CARE UNIT 31.00 335, 461 10,728 0 96,001 442, 190 31.00 04300 NURSERY 0 166, 100 43 00 120, 607 14, 713 30, 780 43 00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1, 295, 432 0 287, 757 1, 695, 867 112, 678 50.00 45, 230 52.00 05200 DELIVERY ROOM & LABOR ROOM 112, 581 0 28. 731 186, 542 52.00 05300 ANESTHESI OLOGY 108, 664 0 140.143 248.807 53 00 53 00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 684, 379 99, 926 317, 121 2, 101, 426 54.00 03630 ULTRA SOUND 118, 277 0 55.00 21, 893 140, 170 55.00 06000 LABORATORY 1, 578, 154 0 1, 932, 150 60.00 42, 177 311, 819 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 94, 788 62.00 94, 788 62.00 65.00 06500 RESPIRATORY THERAPY 628, 257 9,809 0 192, 894 830, 960 65.00 06600 PHYSI CAL THERAPY 0 160, 970 66 00 543, 853 37, 984 742, 807 66.00 67.00 06700 OCCUPATI ONAL THERAPY 184.272 12, 604 0 52, 451 249, 327 67.00 06800 SPEECH PATHOLOGY 0 68 00 184,008 10, 103 45, 581 239, 692 68 00 31, 694 280, 122 06900 ELECTROCARDI OLOGY 198, 207 0 50, 221 69.00 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 2, 339, 403 30, 530 0 2, 369, 933 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 23, 965 23.965 72.00 72.00 0 07300 DRUGS CHARGED TO PATIENTS 42, 545 73.00 3, 345, 339 224, 263 3, 612, 147 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 443, 495 31, 265 0 162, 404 637, 164 90.00 0 90 01 09001 ONCOLOGY 267, 370 23, 480 57.514 348, 364 90 01 09002 OUTPATIENT CLINIC 0 90.02 69, 332 78, 960 18,037 166, 329 90.02 90.03 09003 PROVIDER BASED CLINIC - TCMP 771, 438 155, 456 0 164, 409 1, 091, 303 90.03 09004 PROVIDER BASED CLINIC - DCPC 351, 507 117, 705 0 67, 383 90.04 90.04 536, 595 09005 PROVIDER BASED CLINIC - WESTPORT 0 90.05 105, 186 14, 713 28, 167 148, 066 90.05 90.06 09006 CLI NI C 492, 303 29, 671 0 65, 363 587, 337 90.06 90.07 09007 WOMEN'S HEALTH SERVICES 110, 742 0 169, 185 90.07 50.760 7.683 09100 EMERGENCY 0 1, 738, 249 91 00 91 00 1, 356, 835 77, 918 303, 496 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 1, 257, 920 95.00 962, 443 44.335 251, 142 99. 00 |09900 CMHC 0 Ω 99.00 101.00 10100 HOME HEALTH AGENCY 962,888 32, 222 0 235, 061 1, 230, 171 101. 00 SPECIAL PURPOSE COST CENTERS 5, 478, 362 118 00 SUBTOTALS (SUM OF LINES 1-117) 39, 913, 535 2, 384, 537 0 39, 517, 228 118. 00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 3, 310 0 3, 310 190. 00 0 0 0 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 357, 773 ol 357, 773 192. 00 350, 759 194 00 07950 MARKETING 0 24 407 378, 844 194. 00 3,678 194. 02 07952 OTHER NONREI MBURSABLE 0 28, 618 C 7, 139 35, 757 194. 02 200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 0 0 201.00 0 5, 509, 908 40, 292, 912 202. 00 202.00 TOTAL (sum lines 118-201) 40, 292, 912 2, 749, 298

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provi der CCN: 151332

| Peri od: | Worksheet B | From 01/01/2014 | Part | To 12/31/2014 | Date/Time Prepared: 5/22/2015 1:38 pm

								8 pm
		Cost Center Description		MAINTENANCE &		LAUNDRY &	HOUSEKEEPI NG	
			E & GENERAL	REPAI RS	PLANT	LINEN SERVICE		
			5. 00	6. 00	7. 00	8. 00	9. 00	
		AL SERVICE COST CENTERS						
1.00		CAP REL COSTS-BLDG & FIXT						1.00
2.00		CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8, 002, 035					5.00
6.00	00600	MAINTENANCE & REPAIRS	203, 457	1, 024, 473				6.00
7.00	00700	OPERATION OF PLANT	220, 842	0				7. 00
8.00	00800	LAUNDRY & LINEN SERVICE	28, 937	0	14, 029	159, 736		8.00
9.00	00900	HOUSEKEEPI NG	157, 709	147, 385	0	21, 809	963, 313	9.00
10.00	01000	DI ETARY	78, 873	29, 778	20, 596	305	0	10.00
11.00	01100	CAFETERI A	116, 542	80, 610	3, 201	o	21, 640	11.00
13.00	01300	NURSI NG ADMI NI STRATI ON	201, 360	82, 114	7, 517	0	5, 571	13.00
14.00		CENTRAL SERVICES & SUPPLY	10, 555			o	0	14.00
16.00		MEDICAL RECORDS & LIBRARY	197, 752	18, 047	56, 052	o	9, 854	16.00
17.00	1 1	SOCIAL SERVICE	98, 753			o	2, 463	17.00
		ENT ROUTINE SERVICE COST CENTERS						
30.00		ADULTS & PEDIATRICS	729, 046	74, 895	149, 140	51, 711	385, 510	30.00
31.00		INTENSIVE CARE UNIT	109, 580				0	31.00
43.00		NURSERY	41, 161	7, 520			24, 179	43.00
		LARY SERVICE COST CENTERS	,	.,,	2,010	_,	= .,	
50.00	05000	OPERATING ROOM	420, 254	102, 267	63, 666	21, 341	12, 241	50.00
52. 00		DELIVERY ROOM & LABOR ROOM	46, 227	16, 844			36, 421	52.00
53. 00		ANESTHESI OLOGY	61, 657	0			0	53.00
54. 00		RADI OLOGY-DI AGNOSTI C	520, 756			12, 433	84, 893	1
55. 00		ULTRA SOUND	34, 736			0	0.,070	55.00
60.00		LABORATORY	478, 808		1	o	45, 668	1
62.00		WHOLE BLOOD & PACKED RED BLOOD CELL	23, 490				0	62.00
65. 00	1 1	RESPIRATORY THERAPY	205, 921	1, 504			25, 316	
66.00		PHYSI CAL THERAPY	184, 076	3, 008			13, 795	•
67.00		OCCUPATI ONAL THERAPY	61, 786				5, 420	•
68. 00		SPEECH PATHOLOGY	59, 398				11, 862	•
69. 00		ELECTROCARDI OLOGY	69, 417	0,000			6, 329	1
71.00		MEDICAL SUPPLIES CHARGED TO PATIENT	587, 295				0, 327	71.00
72.00		IMPL. DEV. CHARGED TO PATIENTS	5, 939				0	72.00
		DRUGS CHARGED TO PATIENTS	895, 132	55, 645	1		36, 648	•
73.00		TIENT SERVICE COST CENTERS	073, 132	33, 043	24,037	١	30, 040	73.00
90.00		CLINIC	157, 896	0	17, 666	0	0	90.00
90. 00		ONCOLOGY	86, 328			572	50, 974	90.00
90. 01		OUTPATIENT CLINIC	41, 218				24, 217	90.01
90. 02		PROVIDER BASED CLINIC - TCMP	270, 437	151, 896			24, 217	90.02
90. 03		PROVIDER BASED CLINIC - DCPC	132, 974				5, 533	
90.04		PROVIDER BASED CLINIC - WESTPORT	36, 692	0 38,300			0, 555	90.04
90.06		CLINIC - WESTFORT	145, 549				16, 486	ł
90.00		WOMEN'S HEALTH SERVICES	41, 926				4, 662	ł
91.00		EMERGENCY	430, 757	27,071			126, 241	1
91.00		OBSERVATION BEDS (NON-DISTINCT PART	430, 737	U	44, 020	20, 601	120, 241	92.00
92.00		REIMBURSABLE COST CENTERS						92.00
95. 00		AMBULANCE SERVICES	211 724	1, 504	25 051	1, 925	0	05 00
	1		311, 726					
	09900	HOME HEALTH AGENCY	204 050	0		0		99.00
101.00			304, 850	0	18, 206	U	0	101. 00
110 00		AL PURPOSE COST CENTERS	7 000 010	1 010 020	005 012	150.72/	055 022	110 00
118. 00		SUBTOTALS (SUM OF LINES 1-117)	7, 809, 812	1, 010, 938	905, 912	159, 736	955, 923	1118.00
100.00		MBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	000		4 070		0	100 00
	1 1		820	0				190.00
		PHYSICIANS' PRIVATE OFFICES	88, 660					192.00
		MARKETI NG	93, 882	13, 535	2, 078	0		194.00
	1 1	OTHER NONREIMBURSABLE	8, 861	0	0	0	7, 390	194. 02
200.00		Cross Foot Adjustments	_	_	_	_	_	200.00
201.00		Negative Cost Centers	0 000 000	0	0	0		201.00
202.00	기	TOTAL (sum lines 118-201)	8, 002, 035	1, 024, 473	1, 112, 012	159, 736	963, 313	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provi der CCN: 151332

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

5/22/2015 1:38 pm Cost Center Description DI ETARY CAFETERI A NURSI NG CENTRAL MEDI CAL RECORDS & ADMI NI STRATI O SERVICES & SUPPLY LI BRARY Ν 10 00 11 00 13 00 16.00 14 00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 447, 831 10.00 01100 CAFETERI A 692, 277 11.00 11.00 0 01300 NURSING ADMINISTRATION 13.00 0 17, 775 1, 126, 890 13.00 7, 378 14.00 01400 CENTRAL SERVICES & SUPPLY 0 2, 446 62, 973 14.00 16.00 01600 MEDICAL RECORDS & LIBRARY 0 35, 186 1, 114, 887 16.00 0 01700 SOCIAL SERVICE 11, 658 35, 172 17.00 0 0 0 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 447 831 96,810 292, 068 61, 244 03100 INTENSIVE CARE UNIT 3, 018 35, 471 31.00 31.00 11, 758 0 04300 NURSERY 43.00 0 5, 456 0 0 8, 265 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 0 57, 674 171, 858 0 85, 436 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 5, 093 6, 174 52.00 0 0 52.00 53.00 05300 ANESTHESI OLOGY 5, 586 0 0 4,736 53.00 57, 600 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 227, 604 54.00 00000000 0 55.00 03630 ULTRA SOUND 3, 976 28, 171 0 55.00 0 06000 LABORATORY 60.00 49, 529 15, 493 182, 103 60 00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 6, 147 62.00 06500 RESPIRATORY THERAPY 30, 984 0 65.00 105, 733 27, 369 65.00 o 06600 PHYSI CAL THERAPY 21.704 23.547 66.00 66.00 0 06700 OCCUPATI ONAL THERAPY 0 67.00 6, 491 0 7,810 67.00 68.00 06800 SPEECH PATHOLOGY 5, 710 0 0 6, 263 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 7,508 0 0 35, 393 69.00 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT O 62, 973 46, 745 71 00 C 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0 0 325 72.00 07300 DRUGS CHARGED TO PATIENTS 0 96, 986 142, 023 73.00 32, 148 0 OUTPATIENT SERVICE COST CENTERS 90 00 90 00 09000 CLI NI C 0 18 088 4.116 0 22,820 90.01 09001 ONCOLOGY 7, 564 0 4,829 90.01 09002 OUTPATIENT CLINIC 0 5, 197 0 90.02 5,064 90.02 90 03 09003 PROVIDER BASED CLINIC - TCMP 0 0 0 0 15, 307 90 03 r 09004 PROVIDER BASED CLINIC - DCPC 0 90.04 11,845 0 12, 165 90.04 90.05 09005 PROVIDER BASED CLINIC - WESTPORT 0 0 1, 494 90.05 0 90.06 09006 CLI NI C 7,607 0 o 25, 526 90.06 09007 WOMEN'S HEALTH SERVICES o 90 07 90 07 979 11, 330 91.00 09100 EMERGENCY 0 52, 902 136, 216 0 91, 110 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 95 00 95 00 09500 AMBULANCE SERVICES 0 200, 724 66, 534 0 36, 254 99.00 09900 CMHC 0 0 0 99.00 101.00 10100 HOME HEALTH AGENCY 39,840 15, 670 101. 00 SPECIAL PURPOSE COST CENTERS 1, 114, 887 118. 00 685, 999 118 00 SUBTOTALS (SUM OF LINES 1-117) 447, 831 1, 119, 919 62, 973 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 n 0 190. 00 0 192.00 0 C 0 0 5, 264 194. 00 07950 MARKETI NG 0 3, 911 0 0 194 00 1, 014 194. 02 07952 OTHER NONREI MBURSABLE 0 0 0 194. 02 3,060 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 201, 00 202.00 TOTAL (sum lines 118-201) 447.831 692, 277 1, 126, 890 62, 973 1, 114, 887 202. 00

Health Financia	I Systems	DECATUR CO. MEMO	RIAL HOSPITAL	In Lieu of Form CMS-2552-1			
COST ALLOCATION	N - GENERAL SERVICE COSTS		Provi der		Peri od:	Worksheet B	
					From 01/01/2014 To 12/31/2014	Part Date/Time Pre	narod:
					10 12/31/2014	5/22/2015 1:3	
Cos	st Center Description	SOCI AL	Subtotal	Intern &	Total		
		SERVI CE		Resi dents			
				Cost & Post			
				Stepdown			
		17.00		Adjustments	04.00		
CENEDAL	CEDITION COST CENTEDS	17. 00	24. 00	25. 00	26. 00		
	SERVICE COST CENTERS P REL COSTS-BLDG & FIXT			T			1.00
	P REL COSTS-BLDG & FIXT						2.00
	PLOYEE BENEFITS DEPARTMENT						4.00
	MINISTRATIVE & GENERAL						5.00
ł ł	INTENANCE & REPAIRS						6.00
	ERATION OF PLANT						7.00
8. 00 00800 LAI	JNDRY & LINEN SERVICE						8.00
9. 00 00900 HOU	JSEKEEPI NG						9. 00
10. 00 01000 DI E							10.00
11. 00 01100 CAF							11.00
	RSING ADMINISTRATION						13.00
	NTRAL SERVICES & SUPPLY						14.00
	DICAL RECORDS & LIBRARY	F40, 070					16.00
	CLAL SERVICE	548, 072					17. 00
	T ROUTINE SERVICE COST CENTERS JLTS & PEDIATRICS	465, 671	5, 695, 869		0 5, 695, 869		30.00
	TENSIVE CARE UNIT	403, 071	612, 270		0 5, 643, 864		31.00
43. 00 04300 NUF			263, 231		0 263, 231		43.00
	Y SERVICE COST CENTERS		200, 201	'	200, 201		10.00
	ERATING ROOM	0	2, 630, 604	1	0 2, 630, 604		50.00
52. 00 05200 DEL	LIVERY ROOM & LABOR ROOM	O	328, 830		0 328, 830		52.00
53. 00 05300 ANE	ESTHESI OLOGY	0	320, 786	5	0 320, 786		53.00
	DI OLOGY-DI AGNOSTI C	0	3, 115, 314		0 3, 115, 314		54.00
	TRA SOUND	0	207, 053	1	0 207, 053		55.00
60. 00 06000 LAE		0	2, 775, 708	1	0 2, 775, 708		60.00
	OLE BLOOD & PACKED RED BLOOD CELL	0	124, 425	1	0 124, 425		62.00
	SPI RATORY THERAPY	0	1, 234, 417	1	0 1, 234, 417		65.00
	YSICAL THERAPY CUPATIONAL THERAPY	0	1, 019, 195 366, 531	1	0 1, 019, 195 0 366, 531		66. 00 67. 00
	EECH PATHOLOGY		331, 641	1	0 331, 641		68.00
	ECTROCARDI OLOGY		417, 861		0 417, 861		69.00
	DICAL SUPPLIES CHARGED TO PATIENT		3, 084, 196		0 3, 084, 196		71.00
	PL. DEV. CHARGED TO PATIENTS	o	30, 229		0 30, 229		72.00
	JGS CHARGED TO PATIENTS	O	4, 894, 768	3	0 4, 894, 768		73.00
OUTPATI EI	NT SERVICE COST CENTERS						
90. 00 09000 CLI		0	834, 930		0 834, 930		90.00
90. 01 09001 0N0		12, 469	554, 105		0 554, 105		90. 01
	TPATIENT CLINIC	0	304, 985	•	0 304, 985		90. 02
	OVIDER BASED CLINIC - TCMP	0	1, 621, 428		0 1, 621, 428		90. 03
	OVI DER BASED CLINIC - DCPC	0	804, 704		0 804, 704		90.04
	OVIDER BASED CLINIC - WESTPORT	0	194, 565		0 194, 565		90.05
90. 06 09006 CLI	MEN'S HEALTH SERVICES		811, 674 285, 003		0 811, 674 0 285, 003		90. 06 90. 07
91. 00 09100 EME		16, 263	2, 656, 365	•	0 2, 656, 365		91.00
	SERVATION BEDS (NON-DISTINCT PART	10, 203	2, 030, 300		0 2,030,303		92.00
	I MBURSABLE COST CENTERS				<u> </u>		72.00
	BULANCE SERVICES	0	1, 901, 638	3	0 1, 901, 638		95.00
99. 00 09900 CMF		O			o o		99.00
	ME HEALTH AGENCY	53, 669	1, 662, 406	5	0 1, 662, 406		101.00
SPECI AL I	PURPOSE COST CENTERS						
118. 00 SUE	BTOTALS (SUM OF LINES 1-117)	548, 072	39, 084, 731	1	0 39, 084, 731		118. 00
	URSABLE COST CENTERS			_			
	FT, FLOWER, COFFEE SHOP & CANTEEN	0	6, 000		0 6,000		190.00
	YSICIANS' PRIVATE OFFICES	0	648, 585	1	0 648, 585		192.00
194. 00 07950 MAF		0	497, 514		0 497, 514		194.00
	HER NONREIMBURSABLE DSS Foot Adjustments	١	56, 082		0 56, 082		194. 02 200. 00
	gative Cost Centers		(á	0 0		200.00
1 1 1	TAL (sum lines 118-201)	548, 072	40, 292, 912		0 40, 292, 912		202.00
_52.55 10	(20	0 10, 072	.5, 2, 2, 712	-1	- .5,2,2,7,2		,=02.00

Provi der CCN: 151332

Peri od:

ALLOCATION OF CAPITAL RELATED COSTS

Part II

From 01/01/2014 Date/Time Prepared: 12/31/2014 5/22/2015 1:38 pm CAPITAL RELATED COSTS **EMPLOYEE** Cost Center Description Di rectly BLDG & FIXT MVBLE EQUIP Subtotal Assigned New **BENEFITS** DEPARTMENT Capi tal Related Costs 1.00 2.00 2A 4.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 2, 391 2, 391 2.391 4.00 0 00500 ADMINISTRATIVE & GENERAL 523, 617 5.00 523, 617 0 350 5.00 00600 MAINTENANCE & REPAIRS 0 6.00 44, 335 44, 335 45 6.00 7.00 00700 OPERATION OF PLANT 0000000 210, 887 0 210, 887 0 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 24.828 24,828 6 00900 HOUSEKEEPI NG 0 48 9 00 9 00 0 10.00 01000 DI ETARY 36, 452 36, 452 18 10.00 11.00 01100 CAFETERI A 5, 665 5,665 38 11.00 01300 NURSING ADMINISTRATION 13, 303 0 13, 303 76 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 0 14.00 0 14.00 16.00 01600 MEDICAL RECORDS & LIBRARY 0 99, 203 99, 203 60 16.00 01700 SOCIAL SERVICE 2, 697 <u>2,</u> 697 17.00 0 38 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 263, 953 0 263, 953 252 30.00 31.00 03100 INTENSIVE CARE UNIT 0 10, 728 0 10, 728 42 31.00 43.00 04300 NURSERY 0 14, 713 0 14, 713 43.00 13 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 112,678 0 112, 678 125 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 52.00 52.00 45, 230 45, 230 12 53.00 05300 ANESTHESI OLOGY 0 0 0 0 61 53.00 05400 RADI OLOGY-DI AGNOSTI C 99, 926 0 99.926 138 54 00 54 00 0 55.00 03630 ULTRA SOUND 10 55.00 06000 LABORATORY 00000000 0 135 60.00 42, 177 42, 177 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 62.00 0 62.00 06500 RESPIRATORY THERAPY 0 9, 809 9.809 84 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 37, 984 0 37, 984 70 66.00 06700 OCCUPATI ONAL THERAPY 67.00 12,604 0 12,604 23 67.00 06800 SPEECH PATHOLOGY 0 10, 103 68 00 10, 103 20 68 00 0 69.00 06900 ELECTROCARDI OLOGY 31, 694 31, 694 22 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 71.00 30, 530 30, 530 71.00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 97 42, 545 0 42, 545 73.00 0 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLI NI C 0 31, 265 0 31, 265 71 09001 ONCOLOGY 0 0 90.01 23.480 90.01 23.480 25 οĺ 78, 960 09002 OUTPATIENT CLINIC 90.02 90.02 78, 960 8 0 90.03 09003 PROVIDER BASED CLINIC - TCMP 155, 456 0 155, 456 71 90.03 90.04 09004 PROVIDER BASED CLINIC - DCPC 117, 705 0 117, 705 29 90.04 0 14, 713 09005 PROVIDER BASED CLINIC - WESTPORT 90.05 14, 713 0 90.05 12 0 90.06 09006 CLI NI C 29, 671 29, 671 28 90.06 90.07 09007 WOMEN'S HEALTH SERVICES 0 50, 760 0 50, 760 90.07 0 91.00 09100 EMERGENCY 77, 918 0 77, 918 132 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 0 44, 335 0 44, 335 109 99. 00 09900 CMHC 0 0 99.00 0 101.00 10100 HOME HEALTH AGENCY 0 0 32, 222 32, 222 102 101. 00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) 0 2, 377 118. 00 0 2, 384, 537 2, 384, 537 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 3, 310 0 3, 310 0 190.00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 357, 773 0 192.00 0 0 357, 773 194. 00 07950 MARKETING 0 0 11 194.00 3.678 3.678 194. 02 07952 OTHER NONREI MBURSABLE 0 0 0 3 194.02 200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 0 0 201.00 2, 749, 298 202 00 TOTAL (sum lines 118-201) 0 0 2, 749, 298 2, 391 202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 151332

5/22/2015 1								
	Cost Center D	escription	ADMI NI STRATI V	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
			E & GENERAL	REPAI RS	PLANT	LINEN SERVICE		
			5. 00	6. 00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COS	ST CENTERS						
1.00	00100 CAP REL COSTS							1.00
2.00	00200 CAP REL COSTS	-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENE	FITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI V	E & GENERAL	523, 967					5.00
6.00	00600 MAINTENANCE &	REPAI RS	13, 322	57, 702				6.00
7.00	00700 OPERATION OF	PLANT	14, 460	0	225, 347			7. 00
8.00	00800 LAUNDRY & LIN	EN SERVICE	1, 895	0	2, 843	29, 572		8. 00
9.00	00900 HOUSEKEEPI NG		10, 326	8, 301	0	4, 038	22, 713	9. 00
10.00	01000 DI ETARY		5, 164	1, 677		56	0	10.00
11.00	01100 CAFETERI A		7, 631	4, 540			510	11. 00
13.00	01300 NURSING ADMIN	II STRATION	13, 184	4, 625	1, 523	o	131	13.00
14.00	01400 CENTRAL SERVI	CES & SUPPLY	691	0			0	14.00
16.00	01600 MEDICAL RECOR		12, 948	1, 016	11, 359	o	232	16.00
17.00	01700 SOCIAL SERVIC		6, 466	0	309	o	58	17. 00
		SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI		47, 736	4, 218	30, 223	9, 574	9, 089	30.00
31.00	03100 INTENSIVE CAR		7, 175				0	31.00
43.00	04300 NURSERY		2, 695	424			570	43. 00
	ANCILLARY SERVICE C	COST CENTERS			.,			
50.00	05000 OPERATING ROO		27, 517	5, 760	12, 902	3, 951	289	50.00
52.00	05200 DELIVERY ROOM		3, 027	949			859	52.00
53.00	05300 ANESTHESI OLOG		4, 037	0			0	53.00
54.00	05400 RADI OLOGY-DI A		34, 098	3, 049	11, 442	2, 302	2, 002	54.00
55. 00	03630 ULTRA SOUND		2, 274	0		0	0	55. 00
60.00	06000 LABORATORY		31, 351	2, 711	4, 829	o	1, 077	60. 00
62. 00		PACKED RED BLOOD CELL	1, 538	0			0	62. 00
65. 00	06500 RESPIRATORY T		13, 483	85		_	597	65. 00
66. 00	06600 PHYSI CAL THER		12, 053	169			325	66.00
67. 00	06700 OCCUPATI ONAL		4, 046	1, 609			128	67. 00
68. 00	06800 SPEECH PATHOL		3, 889	169			280	68. 00
69. 00	06900 ELECTROCARDI O		4, 545	0			149	69. 00
71.00		IES CHARGED TO PATIENT	38, 455	Ö			0	71.00
72.00	07200 I MPL. DEV. CH		389				0	72.00
73. 00	07300 DRUGS CHARGED		58, 626	3, 134	_	o o	864	73.00
70.00	OUTPATIENT SERVICE		00,020	0, 101	1,072	<u>۳</u>	001	70.00
90.00	09000 CLI NI C	occ. centene	10, 339	0	3, 580	ol	0	90. 00
90. 01	09001 ONCOLOGY		5, 653				1, 202	90. 01
90. 02	09002 OUTPATIENT CL	LNLC	2, 699			55	571	90. 02
90. 03	09003 PROVI DER BASE		17, 707	8, 558			0	90. 03
90. 04	09004 PROVI DER BASE		8, 707	2, 168		108	130	90. 04
90. 05		D CLINIC - WESTPORT	2, 403	2, 100			0	90.05
90.06	09006 CLI NI C	S SETTION	9, 530	_		348	389	90.06
90. 07	09007 WOMEN'S HEALT	H SERVICES	2, 745	1, 525			110	90. 07
91.00	09100 EMERGENCY	III SERVI GES	28, 205	1, 323			2, 977	91.00
92. 00		EDS (NON-DISTINCT PART	20, 200		0, 722	0,011	2, 777	92.00
72.00	OTHER REIMBURSABLE							72.00
95.00	09500 AMBULANCE SER		20, 411	85	5, 076	356	0	95. 00
	09900 CMHC		0		· ·			99. 00
	10100 HOME HEALTH A	GENCY	19, 961	Ö				101.00
	SPECIAL PURPOSE COS		.,,,,,,,		0,007	<u> </u>		
118.00		M OF LINES 1-117)	511, 381	56, 940	183, 581	29, 572	22, 539	118 00
	NONREI MBURSABLE COS		0.17001	00/ 710	1007001	27,072	22,007	
190 00		COFFEE SHOP & CANTEEN	54	0	379	0	Ω	190. 00
	19200 PHYSI CLANS' P		5, 805					192. 00
	07950 MARKETI NG		6, 147	762				194. 00
	07952 OTHER NONRELM	BURSABLE	580					194. 02
200.00							1,74	200. 00
201.00			0	n	0	n	Ω	201.00
202.00			523, 967	57, 702		29, 572	22, 713	
00	1 1.2 (33 11		525, 767	3.,.02		27,072	22, . 10	

Heal th Financial Systems

DECATUR CO. MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151332

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

Date/Time Prepared:
5/22/2015 1: 38 pm

Cost Center Description

DIETARY

CAFETERIA

ADMINISTRATIO
SERVICES & RECORDS & SUPPLY
LIBRARY

10.00 11.00 13.00 14.00 16.00

	Cost Center Description	DI ETARY	CAFETERI A	NURSING ADMINISTRATIO	CENTRAL SERVICES &	MEDI CAL RECORDS &	
				N	SUPPLY	LI BRARY	
		10.00	11. 00	13.00	14. 00	16. 00	
	GENERAL SERVICE COST CENTERS	1					
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
6. 00	00600 MAINTENANCE & REPAIRS						6.00
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		47, 541					10.00
11. 00	01100 CAFETERI A	0	19, 033				11.00
13.00	01300 NURSING ADMINISTRATION	0	489	33, 331			13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	67	218	980		14.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	967	0	0	125, 785	16.00
17.00	01700 SOCIAL SERVICE	0	321	1, 040	0	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	47, 541	2, 662	8, 639	0	6, 912	30.00
31.00	03100 INTENSIVE CARE UNIT	0	323	1, 049	0	341	31.00
43.00	04300 NURSERY	o	150	0	0	933	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	1, 586	5, 083	0	9, 642	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	o	140	0	o	697	52.00
53.00	05300 ANESTHESI OLOGY	o	154	0	0	534	53.00
54. 00	1	o	1, 584	0	0	25, 645	54.00
55. 00		o	109	0	0	3, 179	55.00
60.00	· · · · · · · · · · · · · · · · · · ·	o	1, 362	458	0	20, 552	60.00
62. 00		0	0	0	0	694	62.00
65. 00		l ol	852	3, 127	0	3, 089	65.00
66. 00	1	0	597	0, 12,	0	2, 657	66.00
67. 00		ا	178	o o	0	881	67.00
68. 00	1 1	0	157	o o	0	707	68.00
69. 00		0	206	o o	0	3, 994	69. 00
71. 00	· · · · · · · · · · · · · · · · · · ·	0	0	o o	980	5, 276	71.00
72.00	l l	0	0	0	0	37	72.00
73. 00	l l		884	2, 869	o	16, 029	73.00
73.00	OUTPATIENT SERVICE COST CENTERS	0	004	2,007	<u> </u>	10, 027	73.00
90. 00		0	497	0	0	464	90.00
90. 01	09001 ONCOLOGY	0	208	675	0	545	90. 01
90. 01			143	0/3	0	572	90.01
90. 02			0	0	0	1, 728	90.02
90. 03	l l		326	0	0		90.03
90.04	l l		320	0	0	1, 373	
	l l		-	0	0	169	90.05
90.06	1		209	0	0	2, 881	90.06
90. 07	09007 WOMEN'S HEALTH SERVICES	0	311	4 020	U O	111	90.07
91.00	• • • • • • • • • • • • • • • • • • •	0	1, 454	4, 029	U	10, 283	91.00
92. 00	`						92.00
05 00	OTHER REIMBURSABLE COST CENTERS		1 000	F 027	ما	4 000	05 00
95.00	· · · · · · · · · · · · · · · · · · ·	0	1, 829		0	4, 092	95.00
	09900 CMHC	0	0	0	0		99.00
101. 0	0 10100 HOME HEALTH AGENCY	0	1, 095	0	0	1, 768	101. 00
	SPECIAL PURPOSE COST CENTERS						
118. 0	,	47, 541	18, 860	33, 124	980	125, 785	118.00
	NONREI MBURSABLE COST CENTERS				_1	_	
	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
	0 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192.00
	0 07950 MARKETI NG	0	145	116	0		194.00
	2 07952 OTHER NONREI MBURSABLE	0	28	91	0		194. 02
200.0							200.00
201. 0		0	0	0	0		201. 00
202. 0	TOTAL (sum lines 118-201)	47, 541	19, 033	33, 331	980	125, 785	202. 00

Heal th	Financial Systems	DECATUR CO. MEMO	RIAL HOSPITAL		In Lie	u of Form C	:MS-2552-10
ALLOCA	ATION OF CAPITAL RELATED COSTS		Provi der	F	Period: From 01/01/2014 To 12/31/2014	Worksheet Part II Date/Time 5/22/2015	Prepared:
	Cost Center Description	SOCI AL SERVI CE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	0, 22, 2010	рш
	GENERAL SERVICE COST CENTERS	17. 00	24. 00	25. 00	26.00		
1. 00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
6.00	00600 MAINTENANCE & REPAIRS					l	6.00
7. 00	00700 OPERATION OF PLANT					l	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE					ł	8. 00
9. 00	00900 HOUSEKEEPI NG					ł	9.00
10.00	01000 DI ETARY						10.00
11. 00 13. 00	O1100 CAFETERI A O1300 NURSI NG ADMI NI STRATI ON						11.00
14. 00	01400 CENTRAL SERVICES & SUPPLY					l	13. 00 14. 00
16. 00							16.00
17. 00		10, 929					17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	9, 286	440, 085	C	440, 085		30.00
31.00	03100 INTENSIVE CARE UNIT	0	21, 274			l	31.00
43.00		0	21, 597	(21, 597		43.00
	ANCILLARY SERVICE COST CENTERS			1			
50.00	l l	0	179, 533				50.00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0	57, 199 4, 786	•			52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C		180, 186				54.00
55. 00	03630 ULTRA SOUND		5, 572	1			55.00
60.00	06000 LABORATORY	o	104, 652				60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	o	2, 232				62.00
65.00	06500 RESPI RATORY THERAPY	0	32, 450	C	32, 450	l	65.00
66. 00	06600 PHYSI CAL THERAPY	0	59, 832			ł	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	20, 912			l	67.00
68. 00 69. 00	06800 SPEECH PATHOLOGY	0	16, 482	1			68.00
71.00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT		44, 458 78, 737	-	1 ,		69. 00 71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS		70, 737 426				72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS		129, 920	•			73.00
	OUTPATIENT SERVICE COST CENTERS		,		, ,		
90.00	09000 CLI NI C	0	46, 216	C	46, 216		90.00
90. 01	09001 ONCOLOGY	249	35, 221	C		l	90. 01
90. 02	09002 OUTPATIENT CLINIC	0	93, 065			l	90. 02
90. 03	09003 PROVI DER BASED CLINIC - TCMP	0	202, 181	C			90. 03
90. 04 90. 05	09004 PROVI DER BASED CLINIC - DCPC 09005 PROVI DER BASED CLINIC - WESTPORT	0	144, 023				90.04
	09006 CLINIC	0	18, 982 47, 046				90. 05 90. 06
90.00	09007 WOMEN'S HEALTH SERVICES		61, 593				90.00
	09100 EMERGENCY	324	138, 058				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	52.1	100,000				92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	0	82, 230			l	95.00
	09900 CMHC	0	0	C		ł	99.00
101.00	10100 HOME HEALTH AGENCY	1, 070	59, 907	<u> </u>	59, 907		101. 00
118. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)	10, 929	2, 328, 855		2, 328, 855		118. 00
110.00	NONREI MBURSABLE COST CENTERS	10, 727	2, 320, 033		2, 320, 633		
190. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3, 743		3, 743		190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	Ö	404, 544			I	192. 00
194.00	07950 MARKETI NG	0	11, 280			l	194. 00
	07952 OTHER NONREI MBURSABLE	0	876			ł	194. 02
200.00	1		0		-	ł	200.00
201.00		10 000	0 740 200	-	1	I	201.00
202.00	TOTAL (sum lines 118-201)	10, 929	2, 749, 298	(2, 749, 298		202.00

				Т	o 12/31/2014	Date/Time Pre 5/22/2015 1:3	
		CAPI TAL REI	LATED COSTS			3/22/2013 1.3	O pili
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE		ADMI NI STRATI V	
		(SQUARE FEET)	(SQUARE FEET)	BENEFITS DEPARTMENT	n	E & GENERAL (ACCUM. COST)	
				(SALARI ES)		(ACCOW. COST)	
		1. 00	2.00	4. 00	5A	5. 00	
	GENERAL SERVICE COST CENTERS						
1. 00	00100 CAP REL COSTS-BLDG & FLXT	224, 233					1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	105	224, 233				2.00
4. 00 5. 00	OO400	195 42, 706	1			32, 290, 877	4. 00 5. 00
6. 00	00600 MAINTENANCE & REPAIRS	3, 616					1
7. 00	00700 OPERATION OF PLANT	17, 200					1
8.00	00800 LAUNDRY & LINEN SERVICE	2, 025	2, 025	49, 145	0	116, 770	8. 00
9. 00	00900 HOUSEKEEPI NG	0	1	,		,	9. 00
10.00	01000 DI ETARY 01100 CAFETERI A	2, 973	1				1
11. 00 13. 00	01300 NURSI NG ADMI NI STRATI ON	462 1, 085					1
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	0				1
16.00	01600 MEDICAL RECORDS & LIBRARY	8, 091	8, 091	474, 422			
17. 00	01700 SOCI AL SERVI CE	220	220	297, 647	0	398, 502	17. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	21 520	21 520	1 00/ 727		2 041 042	20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	21, 528 875					1
	04300 NURSERY	1, 200		· ·	_		1
	ANCILLARY SERVICE COST CENTERS		,				
	05000 OPERATING ROOM	9, 190					1
52.00	05200 DELIVERY ROOM & LABOR ROOM	3, 689					
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY - DI AGNOSTI C	0 8, 150		, =			1
55. 00	03630 ULTRA SOUND	0, 130	0, 130	74, 861		, , , , , ,	1
60.00	06000 LABORATORY	3, 440	3, 440				
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0			1
65.00	06500 RESPI RATORY THERAPY	800					
66. 00 67. 00	O6600 PHYSI CAL THERAPY O6700 OCCUPATI ONAL THERAPY	3, 098				,	1
68.00	06800 SPEECH PATHOLOGY	1, 028 824	1, 028 824				
69. 00	06900 ELECTROCARDI OLOGY	2, 585					1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 490					
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	_	_		
73. 00	07300 DRUGS CHARGED TO PATIENTS	3, 470	3, 470	766, 863	0	3, 612, 147	73.00
90 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	2, 550	2, 550	555, 337	0	637, 164	90.00
90. 01	09001 ONCOLOGY	1, 915					
90. 02	09002 OUTPATIENT CLINIC	6, 440					1
90. 03	09003 PROVIDER BASED CLINIC - TCMP	12, 679				, ,	
90.04	09004 PROVI DER BASED CLI NI C - DCPC	9, 600				,	
90. 05 90. 06	09005 PROVIDER BASED CLINIC - WESTPORT	1, 200 2, 420					
	09007 WOMEN'S HEALTH SERVICES	4, 140					
	09100 EMERGENCY	6, 355					
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
05 00	OTHER REIMBURSABLE COST CENTERS			050 777		1 057 000	
	09500 AMBULANCE SERVI CES 09900 CMHC	3, 616	3, 616				1
	10100 HOME HEALTH AGENCY	2, 628				l .	1
	SPECIAL PURPOSE COST CENTERS	2,020	2, 525	000,700		1,200,171	
118.00		194, 483	194, 483	18, 733, 165	-8, 002, 035	31, 515, 193	118. 00
	NONREI MBURSABLE COST CENTERS			_	_		
	1900 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1920 PHYSICIANS' PRIVATE OFFICES	270	1				190.00
	07950 MARKETING	29, 180 300			_		
	07952 OTHER NONREI MBURSABLE	0	0				194. 02
200.00				,2			200.00
201.00							201. 00
202.00		2, 749, 298	0	5, 509, 908		8, 002, 035	202.00
203. 00	Part I) Unit cost multiplier (Wkst. B, Part I)	12. 260898	0. 000000	0. 292442		0. 247811	203 00
203.00		12. 200090	0.00000	2, 391		523, 967	
2 50	Part II)						
205.00				0. 000127		0. 016226	205. 00
	11)	1		l		I	l

C031 A	COST ALLOCATION - STATISTICAL BASIS				F	from 01/01/2014 o 12/31/2014	Date/Time Pre 5/22/2015 1:3	
		Cost Center Description	MAINTENANCE & REPAIRS (TIME SPENT)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (HOURS OF S ERVI CE)	DI ETARY (MEALS SERV ED)	o pili
			6. 00	7. 00	8.00	9. 00	10.00	
		AL SERVICE COST CENTERS			1			
1. 00 2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	00200 00400 00500 00600 00700 00800 00900 01000	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY CAFETERIA	3, 406 0 0 490 99 268	160, 516 2, 025 0 2, 973 462	251, 506 34, 339	127, 090	15, 800 0	1.00 2.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00
13.00		NURSING ADMINISTRATION	273	1, 085	1		0	13.00
14. 00 16. 00 17. 00	01600	CENTRAL SERVICES & SUPPLY MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	60 0	0 8, 091 220	d	1, 300	0 0 0	
		IENT ROUTINE SERVICE COST CENTERS				, 020		177.00
30. 00 31. 00 43. 00	03100	ADULTS & PEDIATRICS INTENSIVE CARE UNIT NURSERY	249 10 25	21, 528 875 1, 200	1, 863	0	15, 800 0 0	31.00
	ANCI L	LARY SERVICE COST CENTERS						
50. 00 52. 00 53. 00	05200	OPERATING ROOM DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	340 56 0	9, 190 3, 689 0			0 0 0	52.00
54.00		RADI OLOGY-DI AGNOSTI C	180	8, 150	19, 576	11, 200	0	
55. 00 60. 00	1	ULTRA SOUND LABORATORY	0 160	0 3, 440		0 6,025	0	55. 00 60. 00
62. 00	1	WHOLE BLOOD & PACKED RED BLOOD CELL	0	3, 440			0	62.00
65. 00		RESPIRATORY THERAPY	5	800	_	1	0	65.00
66.00	06600	PHYSI CAL THERAPY	10	3, 098	13, 850	1, 820	0	66.00
67.00		OCCUPATI ONAL THERAPY	95	1, 028			0	67.00
68. 00		SPEECH PATHOLOGY	10	824	1	,	0	
69. 00 71. 00		ELECTROCARDIOLOGY MEDICAL SUPPLIES CHARGED TO PATIENT	0	2, 585 2, 490	1	1	0	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	C	o	0	72.00
73. 00		DRUGS CHARGED TO PATIENTS TIENT SERVICE COST CENTERS	185	3, 470		4, 835	0	73.00
90.00		CLINIC	0	2, 550		ol ol	0	90.00
90. 01	1	ONCOLOGY	23	1, 915		6, 725	0	
90. 02		OUTPATIENT CLINIC	60	6, 440	1	1	0	
90. 03	1	PROVIDER BASED CLINIC - TCMP	505	12, 679	1	1	0	
90. 04 90. 05		PROVIDER BASED CLINIC - DCPC PROVIDER BASED CLINIC - WESTPORT	128	9, 600 1, 200	1	1	0	90.04
90.06		CLINIC WESTIGKT	35	2, 420	1	1	0	90.06
90. 07	09007	WOMEN'S HEALTH SERVICES	90	4, 140	1		0	90. 07
		EMERGENCY	0	6, 355	32, 436	16, 655	0	91.00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART REIMBURSABLE COST CENTERS						92.00
95 00		AMBULANCE SERVICES	5	3, 616	3, 031	O	0	95.00
99. 00			0	0,010	0,00		0	
101.00		HOME HEALTH AGENCY	0	2, 628	C	0	0	101.00
118.00		AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)	3, 361	130, 766	251, 506	126, 115	15, 800	118 00
110.00		IMBURSABLE COST CENTERS	0,001	100,700	201,000	120, 110	10,000	1110.00
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0					190. 00
		PHYSICIANS' PRIVATE OFFICES	0	29, 180				192.00
		MARKETI NG OTHER NONREI MBURSABLE	45	300				194. 00 194. 02
200.00	1	Cross Foot Adjustments	U			7/3	U	200.00
201.00	1	Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B,	1, 024, 473	1, 112, 012	159, 736	963, 313	447, 831	202. 00
203. 00 204. 00	1	Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	300. 784792 57, 702	6. 927733 225, 347	1		28. 343734 47, 541	203. 00 204. 00
205 62		Part II)	1/ 0/4000	1 400001	0.447500	0 47071	2 22222	205 22
205.00	ין ו	Unit cost multiplier (Wkst. B, Part II)	16. 941280	1. 403891	0. 117580	0. 178716	3. 008924	205. 00

	LLOCATION - STATISTICAL BASIS		Provi der		Period: From 01/01/2014	Worksheet B-1	
					Го 12/31/2014 	Date/Time Pre 5/22/2015 1:3	
	Cost Center Description	CAFETERI A (HOURS)	NURSI NG ADMI NI STRATI O N (NURSI NG HO URS)	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.)	MEDI CAL RECORDS & LI BRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	
		11. 00	13. 00	14. 00	16. 00	17. 00	
	GENERAL SERVICE COST CENTERS	T	T	Г	1		
. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT						1. (2. (4. (5. (6. (7. (
	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A	564, 410					8. 0 9. 0 10. 0
	01300 NURSING ADMINISTRATION	14, 492	 				13. 0
	01400 CENTRAL SERVICES & SUPPLY	1, 994	1				14.0
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	28, 687 9, 505			91, 842, 572	1 011	16. 0 17. 0
7.00	INPATIENT ROUTINE SERVICE COST CENTERS	9, 505	9, 505		<u>)</u>	1, 011	''.'
	03000 ADULTS & PEDIATRICS	78, 930			5, 045, 198	859	30.0
	03100 I NTENSI VE CARE UNI T	9, 586			248, 634	0	
3. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	4, 448	0		680, 829	0	43.0
	05000 OPERATING ROOM	47, 021	46, 444	(7, 038, 166	0	50.
	05200 DELIVERY ROOM & LABOR ROOM	4, 152			508, 584	0	1 .
	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	4, 554 46, 961	1		390, 126 18, 749, 067	0	
	03630 ULTRA SOUND	3, 242	1		2, 320, 740	0	1
	06000 LABORATORY	40, 381	1		15, 001, 504	0	
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	25 2/1			506, 376	0	1 .
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	25, 261 17, 695	1		2, 254, 627 1, 939, 752	0	
	06700 OCCUPATI ONAL THERAPY	5, 292			643, 345	0	1
	06800 SPEECH PATHOLOGY	4, 655	1		515, 939	0	
	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	6, 121 C	l .		2, 915, 653	0	
	07200 IMPL. DEV. CHARGED TO PATIENTS				3, 850, 775 26, 784	0	1
	07300 DRUGS CHARGED TO PATIENTS	26, 210			11, 699, 696	0	1
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C 09001 0NCOLOGY	14, 747 6, 167	1		339, 032 397, 815	0 23	
	09002 OUTPATIENT CLINIC	4, 237			417, 206	0	
	09003 PROVIDER BASED CLINIC - TCMP	C	1		1, 260, 961	0	1
	09004 PROVI DER BASED CLINIC - DCPC	9, 657	1	1	1, 002, 152	0	
	09005 PROVIDER BASED CLINIC - WESTPORT 09006 CLINIC	6, 202			123, 060 2, 102, 786	0	
	09007 WOMEN'S HEALTH SERVICES	9, 237			80, 687	Ö	
	09100 EMERGENCY	43, 131	36, 812	(7, 505, 596	30	
2. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.
5. 00	09500 AMBULANCE SERVICES	54, 245	54, 245	(2, 986, 611	0	95.
9. 00	09900 CMHC	C	0	(0	0	1
01. 00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	32, 481	0		1, 290, 871	99	101.
	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	559, 291	1				
10.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	C	ł		0		190. 192.
	07950 MARKETING	4, 292					194.
94. 02	07952 OTHER NONREI MBURSABLE	827	1		o o		194.
00.00	, ,						200.
01. 00 02. 00	Cost to be allocated (per Wkst. B, Part I)	692, 277				548, 072	
3.00		1. 226550 19, 033	1			542. 108803 10, 929	
04. 00	Part II) Unit cost multiplier (Wkst. B, Part						

Provi der CCN: 151332

Total Cost Cost Center Description						To 12/31/2014	Date/Time Pre 5/22/2015 1:3	
Total Cost Center Description Cost Center Cente				Ti tl	e XVIII	Hospi tal		о р
INPATIENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00					<u>'</u>			
INPATI ENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00		Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
INPATIENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00		· ·	(from Wkst.	Ādj .		Di sal I owance		
1.00			B, Part I,					
INPATIENT ROUTINE SERVICE COST CENTERS								
30. 00 03000 ADULTS & PEDI ATRICS 5, 695, 869 5, 695, 869 0 0 30. 00			1. 00	2. 00	3. 00	4. 00	5. 00	
31.00								
43.00			5, 695, 869		5, 695, 869	0	0	30.00
ANCI LLARY SERVICE COST CENTERS STOCK							_	
50, 00			263, 231		263, 231	0	0	43.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 328, 830 328, 830 0 0 52.00 53. 00 05300 ANESTHESI OLOGY 320, 786 320, 786 0 0 53. 00 54. 00 05400 RADIOLOGY-DI AGNOSTI C 3, 115, 314 3, 115, 314 0 0 54. 00 55. 00 03630 ULTRA SOUND 207, 053 207, 053 0 0 55. 00 60. 00 06000 LABORATORY 2,775, 708 2,775, 708 0 0 60. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 124, 425 124, 425 0 <								
53. 00 05300 ANESTHESI OLOGY 320, 786 320, 786 0 0 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 3, 115, 314 3, 115, 314 0 0 54.00 55. 00 03630 ULTRA SOUND 207, 053 207, 053 0 0 55.00 60. 00 06000 LABORATORY 2, 775, 708 2, 775, 708 0 0 60.00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 124, 425 124, 425 0 0 62.00 66. 00 06500 RESPI RATORY THERAPY 1, 234, 417 0 1, 234, 417 0 0 65.00 66. 00 06600 PHYSI CAL THERAPY 1, 019, 195 0 1, 019, 195 0 0 66.00 67. 00 06700 OCCUPATI ONAL THERAPY 366, 531 0 366, 531 0 36, 531 0 67.00 69. 00 06800 SPEECH PATHOLOGY 331, 641 0 331, 641 0 68.00 69. 00 06900 ELECTROCARDI OLOGY 417, 861 417, 861 0			2, 630, 604		2, 630, 604	1 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 3, 115, 314 3, 115, 314 0 0 54.00 55. 00 03630 ULTRA SOUND 2077, 053 0 0 55.00 60. 00 06000 LABORATORY 2,775, 708 2,775, 708 0 0 60.00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 124, 425 124, 425 0 0 62.00 65. 00 06500 RESPI RATORY THERAPY 1, 234, 417 0 1, 234, 417 0 0 65.00 66. 00 06600 PHYSI CAL THERAPY 1, 019, 195 0 1, 019, 195 0 0 66.00 67. 00 06700 OCCUPATI ONAL THERAPY 366, 531 0 366, 531 0 67.00 68. 00 06800 SPEECH PATHOLOGY 331, 641 0 331, 641 0 68.00 69. 00 06900 ELECTROCARDI OLOGY 417, 861 0 417, 861 0 69.00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 3, 084, 196 0 0 71.00 72	52. 00 05	200 DELIVERY ROOM & LABOR ROOM	328, 830		328, 830	0	0	
55. 00 03630 ULTRA SOUND 207, 053 207, 053 0 0 55. 00 60. 00 06000 LABORATORY 2, 775, 708 2, 775, 708 0 0 60. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 124, 425 124, 425 0 62. 00 65. 00 06500 RESPI RATORY THERAPY 1, 234, 417 0 1, 234, 417 0 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 1, 019, 195 0 1, 019, 195 0 0 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 366, 531 0 366, 531 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 331, 641 0 331, 641 0 0 67. 00 69. 00 06900 ELECTROCARDI OLOGY 417, 861 417, 861 0 0 69. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 3,084, 196 30,844, 196 0 0 71.00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 30,229 30,229 0<			320, 786		320, 786	0	0	53.00
60. 00 06000 LABORATORY 2, 775, 708 2, 775, 708 0 0 60. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 124, 425 124, 425 0 0 62. 00 65. 00 06500 RESPIRATORY THERAPY 1, 234, 417 0 1, 234, 417 0 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 1, 019, 195 0 1, 019, 195 0 0 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 366, 531 0 366, 531 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 331, 641 0 331, 641 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 417, 861 417, 861 0 0 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 3, 084, 196 3, 084, 196 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 30, 229 30, 229 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 4, 894, 768 4, 894, 768 0 0 70. 01 09000 CLI NI C 834, 930 0 0 90. 00 70. 02 09002 OUTPATI ENT CLI NI C 304, 985 304, 985 0 0 90. 01 70. 03 09003 PROVI DER BASED CLI NI C - TCMP 1, 621, 428 1, 621, 428 0 0 90. 03 70. 04 09004 PROVI DER BASED CLI NI C - WESTPORT 194, 565 194, 565 0 0 90. 05 70. 06 09006 CLI NI C 811, 674 811, 674 0 0 90. 05 70. 00 09000 CLI NI C 811, 674 811, 674 0 0 90. 07 70. 00 09000 CLI NI C 811, 674 811, 674 0 0 90. 05 70. 00 09000 ELERGENCY 0 090. 05 09			3, 115, 314		3, 115, 314	1 0	0	
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 124, 425 124, 425 0 0 62. 00 65. 00 65.00 65.00 65.00 RESPIRATORY THERAPY 1, 234, 417 0 1, 234, 417 0 0 65. 00 66.			207, 053		207, 053	8 0	0	55.00
65. 00 06500 RESPI RATORY THERAPY 1, 234, 417 0 1, 234, 417 0 0 65. 00 66. 00 66. 00 66. 00 66. 00 66. 00 67. 00 67. 00 67. 00 0600 PHYSI CAL THERAPY 366, 531 0 366, 531 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 331, 641 0 331, 641 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 417, 861 417, 861 0 0 69. 00 071. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 3, 084, 196 3, 084, 196 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 30, 229 30, 229 0 0 72. 00 07300 DRUGS CHARGED TO PATI ENTS 4, 894, 768 4, 894, 768 0 0 73. 00 00000 0000 00000 00000 00000 00000 00000 00000 00000 00000 000			2, 775, 708		2, 775, 708	8 0	0	60.00
66. 00			124, 425		124, 425	0	0	62.00
67. 00	65.00 06	500 RESPI RATORY THERAPY	1, 234, 417	0	1, 234, 417	7 0	0	65.00
68. 00 06800 SPEECH PATHOLOGY 331, 641 0 331, 641 0 0 68. 00 69.			1, 019, 195	0	1, 019, 195	0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY 417, 861 417, 861 0 0 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 3, 084, 196 3, 084, 196 0 0 71. 00 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 30, 229 30, 229 0 0 72. 00 07300 DRUGS CHARGED TO PATI ENTS 4, 894, 768 4, 894, 768 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 4, 894, 768 4, 894, 768 0 0 73. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	67.00 06	700 OCCUPATI ONAL THERAPY	366, 531	0	366, 53	0	0	67.00
71. 00			331, 641	0	331, 641	0	0	68. 00
72. 00	69.00 06	900 ELECTROCARDI OLOGY	417, 861		417, 861	0	0	69.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 4, 894, 768 4, 894, 768 0 0 73. 00 0UTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 834, 930 0 0 0 90. 00 90. 01 090.01 0NCOLOGY 554, 105 554, 105 554, 105 0 0 90. 01 90. 02 09002 UTPATIENT CLINIC 304, 985 304, 985 0 0 90. 02 90. 03 09003 PROVI DER BASED CLINIC - TCMP 1, 621, 428 1, 621, 428 0 0 90. 03 09004 PROVI DER BASED CLINIC - DCPC 804, 704 804, 704 0 0 90. 04 90. 05 09005 PROVI DER BASED CLINIC - WESTPORT 194, 565 194, 565 0 0 90. 05 09005 PROVI DER BASED CLINIC - WESTPORT 194, 565 194, 565 0 0 90. 05 09006 CLINIC 0 811, 674 811, 674 0 0 90. 06 09006 CLINIC 0 811, 674 811, 674 0 0 90. 07 09007 WOMEN'S HEALTH SERVICES 285, 003 285, 003 285, 003 0 0 90. 07 91. 00 09100 EMERGENCY 2, 656, 365 2, 656, 365 0 0 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1, 349, 562 1, 349, 562 0 0 92. 00			3, 084, 196		3, 084, 196	0	0	71.00
OUTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 834, 930 0 0 90. 00 90. 01 09001 ONCOLOGY 554, 105 554, 105 0 0 90. 01 90. 02 09002 OUTPATI ENT CLI NI C 304, 985 304, 985 0 0 90. 02 90. 03 09003 PROVI DER BASED CLI NI C - TCMP 1, 621, 428 1, 621, 428 0 0 90. 03 90. 04 PROVI DER BASED CLI NI C - DCPC 804, 704 804, 704 0 0 90. 04 90. 05 09005 PROVI DER BASED CLI NI C - WESTPORT 194, 565 194, 565 0 0 90. 05 90. 06 09006 CLI NI C 811, 674 811, 674 0 0 90. 05 90. 07 09007 WOMEN' S HEALTH SERVI CES 285, 003 285, 003 0 0 90. 07 91. 00 09100 EMERGENCY 2, 656, 365 2, 656, 365 0 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 1, 349, 562 1, 349, 562 1, 349, 562 </td <td></td> <td></td> <td>30, 229</td> <td></td> <td>30, 229</td> <td>0</td> <td>0</td> <td>72.00</td>			30, 229		30, 229	0	0	72.00
90. 00			4, 894, 768		4, 894, 768	0	0	73.00
90. 01 09001 0NCOLOGY 554, 105 554, 105 0 0 90. 01 90. 02 90. 02 09002 0UTPATI ENT CLINI C 304, 985 304, 985 0 0 90. 02 90. 03 09003 PROVI DER BASED CLINI C - TCMP 1, 621, 428 1, 621, 428 0 0 90. 03 90. 04 90. 04 PROVI DER BASED CLINI C - DCPC 804, 704 804, 704 0 0 90. 04 90. 05 90.05 PROVI DER BASED CLINI C - WESTPORT 194, 565 194, 565 0 0 90. 05 90. 06 09006 CLINI C 00. 07 09007 09								
90. 02			834, 930		834, 930			
90. 03			1				0	
90. 04 09004 PROVI DER BASED CLINI C - DCPC 804, 704 804, 704 0 90. 04 90. 05 90. 06 90. 05 PROVI DER BASED CLINI C - WESTPORT 194, 565 194, 565 0 90. 05 90. 06 09006 CLINI C 811, 674 811, 674 0 0 90. 06 90. 07 90. 07 09007 WOMEN' S HEALTH SERVI CES 285, 003 285, 003 0 0 90. 07 91. 00 09100 EMERGENCY 2, 656, 365 2, 656, 365 0 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 1, 349, 562 1, 349, 562 0 92. 00			304, 985		304, 985	5 0	0	1
90. 05 09005 PROVI DER BASED CLINI C - WESTPORT 194, 565 0 0 90. 05 90. 06 09006 CLINI C 811, 674 811, 674 0 0 90. 06 90. 07 09007 WOMEN' S HEALTH SERVI CES 285, 003 285, 003 0 0 90. 07 91. 00 09100 EMERGENCY 2, 656, 365 2, 656, 365 0 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 1, 349, 562 1, 349, 562 0 92. 00		· ·	1, 621, 428		1, 621, 428	8 0	0	
90. 06 09006 CLINIC 811, 674 811, 674 0 0 90. 06 90. 07 09007 WOMEN'S HEALTH SERVICES 285, 003 285, 003 0 0 90. 07 91. 00 09100 EMERGENCY 2, 656, 365 2, 656, 365 0 0 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1, 349, 562 1, 349, 562 0 92. 00			804, 704		804, 704	1 0	0	90.04
90. 07 09007 WOMEN' S HEALTH SERVICES 285, 003 285, 003 0 90. 07 91. 00 09100 EMERGENCY 2, 656, 365 2, 656, 365 0 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1, 349, 562 1, 349, 562 0 92. 00	90. 05 09	005 PROVIDER BASED CLINIC - WESTPORT	194, 565		194, 565	0	0	90.05
91. 00 09100 EMERGENCY 2, 656, 365 2, 656, 365 0 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1, 349, 562 1, 349, 562 0 92. 00							0	90.06
92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART 1, 349, 562 1, 349, 562 0 92. 00	90. 07 09	007 WOMEN'S HEALTH SERVICES	285, 003		285, 003	0	0	90.07
	91.00 09	100 EMERGENCY	2, 656, 365		2, 656, 365	0	0	
	92.00 09	200 OBSERVATION BEDS (NON-DISTINCT PART	1, 349, 562		1, 349, 562	2	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95. 00 09500 AMBULANCE SERVI CES 1, 901, 638 1, 901, 638 0 0 95. 00			1, 901, 638		1, 901, 638	0	0	95.00
99. 00 09900 CMHC 0 0 99. 00			0		(_	
101.00 10100 HOME HEALTH AGENCY 1,662,406 1,662,406 0 101.00								
200.00 Subtotal (see instructions) 40,434,293 0 40,434,293 0 0 200.00			1					
201.00 Less Observation Beds 1, 349, 562 1, 349, 562 0 201.00								
202.00 Total (see instructions) 39,084,731 0 39,084,731 0 0 202.00	202. 00	Total (see instructions)	39, 084, 731	0	39, 084, 73	I 0	0	202. 00

| Peri od: | Worksheet C | From 01/01/2014 | Part | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Da Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provi der CCN: 151332

				'	0 12/31/2014	5/22/2015 1: 3	
			Ti tl	e XVIII	Hospi tal	Cost	<u> </u>
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA I npati ent Rati o	
		6. 00	7. 00	8.00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	'					
30.00	03000 ADULTS & PEDIATRICS	3, 811, 998		3, 811, 998			30.00
	03100 INTENSIVE CARE UNIT	248, 634		248, 634			31.00
	04300 NURSERY	680, 829		680, 829			43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1, 543, 193	5, 494, 973	7, 038, 166	0. 373763	0. 000000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	419, 335	89, 249	508, 584	0. 646560	0.000000	52.00
	05300 ANESTHESI OLOGY	201, 654	188, 472			0.000000	
	05400 RADI OLOGY-DI AGNOSTI C	1, 208, 493	17, 540, 574			0.000000	54.00
	03630 ULTRA SOUND	180, 708	2, 140, 032			0. 000000	
	06000 LABORATORY	1, 713, 745	13, 287, 759			0. 000000	
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	233, 950	272, 426			0. 000000	
	06500 RESPIRATORY THERAPY	1, 378, 693	875, 934			0. 000000	65.00
	06600 PHYSI CAL THERAPY	262, 870	1, 676, 882			0. 000000	66.00
	06700 OCCUPATI ONAL THERAPY	170, 081	473, 264		1	0. 000000	
	06800 SPEECH PATHOLOGY	49, 875	466, 064			0. 000000	
	06900 ELECTROCARDI OLOGY	286, 832	2, 628, 821			0. 000000	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 523, 701	2, 327, 074			0. 000000	
	07200 IMPL. DEV. CHARGED TO PATIENTS	100	26, 684		1	0. 000000	
	07300 DRUGS CHARGED TO PATIENTS	3, 433, 230	8, 266, 466			0. 000000	
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	400	338, 632	339, 032	2. 462688	0. 000000	90.00
90. 01	09001 ONCOLOGY	75	397, 740	397, 815	1. 392871	0.000000	90. 01
90.02	09002 OUTPATIENT CLINIC	52, 922	364, 284	417, 206	0. 731018	0.000000	90.02
90.03	09003 PROVIDER BASED CLINIC - TCMP	67, 606	1, 193, 355	1, 260, 961	1. 285867	0.000000	90. 03
90.04	09004 PROVIDER BASED CLINIC - DCPC	93, 922	908, 230	1, 002, 152	0. 802976	0.000000	90. 04
90.05	09005 PROVIDER BASED CLINIC - WESTPORT	21, 003	102, 057	123, 060	1. 581058	0.000000	90.05
90.06	09006 CLI NI C	12, 625	2, 090, 161	2, 102, 786	0. 385999	0.000000	90.06
90.07	09007 WOMEN'S HEALTH SERVICES	21, 003	59, 684	80, 687	3. 532205	0.000000	90.07
91.00	09100 EMERGENCY	155, 107	7, 350, 489	7, 505, 596	0. 353918	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	3, 500	1, 229, 700	1, 233, 200	1. 094358	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0	2, 986, 611	2, 986, 611	0. 636721	0.000000	95.00
	09900 CMHC	0	0	C			99.00
101.00	10100 HOME HEALTH AGENCY	o	1, 290, 871	1, 290, 871			101.00
200.00	Subtotal (see instructions)	17, 776, 084	74, 066, 488	91, 842, 572	!		200.00
201.00							201.00
202.00	Total (see instructions)	17, 776, 084	74, 066, 488	91, 842, 572	!		202.00
				•			

Heal th Financial Systems DECATUR CO. MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151332
Period:
From 01/01/2014
To 12/31/2014
Pate/Time Prepared:
5/22/2015 1: 38 pm

				5/22/2015 1:38 pm
		Title XVIII	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 000000			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
55. 00 03630 ULTRA SOUND	0. 000000			55.00
60. 00 06000 LABORATORY	0. 000000			60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000			62.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 000000			90.00
90. 01 09001 0NC0L0GY	0. 000000			90. 01
90. 02 09002 OUTPATIENT CLINIC	0. 000000			90. 02
90. 03 09003 PROVIDER BASED CLINIC - TCMP	0. 000000			90. 03
90. 04 09004 PROVI DER BASED CLINIC - DCPC	0. 000000			90.04
90. 05 09005 PROVI DER BASED CLINIC - WESTPORT	0. 000000			90. 05
90. 06 09006 CLINIC	0. 000000			90.06
90. 07 09007 WOMEN' S HEALTH SERVICES	0. 000000			90. 07
91. 00 09100 EMERGENCY	0. 000000			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92.00
OTHER REIMBURSABLE COST CENTERS	0.00000			72.00
95. 00 09500 AMBULANCE SERVICES	0. 000000			95.00
99. 00 09900 CMHC	0.00000			99.00
101.00 10100 HOME HEALTH AGENCY				101.00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				202.00
202.00 Total (366 Histi detions)				1202.00

					To 12/31/2014	Date/Time Pre 5/22/2015 1:3	pared: 8 pm
			Tit	le XIX	Hospi tal	PPS	<u>o p</u>
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	·	(from Wkst.	Adj .		Di sal I owance		
		B, Part I,					
		col. 26)					
		1. 00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	5, 695, 869		5, 695, 869	9 o	5, 695, 869	30.00
31.00	03100 INTENSIVE CARE UNIT	612, 270		612, 270	0	612, 270	31.00
43.00	04300 NURSERY	263, 231		263, 231	0	263, 231	43.00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	2, 630, 604		2, 630, 604	1 0	2, 630, 604	
	05200 DELIVERY ROOM & LABOR ROOM	328, 830		328, 830		328, 830	
53.00	05300 ANESTHESI OLOGY	320, 786		320, 786	0	320, 786	ł
	05400 RADI OLOGY-DI AGNOSTI C	3, 115, 314		3, 115, 314		3, 115, 314	
55.00	03630 ULTRA SOUND	207, 053		207, 053		207, 053	
	06000 LABORATORY	2, 775, 708		2, 775, 708	3 O	2, 775, 708	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	124, 425		124, 425	5 0	124, 425	62.00
65.00	06500 RESPI RATORY THERAPY	1, 234, 417	0	1, 234, 417	7 0	1, 234, 417	65.00
66.00	06600 PHYSI CAL THERAPY	1, 019, 195	0	1, 019, 195	5 0	1, 019, 195	66.00
67.00	06700 OCCUPATI ONAL THERAPY	366, 531	0	366, 53	0	366, 531	67.00
	06800 SPEECH PATHOLOGY	331, 641	0	331, 641		331, 641	68. 00
	06900 ELECTROCARDI OLOGY	417, 861		417, 861	0	417, 861	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 084, 196		3, 084, 196	0	3, 084, 196	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	30, 229		30, 229		30, 229	
73.00	07300 DRUGS CHARGED TO PATIENTS	4, 894, 768		4, 894, 768	8 0	4, 894, 768	73.00
	OUTPATIENT SERVICE COST CENTERS	_					
	09000 CLI NI C	834, 930		834, 930		834, 930	
90. 01	09001 ONCOLOGY	554, 105		554, 105		554, 105	90. 01
90. 02	09002 OUTPATIENT CLINIC	304, 985		304, 985		304, 985	•
90. 03	09003 PROVIDER BASED CLINIC - TCMP	1, 621, 428		1, 621, 428		1, 621, 428	l
	09004 PROVIDER BASED CLINIC - DCPC	804, 704		804, 704		804, 704	
90.05	09005 PROVIDER BASED CLINIC - WESTPORT	194, 565		194, 565		194, 565	1
90.06	09006 CLI NI C	811, 674		811, 674		811, 674	
	09007 WOMEN'S HEALTH SERVICES	285, 003		285, 003		285, 003	
91.00	09100 EMERGENCY	2, 656, 365		2, 656, 365		2, 656, 365	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 349, 562		1, 349, 562	2	1, 349, 562	92.00
	OTHER REIMBURSABLE COST CENTERS	1					
	09500 AMBULANCE SERVICES	1, 901, 638		1, 901, 638		1, 901, 638	
	09900 CMHC	0		(0	99. 00
	10100 HOME HEALTH AGENCY	1, 662, 406		1, 662, 406		1, 662, 406	
200.00		40, 434, 293		,,		40, 434, 293	1
201.00		1, 349, 562		1, 349, 562		1, 349, 562	
202. 00	Total (see instructions)	39, 084, 731	0	39, 084, 73	이	39, 084, 731	J202.00

Heal th Financial Systems

DECATUR CO. MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

Provider CCN: 151332

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

Provide

Cost Center Description							3/22/2013 1.3	o piii
INPATIENT ROUTINE SERVICE COST CENTERS					le XIX	Hospi tal	PPS	
INPATIENT ROUTINE SERVICE COST CENTERS				Charges				
INPATIENT ROUTINE SERVICE COST CENTERS		Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
INPAT IERT ROUTINE SERVICE COST CENTERS 3,811,998 3,811,998 31,000 03100 INTERSIVE CARE UNIT 248,634 248,644 31,000 04300 NURSERY 43,000 04300 NURSERY 43,000 05400 04300 NURSERY 43,000 05400 04300 NURSERY 43,000 05400 04300 04		·		•	+ col. 7)	Rati o	I npati ent	
INPATIENT ROUTINE SERVICE COST CENTERS							Rati o	
INPATI ENT ROUTINE SERVICE COST CENTERS 3.8 811.998 3.8 811.998 3.8 811.998 3.0 0.0 0300 ADULTS & PEDIATRIC S 248.634 248.634 248.634 31.00 43.00			6, 00	7. 00	8, 00	9. 00		
30. 00	I NPA	TIENT ROUTINE SERVICE COST CENTERS				1		
31.00 03100 INTENSI VE CARE UNIT 248, 634 248, 634 31.00 430.			3, 811, 998		3, 811, 998	3		30.00
43. 00 04300 NURSERY 680, 829 680, 829 43. 00								
ANCILLARY SERVICE COST CENTERS								
50. 00 OSDOOI OSD			000, 02 7		000, 02	7		43.00
52.00 05200 DSLIVERY ROOM & LABOR ROOM 419, 335 89, 249 508, 584 0. 646560 0. 000000 52.00 05300 05300 ANESTHESI LOGY 201, 654 188, 472 390, 126 0. 822263 0. 000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 208, 493 17, 540, 574 18, 749, 067 0. 166158 0. 000000 55.00 03630 ULTRA SOUND 180, 708 2, 140, 032 2, 320, 740 0. 089219 0. 000000 55.00 000000 LABORATORY 0. 185029 0. 000000 60.00 06000 LABORATORY 0. 185029 0. 000000 0. 00.00 0. 00			1 5/3 103	5 404 073	7 038 16	0 373763	0.000000	50.00
53. 00 05300 ARSTHESI OLOGY 201, 654 188, 472 390, 126 0.82263 0.000000 53. 00 54. 00 05400 RADIOLOGY-DI AGNOSTI C 1, 208, 493 17, 546, 574 18, 749, 067 0.166158 0.000000 54. 00 05400 0.000000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 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 0.0000000 0.0000000 0.00000000								
54. 00 05400 RADI OLOGY-DI AGNOSTI C 1, 208, 493 17, 540, 574 18, 749, 067 0, 166158 0, 000000 54, 00 03630 ULTRA SOUND 180, 708 2, 140, 032 2, 320, 740 0, 089219 0, 000000 55, 00 06000 LABORATORY 1, 713, 745 13, 287, 759 15, 001, 504 0, 185029 0, 000000 60, 00 062, 00 06200 MHOLE BLOOD & PACKED RED BLOOD CELL 233, 950 272, 426 506, 376 0, 245717 0, 000000 65, 00 06500 RESPIR RATORY THERAPY 1, 378, 693 875, 934 2, 254, 627 0, 547504 0, 000000 65, 00 06600 PHYSI CAL THERAPY 262, 870 1, 676, 882 1, 939, 752 0, 525425 0, 000000 66, 00 06700 0CCUPATI ONAL THERAPY 170, 081 473, 264 643, 345 0, 569727 0, 000000 68, 00 06800 SPECEH PATHOLOGY 49, 875 466, 064 515, 939 0, 642791 0, 000000 68, 00 06800 SPECEH PATHOLOGY 286, 832 2, 628, 821 2, 915, 653 0, 143316 0, 000000 69, 00 0700 IMPL. DEV. CHARGED TO PATI ENTS 100 26, 684 26, 784 1, 128622 0, 000000 72, 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 100 26, 684 26, 784 1, 128622 0, 000000 72, 00 07300 DRUGS CHARGED TO PATI ENTS 3, 433, 230 8, 266, 466 11, 699, 696 0, 418367 0, 000000 72, 00 07400 IMPL THET SERVICE COST CENTERS 100 09001 0NCOLOGY 75 397, 740 397, 815 1, 392871 0, 000000 90, 02 09002 OUTPATI ENT CLINIC 52, 922 364, 284 417, 206 0, 731018 0, 000000 90, 02 000000 00000000000000000000000								
55.00 03630 ULTRA SOUND 180,708 2,140,032 2,320,740 0,089219 0,000000 55.00								
60. 00 06000 LABORATORY 1,713,745 13,287,759 15,001,504 0.185029 0.000000 60.00 62.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 233,950 272,426 506,376 0.245717 0.000000 65.00 06500 RESPIRATORY THERAPY 1,378,693 875,934 2,254,627 0.547504 0.000000 65.00 066.00 06500 RESPIRATORY THERAPY 1,378,693 875,934 2,254,627 0.547504 0.000000 65.00 066.00 06500 RESPIRATORY THERAPY 1,081 473,264 643,345 0.569727 0.000000 66.00 0.000000 0.00000 0.0000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.00000000								
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 233, 950 272, 426 506, 376 0.245717 0.000000 62. 00 65. 00 06500 RESPI RATORY THERAPY 1, 378, 693 875, 934 2, 254, 627 0.547504 0.000000 65. 00 66. 00								
65.00 06500 RESPIRATORY THERAPY 1,378,693 875,934 2,254,627 0.547504 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 262,870 1,676,882 1,939,752 0.525425 0.000000 66.00 67.00 06700 0CCUPATI ONAL THERAPY 170,081 473,264 643,345 0.569727 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 49,875 466,064 515,939 0.642791 0.000000 68.00 69.00 06900 ELECTROCARDIOLOGY 286,832 2,628,821 2,915,653 0.143316 0.000000 69.00 71.00 7100 MEDICAL SUPPLIES CHARGED TO PATIENT 1,523,701 2,327,074 3,850,775 0.800929 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 100 26,684 26,784 1.128622 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 3,433,230 8,266,466 11,699,696 0.418367 0.000000 73.00 73.00 07900 CLINIC 400 338,632 339,032 2.462688 0.000000 73.00 73.00 09000 CLINIC 400 338,632 339,032 2.462688 0.000000 90.01 74.00 09000 CLINIC 52,922 364,284 417,266 0.731018 0.000000 90.02 75.00 09000 09000 09000 090000 090000 090000 090000 090000000 0900000000								
66. 00 06600 PHYSI CAL THERAPY 262, 870 1,676, 882 1,939,752 0.525425 0.000000 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 170, 081 473, 264 643, 345 0.569727 0.000000 67. 00 68. 00 06800 SPEECH PATHOLOGY 49, 875 466, 064 515, 939 0.642791 0.000000 68. 00 69. 00 06900 ELECTROCARDI OLOGY 286, 832 2.628, 821 2.915, 653 0.143316 0.000000 69. 00 69. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 1,523, 701 2.327, 074 3,850, 775 0.800929 0.000000 71. 00 73. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 100 26,684 26,784 1.128622 0.000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 3,433,230 8,266,466 11,699,696 0.418367 0.000000 73. 00 73. 00 09000 CLI NI C 400 338,632 339,032 2.462688 0.000000 90. 01 74. 00 09000 OUTPATI ENT SERVI CE COST CENTERS 397,740 397,815 1.392871 0.000000 90. 01 75. 00 09001 ONCOLOGY 75 397,740 397,815 1.392871 0.000000 90. 01 75. 00 09002 OUTPATI ENT CLI NI C 52,922 364,284 417,206 0.731018 0.000000 90. 01 75. 00 09003 PROVI DER BASED CLI NI C - TCMP 67,606 1,193,355 1,260,961 1.285867 0.000000 90. 03 75. 00 09005 PROVI DER BASED CLI NI C - DCPC 93,922 908,230 1,002,152 0.802976 0.000000 90. 03 75. 00 09005 PROVI DER BASED CLI NI C - WESTPORT 21,003 12,0257 123,060 1.581058 0.000000 90. 05 75. 00 09006 CLI NI C 0.00000 0.000000 0.000000 0.000000 0.00000000				·		0. 245717		
67. 00 06700 06700 06700 06700 06700 06700 06700 06700 06800 06800 SPEECH PATHOLOGY 49, 875 466, 064 515, 939 0.642791 0.000000 68. 00 069. 00 06900 ELECTROCARDI LOGY 286, 832 2, 628, 821 2, 915, 653 0.143316 0.000000 69. 00 071.00 071				875, 934				
68.00 06800 SPEECH PATHOLOGY 49, 875 466, 064 515, 939 0.642791 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 286, 832 2, 628, 821 2, 915, 653 0.143316 0.000000 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 1,523,701 2,327,074 3,850,775 0.800929 0.000000 71.00 72.00 73.00 07200 MPL. DEV. CHARGED TO PATIENTS 100 26,684 26,784 1.128622 0.000000 73.00 07300 DRUGS CHARGED TO PATIENTS 3,433,230 8,266,466 11,699,696 0.418367 0.000000 73.00 07300 07400			262, 870	1, 676, 882	1, 939, 75			
69. 00 06900 ELECTROCARDI OLOGY 286, 832 2, 628, 821 2, 915, 653 0. 143316 0. 000000 69. 00 71. 00 71. 00 77. 00 7	67.00 06700	OCCUPATIONAL THERAPY	170, 081	473, 264	643, 34	0. 569727	0.000000	67.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 1,523,701 2,327,074 3,850,775 0.800929 0.000000 71.00 72.0	68.00 06800	SPEECH PATHOLOGY	49, 875	466, 064	515, 939	0. 642791	0.000000	68. 00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 1,523,701 2,327,074 3,850,775 0.800929 0.000000 71.00 72.00 72.00 73.00 07200 IMPL. DEV. CHARGED TO PATIENTS 100 26,684 26,784 1.128622 0.000000 72.00 73.00 07300 DRIGS CHARGED TO PATIENTS 3,433,230 8,266,466 11,699,696 0.418367 0.000000 73.00 00TPATIENT SERVICE COST CENTERS	69.00 06900	D ELECTROCARDI OLOGY	286, 832	2, 628, 821	2, 915, 65	0. 143316	0. 000000	69.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 100 26,684 26,784 1.128622 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 3,433,230 8,266,466 11,699,696 0.418367 0.000000 73.00 000000 0.	71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT						71.00
73. 00								
OUTPATI ENT SERVI CE COST CENTERS 90.00 O9000 CLI NI C 400 338, 632 339, 032 2.462688 0.000000 90.00 90.01 O9001 ONCOLOGY 75 397, 740 397, 815 1.392871 0.000000 90.01 O9002 OUTPATI ENT CLI NI C 52, 922 364, 284 417, 206 0.731018 0.000000 90.01 O9002 OUTPATI ENT CLI NI C 52, 922 364, 284 417, 206 0.731018 0.000000 90.02 O9002 O9002 OUTPATI ENT CLI NI C TCMP 67, 606 1, 193, 355 1, 260, 961 1.285867 0.000000 90.03 O9003 PROVI DER BASED CLI NI C DCPC 93, 922 908, 230 1, 002, 152 0.802976 0.000000 90.04 O9004 PROVI DER BASED CLI NI C WESTPORT 21, 003 102, 057 123, 060 1.581058 0.000000 90.05 O9005 PROVI DER BASED CLI NI C WESTPORT 21, 003 102, 057 123, 060 1.581058 0.000000 90.05 O9006 CLI NI C 12, 625 2, 090, 161 2, 102, 786 0.385999 0.000000 90.05 O9006 CLI NI C SHEALTH SERVI CES 21, 003 59, 684 80, 687 3.532205 0.000000 90.07 O9007 WOMEN' S HEALTH SERVI CES 21, 003 59, 684 80, 687 3.532205 0.000000 91.00 O9100 EMERGENCY 155, 107 7, 350, 489 7, 505, 596 0.353918 0.000000 91.00 OTHER REI MBURSABLE COST CENTERS 0 2, 986, 611 2, 986, 611 0.636721 0.000000 92.00 OTHER REI MBURSABLE COST CENTERS 0 2, 986, 611 2, 986, 611 0.636721 0.000000 99.00 OTHER REI MBURSABLE COST CENTERS 0 2, 986, 611 2, 986, 611 0.636721 0.000000 99.00 OTHER REI MBURSABLE COST CENTERS 0 2, 986, 611 2, 986, 611 0.636721 0.000000 99.00 OTHER REI MBURSABLE COST CENTERS 0 2, 986, 611 2, 986, 611 0.636721 0.000000 99.00 OTHER REI MBURSABLE COST CENTERS 0 2, 986, 611 0.636721 0.000000 0.000000 0.000000000000								
90. 00 09000 CLINIC 400 338, 632 339, 032 2.462688 0.000000 90.00 90			07 1007 200	0,200,100	1.17077707	0. 1.0007	0.00000	70.00
90. 01			400	338 632	339 03	2 462688	0.000000	90.00
90. 02								
90. 03								
90. 04								
90. 05								
90. 06 09006 CLINIC 12, 625 2, 090, 161 2, 102, 786 0. 385999 0. 000000 90. 06 90. 07 90007 WOMEN'S HEALTH SERVICES 21, 003 59, 684 80, 687 3. 532205 0. 000000 90. 07 91. 00 09100 EMERGENCY 155, 107 7, 350, 489 7, 505, 596 0. 353918 0. 000000 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 3, 500 1, 229, 700 1, 233, 200 1. 094358 0. 000000 92. 00 09500 AMBULANCE SERVICES 0 2, 986, 611 2, 986, 611 2, 986, 611 0. 636721 0. 000000 99. 00 99. 00 09900 CMHC 0 0 0 0 0 0. 000000 000000 000000 0000000 000000								
90. 07								
91. 00								
92. 00								
OTHER REIMBURSABLE COST CENTERS 95. 00								
95. 00			3, 500	1, 229, 700	1, 233, 200	1. 094358	0. 000000	92.00
99. 00								
101.00 10100 HOME HEALTH AGENCY 0 1,290,871 1,290,871 200.00 201.00 Less Observation Beds 17,776,084 74,066,488 91,842,572 200.00			0	2, 986, 611	2, 986, 61	0. 636721	0. 000000	95.00
200. 00 Subtotal (see instructions) 17,776,084 74,066,488 91,842,572 200. 00 201. 00 Less Observation Beds 200. 00	99. 00 09900	D CMHC	0	0	(99.00
200. 00 Subtotal (see instructions) 17,776,084 74,066,488 91,842,572 200. 00 201. 00 Less Observation Beds 200. 00	101.00 10100	O HOME HEALTH AGENCY	o	1, 290, 871	1, 290, 87	1		101.00
201.00 Less Observation Beds 201.00	200.00	Subtotal (see instructions)	17, 776, 084	74, 066, 488	91, 842, 57	2		200.00
				., ,				
[17,776,661] 77,666,164] 77,676,164]			17 776 084	74 066 488	91 842 57			
	232.00	1.013. (000 111011 4011 0110)	17,770,004	, 1, 000, 400	71,012,07	-1	I	1-32.00

Heal th Financial Systems DECATUR CO. MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151332 | Period: From 01/01/2014 | To 12/31/2014 | Provider CCN: 151332 | Period: From 01/01/2014 | Provider CCN: 151332 | Provider CCN: 151332 | Period: From 01/01/2014 | Provider CCN: 151332 | Pro

					5/22/2015 1:38 pm
			Title XIX	Hospi tal	PPS
Cost Center De	escription	PPS Inpatient			
		Ratio			
		11. 00			
INPATIENT ROUTINE S	ERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIA	ATRI CS				30.00
31.00 03100 INTENSIVE CARE	UNIT				31.00
43. 00 04300 NURSERY					43.00
ANCILLARY SERVICE C	OST CENTERS				
50. 00 05000 OPERATING ROOM	1	0. 373763			50.00
52. 00 05200 DELI VERY ROOM	& LABOR ROOM	0. 646560			52.00
53. 00 05300 ANESTHESI OLOGY	<i>'</i>	0. 822263			53.00
54. 00 05400 RADI OLOGY-DI AC	SNOSTI C	0. 166158			54.00
55.00 03630 ULTRA SOUND		0. 089219			55. 00
60. 00 06000 LABORATORY		0. 185029			60.00
1 1	PACKED RED BLOOD CELL	0. 245717			62.00
65. 00 06500 RESPIRATORY TH		0. 547504			65. 00
66. 00 06600 PHYSI CAL THERA		0. 525425			66.00
67. 00 06700 OCCUPATI ONAL		0. 569727			67.00
68. 00 06800 SPEECH PATHOLO		0. 642791			68.00
69. 00 06900 ELECTROCARDI OL		0. 143316			69. 00
71. 00 07100 MEDI CAL SUPPLI		0. 800929			71.00
72.00 07200 I MPL. DEV. CHA		1. 128622			72.00
73. 00 07300 DRUGS CHARGED		0. 418367			73.00
OUTPATIENT SERVICE		0. 1.0007			70.00
90. 00 09000 CLINIC	SOUT SERVICE	2. 462688			90.00
90. 01 09001 0NCOLOGY		1. 392871			90. 01
90. 02 09002 OUTPATIENT CLI	NI C	0. 731018			90. 02
90. 03 09003 PROVI DER BASEI		1. 285867			90.03
90. 04 09004 PROVI DER BASEI		0. 802976			90.04
90. 05 09005 PROVI DER BASEI		1. 581058			90.05
90. 06 09006 CLI NI C	, deriving wegin divi	0. 385999			90.06
90. 07 09007 WOMEN' S HEALTH	I SERVICES	3. 532205			90.07
91. 00 09100 EMERGENCY	1 SERVI GES	0. 353918			91.00
92. 00 09200 OBSERVATION BE	TOS (NON_DISTINCT PART	1. 094358			92.00
OTHER REIMBURSABLE		1.074330			72.00
95. 00 09500 AMBULANCE SERV		0. 636721			95. 00
99. 00 09900 CMHC	1020	0. 030721			99.00
101.00 10100 HOME HEALTH AC	SENCY				101.00
200.00 Subtotal (see					200.00
201.00 Less Observati					201.00
202.00 Total (see ins					202.00
202.00 Total (See 11)	structions)	1			1202.00

Health Financial Systems

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY

				10	12/31/2014	5/22/2015 1: 3	
			Tit	le XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost	Capital Cost	Operating	Capi tal	Operating	
	·	(Wkst. B,	(Wkst. B,	Cost Net of	Reduction	Cost	
		Part I, col.	Part II col.	Capital Cost		Reducti on	
		26)	26)	(col. 1 -		Amount	
				col . 2)			
		1. 00	2. 00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	2, 630, 604	179, 533	2, 451, 071	0	0	
	05200 DELIVERY ROOM & LABOR ROOM	328, 830	57, 199	271, 631	0	0	1 02.00
53.00	05300 ANESTHESI OLOGY	320, 786	4, 786	316, 000	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 115, 314	180, 186	2, 935, 128	0	0	54.00
55.00	03630 ULTRA SOUND	207, 053	5, 572	201, 481	0	0	55.00
60.00	06000 LABORATORY	2, 775, 708	104, 652	2, 671, 056	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	124, 425	2, 232	122, 193	0	0	62.00
65.00	06500 RESPI RATORY THERAPY	1, 234, 417	32, 450	1, 201, 967	o	0	65.00
66.00	06600 PHYSI CAL THERAPY	1, 019, 195	59, 832	959, 363	o	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	366, 531	20, 912	345, 619	o	0	67.00
68.00	06800 SPEECH PATHOLOGY	331, 641	16, 482	315, 159	o	0	68.00
69.00	06900 ELECTROCARDI OLOGY	417, 861	44, 458	373, 403	o	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 084, 196			o	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	30, 229			o	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	4, 894, 768			O	0	1
	OUTPATIENT SERVICE COST CENTERS		·		'		1
90.00	09000 CLI NI C	834, 930	46, 216	788, 714	0	0	90.00
90. 01	09001 ONCOLOGY	554, 105	35, 221	518, 884	0	0	90. 01
90.02	09002 OUTPATIENT CLINIC	304, 985	93, 065	211, 920	o	0	90. 02
90.03	09003 PROVIDER BASED CLINIC - TCMP	1, 621, 428	202, 181	1, 419, 247	o	0	90.03
90.04	09004 PROVIDER BASED CLINIC - DCPC	804, 704	144, 023	660, 681	o	0	90.04
90.05	09005 PROVIDER BASED CLINIC - WESTPORT	194, 565	18, 982	175, 583	o	0	90.05
90.06	09006 CLI NI C	811, 674	47, 046	764, 628	o	0	90.06
90.07	09007 WOMEN'S HEALTH SERVICES	285, 003		223, 410	o	0	90. 07
91.00	09100 EMERGENCY	2, 656, 365	138, 058	2, 518, 307	o	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 349, 562			o	0	92.00
	OTHER REIMBURSABLE COST CENTERS				•		1
95.00	09500 AMBULANCE SERVICES	1, 901, 638	82, 230	1, 819, 408	0	0	95.00
99.00	09900 CMHC	0	0	0	0	0	99. 00
101.00	10100 HOME HEALTH AGENCY	1, 662, 406	59, 907	1, 602, 499	o	0	101.00
200.00	Subtotal (sum of lines 50 thru 199)	33, 862, 923		31, 906, 027	o	0	200.00
201.00	Less Observation Beds	1, 349, 562	110, 997	1, 238, 565	o	0	201.00
202.00	Total (line 200 minus line 201)	32, 513, 361	1, 845, 899	30, 667, 462	o	0	202.00

REDUCTIONS FOR MEDICALD ONLY

						5/22/2015 1:38 pm
				le XIX	Hospi tal	PPS
	Cost Center Description	Cost Net of	Total Charges	Outpati ent		
		Capital and	(Worksheet C,	Cost to		
		Operati ng	Part I,	Charge Ratio)	
		Cost	column 8)	(col. 6 /		
		Reduction		col. 7)		
		6. 00	7. 00	8. 00		
1	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	2, 630, 604	7, 038, 166	0. 37376	3	50.0
52.00	05200 DELIVERY ROOM & LABOR ROOM	328, 830	508, 584	0. 64656	00	52. C
53.00	05300 ANESTHESI OLOGY	320, 786	390, 126	0. 82226	3	53.0
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 115, 314	18, 749, 067	0. 16615	i8	54. C
55.00	03630 ULTRA SOUND	207, 053	2, 320, 740	0. 08921	9	55. C
60.00	06000 LABORATORY	2, 775, 708	15, 001, 504	0. 18502	.9	60.0
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	124, 425			7	62.0
65.00	06500 RESPI RATORY THERAPY	1, 234, 417	2, 254, 627	0. 54750)4	65. C
66.00	06600 PHYSI CAL THERAPY	1, 019, 195	1, 939, 752	0. 52542	!5	66.0
67.00	06700 OCCUPATI ONAL THERAPY	366, 531	643, 345			67. C
68.00	06800 SPEECH PATHOLOGY	331, 641			71	68. C
69.00	06900 ELECTROCARDI OLOGY	417, 861	2, 915, 653		6	69.0
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 084, 196			19	71. C
	07200 IMPL. DEV. CHARGED TO PATIENTS	30, 229				72. C
	07300 DRUGS CHARGED TO PATIENTS	4, 894, 768				73. C
	OUTPATIENT SERVICE COST CENTERS		, , , , , , , , , , , , , , , , , , , ,		•	
	09000 CLI NI C	834, 930	339, 032	2. 46268	18	90.0
90. 01	09001 ONCOLOGY	554, 105				90.0
90. 02	09002 OUTPATIENT CLINIC	304, 985	417, 206	0. 73101	8	90.0
90. 03	09003 PROVIDER BASED CLINIC - TCMP	1, 621, 428			57	90.0
	09004 PROVIDER BASED CLINIC - DCPC	804, 704			'6	90.0
90.05	09005 PROVIDER BASED CLINIC - WESTPORT	194, 565	123, 060	1. 58105	58	90.0
	09006 CLI NI C	811, 674	l '	0. 38599	9	90.0
	09007 WOMEN'S HEALTH SERVICES	285, 003				90.0
	09100 EMERGENCY	2, 656, 365				91.0
	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 349, 562				92.0
	OTHER REIMBURSABLE COST CENTERS	, , , , , ,	, ,			
	09500 AMBULANCE SERVICES	1, 901, 638	2, 986, 611	0. 63672	21	95. C
	09900 CMHC	0				99.0
	10100 HOME HEALTH AGENCY	1, 662, 406	1			101. 0
200.00	Subtotal (sum of lines 50 thru 199)	33, 862, 923				200. 0
201.00	Less Observation Beds	1, 349, 562				201. 0
202.00	Total (line 200 minus line 201)	32, 513, 361	1			202. 0
_52.50	1.2.2. (1.110 200 11.110 201)	02,0.0,001	0., ,	1	T	1202.0

Health Financial Systems D	ECATUR CO. MEMO	ORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS			Period: From 01/01/2014 To 12/31/2014	5/22/2015 1:3	
			e XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col . 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col . 2)			
	col . 26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1		1			
50. 00 05000 OPERATING ROOM	179, 533				12, 975	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	57, 199				0	
53. 00 05300 ANESTHESI OLOGY	4, 786				479	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	180, 186				4, 237	
55. 00 03630 ULTRA SOUND	5, 572				202	55.00
60. 00 06000 LABORATORY	104, 652		1		5, 293	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	2, 232	•			297	
65. 00 06500 RESPI RATORY THERAPY	32, 450					
66. 00 06600 PHYSI CAL THERAPY	59, 832		1			
67. 00 06700 OCCUPATI ONAL THERAPY	20, 912				2, 136	
68. 00 06800 SPEECH PATHOLOGY	16, 482				302	
69. 00 06900 ELECTROCARDI OLOGY	44, 458					
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	78, 737				13, 042	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	426				1	72.00
73. 00 O7300 DRUGS CHARGED TO PATIENTS	129, 920	11, 699, 696	0. 01110	1, 370, 765	15, 222	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	46, 216				54	
90. 01 09001 0NCOLOGY	35, 221	397, 815	1		4	90. 01
90. 02 09002 0UTPATI ENT CLINI C	93, 065			· ·	1, 676	
90. 03 09003 PROVI DER BASED CLINIC - TCMP	202, 181	1, 260, 961			0	90.03
90. 04 09004 PROVI DER BASED CLINIC - DCPC	144, 023				0	
90. 05 09005 PROVI DER BASED CLINIC - WESTPORT	18, 982				0	
90. 06 09006 CLINIC	47, 046				0	90.06
90. 07 09007 WOMEN' S HEALTH SERVI CES	61, 593	l	1		0	90.07
91. 00 09100 EMERGENCY	138, 058					
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	110, 997	1, 233, 200	0. 09000	3, 252	293	92.00
OTHER REIMBURSABLE COST CENTERS	I	l e				05 00
95.00 09500 AMBULANCE SERVICES 200.00 Total (lines 50-199)	1, 814, 759	82, 823, 629		5, 054, 596	73, 410	95. 00 200. 00

Health Financial Systems	DECATUR CO. MEMORIAL HO	OSPI TAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS Pro	rovider CCN: 151332 Pe	eriod: Worksheet D
THROUGH COSTS		Fr	rom 01/01/2014 Part IV

12/31/2014 Date/Time Prepared: To 5/22/2015 1:38 pm Title XVIII Hospi tal Cost Cost Center Description Non Physician Allied Health Total Cost Nursi ng All Other Anestheti st Medi cal (sum of col 1 School Cost Educati on through col. Cost 1. 00 2.00 3.00 4.00 5.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 50.00 50.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 0 0 0 0 0 52.00 53.00 05300 ANESTHESI OLOGY 0 0 53.00 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 0 03630 ULTRA SOUND 0 55.00 55.00 0 0 60.00 06000 LABORATORY 0 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 62.00 06500 RESPIRATORY THERAPY 65.00 0 0 65.00 0 06600 PHYSI CAL THERAPY 0 66.00 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 68.00 06900 ELECTROCARDI OLOGY 69.00 0 0 69.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 0 90.00 90.01 09001 ONCOLOGY 0 0 0 90.01 0 0 0 0 0 0 0 0 0 0 0 0 09002 OUTPATIENT CLINIC 0 90.02 0 90.02 0 0 09003 PROVI DER BASED CLINIC - TCMP 09004 PROVI DER BASED CLINIC - DCPC 0 90.03 90.03 0 90.04 0 0 90.04 09005 PROVIDER BASED CLINIC - WESTPORT 0 0 90.05 90.05 0 0 0 90 06 09006 CLI NI C Ω 90.06 09007 WOMEN'S HEALTH SERVICES 0 90.07 90.07 C 0 0 91. 00 09100 EMERGENCY 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 92.00 ol 0 92.00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95.00

0

0

0

0

0 200.00

200.00

Total (lines 50-199)

Health Financial Systems	DECATUR CO. MEMORIA	L HOSPI TAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 151332	
THROUGH COSTS			From 01/01/2014 Part IV

TIMOUGH COSTS			Γ	o 12/31/2014	Date/Time Pre 5/22/2015 1:3	
		Ti tl	e XVIII	Hospi tal	Cost	
Cost Center Description	Total	Total Charges	Ratio of Cost	Outpati ent	I npati ent	
	Outpati ent	(from Wkst.	to Charges	Ratio of Cost	Program	
	Cost (sum of	C, Part I,	(col. 5 ÷	to Charges	Charges	
	col . 2, 3 and	col. 8)	col. 7)	(col. 6 ÷		
	4)			col. 7)		
	6. 00	7. 00	8. 00	9. 00	10. 00	
ANCILLARY SERVICE COST CENTERS			,			
50.00 05000 OPERATING ROOM	0	7, 038, 166			508, 682	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	508, 584	•		0	52.00
53. 00 05300 ANESTHESI OLOGY	0	390, 126	•		39, 054	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	18, 749, 067			440, 915	54.00
55.00 03630 ULTRA SOUND	0	2, 320, 740			84, 035	
60. 00 06000 LABORATORY	0	15, 001, 504			758, 793	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	506, 376			67, 297	62.00
65. 00 06500 RESPI RATORY THERAPY	0	2, 254, 627			770, 682	65.00
66. 00 06600 PHYSI CAL THERAPY	0	1, 939, 752			107, 396	
67. 00 06700 OCCUPATI ONAL THERAPY	0	643, 345			65, 704	
68. 00 06800 SPEECH PATHOLOGY	0	515, 939			9, 452	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	2, 915, 653			181, 143	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	3, 850, 775			637, 839	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	26, 784			35	72.00
73. 00 O7300 DRUGS CHARGED TO PATIENTS	0	11, 699, 696	0. 000000	0. 000000	1, 370, 765	73.00
OUTPAȚI ENT SERVI CE COST CENTERS						
90. 00 09000 CLI NI C	0	339, 032			393	90.00
90. 01 09001 0NCOLOGY	0	397, 815			42	90. 01
90. 02 09002 OUTPATIENT CLINIC	0	417, 206			7, 513	
90. 03 09003 PROVI DER BASED CLINIC - TCMP	0	1, 260, 961			0	90. 03
90. 04 09004 PROVI DER BASED CLINIC - DCPC	0	1, 002, 152			0	90.04
90. 05 09005 PROVIDER BASED CLINIC - WESTPORT	0	123, 060	•		0	90.05
90. 06 09006 CLI NI C	0	2, 102, 786			0	90.06
90. 07 09007 WOMEN'S HEALTH SERVICES	0	80, 687	•		0	90. 07
91. 00 09100 EMERGENCY	0	7, 505, 596			1, 604	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1, 233, 200	0. 000000	0. 000000	3, 252	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	0	82, 823, 629			5, 054, 596	200. 00

Health Financial Systems

DECATUR CO. MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 151332
From 01/01/2014
To 12/31/2014
Date/Time Prepared:

						10	12/31/2014	5/22/2015 1:	
				Title	e XVIII		Hospi tal	Cost	
	Cost Center Description	I npati ent	Outpa	tient	Outpati ent				
		Program	Prog	gram	Program				
		Pass-Through	Char	-ges	Pass-Through				
		Costs (col. 8			Costs (col.	9			
		x col. 10)			x col. 12)				
		11. 00	12.	00	13. 00				
	ANCILLARY SERVICE COST CENTERS	1 -1		_					
	D5000 OPERATING ROOM	0		0		0			50.00
	D5200 DELIVERY ROOM & LABOR ROOM	0		0		0			52.00
	D5300 ANESTHESI OLOGY	0		0		0			53.00
	D5400 RADI OLOGY-DI AGNOSTI C	0		0		0			54.00
	03630 ULTRA SOUND	0		0		0			55.00
	D6000 LABORATORY	0		0		0			60.00
	D6200 WHOLE BLOOD & PACKED RED BLOOD CELL	0		0		0			62.00
	D6500 RESPI RATORY THERAPY	0		0		0			65.00
	D6600 PHYSI CAL THERAPY	0		0		0			66.00
	06700 OCCUPATI ONAL THERAPY	0		0		0			67.00
	06800 SPEECH PATHOLOGY	0		0		0			68.00
	06900 ELECTROCARDI OLOGY	0		0		0			69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		0		0			71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0		0		0			72.00
_	D7300 DRUGS CHARGED TO PATIENTS	0		0		0			73. 00
	OUTPATIENT SERVICE COST CENTERS			-					
	09000 CLI NI C	0		0		0			90.00
	09001 ONCOLOGY	0		0		0			90. 01
	09002 OUTPATIENT CLINIC	0		0		0			90. 02
	D9003 PROVIDER BASED CLINIC - TCMP D9004 PROVIDER BASED CLINIC - DCPC	0		0		0			90. 03 90. 04
	09005 PROVIDER BASED CLINIC - DCPC	0		0		0			90.04
1	09006 CLINIC	0		0		0			90.05
	D9000 CLINIC D9007 WOMEN'S HEALTH SERVICES	0		0		0			90.06
	D9100/WOMEN S HEALTH SERVICES			0		0			90.07
	D9200 OBSERVATION BEDS (NON-DISTINCT PART			0		0			91.00
	OTHER REIMBURSABLE COST CENTERS	ı U		U		U			72.00
	D9500 AMBULANCE SERVICES					T			95. 00
200.00	Total (lines 50-199)	o		0		0			200.00
200.00	10 tai (111163 30-177)	1 9		ΨĮ	I	U			1200.00

In Lieu of Form CMS-2552-10 From 01/01/2014 Part V 12/31/2014 Date/Time Prepared: 5/22/2015 1:38 pm Title XVIII Hospi tal Cost Charges Costs PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, inst.) Subject To Subject To Part I, col. Ded. & Coins. Ded. & Coins. 9 (see inst.) (see inst.) 1.00 2.00 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 0. 373763 1, 266, 585 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 52.00 0.646560 0 0 0 05300 ANESTHESI OLOGY 0.822263 0 53.00 0 45, 816 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.166158 5, 236, 957 857 0 54.00 55.00 03630 ULTRA SOUND 0.089219 486, 528 0 0 55.00

| Peri od: | Worksheet D | From 01/01/2014 | Part V | To 12/31/2014 | Date/Time Prepared:

					12, 31, 2311	5/22/2015 1:38 pm	
			Ti tl	e XVIII	Hospi tal	Cost	_
		Cos	sts				
	Cost Center Description	Cost	Cost				
	·	Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6. 00	7. 00				
	ILLARY SERVICE COST CENTERS						_
50.00 050	OOO OPERATING ROOM	473, 403	0			50.00)()
52.00 052	200 DELIVERY ROOM & LABOR ROOM	0	0			52.00	00
53.00 053	BOO ANESTHESI OLOGY	37, 673	0			53.00	00
54.00 054	100 RADI OLOGY-DI AGNOSTI C	870, 162	142			54.00	00
55.00 036	30 ULTRA SOUND	43, 408	0			55.00	00
60.00 060	000 LABORATORY	705, 674	0			60.00	00
62. 00 062	200 WHOLE BLOOD & PACKED RED BLOOD CELL	29, 371	0			62.00	00
65.00 065	000 RESPI RATORY THERAPY	227, 180	0			65.00	00
	000 PHYSI CAL THERAPY	234, 364	0			66. 00	
	OO OCCUPATIONAL THERAPY	44, 736	0			67. 0	00
	300 SPEECH PATHOLOGY	31, 528				68. 0	
	200 ELECTROCARDI OLOGY	139, 616				69. 00	00
	00 MEDICAL SUPPLIES CHARGED TO PATIENT	388, 477	0			71.00	
	200 IMPL. DEV. CHARGED TO PATIENTS	12, 002	0			72.00	
	BOO DRUGS CHARGED TO PATIENTS	1, 203, 103				73. 00	
	PATIENT SERVICE COST CENTERS	,	,				
	000 CLI NI C	78, 052	0			90.00	00
90. 01 090	001 ONCOLOGY	251, 406	0			90.0)1
90. 02 090	002 OUTPATIENT CLINIC	24, 458				90. 0)2
	003 PROVIDER BASED CLINIC - TCMP	343, 294		i e		90. 0	
	004 PROVIDER BASED CLINIC - DCPC	108, 821	0			90.0	
90. 05 090	PROVIDER BASED CLINIC - WESTPORT	49, 152	0			90.0)5
	006 CLINIC	357, 338				90.0)6
	007 WOMEN'S HEALTH SERVICES	0				90. 0	
	OO EMERGENCY	494, 487	l o			91.00	
	200 OBSERVATION BEDS (NON-DISTINCT PART	435, 595				92.00	
	IER REIMBURSABLE COST CENTERS	1007070				72.0	
	500 AMBULANCE SERVICES	0				95.00)()
200. 00	Subtotal (see instructions)	6, 583, 300				200. 0	
201.00	Less PBP Clinic Lab. Services-Program	0,000,000	,, 410			201. 0	
231.00	Only Charges					201.00	
202. 00	Net Charges (line 200 +/- line 201)	6, 583, 300	9, 416			202. 0)()
_52. 55	, goo (200 ., 201)	3,555,666	,, 110	1		1202.00	

			Componen	1 CCN: 15Z332 1	0 12/31/2014	5/22/2015 1:3	
			Ti tl	e XVIII Sı	wing Beds - SNF		
				Charges		Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
		Charge Ratio	Reimbursed	Rei mbursed	Rei mbursed	(see inst.)	
		From	Services (see	Servi ces	Services Not		
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.		Ded. & Coins.	Ded. & Coins.		
		9		(see inst.)	(see inst.)		
		1. 00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0. 373763	l .		0	0	
	05200 DELIVERY ROOM & LABOR ROOM	0. 646560	0	0	0	0	02.00
	05300 ANESTHESI OLOGY	0. 822263	0	0	0	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	0. 166158		0	0	0	
	03630 ULTRA SOUND	0. 089219	l e	0	0	0	
	06000 LABORATORY	0. 185029	0	0	0	0	60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 245717	0	0	0	0	62.00
	06500 RESPI RATORY THERAPY	0. 547504	0	0	0	0	
	06600 PHYSI CAL THERAPY	0. 525425	0	0	0	0	66.00
	06700 OCCUPATI ONAL THERAPY	0. 569727	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0. 642791	0	0	0	0	68.00
	06900 ELECTROCARDI OLOGY	0. 143316	0	0	0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 800929	0	0	0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	1. 128622	0	0	0	0	
	07300 DRUGS CHARGED TO PATIENTS	0. 418367	0	0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	2. 462688	0	0	0	0	90.00
	09001 ONCOLOGY	1. 392871	0	0	0	0	
90. 02	09002 OUTPATIENT CLINIC	0. 731018	0	0	0	0	90. 02
	09003 PROVI DER BASED CLINIC - TCMP	1. 285867	0	0	0	0	90. 03
90.04	09004 PROVIDER BASED CLINIC - DCPC	0. 802976	0	0	0	0	90. 04
	09005 PROVIDER BASED CLINIC - WESTPORT	1. 581058	0	0	0	0	90.05
	09006 CLI NI C	0. 385999	0	0	0	0	90.06
90. 07	09007 WOMEN'S HEALTH SERVICES	3. 532205	0	0	0	0	90. 07
91.00	09100 EMERGENCY	0. 353918	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1. 094358	0	0	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0. 636721		0			95. 00
200.00	Subtotal (see instructions)		0	0	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program			0	0		201.00
	Only Charges						
202.00	Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

 Heal th Financial
 Systems
 DECATUR CO.
 MEM

 APPORTIONMENT OF
 MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST
 DECATUR CO. MEMORIAL HOSPITAL

Cos		e XVIII Swing Beds - :	SNF Cost
Cos	te		
003	13		
Cost Center Description Cost	Cost		
Rei mbursed	Rei mbursed		
Servi ces	Services Not		
Subject To	Subject To		
Ded. & Coi ns.	Ded. & Coins.		
(see inst.)	(see inst.)		
6. 00	7. 00		
ANCILLARY SERVICE COST CENTERS			
50. 00 05000 OPERATI NG ROOM O	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM 0	0		52.00
53. 00 05300 ANESTHESI OLOGY 0	0		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C O	0		54.00
55. 00 03630 ULTRA SOUND 0	0		55.00
60. 00 06000 LABORATORY 0	О		60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0	0		62.00
65. 00 06500 RESPIRATORY THERAPY 0	0		65.00
66. 00 06600 PHYSI CAL THERAPY 0	o		66.00
57. 00 06700 OCCUPATI ONAL THERAPY	0		67.00
58. 00 06800 SPEECH PATHOLOGY 0	0		68.00
69. 00 06900 ELECTROCARDI OLOGY	0		69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0		72.00
73. 00 O7300 DRUGS CHARGED TO PATIENTS	0		73.00
OUTPATIENT SERVICE COST CENTERS	<u> </u>		70.00
90. 00 09000 CLINIC 0	0		90.00
90. 01 09001 0NCOLOGY	0		90.01
90. 02 09002 0UTPATIENT CLINIC 0	0		90.02
90. 03 09003 PROVI DER BASED CLINIC - TCMP	0		90.03
90. 04 09004 PROVI DER BASED CLINIC - DCPC 0	0		90.04
90. 05 09005 PROVI DER BASED CLINIC - WESTPORT 0	0		90.05
90. 06 09006 CLI NI C	0		90.06
90. 07 09007 WOMEN' S HEALTH SERVICES 0	0		90.07
91. 00 09100 EMERGENCY 0	0		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0	0		92.00
OTHER REIMBURSABLE COST CENTERS	0		72.00
95. 00 09500 AMBULANCE SERVICES 0			95. 00
200.00 Subtotal (see instructions)	0		200. 00
201.00 Less PBP Clinic Lab. Services-Program 0	۷		200.00
Only Charges			201.00
202.00 Net Charges (line 200 +/- line 201) 0	o		202.00
102.00	O _I		_{[202} .00

Health Financial Systems	DECATUR CO. MEM	ORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITA	L COSTS	Provi der		Peri od:	Worksheet D	
				From 01/01/2014		narad.
				Γο 12/31/2014	Date/Time Pre 5/22/2015 1:3	pareu: 8 nm
-		Ti t	le XIX	Hospi tal	PPS	о рііі
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col . 2)			
	1. 00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	440, 085	0	440, 08!	4, 508	97. 62	30.00
31.00 INTENSIVE CARE UNIT	21, 274		21, 27	113	188. 27	31.00
43. 00 NURSERY	21, 597		21, 59 ⁻	7 342	63. 15	43.00
200.00 Total (lines 30-199)	482, 956		482, 950	4, 963		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	282					30.00
31.00 INTENSIVE CARE UNIT	2	377				31.00
43. 00 NURSERY	0	0				43.00
200.00 Total (lines 30-199)	284	27, 906				200. 00

Health Financial Systems	DECATUR CO. MEM	ORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS			Period: From 01/01/2014 To 12/31/2014		
			le XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col . 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col . 2)			
	col. 26)					
	1. 00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS		,	,			
50. 00 05000 OPERATING ROOM	179, 533					
52. 00 05200 DELIVERY ROOM & LABOR ROOM	57, 199				20, 801	
53. 00 05300 ANESTHESI OLOGY	4, 786		1			
54. 00 05400 RADI OLOGY-DI AGNOSTI C	180, 186					
55. 00 03630 ULTRA SOUND	5, 572				34	55.00
60. 00 06000 LABORATORY	104, 652				0	60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	2, 232					62.00
65. 00 06500 RESPIRATORY THERAPY	32, 450					
66. 00 06600 PHYSI CAL THERAPY	59, 832				2, 048	
67. 00 06700 OCCUPATI ONAL THERAPY	20, 912					
68. 00 06800 SPEECH PATHOLOGY	16, 482				52	
69. 00 06900 ELECTROCARDI OLOGY	44, 458				254	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	78, 737		1		2, 360	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	426				0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	129, 920	11, 699, 696	0. 01110	5 234, 455	2, 604	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	46, 216				0	90.00
90. 01 09001 0NCOLOGY	35, 221				ı	90. 01
90. 02 09002 OUTPATIENT CLINIC	93, 065		1		0	90. 02
90. 03 09003 PROVI DER BASED CLINIC - TCMP	202, 181					
90. 04 09004 PROVI DER BASED CLINIC - DCPC	144, 023					
90. 05 09005 PROVIDER BASED CLINIC - WESTPORT	18, 982				0	90.05
90. 06 09006 CLI NI C	47, 046				8	90.06
90. 07 09007 WOMEN' S HEALTH SERVICES	61, 593				15, 177	90.07
91. 00 09100 EMERGENCY	138, 058				657	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	110, 997	1, 233, 200	0. 09000	7 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						05 00
95. 00 09500 AMBULANCE SERVICES 200. 00 Total (Lines 50-199)	1, 814, 759	82, 823, 629		1, 438, 010	74 224	95. 00 200. 00
200.00 Total (Titles 50-177)	1,014,739	02,023,029	T	1, 430, 010	10,320	₁ 200.00

Health Financial Systems D	ECATUR CO. MEM	ORIAL HOSPITAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS	STS Provi der		Peri od:	Worksheet D	
				From 01/01/2014 To 12/31/2014		epared:
					5/22/2015 1:3	
			le XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng	Allied Health		Swi ng-Bed	Total Costs	
	School	Cost	Medi cal	Adjustment	(sum of cols.	
			Educati on	Amount (see	1 through 3,	
			Cost	instructions)	minus col. 4)	
	1. 00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0		0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		0	0	31.00
43. 00 04300 NURSERY	0	0		o	0	43.00
200.00 Total (lines 30-199)	0	0		0	0	200.00
Cost Center Description	Total Patient	Per Diem	Inpati ent	Inpatient		
· ·	Days	(col. 5 ÷	Program Days	Program		
		col. 6)		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 & PEDIATRICS	4, 508	0.00	28	2 0		30.00
31.00 03100 INTENSIVE CARE UNIT	113	0.00		2 0		31.00
43. 00 04300 NURSERY	342	•		ol o		43.00
200.00 Total (lines 30-199)	4, 963	•	28	4 0		200.00
	•		•	•		

Health Financial Systems	DECATUR CO. MEMORIAI	HOSPI TAL	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 151332	Peri od:	Worksheet D
THROUGH COSTS			From 01/01/2014	

			T	12/31/2014	Date/Time Pre 5/22/2015 1:3	
		Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Allied Health	All Other	Total Cost	
	Anesthetist	School		Medi cal	(sum of col 1	
	Cost			Educati on	through col.	
				Cost	4)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS			_	_1		
50.00 05000 OPERATING ROOM	0	0	0	0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	
53. 00 05300 ANESTHESI OLOGY	0	0	0	0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	54.00
55. 00 03630 ULTRA SOUND	0	0	0	0	0	55.00
60. 00 06000 LABORATORY	0	0	0	0	0	60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65. 00 06500 RESPI RATORY THERAPY	0	0	0	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	0	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	0	0	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73. 00 O7300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS				ما		
90. 00 09000 CLI NI C	0	0	0	0	0	70.00
90. 01 09001 0NCOLOGY	0	0	0	0	0	90. 01
90. 02 09002 0UTPATI ENT CLI NI C	0	0	0	0	0	90. 02
90. 03 09003 PROVI DER BASED CLINIC - TCMP	0	0	0	0	0	90. 03
90. 04 09004 PROVI DER BASED CLINIC - DCPC	0	0	0	0	0	90.04
90. 05 09005 PROVI DER BASED CLINIC - WESTPORT	0	0	0	0	0	90.05
90. 06 09006 CLINIC	0	0	0	0	0	90.06
90. 07 09007 WOMEN'S HEALTH SERVICES	0	0	0	0	0	90.07
91. 00 09100 EMERGENCY	0	0	0	0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						05 00
95. 00 09500 AMBULANCE SERVI CES		0	_		^	95.00
200.00 Total (lines 50-199)	0	0	0	0	U	200.00

Health Financial Systems	D	DECATUR CO.	MEMORI AL	HOSPI TAL	In Lieu	ı of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCI LLARY SEF	RVICE OTHER	PASS	Provi der CCN: 151332		Worksheet D
THROUGH COSTS					From 01/01/2014	Part IV Date/Time Prenared:

TIMOOGIT COSTS				Го 12/31/2014	Date/Time Prepared: 5/22/2015 1:38 pm	
		Ti	tle XIX	Hospi tal	PPS	
Cost Center Description	Total		Ratio of Cost		I npati ent	
	Outpati ent	(from Wkst.	to Charges	Ratio of Cost	Program	
	Cost (sum of	C, Part I,	(col. 5 ÷	to Charges	Charges	
	col. 2, 3 and	col. 8)	col. 7)	(col. 6 ÷		
	4)			col. 7)		
	6. 00	7. 00	8. 00	9. 00	10. 00	
ANCILLARY SERVICE COST CENTERS	1 -		.1			
50. 00 05000 OPERATI NG ROOM	0	7, 038, 16			199, 678	1
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0	508, 58			184, 951	52.00
53. 00 05300 ANESTHESI OLOGY	0	390, 12			159, 578	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	18, 749, 06			52, 618	1
55. 00 03630 ULTRA SOUND	0	2, 320, 74			14, 191	
60. 00 06000 LABORATORY	0	15, 001, 50			0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	506, 37			165, 646	1
65. 00 06500 RESPI RATORY THERAPY	0	2, 254, 62			10, 698	
66. 00 06600 PHYSI CAL THERAPY	0	1, 939, 75	1		66, 412	
67. 00 06700 OCCUPATI ONAL THERAPY	0	643, 34			2, 258	
68. 00 06800 SPEECH PATHOLOGY	0	515, 93	1		1, 616	1
69. 00 06900 ELECTROCARDI OLOGY	0	2, 915, 65			16, 629	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	3, 850, 77	1		115, 402	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	26, 78			0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	11, 699, 69	6 0. 000000	0. 000000	234, 455	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	339, 03			0	90.00
90. 01 09001 0NCOLOGY	0	397, 81			0	90. 01
90. 02 09002 OUTPATIENT CLINIC	0	417, 20			0	90. 02
90. 03 09003 PROVI DER BASED CLINIC - TCMP	0	1, 260, 96			67, 606	1
90. 04 09004 PROVI DER BASED CLINIC - DCPC	0	1, 002, 15			90, 296	
90. 05 09005 PROVI DER BASED CLINIC - WESTPORT	0	123, 06	1		0	90. 05
90. 06 09006 CLI NI C	0	2, 102, 78			379	90.06
90. 07 09007 WOMEN'S HEALTH SERVICES	0	80, 68			19, 882	
91. 00 09100 EMERGENCY	0	7, 505, 59				
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1, 233, 20	0. 000000	0. 000000	0	92.00
OTHER REIMBURSABLE COST CENTERS				1		
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	0	82, 823, 62	9		1, 438, 010	200.00

Health Financial Systems

DECATUR CO. MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 151332
From 01/01/2014
To 12/31/2014
Part IV
Date/Time Prepared:
5/22/2015 1: 38 pm

				5/22/2015 1:3	38 pm	
		Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	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	C	0			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	(0			52.00
53. 00 05300 ANESTHESI OLOGY	0	C	0			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	(0			54.00
55.00 03630 ULTRA SOUND	o	(o o			55.00
60. 00 06000 LABORATORY	o	(o o			60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	o	C	ol o			62.00
65. 00 06500 RESPIRATORY THERAPY	0	C	ol o			65.00
66. 00 06600 PHYSI CAL THERAPY	0	C	ol o			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	C	ol o			67.00
68. 00 06800 SPEECH PATHOLOGY	0	C	ol o			68. 00
69. 00 06900 ELECTROCARDI OLOGY	o	C	ol o			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	C	ol o			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	o	C	ol o			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	o	C				73.00
OUTPATIENT SERVICE COST CENTERS				•		
90. 00 09000 CLINIC	0	(0			90.00
90. 01 09001 0NCOLOGY	o	C	ol o			90. 01
90. 02 09002 OUTPATIENT CLINIC	o	C	ol o			90. 02
90. 03 09003 PROVIDER BASED CLINIC - TCMP	o	C	ol o			90. 03
90. 04 09004 PROVIDER BASED CLINIC - DCPC	o	C	ol o			90. 04
90.05 09005 PROVIDER BASED CLINIC - WESTPORT	o	C	ol o			90. 05
90. 06 09006 CLINIC	o	C				90.06
90.07 09007 WOMEN'S HEALTH SERVICES	o	C				90. 07
91. 00 09100 EMERGENCY	o	C				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	o	C				92.00
OTHER REIMBURSABLE COST CENTERS			-			1
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	0	C	0			200.00

From 01/01/2014 Part V 12/31/2014 Date/Time Prepared: 5/22/2015 1:38 pm Title XIX Hospi tal PPS Charges Costs PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, inst.) Subject To Subject To Ded. & Coins. Part I, col. Ded. & Coins. 9 (see inst.) (see inst.) 1.00 2.00 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 0. 373763 326, 050 05200 DELIVERY ROOM & LABOR ROOM 12, 236 0 52.00 52.00 0.646560 0 0 53. 00 | 05300 | ANESTHESI OLOGY 0.822263 0 46, 498 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.166158 0 685, 122 0 0 0 0 0 0 0 0 54.00 55.00 03630 ULTRA SOUND 0.089219 0 146, 209 0 55.00 06000 LABORATORY 0. 185029 479, 797 60. nn 0 0 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62.00 0. 245717 0 6, 118 0 62.00 65.00 06500 RESPIRATORY THERAPY 0.547504 33, 169 0 65.00 06600 PHYSI CAL THERAPY 0. 525425 0 68, 011 0 66.00 66.00 06700 OCCUPATI ONAL THERAPY 0. 569727 0 28, 336 67.00 67.00 0 68.00 06800 SPEECH PATHOLOGY 0.642791 0 63, 117 0 68.00 06900 ELECTROCARDI OLOGY 0 119, 821 0 69.00 0.143316 0 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.800929 0 108, 197 71.00 71 00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 1. 128622 0 Ω 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.418367 0 205, 421 0 0 73.00 OUTPATIENT SERVICE COST CENTERS 0 90.00 0 90.00 2. 462688 n 09000 CLI NI C 11, 101 09001 ONCOLOGY 90.01 1.392871 0 2, 175 0 90.01 0 09002 OUTPATIENT CLINIC 0. 731018 80, 630 0 90.02 90.02 90.03 09003 PROVIDER BASED CLINIC - TCMP 1. 285867 0 7,015 0 0 0 90.03 09004 PROVIDER BASED CLINIC - DCPC 90 04 0.802976 0 90.04 5,604 0 90.05 09005 PROVIDER BASED CLINIC - WESTPORT 1.581058 0 0 90.05 09006 CLI NI C 0.385999 0 15, 285 0 90.06 90.06 0 09007 WOMEN'S HEALTH SERVICES 90.07 3. 532205 0 3, 480 90.07 0 91.00 09100 EMERGENCY 0 899, 877 91.00 0.353918 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1.094358 0 0 0 92.00 OTHER REIMBURSABLE COST CENTERS 95 00 09500 AMBULANCE SERVICES 95 00 0.636721 Ω 92, 599 200.00 Subtotal (see instructions) C 3, 445, 868 0 0 200.00 201.00 Less PBP Clinic Lab. Services-Program 0 201.00

O

3, 445, 868

0 202.00

0

Only Charges

Net Charges (line 200 +/- line 201)

202.00

					5/22/2015 1:38 pm
		Ti t	le XIX	Hospi tal	PPS
	Cos	sts			
Cost Center Description	Cost	Cost			
· ·	Rei mbursed	Rei mbursed			
	Servi ces	Services 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	121, 865	0			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	7, 911	0			52.00
53. 00 05300 ANESTHESI OLOGY	38, 234	0			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	113, 839				54.00
55. 00 03630 ULTRA SOUND	13, 045				55. 00
60. 00 06000 LABORATORY	88, 776				60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	1, 503				62.00
65. 00 06500 RESPIRATORY THERAPY	18, 160				65. 00
66. 00 06600 PHYSI CAL THERAPY	35, 735				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	16, 144				67.00
68. 00 06800 SPEECH PATHOLOGY	40, 571	0			68.00
69. 00 06900 ELECTROCARDI OLOGY	17, 172	1			69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	86, 658				71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	00,030	1			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	85, 941	0			73.00
OUTPATIENT SERVICE COST CENTERS	03, 741	0			73.00
90. 00 09000 CLI NI C	27, 338	0			90.00
90. 01 09001 0NCOLOGY	3, 029				90.00
90. 02 09002 0UTPATIENT CLINIC	58, 942				90.02
90. 03 09003 PROVI DER BASED CLINIC - TCMP					90.02
90. 04 09004 PROVI DER BASED CLINIC - TCMP	9, 020				90.03
	4, 500	0			
90. 05 09005 PROVI DER BASED CLINIC - WESTPORT	F 000	0			90.05
90. 06 09006 CLI NI C	5, 900				90.06
90. 07 09007 WOMEN'S HEALTH SERVICES	12, 292	0			90.07
91. 00 09100 EMERGENCY	318, 483				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0			92.00
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVI CES	58, 960				95. 00
200.00 Subtotal (see instructions)	1, 184, 018	0			200. 00
201.00 Less PBP Clinic Lab. Services-Program	0				201. 00
Only Charges					
202.00 Net Charges (line 200 +/- line 201)	1, 184, 018	0			202.00

Health Financial Systems	DECATUR CO.	MEMORI AL	. HOSPI TAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 151332	Peri od: From 01/01/2014	Worksheet D-1	
					Date/Time Pre 5/22/2015 1:3	
			Title XVIII	Hospi tal	Cost	
Cost Center Description						

Dept 1 ALL PROPOSED RECOVERNISTS 1.00 Impation days (including private room days and sating-bed days, excluding neutorn) Impation days (including private room days, excluding sating-bed and neotorn days) On private room days (excluding sating-bed and observation bed days) On private room days (excluding sating-bed and observation bed days) On not complete this line. O			Title XVIII	Hospi tal	5/22/2015 1: 3 Cost	8 piii				
INPATE ILL MAY INPATE ILL		Cost Center Description								
IMPARTIANT DAYS 1.00 Impatient days (including private room days and saling-bed days, excluding neoborn) 4.936 1.00 Impatient days (including private room days, excluding saling-bed and memborn days) 3.00		DADT I ALL DDOVI DED COMPONENTS			1. 00					
Impattent days (including private room days and swing-bed days, excluding newborn) 4,936 1,00 2,00 Private room days, (excluding saring-bed and bridge swing-bed and newborn days) 4,508 2,00										
Private room days (excluding swing-bed and observation bed days) 1	1.00		excluding newborn)		4, 936	1.00				
do not complete this line. 4. 05 Semi-private room days (excluding swing-bed and observation bed days) 1. 00 Total swing-bed SW type inpatient days (including private room days) after December 31 of the cost 274 5.00 reporting period (if calendar year, enter 0 on this line) 7. 00 Total swing-bed SW type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 8. 00 Total swing-bed W type inpatient days (including private room days) after December 31 of the cost 154 7.00 reporting period (if calendar year, enter 0 on this line) 8. 00 Total swing-bed W type inpatient days (including private room days) after December 31 of the cost 154 7.00 reporting period (if calendar year, enter 0 on this line) 9. 00 Total Inpatient days including private room days, applicable to the Program (excluding swing-bed and newbord days) 10. 00 Sking-bed SW type inpatient days applicable to title XVIII only (including private room days) 11. 00 Sking-bed SW type inpatient days applicable to title XVIII only (including private room days) 12. 00 Sking-bed SW type inpatient days applicable to title XVIII only (including private room days) 13. 00 Sking-bed SW type inpatient days applicable to title XVIII only (including private room days) 14. 00 Sking-bed SW type inpatient days applicable to title XVIII only (including private room days) 15. 00 Sking-bed SW type inpatient days applicable to title XVIII only (including private room days) 16. 00 Sking-bed SW type inpatient days applicable to title XVIII only (including private room days) 17. 00 Sking-bed SW type inpatient days applicable to title XVIII only (including private room days) 18. 00 Sking-bed SW type inpatient days applicable to title XVIII only (including private room days) 18. 00 Total converse type type the title XVIII only (including private room days) 18. 00 Sking-bed SW type inpatient days applicable to title XVIII only (including private room days) 18. 00 Name Seman Sw type inpatien		Inpatient days (including private room days, excluding swing-bed and newborn days)								
3.371 4.00	3. 00									
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost of Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.01 Total inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10.02 SN inpatient days including private room days applicable to the Program (excluding swing-bed and newtorn days) 11.03 SN inpatient days applicable to this XVIII only (including private room days) 12.00 SN inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 SN inpatient days applicable to titles V or XIX only (including private room days) 13.00 SN inpatient days applicable to titles V or XIX only (including private room days) 14.00 Total nursery days (title V or XIX only) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (including private room days) 18.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (including private room days) 18.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (including private room days) 18.00 SNF	4 00	· ·	days)		3 371	4 00				
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total swing-bed 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-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days) Total inpatient days including private room days apricable to the Program (excluding swing-bed and 1, 603 9.00 No. Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) Total through December 31 of the cost reporting period (see Instructions) Total SNF type inpatient days applicable to title XVIII only (including private room days) Total SNF type inpatient days applicable to thit see the cost reporting period (see Instructions) Total SNF type inpatient days applicable to titles V or XIX only (including private room days) Total SNF type inpatient days applicable to titles V or XIX only (including private room days) Total SNF type inpatient days applicable to titles V or XIX only (including private room days) Total SNF type inpatient days applicable to the regram (excluding swing-bed days) Total SNF type inpatient days applicable to the Program (excluding swing-bed days) Total SNF type inpatient days applicable to the Program (excluding swing-bed days) Total SNF type inpatient days applicable to the Program (excluding swing-bed days) Total SNF type inpatient days applicable to services through December 31 of the cost reporting period Total SNF type services applicable to services through December 31 of the cost reporting period Total SNF type services applicable to services after December 31 of the cost reporting period (line 1) Total SNF type services after December 31 of the cost reporting period (line 2) Total gene				er 31 of the cost						
reporting period (if calendar year, enter 0 on this line) 7.00 Total sawing-bod NF type inpatient days (including private room days) through December 31 of the cost reporting period 8.00 Total sawing-bod NF type inpatient days (including private room days) after December 31 of the cost of the cost reporting period (if calendar year, enter 0 on this line) 9.00 Total inpapered (if calendar year, enter 0 on this line) 10.00 Swing-bod SNF type inpatient days applicable to the Program (excluding swing-bod and newborn days) 11.00 Swing-bod SNF type inpatient days applicable to III EXVIII only (including private room days) after 0 page-bod SNF type inpatient days applicable to III EXVIII only (including private room days) 11.00 Swing-bod SNF type inpatient days applicable to III EXVIII only (including private room days) 12.00 Swing-bod SNF type inpatient days applicable to III EXVIII only (including private room days) 13.00 Swing-bod SNF type inpatient days applicable to III EXVIII only (including private room days) 14.00 Modically necessary private room days applicable to III ties V or XIX only (including private room days) 15.00 Total nursery days (III te V or XIX only) 16.00 Noursery days (III te V or XIX only) 17.00 Modically necessary private room days applicable to Titles V or XIX only (including private room days) 18.00 Modically necessary private room days applicable to Titles V or XIX only (including private room days) 18.00 Modical or neter for swing-bod SNF services applicable to Services through December 31 of the cost 19.00 Modical or neter for swing-bod SNF services applicable to services after December 31 of the cost 19.00 Modicare rate for swing-bod SNF services applicable to services after December 31 of the cost 19.00 Modicare rate for swing-bod SNF services applicable to services after December 31 of the cost 19.00 Modicare rate for swing-bod SNF services applicable to services after December 31 of the cost reporting period (III ne SNF year) 19.00 Modicare rate for swing-bod SNF services after Decem										
Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and 1,693 9.00 1,000	6. 00		days) after December	31 of the cost	0	6. 00				
reporting period 8. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 10. 00 Swing-bed SWI type inpatient days applicable to title XVIII only (including private room days) 274 10. 00 Swing-bed SWI type inpatient days applicable to title XVIII only (including private room days) after 0 11.00 December 31 of the cost reporting period (see instructions) 284 10. 00 Swing-bed SWI type inpatient days applicable to title XVIII only (including private room days) after 0 11.00 December 31 of the cost reporting period (including private room days) after 0 11.00 Swing-bed SWI type inpatient days applicable to titles V or XIX only (including private room days) 0 12.00 through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 18. 00 Swing-bed SWI type inpatient days applicable to titles V or XIX only (including private room days) 0 13.00 Swing-bed SWI type inpatient days applicable to titles V or XIX only (including private room days) 0 13.00 Swing-bed SWI type inpatient days applicable to the Program (excluding swing-bed days) 0 13.00 SWING-BWI SWING (if I was applicable to the Program (excluding swing-bed days) 0 15.00 Total nursery days (title V or XIX only) 0 15.00 Total nursery days (title V or XIX only) 0 15.00 Total nursery days (title V or XIX only) 0 15.00 Total nursery days (title V or XIX only) 0 15.00 Total nursery days (title V or XIX only) 0 15.00 Total nursery days (title V or XIX only) 0 15.00 Total nursery days (title V or XIX only) 0 15.00 Total nursery days (title V or XIX only) 0 15.00 Total nursery days (title V or XIX only) 0 15.00 Total nursery days (title V or XIX only) 0 15.00 Total nursery days (title V or XIX only) 0 15.00 Total nursery days (title V or XIX only) 0 15.00 Total nursery days (title V or XIX only) 0 15.00 Total nursery da	7 00		days) through December	31 of the cost	154	7 00				
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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) 27.00 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) 30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 30.00 Average private room per diem charge (line 29 ÷ line 3) 30.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 30.00 Average per diem private room cost differential (line 32 x line 31) 30.00 Private room cost differential adjustment (line 3 x line 35) 31.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 350, 757) 32.00 Average per diem private room cost differential (line 3 x line 31) 33.00 Average per diem private room cost differential (line 3 x line 35) 34.00 Private room cost differential adjustment (line 3 x line 35) 35.00 Average neral inpatient routine service cost per diem (see instructions) 36.00 Private room cost differential cost before PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 20.00 Average general inpatient routine service cost (line 9 x line 38) 20.00 Average per diem provente room cost applicable to the Program (line 14 x line 35) 40.00 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)	24.00] 3	31 of the cost reporti	ng period (line	19, 888	24.00				
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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) 30. 00 Semi-private room charges (excluding swing-bed charges) 30. 00 General inpatient routine service cost/charge ratio (line 27 + line 28) 30. 00 Average private room per diem charge (line 29 + line 3) 30. 00 Average semi-private room per diem charge (line 30 + line 4) 30. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 30. 00 Average per diem private room cost differential (line 34 x line 31) 30. 00 Average per diem private room cost differential (line 34 x line 31) 30. 00 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 differential (line 3 x line 35) 30. 00 Average per diem private room				, , , ,						
PRI VATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) 9. 00 Pri vate 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 5, 350, 757) 38. 00 Ajusted general inpatient routine service cost per diem (see instructions) 39. 00 Program general inpatient routine service cost (line 9 x line 38) 1, 186. 95 2, 009, 506 39. 00 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 28. 00 28. 00 29. 00 20. 0		,	ino 21 minuo lino 24)							
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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 5, 350, 757) 37.00 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) 0.00 000 32.00 31.00 000 32.00 32.00 000 33.00 34.00 35.00 35.00 36.00 37.00 0	29. 00	Private room charges (excluding swing-bed charges)								
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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 5, 350, 757) 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) 79.00 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) 38.00 Average per diem private room charge differential (line 33 x line 31) 38.00 Average per diem private room cost differential (line 5, 350, 757) 38.00 Average per diem private room cost differential (line 34 x line 31) 38.00 Average per diem private room cost differential (line 34 x line 31) 39.00 Average per diem private room cost differential (line 34 x line 31) 39.00 Average per diem private room cost differential (line 34 x line 31) 39.00 Average per diem private room cost differential (line 34 x line 31) 39.00 Average per diem private room cost differential (line 34 x line 31) 39.00 Average per diem private room cost differential (line 34 x line 31) 39.00 Average per diem private room cost differential (line 34 x line 31) 39.00 Average per diem private room cost differential (line 34 x line 31) 39.00 Average per diem private room cost differential (line 34 x line 31) 39.00 Average per diem private room cost differential (line 34 x line 31) 39.00 Average per diem private room cost differential (line 34 x line 31) 39.00 Average per diem private room cost differential (line 34 x line 31) 39.00 Average per diem private room cost differential (line 34 x line 31) 39.00 Average per diem private roo		, ,	11 ne 28)							
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 5, 350, 757) 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) 0 .00 35.00 36.00 37.00										
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 5, 350, 757) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 36.00 37.00 37.00 38.00 38.00 40.00		Average per diem private room charge differential (line 32 minu	s line 33)(see instrud	ctions)						
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 37.00 2, 350, 757 37.00		,	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, 186. 95 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 40.00		, , , , , , , , , , , , , , , , , , , ,	d nrivate room cost di	fferential (line						
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) 1,186.95 38.00 Program general inpatient routine service cost (line 9 x line 38) 2,009,506 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	57.00		a private room cost ur		3,330,737	37.00				
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,186.95 39.00 Program general inpatient routine service cost (line 9 x line 38) 2,009,506 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 38.00 40.00		PART II - HOSPITAL AND SUBPROVIDERS ONLY								
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) 2,009,506 39.00 40.00	20.00				4 407 5=	20.00				
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			,							
		,	*							
	41.00	, , , , , , , , , , , , , , , , , , , ,	,		2, 009, 506					

COMPUT	Financial Systems DI FATION OF INPATIENT OPERATING COST	ECATUR CO. MEMO			Peri od:	u of Form CMS-2 Worksheet D-1	
					From 01/01/2014 To 12/31/2014	Date/Time Pre 5/22/2015 1:3	
			Ti tl	e XVIII	Hospi tal	Cost	о рііі
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1. 00	2.00	3.00	4. 00	5. 00	
42.00		0	C	0.0	0 0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43. 00 44. 00		612, 270	113	5, 418. 3	2 80	433, 466	43.00
45.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						45.00
	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description						
48. 00	Program inpatient ancillary service cost (Wk	ct D 2 col 1	2 line 200)			1. 00 2, 102, 818	48.00
49. 00	,			ons)		4, 545, 790	
17.00	PASS THROUGH COST ADJUSTMENTS	Tr thi ough 10)	(See Thistracti	0113)		1,010,770	17.00
50.00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sur	m of Parts I and	0	50.00
						_	
51. 00	Pass through costs applicable to Program inpland IV)	atient ancilla	ry services (f	rom Wkst. D, s	sum of Parts II	0	51.00
52. 00	Total Program excludable cost (sum of lines	50 and 51)				0	52.00
53.00	Total Program inpatient operating cost exclu		elated, non-ph	ysician anesth	netist, and	0	
	medical education costs (line 49 minus line	52)		-]
F4 00	TARGET AMOUNT AND LIMIT COMPUTATION					0] 54. 00
55. 00	Program discharges Target amount per discharge						55.00
56.00						0.00	1
57.00	Difference between adjusted inpatient operat	0	57.00				
58.00	1 7 1	0					
59. 00	Lesser of lines 53/54 or 55 from the cost re market basket	porting period	endi ng 1996,	updated and co	ompounded by the	0.00	59.00
60.00		cost report. u	odated by the	market basket		0.00	60.00
61.00	If line 53/54 is less than the lower of line				the amount by	0	1
	which operating costs (line 53) are less tha		ts (lines 54 x	60), or 1% of	f the target		
42.00	amount (line 56), otherwise enter zero (see	instructions)				0	42.00
	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instr	ictions)			0	
00.00	PROGRAM INPATIENT ROUTINE SWING BED COST	(300 1113111	4011 0113)			0	00.00
64.00	Medicare swing-bed SNF inpatient routine cos	ts through Dec	ember 31 of th	e cost reporti	ng period (See	325, 224	64.00
(instructions)(title XVIII only)	+£+ D	21 -6 +1			0	/ - 00
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after becemi	per 31 of the	cost reportino	g period (See	0	65.00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVII	I only). For	325, 224	66.00
	CAH (see instructions)						
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	n December 31	of the cost re	eporting period	0	67.00
68 00	Title V or XIX swing-bed NF inpatient routin	e costs after l	December 31 of	the cost ren	orting period	0	68.00
00.00	(line 13 x line 20)		3000	:o ooo: . op.	s. c.r.ig por rou	· ·	
69. 00	Total title V or XIX swing-bed NF inpatient					0	69.00
70.00	PART III - SKILLED NURSING FACILITY, OTHER N						70.00
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c	,		•			70.00
72. 00	Program routine service cost (line 9 x line		70 . 11116	-,			72.00
73.00	Medically necessary private room cost applic	abĺe to Program					73.00
74.00	Total Program general inpatient routine serv	•			Don't II - I		74.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	e cosis (Trom	worksneet B, F	art II, COIUMN		75.00
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76.00
77. 00	Program capital-related costs (line 9 x line	76)					77.00
78.00	1 .	,	ama, d el	da)			78.00
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp	, ,		*.	nus line 70)		79.00
81. 00	Inpatient routine service costs for comp			(11110-70-11111	143 TTHE 77)		81.0
82. 00	1 .		1)				82.0
83. 00	Reasonable inpatient routine service costs (ns)				83.0
84.00	Program inpatient ancillary services (see in		anc)				84.0
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum	•					85. 00 86. 00
50.00	PART IV - COMPUTATION OF OBSERVATION BED PASS		ii Jugii UJ)				1 55.00
87. 00	Total observation bed days (see instructions)				1, 137	
	Individual deporal inputions routing cost per	diem (line 27 .	: line 2)			1, 186. 95	I 88 00
88. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	•	,			1, 349, 562	1

Health Financial Systems D	ECATUR CO.	MEMORI A	L HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST			Provi der	CCN: 151332	Peri od:	Worksheet D-1	
					From 01/01/2014 To 12/31/2014	Date/Time Pre 5/22/2015 1:3	pared: 8 pm
			Ti tl	e XVIII	Hospi tal	Cost	
Cost Center Description	Cost		utine Cost	column 1 ÷	Total	Observation	
		(1	from line	column 2	Observation	Bed Pass	
			27)		Bed Cost	Through Cost	
					(from line	(col. 3 x	
					89)	col. 4) (see	
						instructions)	
	1. 00		2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST						
90.00 Capital -related cost	440,	085	5, 350, 757	0. 08224	7 1, 349, 562	110, 997	90.00
91.00 Nursing School cost		0	5, 350, 757	0.00000	1, 349, 562	0	91.00
92.00 Allied health cost		0	5, 350, 757	0. 00000	1, 349, 562	0	92.00
93.00 All other Medical Education		o	5, 350, 757	0. 00000	1, 349, 562	0	93. 00

Health Financial Systems	DECATUR C	O. MEMOR	RLAL	HOSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF INPATIENT OPERATING COST			1	Provi der C	CCN: 151332	Peri od: From 01/01/2014	Worksheet D-1	
						To 12/31/2014	Date/Time Pre 5/22/2015 1:3	pared: 8 pm
				Title	e XIX	Hospi tal	PPS	
Cost Center Description								
							1. 00	
PART I - ALL PROVIDER COMPONENTS								

		Title XIX	Hospi tal	PPS	
	Cost Center Description		-	1 00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,	excluding newborn)		4, 936	1.00
2.00	Inpatient days (including private room days, excluding swing-be			4, 508	2.00
3.00	Private room days (excluding swing-bed and observation bed days	s). If you have only pr	rivate room days,	0	3.00
4 00	do not complete this line.	d days)		2 271	4 00
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation bed Total swing-bed SNF type inpatient days (including private room		or 31 of the cost	3, 371 0	4. 00 5. 00
3.00	reporting period	adys) through become		O	3.00
6.00	Total swing-bed SNF type inpatient days (including private roor	m days) after December	31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line)				
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	days) through December	31 of the cost	154	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room	days) after December 3	R1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	aayo, a. to. Becomber e		Ü	0.00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	g swing-bed and	282	9. 00
10.00	newborn days)	v (including private r	soom dovo)	0	10.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl through December 31 of the cost reporting period (see instructi		oolii days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl		room days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, en				
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	te room days)	0	12. 00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	te room days)	0	13. 00
13.00	after December 31 of the cost reporting period (if calendar year			O	13.00
14.00	Medically necessary private room days applicable to the Program			0	14.00
15. 00	Total nursery days (title V or XIX only)			342	
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	s through December 31 o	of the cost		17. 00
	reporting period	o in ough becomes of			.,, 00
18. 00	Medicare rate for swing-bed SNF services applicable to services	s after December 31 of	the cost		18. 00
10.00	reporting period	+h		0.00	10.00
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	Medicaid rate for swing-bed NF services applicable to services	after December 31 of 1	the cost	0.00	20. 00
	reporting period				
21. 00	Total general inpatient routine service cost (see instructions)			5, 695, 869	
22. 00	Swing-bed cost applicable to SNF type services through December 5×1 line 17)	1 31 of the cost report	ting period (line	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December 3	31 of the cost reportir	na period (line 6	0	23. 00
	x line 18)		.9	_	
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24.00
25 00	7 x line 19) Swing-bed cost applicable to NF type services after December 3	l of the cost respective	r ported (line O	0	25. 00
25. 00	x line 20)	i or the cost reporting	j period (iine 8	U	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 (ine 21 minus line 26)		5, 695, 869	27.00
00.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT	and above all and a ball at			00.00
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	and observation bed cr	narges)	0	
30. 00	Semi -pri vate room charges (excluding swing-bed charges)			0	
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	32.00
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		ctions)	0.00	
35. 00 36. 00	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)	9 31)		0.00	35. 00 36. 00
37. 00	General inpatient routine service cost net of swing-bed cost ar	nd private room cost di	fferential (line	5, 695, 869	37.00
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	THELTO			
20 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS			1 2/2 50	20 00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see i Program general inpatient routine service cost (line 9 x line 3			1, 263. 50 356, 307	
40. 00	Medically necessary private room cost applicable to the Program	•		0	40.00
	Total Program general inpatient routine service cost (line 39			356, 307	

7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	154	7. 00
	reporting period		
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line)	282	9. 00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	202	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
10.00	through December 31 of the cost reporting period (see instructions)	Ĭ	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
	through December 31 of the cost reporting period		
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
	Total nursery days (title V or XIX only)		15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost		17. 00
10.00	reporting period		10.00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost		18. 00
19. 00	reporting period	0.00	19. 00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20. 00	Medicald rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20.00
20.00	reporting period	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions)	5, 695, 869	21.00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line		22. 00
	5 x line 17)		
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23.00
	x 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)	_	
	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)	5, 695, 869	27.00
20.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	0	20.00
	General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges)	0	28. 00 29. 00
	Semi - pri vate room charges (excluding swing-bed charges)	0	30.00
	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	
	Average private room per diem charge (line 29 ÷ line 3)		32.00
	Average semi-private room per diem charge (line 30 ÷ line 4)		33.00
	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		34.00
	Average per diem private room cost differential (line 34 x line 31)	0.00	
	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	5, 695, 869	37.00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
	Adjusted general inpatient routine service cost per diem (see instructions)	1, 263. 50	
	Program general inpatient routine service cost (line 9 x line 38)	356, 307	
	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	356, 307	41.00

	Financial Systems D ATION OF INPATIENT OPERATING COST	ECATUR CO. MEMO			eri od:	u of Form CMS-2 Worksheet D-1		
				F	rom 01/01/2014 o 12/31/2014		pared:	
			Ti t	le XIX	Hospi tal	PPS	<u> </u>	
	Cost Center Description	Total I npati ent	Total Inpati ent	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x		
		Cost	Days	÷ col . 2)	4.00	col. 4)		
42. 00	NURSERY (title V & XIX only)	1. 00 263, 231	2.00	3. 00 769. 68	4.00	5. 00 0	42.00	
42.00	Intensive Care Type Inpatient Hospital Units		110	F 410 22	2	10.027	42.00	
43. 00 44. 00		612, 270	113	5, 418. 32	2	10, 837	43. 00 44. 00	
45.00	BURN INTENSIVE CARE UNIT						45.00	
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00	
	Cost Center Description				<u> </u>	1.00		
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	3, line 200)			1. 00 854, 568	48. 00	
49. 00	Total Program inpatient costs (sum of lines	41 through 48)	(see instructi	ons)		1, 221, 712	49. 00	
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inc	patient routine	servi ces (fro	m Wkst. D, sum	of Parts I and	27, 906	50.00	
51. 00	III) Pass through costs applicable to Program inp	nationt ancilla	rv sarvicas (f	rom Wkst D s	um of Darte II	76, 326	51.00	
	and IV)		y services (i	TOIII WKSt. D, S	um or rarts rr			
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		alated non-nh	veician angeth	atist and	104, 232 1, 117, 480		
33.00	medical education costs (line 49 minus line		eratea, non pri	ysi ci dii dilestii	etrot, and	1, 117, 400	33.00	
54 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00	
55. 00	Target amount per discharge		0. 00	55.00				
56. 00 57. 00	Target amount (line 54 x line 55)	0	56. 00 57. 00					
58. 00								
59. 00	Lesser of lines 53/54 or 55 from the cost re	eporting period	endi ng 1996,	updated and co	mpounded by the	0. 00	59. 00	
60.00	market basket Lesser of lines 53/54 or 55 from prior year	cost report, up	odated by the	market 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 that amount (line 56), otherwise enter zero (see		ts (lines 54 x	60), or 1% or	the target			
	Relief payment (see instructions) O 62. Allowable Inpatient cost plus incentive payment (see instructions) O 63.							
PROGRAM INPATIENT ROUTINE SWING BED COST								
64. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	sts through Dece	ember 31 of th	e cost reporti	ng period (See	0	64.00	
65.00	Medicare swing-bed SNF inpatient routine cos	sts after Decemb	per 31 of the	cost reporting	period (See	0	65. 00	
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVII	l only). For	0	66. 00	
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routir	ne costs through	n December 31	of the cost re	porting period	0	67.00	
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routir	ne costs after [December 31 of	the cost repo	rtina period	0	68. 00	
	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient			•	3 1	0		
	PART III - SKILLED NURSING FACILITY, OTHER N	URSING FACILITY	, AND ICF/MR	ONLY		Ü		
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of	,		•			70. 00 71. 00	
72.00	Program routine service cost (line 9 x line		THE 70 THE	2)			72.00	
73. 00 74. 00	Medically necessary private room cost applic Total Program general inpatient routine serv						73. 00 74. 00	
75.00	Capital-related cost allocated to inpatient	•		,	art II, column		75. 00	
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00	
77. 00	Program capital-related costs (line 9 x line						77.00	
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		orovi der recor	ds)			78. 00 79. 00	
80.00	Total Program routine service costs for comp		cost limitatio	n (line 78 min	us line 79)		80.00	
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (1)				81. 00 82. 00	
83.00	Reasonable inpatient routine service costs (* .				83.00	
84.00	Program inpatient ancillary services (see in		ane)				84.00	
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum	•					85. 00 86. 00	
	PART IV - COMPUTATION OF OBSERVATION BED PAS	S THROUGH COST				4 407		
87.00	Total observation bed days (see instructions	•	: line 2)			1, 137 1, 263. 50	1	
88. 00	Adjusted general inpatient routine cost per	urem (True 27 -	- IIIIC 2)			1, 200. 001		

Health Financial Systems D	ECATUR CO.	MEMORI A	L 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 Pre 5/22/2015 1:3	pared: 8 pm
			Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	Cost		utine Cost	column 1 ÷	Total	Observati on	
		(1	from line	column 2	Observati on	Bed Pass	
			27)		Bed Cost	Through Cost	
					(from line	(col. 3 x	
					89)	col. 4) (see	
						instructions)	
	1. 00		2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST						
90.00 Capital -related cost	440,	085	5, 695, 869	0. 07726	4 1, 436, 600	110, 997	90.00
91.00 Nursing School cost		0	5, 695, 869	0. 00000	0 1, 436, 600	0	91.00
92.00 Allied health cost		0	5, 695, 869	0. 00000	0 1, 436, 600	0	92.00
93.00 All other Medical Education		o	5, 695, 869	0. 00000	1, 436, 600	0	93. 00

	ancial Systems ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 151332	Peri od:	Worksheet D-3	
				From 01/01/2014	Dalla (Time Dan	
				To 12/31/2014	Date/Time Prepa 5/22/2015 1:38	
		Ti tl	e XVIII	Hospi tal	Cost	
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col. 2)	
			1.00	2. 00	3. 00	
I NPA	TIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	0.00	
30. 00 0300	OO ADULTS & PEDIATRICS			1, 876, 813		30. C
	OO INTENSIVE CARE UNIT			172, 200		31.0
	00 NURSERY					43. C
	LLARY SERVICE COST CENTERS					ļ
	OO OPERATING ROOM		0. 37376		190, 127	50.0
	DO DELIVERY ROOM & LABOR ROOM		0. 64656		0	52.0
	00 ANESTHESI OLOGY 00 RADI OLOGY-DI AGNOSTI C		0. 82226		32, 113	
	BO ULTRA SOUND		0. 16615		73, 262	1
	OO LABORATORY		0. 08921 0. 18502		7, 498 140, 399	
	00 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 16502		16, 536	
	O RESPIRATORY THERAPY		0. 54750		421, 951	1
	00 PHYSI CAL THERAPY		0. 52542		56, 429	
	00 OCCUPATI ONAL THERAPY		0. 56972		37, 433	1
	OO SPEECH PATHOLOGY		0. 64279		6, 076	1 .
9.00 0690	OO ELECTROCARDI OLOGY		0. 1433		25, 961	69.
1.00 0710	MEDICAL SUPPLIES CHARGED TO PATIENT		0. 80092	29 637, 839	510, 864	71.
2.00 0720	OO IMPL. DEV. CHARGED TO PATIENTS		1. 12862	22 35	40	72.
	DO DRUGS CHARGED TO PATIENTS		0. 41836	1, 370, 765	573, 483	73.
	PATIENT SERVICE COST CENTERS					
	OO CLI NI C		2. 46268		968	1
	ONCOLOGY		1. 39287		59	
	02 OUTPATIENT CLINIC		0. 73101		5, 492	1
	PROVIDER BASED CLINIC - TCMP		1. 28586		0	
	PROVIDER BASED CLINIC - DCPC		0.80297		0	
	D5 PROVIDER BASED CLINIC - WESTPORT		1. 58105		0	90.
	06 CLINIC 07 WOMEN'S HEALTH SERVICES		0. 38599 3. 53220		0	
4	00 EMERGENCY		0. 3539		568	
- 1	00 OBSERVATION BEDS (NON-DISTINCT PART		1. 09435		3, 559	1
	R REIMBURSABLE COST CENTERS		1.0743	JO _I 3, 232	3, 339	12.
	00 AMBULANCE SERVICES					95.
00.00	Total (sum of lines 50-94 and 96-98)			5, 054, 596	2, 102, 818	
01. 00	Less PBP Clinic Laboratory Services-F	Program only charges (line 61)		0	_,, 0.0	201.
202.00	Net Charges (line 200 minus line 201)			5, 054, 596		202.

Health Financial Systems	DECATUR CO. MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Γ	Provi der		Peri od:	Worksheet D-3	
		Component		From 01/01/2014 To 12/31/2014	Date/Time Pre 5/22/2015 1:3	
		Ti tl	e XVIII	Swing Beds - SNF		
Cost Center Description			Ratio of Cos	t Inpatient	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x	
					col . 2)	
LABORT FAIT DOUTLAND OFFICE OFFICE			1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			1	1		
30. 00 03000 ADULTS & PEDI ATRI CS				0		30.00
31. 00 03100 INTENSIVE CARE UNIT				0		31.00
43. 00 O4300 NURSERY						43.00
ANCILLARY SERVICE COST CENTERS 50. 00 O5000 OPERATING ROOM			0. 37376	1, 274	476	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM			0. 37376		476	50.00
53. 00 05300 ANESTHESI OLOGY			0. 82226		0	53.00
54. 00 05400 RADI OLOGY			0. 82228		1, 488	1
55. 00 03630 ULTRA SOUND			0. 18013		245	•
60. 00 06000 LABORATORY			0. 18502	•	5, 976	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CEL	1		0. 10502	•	0, 770	62.00
65. 00 06500 RESPIRATORY THERAPY			0. 54750		33, 949	65.00
66. 00 06600 PHYSI CAL THERAPY			0. 52542		30, 170	1
67. 00 06700 OCCUPATI ONAL THERAPY			0. 56972		18, 328	1
68. 00 06800 SPEECH PATHOLOGY			0. 64279	•	1, 134	
69. 00 06900 ELECTROCARDI OLOGY			0. 14331	6 142	20	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIEN	NT		0. 80092	2, 749	2, 202	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS			1. 12862	22 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS			0. 41836	7 112, 980	47, 267	73.00
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLI NI C			2. 46268	38 0	0	90.00
90. 01 09001 0NC0L0GY			1. 39287	14	20	90. 01
90. 02 09002 OUTPATIENT CLINIC			0. 73101	0	0	90. 02
90. 03 09003 PROVIDER BASED CLINIC - TCMP			1. 28586		0	90. 03
90. 04 09004 PROVI DER BASED CLINIC - DCPC			0. 80297		0	90. 04
90.05 09005 PROVIDER BASED CLINIC - WESTPORT			1. 58105		0	90. 05
90. 06 09006 CLI NI C			0. 38599		0	90.06
OO O7 OOOO7 WOMEN'S HEALTH SERVICES			2 52220)E	Λ.	00 07

0 0 0

314, 517

314, 517

3.532205

0. 353918

1. 094358

0

0

0

141, 275 200. 00 201. 00 202. 00

90.07

91.00

92.00

95.00

09007 WOMEN'S HEALTH SERVICES

09500 AMBULANCE SERVICES

09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS

Net Charges (line 200 minus line 201)

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

09100 EMERGENCY

90.07

91.00

92.00

95.00

200.00

201.00 202.00

Medith Financial Systems	HOCDI TAI		la li a	u of Form CMS	2552 10
Health Financial Systems DECATUR CO. MEMORIAL INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		CCN: 151332	Peri od:	u of Form CMS-2 Worksheet D-3	
THE ATTENT AND LEARLY SERVICE GOST ATTORTION MENT	TTOVIGCI	0011. 131332	From 01/01/2014		
			To 12/31/2014	5/22/2015 1: 3	
	Ti 1	tle XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col . 1 x	
		1.00	2.00	col . 2) 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS			370, 967		30.00
31. 00 03100 NTENSI VE CARE UNI T			28, 279		31.00
43. 00 04300 NURSERY			326, 521		43.00
ANCILLARY SERVICE COST CENTERS					1
50. 00 05000 OPERATING ROOM		0. 3737	53 199, 678	74, 632	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 64656	184, 951	119, 582	52.00
53. 00 05300 ANESTHESI OLOGY		0. 8222	53 159, 578	131, 215	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1661	58 52, 618	8, 743	54.00
55. 00 03630 ULTRA SOUND		0. 0892	19 14, 191	1, 266	55.00
60. 00 06000 LABORATORY		0. 1850	29 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 2457	17 165, 646	40, 702	62.00
65. 00 06500 RESPI RATORY THERAPY		0. 54750	10, 698	5, 857	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 52542		34, 895	1
67. 00 06700 OCCUPATI ONAL THERAPY		0. 56972			1
68. 00 06800 SPEECH PATHOLOGY		0. 6427	· ·	1, 039	
69. 00 06900 ELECTROCARDI OLOGY		0. 1433		2, 383	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 80092		92, 429	1
72. 00 O7200 I MPL. DEV. CHARGED TO PATI ENTS		1. 1286		0	
73. 00 O7300 DRUGS CHARGED TO PATIENTS		0. 4183	234, 455	98, 088	73.00
OUTPATIENT SERVICE COST CENTERS		2 4/2/	20 0		00 00
90. 00 09000 CLI NI C 90. 01 09001 0NCOLOGY		2. 46268 1. 3928		0	
90. 01 09001 0NCOLOGY 90. 02 09002 OUTPATIENT CLINIC		0. 7310		0	
90. 03 09003 PROVI DER BASED CLINI C - TCMP		1. 2858		· -	
90. 04 09004 PROVI DER BASED CLINI C - DCPC		0. 8029		72, 506	1
90. 05 09005 PROVI DER BASED CLINI C - WESTPORT		1. 5810		72,300	1
90. 06 09006 CLINIC WESTFORT		0. 3859		146	1
90. 07 09007 WOMEN' S HEALTH SERVICES		3. 53220		70, 227	
91. 00 09100 EMERGENCY		0. 3539		12, 640	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		1. 0943!		0	1
OTHER REI MBURSABLE COST CENTERS		11.07.10.	50, 0		72.00
95. 00 09500 AMBULANCE SERVICES					95. 00
200.00 Total (sum of lines 50-94 and 96-98)			1, 438, 010	854, 568	1
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00 Net Charges (line 200 minus line 201)	,		1, 438, 010		202.00
•					

Health Financial Systems	DECATUR CO. MEMORIA	AL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 151332	From 01/01/2014	Worksheet E Part B Date/Time Prepared: 5/22/2015 1:38 pm
		Ti +Lo VVIII	Hocni tal	Coct

			To 12/31/2014	Date/Time Pre 5/22/2015 1:3		
		Title XVIII	Hospi tal	Cost	<u> </u>	
				1. 00		
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1. 00		
1. 00	Medical and other services (see instructions)			6, 592, 716	1.00	
2.00	Medical and other services reimbursed under OPPS (see instructi	ons)		0	2.00	
3. 00 4. 00	PPS payments Outlier payment (see instructions)			0	3. 00 4. 00	
5. 00	Enter the hospital specific payment to cost ratio (see instruct	0.000	1			
6. 00	Line 2 times line 5					
7.00	Sum of line 3 plus line 4 divided by line 6			0. 00	1	
8. 00	Transitional corridor payment (see instructions)			0		
9.00	Ancillary service other pass through costs from Wkst. D, Pt. I	V, col. 13, line 200		0	9.00	
10. 00 11. 00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0 6, 592, 716	10.00 11.00	
11.00	COMPUTATION OF LESSER OF COST OR CHARGES			0, 372, 710	11.00	
	Reasonable charges					
12.00	Ancillary service charges			0	12.00	
	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, co	ol. 4)		0		
14. 00	Total reasonable charges (sum of lines 12 and 13)			0	14. 00	
15. 00	Customary charges Aggregate amount actually collected from patients liable for pa	avment for services on	a charge basis	0	15.00	
16. 00	Amounts that would have been realized from patients liable for			0		
10.00	had such payment been made in accordance with 42 CFR §413.13(e)		on a ona gozaoro	Ü	10.00	
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17. 00	
18. 00	Total customary charges (see instructions)			0		
19. 00	Excess of customary charges over reasonable cost (complete only	y if line 18 exceeds l	ine 11) (see	0	19. 00	
20. 00	instructions) Excess of reasonable cost over customary charges (complete only	vifline 11 evceeds l	ina 18) (saa	0	20.00	
20.00	instructions)	y II IIIIe II exceeds I	1116 10) (366		20.00	
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		6, 658, 643	21.00	
22. 00	Interns and residents (see instructions)			0	22. 00	
	Cost of physicians' services in a teaching hospital (see instru	uctions)		0		
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)			0	24.00	
25. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance (for CAH, see instructions)			104, 963	25.00	
26. 00	Deductibles and Coinsurance relating to amount on line 24 (for	CAH see instructions)	3, 148, 153	ł	
27. 00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) pl			3, 405, 527	1	
	CAH, see instructions)		- ,			
28. 00	Direct graduate medical education payments (from Wkst. E-4, lir	ne 50)		0	28. 00	
	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29.00	
30. 00 31. 00	Subtotal (sum of lines 27 through 29) Primary payer payments			3, 405, 527 5, 952	30. 00 31. 00	
32. 00				3, 399, 575		
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	ES)		5/ 511/ 515		
	Composite rate ESRD (from Wkst. I-5, line 11)			0	33.00	
	Allowable bad debts (see instructions)			474, 566	•	
	Adjusted reimbursable bad debts (see instructions)	inti ana)		360, 670		
36. 00 37. 00	Allowable bad debts for dual eligible beneficiaries (see instrustions)	uctions)		322, 551 3, 760, 245		
	MSP-LCC reconciliation amount from PS&R			3, 700, 243		
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0		
39. 50	Pioneer ACO demonstration payment adjustment (see instructions))		0	39. 50	
39. 98	Partial or full credits received from manufacturers for replace	ed devices (see instru	ctions)	0	39. 98	
	RECOVERY OF ACCELERATED DEPRECIATION				39. 99	
40.00	Subtotal (see instructions)			3, 760, 245 75, 205		
40. 01 41. 00						
42. 00					42.00	
43.00						
44.00					44.00	
	§115. 2					
00.00	TO BE COMPLETED BY CONTRACTOR			-	00.00	
	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0		
	The rate used to calculate the Time Value of Money			0. 00		
	Time Value of Money (see instructions)			0.00	1	
	Total (sum of lines 91 and 93)			0		

Health Financial Systems DECATURATION OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 151332 | Period: | Worksheet E-1 | From 01/01/2014 | To 12/31/2014 | Date/Time Prepared: | 5/22/2015 1:38 pm

					5/22/2015 1: 38	3 pm
			e XVIII	Hospi tal	Cost	
		Inpatier	nt Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3.00	4.00	
1. 00	Total interim payments paid to provider		3, 678, 711		4, 395, 246	1.00
2. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,		C		0	2. 00
3. 00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment					3. 00
0.00	amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					0.00
	Program to Provider					
2 01	ADJUSTMENTS TO PROVIDER	07/30/2014	57, 900		0	3. 01
3. 01	ADJUSTMENTS TO PROVIDER	07/30/2014	1			
3. 02						3. 02
3. 03 3. 04			1			3. 03
			C			
3. 05	Dravi dan ta Dragnam		<u> </u>		0	3. 05
3. 50	Provider to Program ADJUSTMENTS TO PROGRAM				0	3. 50
3. 50	ADJUSTIMENTS TO PROGRAM					3. 50
3. 52						3. 52
3. 52					0	3. 52
3. 54						3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		57, 900			3. 99
	3. 50-3. 98)					
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3, 736, 611		4, 395, 246	4. 00
	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	TENTATI VE TO PROVI DER		C		0	5. 01
5.02					0	5.02
5.03			l c		0	5.03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM		C		0	5.50
5. 51			l c		0	5. 51
5.52			c		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		C		0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		325, 982		0	6. 01
6.02	SETTLEMENT TO PROGRAM		[c		710, 206	6. 02
7.00	Total Medicare program liability (see instructions)		4, 062, 593		3, 685, 040	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8. 00	Name of Contractor					8. 00

Health Financial Systems DECATURATION OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

		<u>'</u>			5/22/2015 1: 3	8 pm
		Ti tl	e XVIII S	wing Beds - SNF	Cost	
		Inpatien	t 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 p	payments paid to provider		469, 767		0	1.00
	s payable on individual bills, either				0	2.00
	be submitted to the contractor for					
servi ces render	red in the cost reporting period. If none,					
write "NONE" or	enter a zero					
3.00 List separately	/ each retroactive lump sum adjustment					3.00
	n subsequent revision of the interim rate					
	eporting period. Also show date of each					
	ne, write "NONE" or enter a zero. (1)					
Program to Prov						ļ
3. 01 ADJUSTMENTS TO	PROVI DER		C		0	3. 01
3. 02			C		0	3. 02
3. 03			C		0	3.03
3. 04			C		0	3.04
3. 05			C		0	3.05
Provider to Pro				1		ا م در
3.50 ADJUSTMENTS TO 3.51	PRUGRAM		C		0	3. 50 3. 51
3. 52 3. 53						3. 52 3. 53
3. 54						3.54
	of lines 3.01-3.49 minus sum of lines				0	3. 99
3. 50-3. 98)	of titles 5.01-5.49 millius sum of titles				0	3.99
1	payments (sum of lines 1, 2, and 3.99)		469, 767		0	4.00
	kst. E or Wkst. E-3, line and column as		407, 707		Ĭ	7.00
appropri ate)	terr E or miter. E or rivio and ceramin de					
TO BE COMPLETED	BY CONTRACTOR			"	ļ.	ĺ
	y each tentative settlement payment after					5.00
desk review. Al	so show date of each payment. If none,					
write "NONE" or	enter a zero. (1)					
Program to Prov	i der					
5. 01 TENTATI VE TO PR	ROVI DER		C		0	5. 01
5. 02			C		0	5.02
5. 03			C		0	5.03
Provi der to Pro						
5.50 TENTATIVE TO PR	ROGRAM		C		0	5.50
5. 51			C		0	5. 51
5. 52			C		0	5. 52
5. 99 Subtotal (sum of 5. 50-5. 98)	of lines 5.01-5.49 minus sum of lines		C		0	5. 99
	settlement amount (balance due) based on					6.00
the cost report						0.00
6. 01 SETTLEMENT TO F			(0	6. 01
6. 02 SETTLEMENT TO F			11, 005		0	6. 02
	program liability (see instructions)		458, 762		Ö	
The process mean day of	p. 25. 2		1.55,762	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		()	1. 00	2.00	
8.00 Name of Contrac	ctor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Heal th	Financial Systems DECATUR CO. MEM	IORI AL HOSPI TAL	In Lie	u of Form CMS-2	2552-10
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 1.130 1.00 2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 7.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 10.00 Initial /interim HIT payment adjustment (see instructions) 10.00 Other Adjustment (specify)		CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 151332 Period: V From 01/01/2014 From 01/2014 From 12/31/2014 F			Worksheet E-1 Part II Date/Time Pre	pared:
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 1.100 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 10.00 Initial/interim HIT payment adjustment (see instructions) 0 30.00 31.00 Other Adjustment (specify)			Title XVIII	Hospi tal	Cost	
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 1.100 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 10.00 Initial/interim HIT payment adjustment (see instructions) 0 30.00 31.00 Other Adjustment (specify)						
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 2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 10.00 INPATIENT HOSPITAL SERVICES UNDER PPS & CAH 30.00 Initial/interim HIT payment adjustment (see instructions) 0 30.00 31.00 Other Adjustment (specify)					1. 00	
Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14 2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 10.00 INPATIENT HOSPITAL SERVICES UNDER PPS & CAH 30.00 Initial/interim HIT payment adjustment (see instructions) 0 30.00 31.00 Other Adjustment (specify)		TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORT	S			
2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I or 7.00 line 168 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 10.00 INPATIENT HOSPITAL SERVICES UNDER PPS & CAH 30.00 Initial / interim HIT payment adjustment (see instructions) 0 30.00 31.00 Other Adjustment (specify)		HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULAT	I ON			
3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I 0 7.00 line 168 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 1NPATIENT HOSPITAL SERVICES UNDER PPS & CAH 30.00 Initial / interim HIT payment adjustment (see instructions) 0 30.00 31.00 Other Adjustment (specify)	1.00	Total hospital discharges as defined in AARA §4102 from Wk	kst. S-3, Pt. I col. 15 line	e 14	1, 130	1.00
4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I 0 7.00 line 168 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 10.00 INPATIENT HOSPITAL SERVICES UNDER PPS & CAH 30.00 Initial/interim HIT payment adjustment (see instructions) 0 30.00 31.00 Other Adjustment (specify)	2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1	, 8-12		1, 773	2.00
5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I 0 7.00 line 168 8.00 Calculation of the HIT incentive payment (see instructions) 0 8.00 9.00 Sequestration adjustment amount (see instructions) 0 9.00 10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 10.00 INPATIENT HOSPITAL SERVICES UNDER PPS & CAH 30.00 Initial/interim HIT payment adjustment (see instructions) 0 30.00 31.00 Other Adjustment (specify)	3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			276	3.00
6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I 0 7.00 line 168 8.00 Calculation of the HIT incentive payment (see instructions) 0 8.00 Sequestration adjustment amount (see instructions) 0 9.00 Calculation of the HIT incentive payment after sequestration (see instructions) 0 10.00 INPATIENT HOSPITAL SERVICES UNDER PPS & CAH Initial/interim HIT payment adjustment (see instructions) 0 30.00 31.00 Other Adjustment (specify) 0 31.00	4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1	, 8-12		3, 484	4. 00
7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I 0 7.00 line 168 8.00 Calculation of the HIT incentive payment (see instructions) 0 8.00 9.00 Sequestration adjustment amount (see instructions) 0 9.00 10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 0 10.00 INPATIENT HOSPITAL SERVICES UNDER PPS & CAH 30.00 Initial/interim HIT payment adjustment (see instructions) 0 30.00 31.00 Other Adjustment (specify) 0 31.00	5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200)		91, 842, 572	5.00
I ine 168	6.00	Total hospital charity care charges from Wkst. S-10, col.	3 line 20		2, 738, 430	6.00
9.00 Sequestration adjustment amount (see instructions) 10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 10.00 INPATIENT HOSPITAL SERVICES UNDER PPS & CAH 30.00 Initial/interim HIT payment adjustment (see instructions) 0 30.00 31.00 Other Adjustment (specify) 0 31.00	7. 00		of certified HIT technology	Wkst. S-2, Pt. I	0	7. 00
10.00 Calculation of the HIT incentive payment after sequestration (see instructions) INPATIENT HOSPITAL SERVICES UNDER PPS & CAH 30.00 Initial/interim HIT payment adjustment (see instructions) 0 30.00 31.00 Other Adjustment (specify)	8. 00	Calculation of the HIT incentive payment (see instructions	5)		0	8.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH 30.00 Initial/interim HIT payment adjustment (see instructions) 0 30.00 31.00 Other Adjustment (specify) 0 31.00	9. 00	Sequestration adjustment amount (see instructions)			0	9.00
30.00 Initial/interim HIT payment adjustment (see instructions) 0 30.00 31.00 Other Adjustment (specify) 0 31.00	10.00	Calculation of the HIT incentive payment after sequestrati	on (see instructions)		0	10.00
31.00 Other Adjustment (specify) 0 31.00						
	30.00	<pre>Initial/interim HIT payment adjustment (see instructions)</pre>			0	30.00
32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions) 0 32.00	31.00	Other Adjustment (specify)			0	31.00
	32.00	Balance due provider (line 8 (or line 10) minus line 30 an	nd line 31) (see instruction	ns)	0	32.00

Health Financial Systems	DECATUR CO. MEMORIA	AL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWI NG BEDS	Provi der CCN: 151332	Peri od: From 01/01/2014	Worksheet E-2
		Component CCN: 15Z332		
		Title XVIII	Swing Beds - SNE	

		Component CCN: 15Z332	10 12/31/2014	5/22/2015 1:3	
		Title XVIII	Swing Beds - SNF		
			Part A	Part B	
			1. 00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		328, 476	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200 for Pt. A,		142, 688	0	3. 00
	Part V, cols. 6 and 7, line 202 for Pt. B) (For CAH, see instru				
4.00	Per diem cost for interns and residents not in approved teachin	g program (see		0. 00	4. 00
	instructions)				
5.00	Program days		274	0	1 0.00
6. 00	Interns and residents not in approved teaching program (see ins			0	0.00
7.00	Utilization review - physician compensation - SNF optional meth	od only	0		7. 00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		471, 164	0	
9.00	Primary payer payments (see instructions)		0	0	
10.00	Subtotal (line 8 minus line 9)		471, 164	0	
11. 00	Deductibles billed to program patients (exclude amounts applica	ble to physician	0	0	11. 00
	professional services)				
	Subtotal (line 10 minus line 11)		471, 164	0	1
13. 00	Coinsurance billed to program patients (from provider records)	(excl ude coi nsurance	3, 040	0	13.00
	for physician professional services)				
	80% of Part B costs (line 12 x 80%)			0	1
	Subtotal (enter the lesser of line 12 minus line 13, or line 14	.)	468, 124	0	1
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	1
	Pioneer ACO demonstration payment adjustment (see instructions)		0	0	1
	410A RURAL DEMONSTRATION PROJECT		0		16. 55
	Allowable bad debts (see instructions)		0	0	1
	Adjusted reimbursable bad debts (see instructions)		0	0	1
	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)	0	0	1
	Total (see instructions)		468, 124	0	1
	Sequestration adjustment (see instructions)		9, 362	0	1 . ,
	Interim payments		469, 767	0	
	Tentative settlement (for contractor use only)		0	0	1 00
	Balance due provider/program (line 19 minus lines 19.01, 20, an	•	-11, 005	0	00
23. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	0	0	23. 00
	§115. 2				

Health Financial Systems	DECATUR CO.	MEMORI AL	. HOSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT			Provi der CCN: 151332	From 01/01/2014	Worksheet E-3 Part V Date/Time Pre 5/22/2015 1:3	pared:
			Title XVIII	Hospi tal	Cost	

				5/22/2015 1:3	8 pm
		Title XVIII	Hospi tal	Cost	
				1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE F	PART A SERVICES - COST	REI MBURSEMENT		
1.00	Inpatient services			4, 545, 790	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction	ns)		0	2.00
3. 00	Organ acquisition	-,		0	3.00
4. 00	Subtotal (sum of lines 1 through 3)			4, 545, 790	4.00
5. 00	Primary payer payments			5, 993	5.00
6. 00	Total cost (line 4 less line 5). For CAH (see instructions)			4, 585, 255	6.00
0.00	COMPUTATION OF LESSER OF COST OR CHARGES			1, 000, 200	0.00
	Reasonable charges				
7. 00	Routi ne servi ce charges			0	7.00
8. 00	Ancillary service charges			0	8.00
9. 00	Organ acquisition charges, net of revenue			0	9.00
	Total reasonable charges			0	10.00
10.00				0	10.00
11 00	Customary charges				11 00
11.00	Aggregate amount actually collected from patients liable for pa			0	
12. 00	· ·	payment for services of	on a charge basis	0	12.00
40.00	had such payment been made in accordance with 42 CFR 413.13(e)			0 000000	40.00
	Ratio of line 11 to line 12 (not to exceed 1.000000)			0. 000000	
14.00	1		() (0	14.00
15. 00	, , , , , , , , , , , , , , , , , , , ,	y if line 14 exceeds li	ne 6) (see	0	15. 00
4, 00	instructions)		442 (4, 00
16. 00		y if line 6 exceeds lir	ne 14) (see	0	16. 00
	instructions)			_	
17. 00	Cost of physicians' services in a teaching hospital (see instru	uctions)		0	17. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18. 00	1 3	line 49)		0	18.00
	Cost of covered services (sum of lines 6, 17 and 18)			4, 585, 255	
20. 00	Deductibles (exclude professional component)			473, 024	
	Excess reasonable cost (from line 16)			0	21.00
22. 00	Subtotal (line 19 minus line 20 and 21)			4, 112, 231	
23.00				4, 256	
24.00	Subtotal (line 22 minus line 23)			4, 107, 975	24.00
25.00	Allowable bad debts (exclude bad debts for professional service	es) (see instructions)		49, 379	25. 00
26.00	Adjusted reimbursable bad debts (see instructions)			37, 528	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instru	uctions)		26, 560	27.00
28.00	, , , , , , , , , , , , , , , , , , ,				28. 00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29. 00
29. 50	Pioneer ACO demonstration payment adjustment (see instructions))		0	29. 50
29. 99	Recovery of Accelerated Depreciation			0	29. 99
30.00					30.00
30. 01					
	Interim payments			82, 910 3, 736, 611	
	Tentative settlement (for contractor use only)			0	32.00
	Balance due provider/program (line 30 minus lines 30.01, 31, ar	nd 32)		325, 982	33.00
34. 00	Protested amounts (nonallowable cost report items) in accordance		chapter 1	020, 702	34.00
51.00	§115. 2	33 11 OMO 1 db. 10 Z,	5ap (6) 1,	ĺ	31.00
				1	1

Health Financial Systems	DECATUR CO. MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 151332	From 01/01/2014	Worksheet E-3 Part VII Date/Time Prepared:

			o 12/31/2014	Date/Time Pre 5/22/2015 1:3	
		Title XIX	Hospi tal	PPS	<u>o p</u>
			Inpatient	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		0		1.00
2.00	Medical and other services			1, 184, 018	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	1, 184, 018	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpati ent pri mary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	1, 184, 018	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
8.00	Routine service charges		370, 967		8.00
9.00	Ancillary service charges		1, 438, 010	3, 445, 868	9. 00
10.00	Organ acquisition charges, net of revenue		0		10.00
	Incentive from target amount computation		0		11.00
12. 00	Total reasonable charges (sum of lines 8 through 11)		1, 808, 977	3, 445, 868	12.00
	CUSTOMARY CHARGES				
13. 00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13.00
44.00	basis				
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	2 CFR §413.13(e)	0. 000000	0. 000000	15 00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000) Total customary charges (see instructions)			3, 445, 868	
16. 00 17. 00	Excess of customary charges over reasonable cost (complete only	if line 14 eveneds	1, 808, 977 1, 808, 977		1
17.00	line 4) (see instructions)	y II IIIle 16 exceeds	1,000,977	2, 261, 850	17.00
18. 00	Excess of reasonable cost over customary charges (complete only	/if line 4 exceeds line	0	0	18.00
10.00	16) (see instructions)	y II IIIIC 4 CACCCUS IIIIC		0	10.00
19. 00	Interns and Residents (see instructions)		0	0	19. 00
	Cost of physicians' services in a teaching hospital (see instru	uctions)	0	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 16		0	1, 184, 018	
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be of		ers.	, , , , , , , , , , , , , , , , , , , ,	
22.00	Other than outlier payments		0	0	22.00
	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27. 00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		0	1, 184, 018	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	1, 184, 018	
32.00	Deducti bl es		0	0	
33.00	Coinsurance		0	0	
34. 00	Allowable bad debts (see instructions)		0	0	34. 00
	Utilization review		0		35.00
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	0	1, 184, 018	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
	Subtotal (line 36 ± line 37)		0	1, 184, 018	
	Direct graduate medical education payments (from Wkst. E-4)		0	4 404 040	39.00
	Total amount payable to the provider (sum of lines 38 and 39)		0	1, 184, 018	
41.00			0	1, 184, 018 0	
42. 00 43. 00	Balance due provider/program (line 40 minus line 41) Protested amounts (nonallowable cost report items) in accordance	co with CMS Dub 1E 2	0	0	
43.00	chapter 1, §115.2	LE WI LII CWS PUD 13-2,		0	43.00
	Onaptor 1, 3110.2		1		I

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

Provi der CCN: 151332

				12,01,2011	5/22/2015 1: 3	8 pm
		General Fund	Speci fi c	Endowment	Plant Fund	
		1.00	Purpose Fund	Fund	4.00	
	CURRENT ACCETS	1. 00	2.00	3. 00	4. 00	
1. 00	CURRENT ASSETS Cash on hand in banks	6, 265, 859	0	0	0	1.00
2. 00	Temporary investments	9, 739, 017		0	0	2.00
3. 00	Notes recei vabl e	0	o o	Ö	0	3.00
4.00	Accounts recei vable	17, 783, 547	0	0	0	
5.00	Other recei vabl e	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-10, 316, 543	0	0	0	6.00
7.00	Inventory	484, 748	0	0	0	
8.00	Prepai d expenses	0	0	0	0	
9. 00	Other current assets	2, 464, 561		0	0	
10.00	Due from other funds	0	0	0	0	
11. 00	Total current assets (sum of lines 1-10)	26, 421, 189	0	0	0	11.00
12 00	FIXED ASSETS	1 107 (07	. 0	O	0	12 00
12. 00 13. 00	Land Land improvements	1, 127, 637 440, 624		0	0	
14. 00	Accumulated depreciation	-339, 908		0	0	
15. 00	Bui I di ngs	37, 615, 626		0	0	15.00
16. 00	Accumulated depreciation	-11, 643, 894		0	0	16.00
17. 00	Leasehold improvements	0	o o	0	Ö	17.00
18. 00	Accumulated depreciation	Ö	o	O	0	18.00
19.00	Fi xed equi pment	3, 320, 033	0	0	0	19.00
20.00	Accumulated depreciation	-1, 706, 092	2	0	0	20.00
21.00	Automobiles and trucks	84, 519	0	0	0	21.00
22.00	Accumulated depreciation	-52, 820	0	0	0	22.00
23.00	Major movable equipment	18, 411, 012	0	0	0	23. 00
24.00	Accumulated depreciation	-14, 142, 964	0	0	0	24.00
25.00	Mi nor equi pment depreci abl e	0	0	0	0	25. 00
26.00	Accumulated depreciation	0	0	0	0	26. 00
27. 00	HIT designated Assets	0	0	0	0	27. 00
28. 00	Accumulated depreciation	0	0	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	0	0	0	
30. 00	Total fixed assets (sum of lines 12-29)	33, 113, 773	0	0	0	30.00
	OTHER ASSETS			_1	_	
31.00	Investments	4, 590, 663		0	0	31.00
32.00	Deposits on Leases	0	0	0	0	32.00
33.00	Due from owners/officers	120 042	0	0	0	33.00
34. 00 35. 00	Other assets	139, 842 4, 730, 505		0	0	34. 00 35. 00
36. 00	Total other assets (sum of lines 31-34) Total assets (sum of lines 11, 30, and 35)	64, 265, 467	1	0	0	36.00
30.00	CURRENT LIABILITIES	04, 203, 407		<u> </u>	0	30.00
37. 00	Accounts payable	1, 467, 253	0	O	0	37.00
38. 00	Salaries, wages, and fees payable	664, 625		0	0	38.00
39. 00	Payrol I taxes payable	197, 255		0	0	39.00
40. 00	Notes and Loans payable (short term)	1, 112, 269		0	Ö	40.00
41. 00	Deferred income	0	o	Ö	0	41.00
42.00	Accel erated payments	0)			42.00
43.00	Due to other funds	1, 828, 683	0	0	0	43.00
44.00	Other current liabilities	1, 540, 743		0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6, 810, 828	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46. 00
47.00	Notes payable	8, 159, 980	0	0	0	47.00
48. 00	Unsecured Loans	0	0	0	0	48. 00
49.00	Other long term liabilities	0	0	0	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49	8, 159, 980		0	0	50.00
51. 00	Total liabilites (sum of lines 45 and 50)	14, 970, 808	0	0	0	51.00
	CAPITAL ACCOUNTS					
52. 00	General fund balance	49, 294, 659				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			O	_	56.00
57.00	Plant fund balance - invested in plant				0	
58. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58. 00
59. 00	Total fund balances (sum of lines 52 thru 58)	49, 294, 659	o	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and	64, 265, 467		٥	0	60.00
55. 66	[59]	31, 203, 407		Ĭ		55. 55
	· ·	•		'	ı	•

		General	Fund	Special Pu	rpose Fund	Endowment Fund	
		1.00	0.00	2 22	4 00	F 00	
1. 00	Fund balances at beginning of period	1. 00	2. 00 47, 927, 840	3. 00	4. 00	5. 00	1. 00
2. 00	Net income (loss) (from Wkst. G-3, line 29)		1, 366, 819		ď		2.00
3. 00	Total (sum of line 1 and line 2)		49, 294, 659		0		3.00
4. 00	Additions (credit adjustments) (specify)	0	47, 274, 037	0	J	0	4.00
5. 00	That there (ereal that as theres) (specify)	0		0		0	5.00
6. 00		o		0		0	6.00
7. 00		o		0		0	7.00
8.00		o		0		0	8.00
9.00		o		0		0	9.00
10.00	Total additions (sum of line 4-9)		o		o		10.00
11. 00	Subtotal (line 3 plus line 10)		49, 294, 659		0		11. 00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13. 00		0		0		0	13.00
14.00		0		0		0	14.00
15. 00		0		0		0	15. 00
16. 00		0		0		0	16.00
17. 00	T	0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		40, 204, (50		0		18.00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)		49, 294, 659		O ₁		19. 00
	Sheet (Title II IIII lius IIIIe 10)	Endowment	PI ant	Fund			
		Fund					
		6. 00	7. 00	8. 00			
1. 00	Fund balances at beginning of period	0		0			1. 00
2. 00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3. 00	Total (sum of line 1 and line 2)	0	_	0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6. 00 7. 00			0				6. 00 7. 00
7. 00 8. 00			U				7. 00 8. 00
9. 00			0				9.00
10. 00	Total additions (sum of line 4-9)	0	۷	0			10.00
11. 00	Subtotal (line 3 plus line 10)	0		0			11.00
12. 00	Deductions (debit adjustments) (specify)	ŏ	0	O			12.00
13. 00	beddetrons (dobrt day dotiments) (specify)		0				13.00
14. 00			n n				14.00
15. 00			ol				15. 00
16. 00			o				16.00
17. 00			O				17.00
18.00	Total deductions (sum of lines 12-17)	О		0			18. 00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19. 00

Health Financial Systems DECASTATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

			10 12/31/2014	5/22/2015 1:3	
	Cost Center Description	Inpatient	Outpati ent	Total	O piii
	oost oontor boson per on	1, 00	2.00	3. 00	
	PART I - PATIENT REVENUES		2.00	0.00	
	General Inpatient Routine Services				1
1.00	Hospi tal	4, 393, 0	41	4, 393, 041	1.00
2.00	SUBPROVIDER - I PF				2.00
3.00	SUBPROVI DER - I RF				3.00
4.00	SUBPROVI DER				4.00
5.00	Swing bed - SNF	99, 7	36	99, 786	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)	4, 492, 8	27	4, 492, 827	10.00
	Intensive Care Type Inpatient Hospital Services				
11. 00	INTENSIVE CARE UNIT	248, 6	34	248, 634	
12.00	CORONARY CARE UNIT				12.00
13. 00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T				14.00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15.00
16. 00	Total intensive care type inpatient hospital services (sum of lines	248, 6	34	248, 634	16. 00
47.00	11-15)	4 744 4		4 744 4/4	47.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	4, 741, 4		4, 741, 461	
18.00	Ancillary services	14, 843, 0			1
19. 00 20. 00	Outpati ent servi ces RURAL HEALTH CLINIC		0 394, 536		1
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0 0	_	
21.00	HOME HEALTH AGENCY		1, 290, 871	1, 290, 871	
23. 00	AMBULANCE SERVICES		0 1, 290, 871	1, 290, 871	
24. 00	CMHC		0	0	1
25. 00	AMBULATORY SURGI CAL CENTER (D. P.)		0	0	25.00
26. 00	HOSPICE				26.00
27. 00	OTHER (SPECIFY)		0	0	1
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wks	t. 19, 584, 5	40 84, 380, 876	-	
20.00	G-3, line 1)	1,7,001,70	01,000,070	1007 7007 110	20.00
	PART II - OPERATING EXPENSES	<u> </u>			
29.00	Operating expenses (per Wkst. A, column 3, line 200)		48, 665, 973		29. 00
30.00	ADD (SPECIFY)		0		30.00
31.00			0		31.00
32.00			0		32.00
33.00			0		33.00
34.00			0		34.00
35.00			0		35.00
36.00	Total additions (sum of lines 30-35)		0		36. 00
37.00	DEDUCT (SPECIFY)		0		37.00
38. 00			0		38. 00
39. 00			0		39.00
40.00			0		40.00
41. 00			0		41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(trans	sfer	48, 665, 973		43.00
	to Wkst. G-3, line 4)	I	I	I	I

Heal th	Financial Systems	DECATUR CO. MEMO	RIAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
STATEM	ENT OF REVENUES AND EXPENSES		Provi der CCN: 151332	Peri od:	Worksheet G-3	
				From 01/01/2014		
				To 12/31/2014	Date/Time Pre 5/22/2015 1:3	
					3/22/2013 1.3	O PIII
					1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Pa	rt I, column 3, I	ine 28)		103, 965, 416	1.00
2.00	Less contractual allowances and discounts	on patients' acco	unts		55, 478, 299	2.00
3.00	Net patient revenues (line 1 minus line 2)	·			48, 487, 117	3.00
4.00	Less total operating expenses (from Wkst.	G-2, Part II, lin	e 43)		48, 665, 973	4.00
5.00	Net income from service to patients (line				-178, 856	5.00
	OTHER INCOME					
6.00	Contributions, donations, bequests, etc				0	6.00
7.00	Income from investments				0	7. 00
8.00	Revenues from telephone and other miscella	neous communicati	on services		0	8. 00
9.00	Revenue from television and radio service				0	9. 00
10.00	Purchase di scounts				0	10.00
11. 00	Rebates and refunds of expenses				0	11.00
12.00	Parking Lot receipts				0	1 .2.00
13.00	Revenue from Laundry and Linen service				0	1
14.00	Revenue from meals sold to employees and g	uests			0	1
	Revenue from rental of living quarters				0	
	Revenue from sale of medical and surgical		than patients		0	1
	Revenue from sale of drugs to other than p				0	1
18. 00	Revenue from sale of medical records and a				0	1 .0.00
19. 00					0	
20. 00	Revenue from gifts, flowers, coffee shops,	and canteen			0	
21. 00	Rental of vending machines				0	21.00
22. 00	Rental of hospital space				0	22.00
	Governmental appropriations				0	23. 00
24. 00	OPERATING & NON OPERATING REVENUE				1, 545, 675	24.00

1, 545, 675 25. 00 1, 366, 819 26. 00

0 27.00

0 28.00 1, 366, 819 29.00

25.00 Total other income (sum of lines 6-24)
26.00 Total (line 5 plus line 25)

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)

27.00 OTHER EXPENSES (SPECIFY)

15.00

16.00

17.00

18.00

19.00

20.00

21.00

22.00

23.00

24.00

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962, 888

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

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17.00

18.00

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20.00

21.00

22.00

Clinic

Home Dialysis Aide Services

Health Promotion Activities

Home Delivered Meals Program

Respiratory Therapy

Private Duty Nursing

Day Care Program

Homemaker Service

24.00 Total (sum of lines 1-23)

23.00 All Others (specify)

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0

0

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962.888

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19.00

20.00

21 00

22.00

23.00

Drugs

Clinic

DMF

Supplies (see instructions)

HHA NONREIMBURSABLE SERVICES

Home Dialysis Aide Services

Health Promotion Activities

Home Delivered Meals Program

Respiratory Therapy

Day Care Program

Homemaker Service

All Others (specify)

24.00 Total (sum of lines 1-23)

Private Duty Nursing

Health Financial Systems	DECATUR CO.	MEMORI AL	HOSPI TAL		In Lie	u of Form CMS-2552-10
COST ALLOCATION - HHA STATISTICAL BASIS			Provi der CC	N: 151332		Worksheet H-1
					From 01/01/2014	Part II
			HHA CCN:	157153	To 12/31/2014	Date/Time Prepared:
						5/22/2015 1:38 pm
					Home Heel th	DDC

							5/22/2015 1:3	8 pm
						Home Health	PPS	
						Agency I		
		Capi tal Rel	ated Costs					
		·						
		BI dgs &	Movabl e	Plant	Transportation	Reconciliatio	Admi ni strati v	
		Fixtures	Equi pment	Operation &	n (MI LEAGE)	n	e & General	
		(SQUARE FEET)	(DOLLAR	Mai ntenance	(===/		(ACCUM. COST)	
		(VALUE)	(SQUARE FEET)			(**************************************	
		1. 00	2. 00	3.00	4.00	5A. 00	5. 00	
	GENERAL SERVICE COST CENTERS	11.00	2.00	0.00	1 00	07.1. 00	0.00	
1. 00	Capital Related - Bldg. &	0				0		1.00
1.00	Fixtures							1.00
2. 00	Capital Related - Movable		0			0		2.00
2.00	Equi pment		0			0		2.00
3. 00	Plant Operation & Maintenance	0	0			0		3.00
4. 00	Transportation (see	0	0					4.00
4.00		١	U		٩	U .		4.00
Г 00	instructions)		0			107 070	025 510	F 00
5. 00	Administrative and General	0	0		0	0 -127, 378	835, 510	5.00
	HHA REIMBURSABLE SERVICES			ı	ما		110 510	
6. 00	Skilled Nursing Care	0	0		~	0	418, 518	
7. 00	Physical Therapy	0	0		0	0	265, 092	
8.00	Occupational Therapy	0	0		이	0 0	58, 445	
9.00	Speech Pathology	0	0		0	0	18, 349	
	Medical Social Services	0	0		0	0	9, 731	
11.00	Home Health Aide	0	0		0	0 0	65, 375	11.00
12.00	Supplies (see instructions)	0	0		0	0	0	12.00
13.00	Drugs	0	0		0	0	0	13.00
14.00	DME	0	0		ol	o o	0	14.00
	HHA NONREIMBURSABLE SERVICES				•			
15.00	Home Dialysis Aide Services	0	0		ol	0 0	0	15.00
16.00	Respiratory Therapy	o	0		ol	o o	0	16.00
	Private Duty Nursing	0	0		ol	0	0	17.00
	Clinic	أ	0		ol	0	0	18.00
	Health Promotion Activities	0	0			0	l o	19.00
	Day Care Program		0				l o	20.00
	Home Delivered Meals Program		0			0		21.00
	Homemaker Service	0	0			0		22.00
	All Others (specify)	0	0			0	0	
		U	0			0 107 070		
	Total (sum of lines 1-23)	0	0			0 -127, 378		
25. 00	Cost To Be Allocated (per		0		٩	U	127, 378	25.00
04.00	Worksheet H-1, Part I)	0.000000	0.000000	0.00000	0 00000		0.450:55	04 06
26.00	Unit Cost Multiplier	0. 000000	0. 000000	0.00000	0. 00000	U	0. 152455	26.00

151332 | Peri od: | Worksheet H-2 | Part | I | Date/Time Prepared: 5/22/2015 1:38 pm HHA CCN:

								5/22/2015 1: 3	3 pm
							Home Health Agency I	PPS	
			CAPI TAL REL	ATED COSTS			Agency		
			BL BO & ELVE	10/01 5 50/11	$\overline{}$	5451 0V55	0.1.1.1	ABULAU OTDATIV	
	Cost Center Description	HHA Trial	BLDG & FIXT	MVBLE EQUI	Р	EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIV E & GENERAL	
		Bal ance (1)				DEPARTMENT		E & GENERAL	
		0	1. 00	2.00		4. 00	4A	5. 00	
	00 Administrative and General	0	32, 222		0	10, 774	42, 996	10, 655	1.00
	00 Skilled Nursing Care	482, 323	0		0	122, 393	604, 716		2.00
	00 Physical Therapy 00 Occupational Therapy	305, 507 67, 355	0		0	57, 472 17, 092	362, 979 84, 447	89, 950 20, 927	3. 00 4. 00
	00 Speech Pathology	21, 146	0		0	5, 366			5.00
	00 Medical Social Services	11, 215	0		o	2, 846		3, 484	6.00
7.	00 Home Health Aide	75, 342	0		0	19, 118			7.00
	00 Supplies (see instructions)	0	0		0	0	0	0	8.00
	00 Drugs	0	0		0	0	0	0	9.00
	0.00 DME .00 Home Dialysis Aide Services	0	0		0	0	0	0	10. 00 11. 00
	2.00 Respiratory Therapy	0	0		0	0	0	0	12.00
	.00 Private Duty Nursing	0	0		0	0	0	o	13.00
	. 00 Clinic	0	0		0	0	0	0	14.00
	6.00 Health Promotion Activities	0	0		0	0	0	0	15.00
	0.00 Day Care Program 0.00 Home Delivered Meals Program	0	0		0	0	0	0	16. 00 17. 00
	7.00 Home Delivered Meals Program 8.00 Homemaker Service	0	0		0	0	0	0	18.00
	0.00 All Others (specify)	0	0		o	0	0	Ö	19.00
20	0.00 Total (sum of lines 1-19) (2)	962, 888	32, 222		0	235, 061	1, 230, 171	304, 850	20.00
21	.00 Unit Cost Multiplier: column						0. 000000		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		OPERATION OF	LAUNDRY &		HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		REPAIRS 6.00	PLANT 7. 00	LI NEN SERVI 8.00	CE	9. 00	10. 00	11.00	
1.	00 Administrative and General	0.00	18, 206	8.00	0	9.00	10.00	39, 840	1.00
	00 Skilled Nursing Care	0	0		0	0	0	0	2.00
	00 Physical Therapy	0	0		0	0	0	0	3.00
	00 Occupational Therapy	0	0		0	0	0	0	4.00
	00 Speech Pathology 00 Medical Social Services	0	0		0	0	0	0	5. 00 6. 00
	00 Home Heal th Ai de	0	0		0	0	0	0	7. 00
	00 Supplies (see instructions)	0	0		0	0	0	o	8.00
	00 Drugs	0	0		0	0	0	0	9.00
	0. 00 DME	0	0		0	0	0	0	10.00
	.00 Home Dialysis Aide Services 2.00 Respiratory Therapy	0	0		0	0	0	0	11. 00 12. 00
	8.00 Private Duty Nursing	0	0		0	0	0	0	13.00
	. 00 Clinic	0	0	•	0	0	0	o	14.00
	6.00 Health Promotion Activities	0	0		0	0	0	0	15.00
	.00 Day Care Program	0	0		0	0	0	0	16.00
	7.00 Home Delivered Meals Program	0	0		0	0	0	0	17.00
	1.00 Homemaker Service 1.00 AII Others (specify)	0	0		0	0	0	0	18. 00 19. 00
	0.00 Total (sum of lines 1-19) (2)	0	18, 206		o	0	0	39, 840	
21	.00 Unit Cost Multiplier: column								21.00
	26, line 1 divided by the sum								
	of column 26, line 20 minus column 26, line 1, rounded to								
	6 decimal places.								
	•	•	•	-					

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

near til Fillancial Systems	5		DECATOR CO.	WEWORT AL	HUSPI IAL				III LI EU	I OI FOIII CW3-2	1002-10
ALLOCATION OF GENERAL S	SERVICE COSTS	TO HHA COST	CENTERS		Provi der	CCN:	151332	Perio	od:	Worksheet H-2	
								From	01/01/2014	Part I	
					HHA CCN:		157153	To	12/31/2014	Date/Time Pre	
										5/22/2015 1: 3	8 pm
								Hor	me Health	PPS	

							3/22/2013 1.3	о рііі
						Home Health	PPS	
	Cost Center Description	NURSI NG	CENTRAL	MEDI CAL	SOCI AL	Agency I Subtotal	Intern &	
	cost center bescription	ADMI NI STRATI O	SERVICES &	RECORDS &	SERVI CE	Subtotal	Resi dents	
		N	SUPPLY	LI BRARY	SERVICE		Cost & Post	
		IN	JUFFLI	LIDRAKI				
							Stepdown	
		13. 00	14. 00	16. 00	17. 00	24. 00	Adjustments 25.00	
1. 00	Administrative and General	13.00	14.00	15, 670	53, 669	181, 036	25.00	1.00
2. 00	Skilled Nursing Care	0	0	15, 670	03,009	754, 572	C	1
3. 00	Physical Therapy	0	0	0	0	452, 929		
4. 00	Occupational Therapy		0	0	0	105, 374		1
5. 00	Speech Pathology		0	0	0	33, 082		1
6. 00	Medical Social Services		0	0	0	17, 545	C	
7. 00	Home Heal th Ai de	0	0	0		The state of the s	C	1
8. 00	Supplies (see instructions)	0	0	0		117, 868		1
9. 00	Drugs	0	0	0		0		
10.00	DME	0	0	0		0		
11. 00	Home Dialysis Aide Services	0	0	0		0		
12. 00	Respiratory Therapy	0	0	0	0	0		1
13. 00			0	0	0	0		1
14. 00	Clinic	0	0	0		0		1
15. 00		0	0	0	0	0		1
16. 00	Day Care Program	0	0	0	0	0		
17. 00	9	0	Ö	0	0	0	Ċ	
18. 00	Homemaker Service	0	o	o	0	0	Ċ	
19. 00	1	0	0	0	0	0		1
20. 00	Total (sum of lines 1-19) (2)		0	15, 670	53, 669	1, 662, 406		20.00
21. 00	Unit Cost Multiplier: column		ŏ	13, 070	33,007	1,002,400		21.00
21.00	26, line 1 divided by the sum							21.00
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.							
	Cost Center Description	Subtotal	Allocated HHA	Total HHA				
	·		A&G (see Part	Costs				
			11)					
		26. 00	27. 00	28. 00				
1.00	Administrative and General	181, 036						1.00
2.00	Skilled Nursing Care	754, 572	92, 215	846, 787				2.00
3.00	Physi cal Therapy	452, 929	55, 352	508, 281				3. 00
4.00	Occupational Therapy	105, 374	12, 878	118, 252				4.00
5.00	Speech Pathology	33, 082	4, 043	37, 125				5. 00
6.00	Medical Social Services	17, 545	2, 144	19, 689				6.00
7.00	Home Health Aide	117, 868	14, 404	132, 272				7. 00
8.00	Supplies (see instructions)	0	0	0				8. 00
9. 00	Drugs	0	0	0				9. 00
10.00	DME	0	0	0				10.00
11. 00	Home Dialysis Aide Services	0	0	0				11. 00
12.00	Respiratory Therapy	0	0	0				12.00
13. 00	Private Duty Nursing	0	0	0				13. 00
14. 00	·	0	0	0				14.00
15. 00	•	0	=	0				15. 00
16. 00	Day Care Program	0	0	0				16. 00
17. 00	Home Delivered Meals Program	0	0	0				17.00
18.00		0	0	0				18.00
	All Others (specify)	0	0	0				19.00
20.00	Total (sum of lines 1-19) (2)	1, 662, 406		1, 662, 406				20.00
21. 00	Unit Cost Multiplier: column		0. 122208					21.00
	26, line 1 divided by the sum							
	of column 26, line 20 minus							
	column 26, line 1, rounded to 6 decimal places.							
	To deciliai pi aces.	I	ı I		I			I

⁽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.

5/22/2015 1:38 pm

0.000000 22.00

Home Health PPS Agency I CAPITAL RELATED COSTS MVBLE FOLLE Reconciliatio ADMINISTRATIV MAINTENANCE & BLDG & FIXT **EMPLOYEE** Cost Center Description (SQUARE FEET) (SQUARE FEET) **BENEFITS** E & GENERAL **REPAIRS** n (ACCUM. COST) DEPARTMENT (TIME SPENT) (SALARIES) 1. 00 2. 00 5A 5. 00 6. 00 4.00 1.00 Administrative and General 2,628 2, 628 36, 843 0 42, 996 1.00 2.00 Skilled Nursing Care 418, 518 0 604, 716 0 2.00 3.00 Physical Therapy 0 0 196, 525 0 362, 979 3.00 0 0 0 84, 447 4 00 Occupational Therapy 58, 445 O 4 00 0 0 0 5.00 Speech Pathology 18, 349 26, 512 5.00 6.00 Medical Social Services 0 9, 731 0 14,061 6.00 0 65, 375 7.00 Home Health Aide 0 0 0 94, 460 7.00 O 0 0 8.00 Supplies (see instructions) 8.00 9.00 Drugs 0 9.00 0 0 0 10.00 DME 0 0 0 10.00 0 Home Dialysis Aide Services 0 0 11 00 Ω 11 00 12.00 Respiratory Therapy 0 0 12.00 13.00 Private Duty Nursing 0 0 0 0 13.00 0 Clinic 0 14.00 14.00 0 0 0 Health Promotion Activities 15 00 Ω 15 00 16.00 Day Care Program 0 0 0 16.00 0 Home Delivered Meals Program 0 0 17.00 17.00 Homemaker Service 0 0 0 0 18.00 18.00 0 All Others (specify) 0 0 0 19 00 19.00 0 20.00 Total (sum of lines 1-19) 2,628 2,628 803, 786 1, 230, 171 20.00 235, 061 304, 850 21.00 Total cost to be allocated 32, 222 21.00 12. 261035 0. 292442 0. 247811 0.000000 22.00 Unit cost multiplier 0.000000 22.00 Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY CAFFTERIA NURSI NG **PLANT** LINEN SERVICE (HOURS OF S (MEALS SERV (HOURS) ADMI NI STRATI O (SQUARE FEET) (POUNDS OF ERVICE) ED) LAUNDRY) (NURSING HO URS) 8. 00 7. 00 9.00 10.00 13.00 11.00 1.00 Administrative and General 2, 628 0 0 32, 481 1.00 2.00 Skilled Nursing Care 000000000000000000 0 0 2.00 0 Physi cal Therapy 0 0 3.00 0 0 3 00 0 4.00 Occupational Therapy 0 0 0 0 4.00 Speech Pathology 5.00 0 5.00 6.00 Medical Social Services 0 0 0 6.00 0 0 0 0 0 0 7.00 Home Health Aide 7.00 8.00 Supplies (see instructions) 0 8.00 0 0 9.00 Drugs 0 0 0 9.00 0 0 10.00 DMF 0 10.00 0 0 11.00 Home Dialysis Aide Services Ω 11.00 12.00 Respiratory Therapy 0 0 0 0 12.00 13.00 Private Duty Nursing 13.00 0 0 0 14.00 Clinic O 14.00 15.00 Health Promotion Activities C 0 15.00 Day Care Program 0 16.00 16.00 0 0 o 17.00 Home Delivered Meals Program 0 17.00 18.00 Homemaker Service 0 C 0 0 18.00 0 0 19.00 All Others (specify) 0 C 0 19.00 Total (sum of lines 1-19) 2, 628 0 0 32, 481 20.00 20.00 Total cost to be allocated 39, 840 21.00 21.00 18, 206 0

6. 927702

0.000000

0.000000

0.000000

1. 226563

22.00 Unit cost multiplier

Health Financial Systems	DECATUR CO. MEMORIAL	. HOSPI TAL	In Lie	u of Form CMS-2552-10
ALLOCATION OF GENERAL SERVICE COSTS TO HHA	COST CENTERS STATISTICAL	Provider CCN: 151332	Peri od: From 01/01/2014	Worksheet H-2
BASIS		HHA CCN: 157153		Date/Time Prepared:
				5/22/2015 1:38 pm
			Home Health	PPS

					Home Health	PPS	
	Cost Center Description	CENTRAL	MEDI CAL	SOCI AL	Agency I		
	cost center bescription	SERVICES &	RECORDS &	SERVI CE			
		SUPPLY	LI BRARY	(TIME SPENT)			
		(COSTED	(GROSS	(IIWL SELNI)			
		REQUIS.)	CHARGES)				
		14. 00	16. 00	17. 00			
1. 00	Administrative and General	14.00	1, 290, 871	17.00			1. 00
2. 00	Skilled Nursing Care		1, 270, 071) 1			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		0	0	0			8.00
	Supplies (see instructions)	0	0	0			9.00
9.00	Drugs	0	0	0			
10.00	DME	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0			12.00
13. 00	Private Duty Nursing	0	0	0			13.00
14.00	Clinic	0	0	0			14. 00
15. 00	Health Promotion Activities	0	0	0			15.00
16. 00	Day Care Program	0	0	0			16.00
17. 00	Home Delivered Meals Program	0	0	0			17. 00
18.00	Homemaker Service	0	0	0			18.00
19.00	All Others (specify)	0	0	0			19.00
20.00	Total (sum of lines 1-19)	0	1, 290, 871	99			20.00
21.00	Total cost to be allocated	0	15, 670				21.00
22.00	Unit cost multiplier	0. 000000	0. 012139	542. 111111			22. 00

Heal th	Financial Systems	D	ECATUR CO. MEMO	ORIAL HOSPIT	ΔΙ	In li	eu of Form CMS-2	2552-10
	TIONMENT OF PATIENT SERVICE COST		20711011 001 1112111		er CCN: 151332		Worksheet H-3	
				нна ссі		From 01/01/201	4 Part I	pared:
				Ti	tle XVIII	Home Health Agency I	PPS	ю рііі
	Cost Center Description	From, Wkst.	Facility	Shared	Total HH	A Total Visits		
		H-2, Part I,	Costs (from	Ancillary		S.	Per Visit	
		col. 28, line	Wkst. H-2,	Costs (fro	m 1 + 2)		(col. 3 ÷	
		0	Part I) 1.00	Part II) 2.00	3.00	4.00	col . 4) 5.00	
	PART I - COMPUTATION OF LESSER							
	COST LIMITATION	OI AGGILLOATE	I KOOKAW COST, I	AUGINEUNIE UI	THE TROOKAW	LIWITATION COST,	OK BENEFICIARI	
	Cost Per Visit Computation							1
1.00	Skilled Nursing Care	2.00	846, 787		846,	787 4, 47	3 189. 31	1.00
2.00	Physi cal Therapy	3.00	508, 281		0 508,	281 2, 12	2 239. 53	2.00
3.00	Occupational Therapy	4.00	118, 252		0 118,	252 39	6 298. 62	3.00
4.00	Speech Pathology	5.00				125 10	I	
5. 00	Medical Social Services	6.00				689 5		
6.00	Home Health Aide	7.00			132,			1
7. 00	Total (sum of lines 1-6)		1, 662, 406		0 1, 662,		5	7.00
					Program Vis	si ts		
						Part B		1
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subje			
	, , , , , , , , , , , , , , , , , , ,				to	Deducti bl es		
					Deducti bl e			
		0	1. 00	2.00	Coi nsuran		F 00	
	Limitation Cost Computation	0	1.00	2. 00	3.00	4. 00	5. 00	
8. 00	Skilled Nursing Care		17140		0 2,	517		8.00
8. 01	Skilled Nursing Care		18020		0	0		8. 01
8. 02	Skilled Nursing Care		26900		o	O		8. 02
8. 03	Skilled Nursing Care		99915		o	0		8. 03
9.00	Physi cal Therapy		17140		0 1,	371		9.00
9. 01	Physi cal Therapy		18020		0	0		9. 01
9. 02	Physi cal Therapy		26900		0	0		9. 02
9. 03	Physi cal Therapy		99915		0	0		9. 03
10.00	Occupational Therapy		17140		0	292		10.00
10. 01	Occupational Therapy		18020		0	0		10. 01
10. 02	Occupational Therapy		26900		0	0		10. 02
10. 03	Occupational Therapy		99915		0	0		10.03
11.00	Speech Pathology		17140		0	28		11.00
11. 01	Speech Pathology		18020		0	0		11.01
11. 02 11. 03	Speech Pathology Speech Pathology		26900 99915		0	0		11. 02 11. 03
12.00	Medical Social Services		17140		ol	43		12.00
12. 00	Medical Social Services		18020			0		12.00
12. 01	Medical Social Services		26900		0	0		12.01
	Medical Social Services		99915		o	0		12.02
	Home Heal th Ai de		17140			842		13.00
13. 01	Home Heal th Aide		18020		o	0		13.01
13. 02	Home Heal th Ai de		26900			0		13. 02
13. 03	Home Heal th Ai de		99915		ol	Ö		13. 03
	Total (sum of lines 8-13)				- 1	093		14.00
	Cost Center Description	From Wkst.	Facility	Shared	Total HH		Ratio (col. 3	
	•	H-2 Part I,	Costs (from	Ancillary		s. (from HHA	÷ col . 4)	
		col. 28, line	Wkst. H-2,	Costs (fro	m 1 + 2)	Record)		
			Part I)	Part II)				
	Supplies and Drugs Cost Comput	0 ations	1. 00	2.00	3.00	4.00	5. 00	
15. 00	Cost of Medical Supplies	8. 00	0		0	0	0. 000000	15 00
	Cost of Drugs	9. 00			o		0. 000000	
		,	'	,	'	į.	,	

	Financial Systems		ECATUR CO. MEMO				u of Form CMS-2	
APPORT	TIONMENT OF PATIENT SERVICE COST	S		Provi der	CCN: 151332	Period: From 01/01/2014	Worksheet H-3 Part I	
				HHA CCN:	157153			
				Ti t	le XVIII	Home Health Agency I	PPS	.о р
			Program Visits		Cost of Services	Agency 1		
			Par	t B	Jei vi ces	Part B		
	Cost Center Description	Part A	Not Subject	Subject to	Part A	Not Subject	Subject to	
	·		to	Deductibles 8	k	to	Deductibles &	
			Deductibles &	Coi nsurance		Deductibles &	Coi nsurance	
			Coi nsurance	0.00	0.00	Coi nsurance	11 00	
	DADT I COMPUTATION OF LESSED	6. 00	7. 00	8. 00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER COST LIMITATION	OF AGGREGATE	PRUGRAW CUST, I	AGGREGATE OF	THE PROGRAM LI	IMITATION COST, C	JR BENEFICIARY	
	Cost Per Visit Computation							1
1. 00	Skilled Nursing Care	0	2, 517			0 476, 493		1.00
2. 00	Physical Therapy	0				0 328, 396		2.00
3. 00	Occupational Therapy	0	292			0 87, 197		3.00
4. 00	Speech Pathology	0	28			0 10, 292		4.00
5. 00	Medical Social Services	0	43			0 16, 933		5.00
6. 00	Home Health Aide	0	842			0 46, 739		6.00
7. 00	Total (sum of lines 1-6)	0	5, 093			0 966, 050		7.00
	Cost Center Description							
		6. 00	7. 00	8. 00	9. 00	10. 00	11. 00	
	Limitation Cost Computation			1	_		1	
8. 00	Skilled Nursing Care							8.00
8. 01	Skilled Nursing Care							8. 01
8. 02	Skilled Nursing Care							8. 02
8. 03	Skilled Nursing Care							8.03
9. 00	Physical Therapy							9.00
9. 01 9. 02	Physical Therapy							9. 01 9. 02
9. 02 9. 03	Physical Therapy Physical Therapy							9.02
9. 03 10. 00	Occupational Therapy							10.00
10. 00	Occupational Therapy							10.00
10. 02								10.02
10. 03	Occupational Therapy							10.03
11.00	Speech Pathology							11.00
11. 01	Speech Pathology							11.0
11. 02	Speech Pathology							11. 02
11. 03	Speech Pathology							11. 03
12.00	Medical Social Services							12.00
12. 01	Medical Social Services							12. 0
12.02	Medical Social Services							12. 02
12. 03	Medical Social Services							12. 03
13.00	Home Health Aide							13.00
13. 01	Home Heal th Aide							13.01
	Home Health Aide							13. 02
	Home Heal th Aide							13.03
14.00	Total (sum of lines 8-13)	Donor			C+ -£			14.00
		Progi	ram Covered Cha	ar ges	Cost of Services			
					Jei vi ces			
			Par	t B		Part B		
	Cost Center Description	Part A	Not Subject	Subject to	Part A	Not Subject	Subject to	
	2222 22o. 2000. Pt on		to	Deductibles 8		to	Deductibles &	
			Deductibles &	Coi nsurance		Deductibles &	Coi nsurance	
			Coi nsurance			Coi nsurance		
		6. 00	7. 00	8. 00	9. 00	10. 00	11. 00	
	Supplies and Drugs Cost Computa							
	Cost of Medical Supplies	0			0			15.00
	Cost of Drugs		0	I	0	0	ι 0	16.00

APPOR1	TIONMENT OF PATIENT SERVICE COST		Provi der CCN:	: 151332	Peri od:	Worksheet H-3	3	
				HHA CCN:	157153	From 01/01/2014 To 12/31/2014	Part I Date/Time Pre 5/22/2015 1:3	epared:
				Title XV	/111	Home Health Agency I	PPS	-
	Cost Center Description	Total Program Cost (sum of cols. 9-10)				rigency		
	PART I - COMPUTATION OF LESSER COST LIMITATION		PROGRAM COST, AGGRI	EGATE OF THE P	ROGRAM LI	MITATION COST, O	R BENEFICIARY	
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	476, 493						1.00
2.00	Physi cal Therapy	328, 396						2.00
3. 00	Occupational Therapy	87, 197						3.00
4.00	Speech Pathology	10, 292						4.00
5.00	Medical Social Services	16, 933						5.00
6. 00 7. 00	Home Health Aide Total (sum of lines 1-6)	46, 739 966, 050						6. 00 7. 00
7.00	Cost Center Description	900, 030	·					7.00
	cost center bescription	12. 00				-		1
	Limitation Cost Computation	12.00				I		
8.00	Skilled Nursing Care							8.00
8. 01	Skilled Nursing Care							8.0
8. 02	Skilled Nursing Care							8. 02
8.03	Skilled Nursing Care							8.0
9. 00	Physi cal Therapy							9. 0
9. 01	Physi cal Therapy							9.0
9. 02	Physical Therapy							9. 0
9. 03 10. 00	Physical Therapy Occupational Therapy							9.0
10. 00	Occupational Therapy							10.00
10. 01	Occupational Therapy							10.0
10. 02								10.0
11. 00	Speech Pathology							11.0
11. 01	. 03							11.0
11. 02	. 03							11.0
11. 03	Speech Pathology							11.0
12. 00	Medical Social Services							12.0
12. 01	Medical Social Services							12.0
12. 02	Medical Social Services							12.0
12. 03	Medical Social Services							12.0
13.00	Home Heal th Ai de							13.0
13. 01	Home Health Aide							13.0
13. 02 13. 03	II							13. 0
	Home Health Aide	1						1 1.5 ()

Health Financial Systems DECATUR CO. MEMORIA								In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF PATIENT SERVICE COSTS						CCN: 151332		i od:	Worksheet H-3	
						157153		om 01/01/2014 12/31/2014	Part II Date/Time Pre	pared:
									5/22/2015 1:3	
					Title XVIII		Home Health		PPS	
					,		Agency I			
	Cost Center Description	From Wkst. C,	Cost to	Tot	tal HHA	HHA Shared		Transfer to		
		Part I, col.	Charge Ratio	Char	ge (from	Ancillary		Part I as		
		9, line		pr	ovi der	Costs (col.	1	Indi cated		
				re	cords)	x col. 2)				
		0	1. 00		2.00	3. 00		4. 00		
	PART II - APPORTIONMENT OF COS	T OF HHA SERVI	CES FURNISHED I	BY SHA	ARED HOSP	TAL DEPARTME	ENTS			
1.00	Physi cal Therapy	66.00	0. 525425		0		0 c	ol. 2, line 2.	. 00	1.00
2.00	Occupational Therapy	67.00	0. 569727		0		0 c	ol. 2, line 3.	. 00	2.00
3.00	Speech Pathology	68.00	0. 642791		0		0 c	ol. 2, line 4.	. 00	3.00
4.00	Cost of Medical Supplies	71.00	0. 800929		0		0 c	ol. 2, line 1!	5. 00	4.00
5.00	Cost of Drugs	73.00	0. 418367		0		0 c	ol. 2, line 1	6. 00	5.00

LOUL	Financial Systems DECATUR CO. MEMORIAL ATION OF HHA REIMBURSEMENT SETTLEMENT	Provi der	CCN: 151332	Period:	eu of Form CMS-2 Worksheet H-4	
	ATTON OF THE RETWINDORSEMENT SETTLEMENT	HHA CCN:	157153	From 01/01/2014	Part I-II	pared
		Ti tl	e XVIII	Home Health Agency I	PPS	ο μιι
					rt B	
			Part A	Not Subject to Deductibles &	Subject to Deductibles & Coinsurance	
			1.00	Coi nsurance		
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTON	INDV CHADO	1.00	2. 00	3. 00	
	Reasonable Cost of Part A & Part B Services	IART CHARG	LJ			1
00	Reasonable cost of services (see instructions)			0 0	0	1.0
00	Total charges			0 0	0	2.0
	Customary Charges					
. 00	Amount actually collected from patients liable for payment for on a charge basis (from your records)	servi ces		0 0	0	3.0
00	Amount that would have been realized from patients liable for p	payment		0 0	0	4. (
	for services on a charge basis had such payment been made in ac	cordance				
00	with 42 CFR §413.13(b)		0.0000	0.00000	0.00000	۱.,
00	Ratio of line 3 to line 4 (not to exceed 1.000000) Total customary charges (see instructions)		0.0000	0.000000	0.000000	1
00	Excess of total customary charges over total reasonable cost (c	complete		0 0	1	
00	only if line 6 exceeds line 1)	omprete				′.
00	Excess of reasonable cost over customary charges (complete only 1 exceeds line 6)	/if line		0 0	0	8.
00	Primary payer amounts			0 0	0	9.
			1	Part A	Part B	
				Servi ces	Servi ces	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			1.00	2. 00	
	Total reasonable cost (see instructions)			0	0	10.
	Total PPS Reimbursement - Full Episodes without Outliers			C	726, 000	11.
. 00	Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers			C	726, 000 4, 425	
				0	, , , , , , , , , , , , ,	12.
. 00	Total PPS Reimbursement - Full Episodes with Outliers			000000000000000000000000000000000000000	4, 425	12. 13.
. 00 . 00 . 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers			000000000000000000000000000000000000000	4, 425 11, 201 8, 335 39	12. 13. 14. 15.
. 00 . 00 . 00 . 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes			C C C C C C C C C C C C C C C C C C C	4, 425 11, 201 8, 335 39	12. 13. 14. 15. 16.
00 00 00 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments			000000000000000000000000000000000000000	4, 425 11, 201 8, 335 39 0 0	12 13 14 15 16 17
. 00 . 00 . 00 . 00 . 00 . 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments				4, 425 11, 201 8, 335 0 0 0 0	12. 13. 14. 15. 16. 17. 18.
. 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments				4, 425 11, 201 8, 335 0 0 0 0 0 0	12. 13. 14. 15. 16. 17. 18.
00 00 00 00 00 00 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments	rance)			4, 425 11, 201 8, 335 0 0 0 0 0 0	12. 13. 14. 15. 16. 17. 18. 19. 20.
00 00 00 00 00 00 00 00 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsur	rance)			4, 425 11, 201 8, 335 0 0 0 0 0 0 0 0	12. 13. 14. 15. 16. 17. 18. 19. 20. 21.
.00 .00 .00 .00 .00 .00 .00 .00 .00 .00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments	rance)			4, 425 11, 201 8, 335 0 0 0 0 0 0 0 0 0 0	12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22.
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsur Subtotal (sum of lines 10 thru 20 minus line 21)	rance)			4, 425 11, 201 8, 335 0 0 0 0 0 0 0 0 0 750, 000	12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23.
.00 .00 .00 .00 .00 .00 .00 .00 .00 .00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments 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)	rance)			4, 425 11, 201 8, 335 0 0 0 0 0 0 0 0 0 750, 000	12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24.
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments 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) Subtotal (line 22 minus line 23)	-ance)			4, 425 11, 201 8, 335 0 0 0 0 0 0 0 0 0 750, 000 0 750, 000	12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25.
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments 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) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records)	ŕ			4, 425 11, 201 8, 335 0 0 0 0 0 0 0 0 0 750, 000 0 750, 000	12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27.
.00 .00 .00 .00 .00 .00 .00 .00 .00 .00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments 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) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see ins	structi ons)		4, 425 11, 201 8, 335 9 0 0 0 0 0 0 0 0 750, 000 0 750, 000	12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28.
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments 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) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see ins Total costs - current cost reporting period (line 26 plus line	structi ons)		4, 425 11, 201 8, 335 39 0 0 0 0 0 750, 000 0 750, 000	12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29.
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments 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) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see ins Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	structi ons 27))		4, 425 11, 201 8, 335 39 0 0 0 0 0 0 750, 000 0 750, 000 0 750, 000	12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30.
00 00 00 00 00 00 00 00 00 00 00 00 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments 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) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see ins Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)	structi ons 27))		4, 425 11, 201 8, 335 39 0 0 0 0 0 750, 000 750, 000 750, 000 750, 000 750, 000 0 750, 000	12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 30.
00 00 00 00 00 00 00 00 00 00 00 00 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments 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) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see ins Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)	structi ons 27))		4, 425 11, 201 8, 335 39 0 0 0 0 0 750, 000 750, 000 750, 000 750, 000 750, 000	12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 30. 31.
00 00 00 00 00 00 00 00 00 00 00 00 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments DME Payments 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) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see ins Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) Sequestration adjustment (see instructions)	structi ons 27))		4, 425 11, 201 8, 335 39 0 0 0 0 0 750, 000 750, 000 750, 000 750, 000 750, 000 750, 000 750, 000	12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 30. 31. 31.
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments 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) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see ins Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) Sequestration adjustment (see instructions) Interim payments (see instructions)	structi ons 27))		750,000 750,000 750,000 750,000 750,000 750,000	12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 30. 30. 31. 31.
3. 00 4. 00 5. 00 5. 00 7. 00 8. 00 7. 00 8. 00 9.	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments DME Payments 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) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see ins Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) Sequestration adjustment (see instructions)	structions 27))		4, 425 11, 201 8, 335 39 0 0 0 0 0 750, 000 750, 000 750, 000 750, 000 750, 000 750, 000 750, 000 0 750, 000 0 750, 000	12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 30. 31. 31. 32. 33.

In Lieu of Form CMS-2552-10

Health Financial Systems

DECATUR CO. MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAS FOR SERVICES RENDERED TO Provider CCN: 151332

Period: From 01/01/2014 To 12/31/2014 Date/Time Prepared: 5/22/2015 1:38 pm

PPS

				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 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	735, 000 0	1. 00 2. 00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. 00
3. 01				0	0	3. 01
3. 02				0	0	3. 02
3. 03 3. 04				0	0 0	3. 03 3. 04
3. 04				0		3. 04
3.03	Provider to Program			<u> </u>	0	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	Cultural (0	0 0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	ا	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)			0	735, 000	4. 00
	TO BE COMPLETED BY CONTRACTOR			<u>'</u>		
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
5. 01	Program to Provider			ol	0	5. 01
5. 01				0		5. 02
5. 03				o	l ől	5. 03
	Provider to Program					
5. 50				0	0	5. 50
5. 51				0	0	5. 51
5. 52 5. 99	Subtatal (sum of lines F 01 F 40 minus sum of lines			0	0 0	5. 52 5. 99
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			O		
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER			0	0	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	735 000	6. 02
7. 00	Total Medicare program liability (see instructions)			Contractor	735,000 NPR Date	7. 00
		,)	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor		J	1.00	2.00	8. 00
5.00	Tham 3. John de toi			1	1	5. 00