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 MORGAN COUNTY HOSPITAL (150038) for the cost reporting period beginning 01/01/2014 and ending 12/31/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	212, 225	710	333, 933	0	1. 00
2.00	Subprovi der - I PF	0	1	0		0	2. 00
3.00	Subprovi der - I RF	0	0	0		0	3. 00
4.00	SUBPROVI DER I	0	0	0		0	4. 00
5.00	Swing bed - SNF	0	0	0		0	5. 00
6.00	Swing bed - NF	0				0	6. 00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7. 00
8.00	NURSING FACILITY	0				0	8. 00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9. 00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11. 00
12.00	CMHC I	0		0		0	12. 00
200.00	Total	0	212, 226	710	333, 933	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 MORGAN COUNTY HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 150038 Peri od: Worksheet S-2 From 01/01/2014 Part I 12/31/2014 Date/Time Prepared: 5/28/2015 1:03 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 2209 JOHN R WOODEN DRIVE 1.00 1.00 PO Box: State: IN 2.00 City: MARTINSVILLE Zip Code: 46151 County: MORGAN 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N)

/ XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal MORGAN COUNTY HOSPITAL 150038 26900 01/01/1966 Ν 0 3.00 Subprovider - IPF MORGAN COUNTY PSYCH 01/01/2004 Р 0 N 4.00 15S038 26900 4 4.00 UNI T 5.00 Subprovider - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7 00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 14.00 Hospi tal -Based Hospi ce 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 16.00 Hospital-Based Health Clinic - FQHC 16.00 Hospital-Based (CMHC) I 17.00 17.00 17. 10 Hospi tal -Based (CORF) I 17.10 18.00 Renal Dialysis 18.00 19. 00 19.00 Other To: From: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 20.00 01/01/2014 12/31/2014 21.00 Type of Control (see instructions) 21.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for disproportionate N 22.00 Υ share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(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 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 N Ν 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 "Y" for yes or "N" for no, for the portion of the cost reporting period on in column 2. or after October 1. Did this hospital receive a geographic reclassification from urban to rural as a result Ν 22.03 Ν 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. Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 3 N 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	0ther	
	Medi cai d	Medi cai d	State	State	HMO days	Medi cai d	
	pai d days	eligible	Medi cai d	Medi cai d		days	
		unpai d	pai d days	el i gi bl e			
		days		unpai d			
	1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
24.00 If this provider is an IPPS hospital, enter the	106	12	0	0	54	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.							
25.00 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.							

Health Financial Systems MORGAN COUNTY HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 150038 Peri od: Worksheet S-2 From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/28/2015 1:03 pm Unwei ghted Program Name Program Code Unweighted IME Direct GME FTE FTE Count Count 1.00 2.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0.00 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count. 61. 20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column direct GME FTE unweighted count. 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 62 01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter Ν 63.00 for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions) Unwei ghted Ratio (col. 1/ Unwei ahted **FTES** FTEs in (col . 1 + col Nonprovi der Hospi tal 2)) Si te 1. 00 2.00 3.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. 64.00 Enter in column 1, if line 63 is yes, or your facility trained residents 0.000000 64.00 0.00 n the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Unwei ghted Program Name Program Code Unwei ghted Ratio (col. 3/ FTĔs FTEs in (col. 3 + col. Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 0.00 0.00 0.000000 65.00 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all

non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)

Health Financial Systems MORGAN COUNTY HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 150038 Peri od: Worksheet S-2 From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/28/2015 1:03 pm Unwei ghted Unwei ghted Ratio (col. (col. 1 + col FTEs FTEs in Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 0. 00 66.00 Enter in column 1 the number of unweighted non-primary care resident 0.00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Program Code Unwei ghted Unwei ghted Ratio (col. 3/ FTEs FTEs in (col. 3 + colNonprovi der Hospi tal 4)) Si te 1.00 2 00 3. 00 4.00 5 00 67.00 Enter in column 1, the program 0. 00 0.00 0.000000 67.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS 70.00 70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Υ Enter "Y" for yes or "N" for no. If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most 71.00 Ν Ν 0 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF N 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most Ν 0 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions) 1.00 Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 80.00 N 81.00 | Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter N 81.00 Y" for yes and "N" for no. TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section N 85.00 86.00 §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.

Health Financial Systems MORGAN COUNTY HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 150038 Peri od: Worksheet S-2 From 01/01/2014 Part I 12/31/2014 Date/Time Prepared: 5/28/2015 1:03 pm 1. 00 2.00 128.00||f this is a Medicare certified liver transplant center, enter the certification date 128.00 in column 1 and termination date, if applicable, in column 2. 129.00|f this is a Medicare certified lung transplant center, enter the certification date in 129.00 column 1 and termination date, if applicable, in column 2. 130.00 of this is a Medicare certified pancreas transplant center, enter the certification 130.00 date in column 1 and termination date, if applicable, in column 2. 131.00 olf this is a Medicare certified intestinal transplant center, enter the certification 131.00 date in column 1 and termination date, if applicable, in column 2. 132.00 If this is a Medicare certified islet transplant center, enter the certification date 132.00 in column 1 and termination date, if applicable, in column 2. 133.00 If this is a Medicare certified other transplant center, enter the certification date 133.00 in column 1 and termination date, if applicable, in column 2. 134.00 If this is an organ procurement organization (0P0), enter the 0P0 number in column 1 134 00 and termination date, if applicable, in column 2. All Providers 140.00 Are there any related organization or home office costs as defined in CMS Pub. 15-1, 15H059 140.00 chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)

1.00

2.00 3 00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number. 141.00 Name: IU HEALTH, INC. Contractor's Name: WPS Contractor's Number: 08101 141.00 142.00 Street: 340 WEST 10TH ST PO Box: 142. 00 143.00 City: INDIANAPOLIS State: ΙN Zip Code: 46202 143. 00 1.00 144.00 Are provider based physicians' costs included in Worksheet A? 144.00 145.00 If costs for renal services are claimed on Worksheet A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no. N 145.00 1. 00 2.00 146.00 Has the cost allocation methodology changed from the previously filed cost report? 146. 00 Ν Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, § 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. N 147. 00 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 148. 00 Ν 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for Ν 149.00 no. Part A Title V 1.00 2.00 3.00 4.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal N N 155.00 Ν Ν N 156.00 Subprovi der - IPF Ν Ν Ν 156.00 157. 00 Subprovi der - IRF Ν 157. 00 Ν N Ν 158. 00 SUBPROVI DER 158 00 159. 00 SNF Ν Ν Ν Ν 159.00 160.00 HOME HEALTH AGENCY Ν Ν Ν Ν 160. 00 161.00 CMHC 161.00 Ν Ν Ν 161. 10 CORF N Ν Ν 161. 10 1.00 Multicampus 165.00|Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Enter "Y" for yes or "N" for no. FTE/Campus CBSA Name County State | Zip Code 5.00 0 1.00 2 00 3 00 4.00 166.00 If line 165 is yes, for each 0.00 166.00 campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 1.00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00|Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no. 167 00 Υ 168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the d168.00 reasonable cost incurred for the HIT assets (see instructions) 169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the 0.50169.00 transition factor. (see instructions)

Health Financial Systems				Lieu of Form CMS-2552-10		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTI	SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 150038 Period:					
			From 01/01/2014			
			To 12/31/2014		pared:	
				5/28/2015 1:0	3 pm	
			Begi nni ng	Endi ng		
			1. 00	2.00		
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting 07/01/2004 period respectively (mm/dd/yyyy)					170. 00	
				1.00		
171.00 If line 167 is "Y", does this provider have	e any days for individ	luals enrolled in secti	on 1876	N	171. 00	
Medicare cost plans reported on Wkst. S-3, (see instructions)						

	Financial Systems AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE:	MORGAN COUNTY HOSPITAL STIONNAIRE Provid		Peri od:	worksheet S-	
			F	From 01/01/2014 To 12/31/2014	Date/Time Pr	
				Y/N	5/28/2015 1: Date	03 pm
				1. 00	2.00	
	General Instruction: Enter Y for all YES resp mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	onses. Enter N for all NO	responses. Enter	all dates in	the	
. 00	Provider Organization and Operation Has the provider changed ownership immediatel reporting period? If yes, enter the date of	y prior to the beginning of the change in column 2. (so	of the cost	N		1.00
			Y/N	Date	V/I	
. 00	Has the provider terminated participation in yes, enter in column 2 the date of termination		1.00 N	2. 00	3.00	2.00
. 00	voluntary or "I" for involuntary. Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)					3. 00
			Y/N	Туре	Date	
	Financial Data and Reports		1.00	2. 00	3. 00	
. 00	Column 1: Were the financial statements prep Accountant? Column 2: If yes, enter "A" for or "R" for Reviewed. Submit complete copy or column 3. (see instructions) If no, see instr	Audited, "C" for Compiled enter date available in		R		4.00
. 00	Are the cost report total expenses and total	revenues different from	N			5. 00
	those on the filed financial statements? If y	yes, submit reconciliation		Y/N	Legal Oper.	
				1. 00	2.00	
	Approved Educational Activities Column 1: Are costs claimed for nursing school the legal operator of the program?	ool? Column 2: If yes, is	the provider is	N		6.00
00	Are costs claimed for Allied Health Programs? Were nursing school and/or allied health procost reporting period? If yes, see instruction	N N		7. 00 8. 00		
00	Are costs claimed for Intern-Resident program yes, see instructions.		cost report? If	N		9. 00
0. 00	Was an Intern-Resident program been initiated	d or renewed in the curren	t cost reporting	N		10.00
1. 00	period? If yes, see instructions. Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see		Approved	N		11. 00
					1. 00	
	Bad Debts					10.0
3. 00	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad deb period? If yes, submit copy.	ot collection policy change	e during this cos		Y N	12.00
	<u>If line 12 is yes, were patient deductibles a</u> Bed Complement	and/or co-payments waived?	If yes, see inst	ructions.	N	14. 00
	Did total beds available change from the price	or cost reporting period?	lf yes, see instr	ructions.	N	15. 0
		Dogosi nti on		rt A	Part B	
		Description O	Y/N 1.00	2. 00	Y/N 3.00	+
	PS&R Data			1		
5. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see		N		N	16.00
. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is		Y	04/21/2014	Y	17. 00
. 00	yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional		N		N	18. 00
9. 00	claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of		N		N	19. 00
	other PS&R Report information? If yes, see instructions.		N			20.00

Health Financial Systems MORGAN COUNTY HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provi der CCN: 150038 Peri od: Worksheet S-2 From 01/01/2014 Part II Date/Time Prepared: 12/31/2014 5/28/2015 1:03 pm Part A Part B Description Y/N Date Y/N 0 1.00 2.00 3.00 21 00 21.00 Was the cost report prepared only using the Ν N 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 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost 23.00 23.00 Ν reporting period? If yes, see instructions. 24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? Ν 24.00 If ves. see instructions Have there been new capitalized leases entered into during the cost reporting period? If yes, see Ν 25.00 25.00 instructions. 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see Ν 26,00 instructions. 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 N 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) Ν 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 instructions. 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see Ν 31.00 instructions. Purchased Services 32.00 Have changes or new agreements occurred in patient care services furnished through contractual N 32.00 arrangements with suppliers of services? If yes, see instructions.

If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If Ν 33.00 33.00 no, see instructions. Provider-Based Physicians Are services furnished at the provider facility under an arrangement with provider-based physicians? Υ 34.00 If yes, see instructions. Iffine 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

36.00	Were home office costs claimed on the cost report?		Υ		36.00
37.00	If line 36 is yes, has a home office cost statement been pr	repared by the home office?	Υ		37. 00
	If yes, see instructions.				
38.00	If line 36 is yes , was the fiscal year end of the home off	fice different from that of	N		38. 00
	the provider? If yes, enter in column 2 the fiscal year end				
39. 00	If line 36 is yes, did the provider render services to other	er chain components? If yes,	N		39. 00
	see instructions.				
40.00	j '	home office? If yes, see	N		40. 00
	i nstructi ons.				
		1.00	2.	00	
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position	RHONDA	UTTER		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	INDIANA UNIVERSITY HEALTH,			42.00
	preparer.	I NC.			
43.00	Enter the telephone number and email address of the cost	317-962-1093	RUTTER@I UHEALT	H. ORG	43. 00
	report preparer in columns 1 and 2, respectively.				

Heal th	Financial Systems	MORGAN COUNTY	/ HOSPI TAL	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMEN	QUESTI ONNAI RE	Provi der CCN: 150038	From 01/01/2014	Worksheet S-2 Part II Date/Time Pre 5/28/2015 1:0	pared:
		Part B Date 4.00				
16. 00	PS&R Data Was the cost report prepared using the F Report only? If either column 1 or 3 is					16. 00

		Pai L D			
		Date			
		4, 00			
	PS&R Data				
16. 00	Was the cost report prepared using the PS&R				16. 00
10.00	Report only? If either column 1 or 3 is yes,				10.00
	enter the paid-through date of the PS&R				
	Report used in columns 2 and 4 (see				
47.00	instructions)	04/04/0044			47.00
17. 00	Was the cost report prepared using the PS&R	04/21/2014			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				21. 00
21.00	provider's records? If yes, see				21.00
	instructions.				
	The trader one.				
			3.00		
	Cost Report Preparer Contact Information		3. 55		
41. 00		nosition	MANAGER		41. 00
41.00	held by the cost report preparer in columns		MANAGEN		41.00
	respectively.	i, 2, and 3,			
42. 00	Enter the employer/company name of the cost i	conort			42. 00
42.00		eboi r			42.00
42.00	preparer. Enter the telephone number and email address	of the cost	1		43. 00
43.00	report preparer in columns 1 and 2, respective				43.00
	Treport preparer in corumns rand 2, respectiv	vei y.	I	l	1

Provider CCN: 150038 | Period: | Worksheet S-3 | From 01/01/2014 | Part I | To 12/21/2014 | Part I | P Health Financial Systems MORGAI HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

					o 12/31/2014	Date/Time Prep 5/28/2015 1:03	
						I/P Days / 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	29	10, 585	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2. 00
3.00	HMO I PF 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		20	10 505	0.00	0	6. 00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)		29	10, 585	0.00	0	7. 00
8. 00	INTENSIVE CARE UNIT	31. 00	8	2, 920	0.00	0	8. 00
9. 00	CORONARY CARE UNIT	32. 00		1	0.00	0	9. 00
10. 00	BURN INTENSIVE CARE UNIT	33. 00		1			10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT	34. 00		1	0.00		11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)	54.00		,	0.00	o l	12. 00
13. 00	NURSERY	43. 00				o	13. 00
14. 00	Total (see instructions)	10.00	37	13, 505	0.00		14. 00
15. 00	CAH visits		0.	10,000	0.00	0	15. 00
16.00	SUBPROVIDER - IPF	40. 00	10	3, 650		o	16. 00
17.00	SUBPROVIDER - IRF	41. 00	C	0		o	17.00
18.00	SUBPROVI DER	42. 00	C	0		0	18.00
19.00	SKILLED NURSING FACILITY	44. 00	C	0		0	19.00
20.00	NURSING FACILITY	45. 00	C	0		0	20.00
21.00	OTHER LONG TERM CARE	46. 00	C	0			21.00
22. 00	HOME HEALTH AGENCY	101. 00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)	115. 00					23.00
24. 00	HOSPI CE	116. 00	C	0			24.00
24. 10	HOSPICE (non-distinct part)	30. 00					24. 10
25. 00	CMHC - CMHC	99. 00				0	
25. 10	CMHC - CORF	99. 10				0	25. 10
26. 00	RURAL HEALTH CLINIC	88. 00				0	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
27. 00	Total (sum of lines 14-26)		47				27. 00
28. 00	Observation Bed Days					0	28. 00
29. 00	Ambulance Trips						29. 00
30.00	Employee discount days (see instruction)						30.00
31. 00 32. 00	Employee discount days - IRF Labor & delivery days (see instructions)		c				31. 00 32. 00
32. 00	Total ancillary labor & delivery room			ή			32. 00 32. 01
32. UI	outpatient days (see instructions)						JZ. U1
33 00	LTCH non-covered days						33. 00
55.50			ı	1	l .	'	_0.00

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

				Т	o 12/31/2014	Date/Time Pre 5/28/2015 1:0	
		I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7. 00	8. 00	9. 00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	536	66	1, 088			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)	229	66				2. 00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO IRF Subprovider	0	0				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6. 00
7.00	Total Adults and Peds. (exclude observation	536	66	1, 088			7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	408	40	657			8. 00
9.00	CORONARY CARE UNIT	0	0	0			9. 00
10.00	BURN INTENSIVE CARE UNIT	0	0	0			10.00
11. 00	SURGICAL INTENSIVE CARE UNIT	0	0	0			11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		o	0			13. 00
14.00	Total (see instructions)	944	106	1, 745	0.00	206. 04	14.00
15.00	CAH visits	0	o	0			15. 00
16.00	SUBPROVI DER - I PF	2, 314	83	2, 764	0.00	16. 29	16. 00
17.00	SUBPROVI DER - I RF	O	o	0	0.00	0.00	17. 00
18.00	SUBPROVI DER	O	o	0	0.00	0.00	18. 00
19.00	SKILLED NURSING FACILITY	O	o	0	0.00	0.00	19. 00
20.00	NURSING FACILITY		o	0	0.00	0.00	20.00
21. 00	OTHER LONG TERM CARE			0	0.00	0.00	21. 00
22. 00	HOME HEALTH AGENCY	O	o	0	0.00	0.00	22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	İ			0.00	0.00	23. 00
24.00	HOSPI CE	o	o	0	0.00	0.00	24. 00
24. 10	HOSPICE (non-distinct part)	O	o	0			24. 10
25. 00	CMHC - CMHC	o	o	0	0.00	0.00	25. 00
25. 10	CMHC - CORF	o	o	0			
26. 00	RURAL HEALTH CLINIC	o	o	0			
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	o	o	0	0.00	0.00	26, 25
27. 00					0.00		27. 00
28. 00	Observation Bed Days		98	605			28. 00
29. 00		O					29. 00
30.00	Employee discount days (see instruction)			0			30.00
31. 00	1 . 3		İ	0			31. 00
32. 00	Labor & delivery days (see instructions)	O	o	0			32.00
32. 01	Total ancillary labor & delivery room	9	Ĭ	0			32. 01
	outpatient days (see instructions)			· ·			
33. 00	LTCH non-covered days	0					33. 00

Provider CCN: 150038 | Period: | Worksheet S-3 | From 01/01/2014 | Part I | To 12/31/2014 | Date/Time Prepared:

				To	12/31/2014	Date/Time Prep 5/28/2015 1:03	
		Full Time		Di scha	arges	372072013 1.0	J piii
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	268	64	540	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)			65	28		2. 00
3. 00	HMO IPF Subprovider			03	20		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
7.00	beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13.00	NURSERY						13. 00
14.00	Total (see instructions)	0. 00	0	268	64	540	14. 00
15. 00	CAH visits						15. 00
16. 00	SUBPROVI DER - I PF	0. 00	0	189	6	224	16. 00
17. 00	SUBPROVI DER - I RF	0. 00	0	0	0	0	17. 00
18. 00	SUBPROVI DER	0. 00	0	0	0	0	18. 00
19. 00	SKILLED NURSING FACILITY	0. 00					19. 00
20.00	NURSING FACILITY	0. 00					20.00
21. 00	OTHER LONG TERM CARE	0.00				0	21.00
22. 00	HOME HEALTH AGENCY	0.00					22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	0.00					23. 00
24. 00 24. 10	HOSPICE HOSPICE (non-distinct part)	0. 00					24. 00
25. 00	CMHC - CMHC	0. 00					25. 00
25. 10	CMHC - CORF	0.00					25. 00
26. 00	RURAL HEALTH CLINIC	0.00					26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27. 00	Total (sum of lines 14-26)	0.00					27. 00
28. 00	Observation Bed Days	0.00					28. 00
29. 00	Ambul ance Trips						29. 00
30.00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33 00	LTCH non-covered days						33.00

Provi der CCN: 150038

					Т	o 12/31/2014	Date/Time Pre 5/28/2015 1:0	
		Worksheet A	Amount	Reclassi fi cati	Adj usted	Paid Hours	Average Hourly	
		Line Number	Reported	on of Salaries (from	Sal ari es $(col.2 \pm col.$	Related to Salaries in	Wage (col. 4 ÷ col. 5)	
				Worksheet A-6)	3)	col . 4	001. 0)	
	DADT II WACE DATA	1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART II - WAGE DATA SALARIES							1
1.00	Total salaries (see	200. 00	12, 056, 690	0	12, 056, 690	462, 446. 00	26. 07	1.00
2. 00	instructions) Non-physician anesthetist Part		0	0	0	0.00	0. 00	2.00
2.00	A		0	,	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part		0	0	0	0.00	0. 00	3.00
4.00	B Physician-Part A -		0	0	0	0.00	0. 00	4.00
	Admi ni strati ve							
4. 01 5. 00	Physicians - Part A - Teaching Physician-Part B		0 354, 595	0	0 354, 595	0. 00 4, 432. 00	1	
6.00	Non-physician-Part B		0	ő	0	0.00		
7.00	Interns & residents (in an	21. 00	0	0	0	0.00	0. 00	7. 00
7. 01	approved program) Contracted interns and		0	0	0	0.00	0. 00	7. 01
	residents (in an approved				_			
8. 00	programs) Home office personnel		779, 329	0	779, 329	14, 676. 00	53. 10	8.00
9. 00	SNF	44. 00	0	Ö	0	0.00		
10. 00	Excluded area salaries (see		758, 892	. 0	758, 892	34, 479. 00	22. 01	10.00
	instructions) OTHER WAGES & RELATED COSTS							l
11. 00	Contract Labor: Direct Patient		0	0	0	0.00	0. 00	11. 00
12. 00	Care Contract Labor: Top Level		0	0	0	0.00	0.00	12.00
12.00	management and other					0.00	0.00	12.00
	management and administrative services							
13. 00	Contract Labor: Physician-Part		0	o	0	0.00	0.00	13. 00
14.00	A - Administrative		712 072		710 070	12 47/ 00	F2 04	14.00
14. 00	Home office salaries & wage-related costs		712, 073	0	712, 073	13, 476. 00	52.84	14. 00
15. 00	Home office: Physician Part A		0	0	0	0.00	0. 00	15. 00
16. 00	- Administrative Home office and Contract		0	0	0	0.00	0.00	16.00
	Physicians Part A - Teaching				_]
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		2, 779, 369	0	2, 779, 369		<u> </u>	17. 00
	instructions)				2, , 66 .			
18. 00	Wage-related costs (other) (see instructions)		0	0	0			18. 00
19. 00	Excluded areas		192, 744	. 0	192, 744			19. 00
20. 00	Non-physician anesthetist Part		0	0	0			20. 00
21. 00	Non-physician anesthetist Part		0	0	0			21. 00
00.00	В							00.00
22. 00	Physician Part A - Administrative		U) U	U			22. 00
22. 01	Physician Part A - Teaching		0	0	0			22. 01
23. 00 24. 00	Physician Part B Wage-related costs (RHC/FQHC)		90, 061	0	90, 061			23. 00 24. 00
25. 00	Interns & residents (in an		0	ő	0			25. 00
	approved program) OVERHEAD COSTS - DIRECT SALARIE	c						
26. 00	Employee Benefits Department	4. 00	274, 311	0	274, 311	7, 506. 00	36. 55	26. 00
27. 00	Administrative & General	5. 00	1, 585, 396	0	1, 585, 396			
28. 00	Administrative & General under contract (see inst.)		0	0	0	0.00	0. 00	28. 00
29. 00	Maintenance & Repairs	6. 00	0	0	0	0.00		
30. 00 31. 00	Operation of Plant Laundry & Linen Service	7. 00 8. 00	351, 371 9, 098		351, 371 9, 098	· ·		
32. 00	Housekeepi ng	9. 00	438, 951		438, 951			1
33. 00	Housekeeping under contract		0	1	0			1
34. 00	(see instructions) Dietary	10. 00	353, 952	-176, 254	177, 698	13, 589. 00	13. 08	34.00
35. 00	Di etary under contract (see	. 3. 30	0	0	0	0.00		1
36. 00	instructions) Cafeteria	11. 00	0	176, 254	176, 254	13, 478. 00	13. 08	36.00
37. 00	Maintenance of Personnel	12. 00	0	0	170, 254	0.00		
38. 00	Nursing Administration	13. 00	309, 537	0	309, 537			38.00
39. 00 40. 00	Central Services and Supply Pharmacy	14. 00 15. 00	572, 921	0	572, 921	0. 00 14, 155. 00		39.00
	·				-, -, -, -, -, -, -, -, -, -, -, -, -, -	.,		

Health Financial Systems	MORGAN COUNT	ΓΥ HOSPI TAL		In Lie	eu of Form CMS-2			
HOSPITAL WAGE INDEX INFORMATION						Worksheet S-3		
				l -	From 01/01/2014 Fo 12/31/2014		narod:	
						5/28/2015 1:0		
	Worksheet A	Amount	Recl assi fi cati			Average Hourly		
	Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷		
			(from	(col.2 ± col.	Salaries in	col. 5)		
			Worksheet A-6)	3)	col. 4			
	1.00	2. 00	3.00	4. 00	5. 00	6. 00		
41.00 Medical Records & Medical	16. 00	1, 669	0	1, 669	86.00	19. 41	41.00	
Records Library								
42.00 Social Service	17. 00	C	0	(0.00	0.00	42.00	
43.00 Other General Service	18. 00	C) o		0.00	0. 00	43. 00	

Hearth Financial Systems				MORGAN COUNT	Y HUSPITAL		In Lieu of Form CMS-2			
	HOSPI T	AL WAGE INDEX INFORMATION			Provi der		Peri od:	Worksheet S-3		
							From 01/01/2014	Part III		
							To 12/31/2014	Date/Time Pre	pared:	
								5/28/2015 1:0	3 pm	
			Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly		
			Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷		
					(from	(col.2 ± col.	Salaries in	col. 5)		
					Worksheet A-6)	3)	col. 4			
			1.00	2.00	3. 00	4. 00	5. 00	6. 00		
		PART III - HOSPITAL WAGE INDEX	SUMMARY							
	1.00	Net salaries (see		10, 922, 766	0	10, 922, 76	6 443, 338. 00	24. 64	1. 00	
		l:	1		1	I	1	1	1	

758, 892

712, 073

2, 779, 369

13, 655, 316

3, 897, 206

10, 163, 874

0

0

0

34, 479. 00

408, 859. 00

13, 476. 00

422, 335. 00

176, 859. 00

0.00

22.01

24. 86

52.84

27. 35

32. 33

22.04

2.00

3.00

4.00

5.00

6.00

7.00

758, 892

712, 073

2, 779, 369

13, 655, 316

3, 897, 206

10, 163, 874

instructions)

instructions)

minus line 2)

(see inst.)

instructions)

Excluded area salaries (see

Subtotal other wages & related

costs (see inst.) Subtotal wage-related costs

Total (sum of lines 3 thru 5)

Total overhead cost (see

Subtotal salaries (line 1

2.00

3.00

4.00

5.00

6.00

7.00

Health Financial Systems	MORGAN COUNTY HOSPITAL	OSPITAL In Lieu of Form CMS-25		
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 150038	From 01/01/2014	Worksheet S-3 Part IV Date/Time Prepared:	

	To 12/31/2014	Date/Time Prep 5/28/2015 1:03	pared: 3 pm
		Amount	
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	313, 272	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	ol	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	o	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	o	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	1, 774, 068	8. 00
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	35, 969	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	2, 827	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	29, 333	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	68, 547	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16.00
	Non cumulative portion)		
	TAXES		
	FICA-Employers Portion Only	798, 370	
18.00	Medicare Taxes - Employers Portion Only	0	18. 00
19.00	Unempl oyment Insurance	0	19. 00
20.00	State or Federal Unemployment Taxes	39, 788	20. 00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see	0	21. 00
	instructions))		
	Day Care Cost and Allowances	0	22. 00
	Tuition Reimbursement	0	23. 00
24. 00	Total Wage Related cost (Sum of lines 1 -23)	3, 062, 174	24. 00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00

	51		001.741			6.5. 0110.4	
	Financial Systems	MORGAN COUNTY HO	-			u of Form CMS-2	2552-10
HOSPI I	AL CONTRACT LABOR AND BENEFIT COST		Provi der CC	: 150038	Peri od:	Worksheet S-3	
					From 01/01/2014 To 12/31/2014	Part V Date/Time Pre	narod:
					10 12/31/2014	5/28/2015 1:0	
	Cost Center Description				Contract Labor		
					1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost						
	Hospital and Hospital-Based Component Identif	i cati on:					
1.00	Total facility's contract labor and benefit of	cost			0	3, 062, 174	1. 00
2.00	Hospi tal				0	2, 779, 369	2. 00
3.00	Subprovider - IPF				0	192, 744	3.00
4.00	Subprovider - IRF				0	0	4.00
5.00	Subprovider - (Other)				0	0	5.00
6.00	Swing Beds - SNF				0	0	6. 00
7.00	Swing Beds - NF				0	0	7. 00
8.00	Hospi tal -Based SNF				0	0	8. 00
9.00	Hospi tal -Based NF				0	0	9. 00
10.00	Hospi tal -Based OLTC						10.00
11.00	Hospi tal -Based HHA				0	0	11. 00
12.00	Separately Certified ASC				0	0	12.00
13.00	Hospi tal -Based Hospi ce				0	0	13.00
14.00	Hospital-Based Health Clinic RHC				0	0	14.00
15. 00	Hospital-Based Health Clinic FQHC				0	0	15.00
16.00	Hospi tal -Based-CMHC				0	0	16. 00
16. 10	Hospi tal -Based-CMHC 10				0	0	16. 10
17. 00	Renal Dialysis				0	0	17. 00
18.00	Other				0	90, 061	18. 00
	•				•	'	

	Financial Systems MORGAN COUNTY HO	_		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der	CCN: 150038	Peri od:	Worksheet S-10	0
				From 01/01/2014 To 12/31/2014	Date/Time Prep 5/28/2015 1:03	
	Uncompensated and indigent care cost computation				1. 00	
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	ided by Li	ne 202 colum	n 8)	0. 275288	1.00
1.00	Medicaid (see instructions for each line)	raca by iii	10 202 COT UIII	11 0)	0.270200	1.00
2. 00	Net revenue from Medicaid				6, 434, 516	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental	payments	from Medicai	d?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from	Medi cai d			0	5.00
6.00	Medicaid charges				19, 130, 355	6.00
7.00	Medicaid cost (line 1 times line 6)				5, 266, 357	7. 00
8. 00	Difference between net revenue and costs for Medicaid program (< zero then enter zero)	line 7 min	us sum of li	nes 2 and 5; if	0	8. 00
	State Children's Health Insurance Program (SCHIP) (see instruct	ions for ea	ach line)			
9.00	Net revenue from stand-alone SCHIP				0	
10. 00	Stand-alone SCHIP charges				0	10.00
11. 00	Stand-alone SCHIP cost (line 1 times line 10)				0	
12. 00	Difference between net revenue and costs for stand-alone SCHIP enter zero)				0	12.00
	Other state or local government indigent care program (see inst					
13.00	Net revenue from state or local indigent care program (Not incl				539, 137	
14. 00	Charges for patients covered under state or local indigent care 10)		NOT INCIUAEA	in lines 6 or	3, 720, 123	14.00
15. 00	State or local indigent care program cost (line 1 times line 14	,			1, 024, 105	
16. 00	Difference between net revenue and costs for state or local ind 13; if < zero then enter zero)	igent care	program (li	ne 15 minus line	484, 968	16.00
	Uncompensated care (see instructions for each line)					
17. 00	Private grants, donations, or endowment income restricted to fu				0	
18.00	Government grants, appropriations or transfers for support of h			ma (aum af linas	404.060	
19. 00	Total unreimbursed cost for Medicaid , SCHIP and state and loca 8, 12 and 16)	ı ınaigent			484, 968	19. 00
			Uni nsured	Insured	Total (col. 1	
		-	patients 1.00	pati ents 2.00	+ col . 2)	
20. 00	Total initial obligation of patients approved for charity care	(at full	1, 606, 4		3. 00 2, 103, 735	20.00
20.00	charges excluding non-reimbursable cost centers) for the entire		1, 000, 4	477, 202	2, 103, 730	20.00
21. 00	Cost of initial obligation of patients approved for charity car times line 20)		442, 2	136, 890	579, 133	21. 00
22. 00	Partial payment by patients approved for charity care	ŀ	3, 9	32 12, 311	16, 243	22. 00
23. 00	Cost of charity care (line 21 minus line 22)		438, 3	·	562, 890	
		'	, .	,	1. 00	
24. 00	Does the amount in line 20 column 2 include charges for patient	days heve	nd a Length	of stay limit	1.00	24. 00
∠→. ∪∪	imposed on patients covered by Medicaid or other indigent care		ia a rengtii	or stay irmit		24.00
25. 00	If line 24 is "yes," charges for patient days beyond an indige		ogram's Lena	th of stav limit	0	25. 00
26. 00	Total bad debt expense for the entire hospital complex (see ins		5		6, 338, 267	
27. 00	Medicare bad debts for the entire hospital complex (see instruc				1, 300	
28. 00	Non-Medicare and non-reimbursable Medicare bad debt expense (li		s line 27)		6, 336, 967	
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt exp			e 28)	1, 744, 491	
	Cost of uncompensated care (line 23 column 3 plus line 29)				2, 307, 381	30.00
30.00	loost of discomposited out o (11110 20 out amin o pride 11110 27)					

	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	MORGAN COUNTY		CCN: 150038 F	In Lie Period:	u of Form CMS-2 Worksheet A	2552-10
KLULAS	STITICATION AND ADJUSTMENTS OF TRIAL BALANCE C	JI EAFLINGES	Frovider	1	rom 01/01/2014		
					Го 12/31/2014	Date/Time Pre 5/28/2015 1:0	
	Cost Center Description	Sal ari es	0ther		Reclassificati	Reclassified	
				+ col. 2)	ons (See A-6)	Trial Balance (col. 3 +-	
		1.00	0.00	2.22		col . 4)	
	GENERAL SERVICE COST CENTERS	1.00	2. 00	3. 00	4. 00	5. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT		0	(2, 592, 171	2, 592, 171	1.00
2. 00 3. 00	00200 CAP REL COSTS-MVBLE EQUIP 00300 OTHER CAP REL COSTS		0	(782, 840	782, 840 0	2. 00 3. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	274, 311	3, 171, 776	3, 446, 08 ⁻	7 -10, 710	3, 435, 377	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	1, 585, 396	10, 973, 885			9, 674, 654	
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	351, 371 9, 098	1, 347, 204 61, 264			1, 698, 575 70, 362	
9. 00	00900 HOUSEKEEPI NG	438, 951	68, 198	'		507, 149	
10.00	01000 DI ETARY	353, 952	142, 446	496, 398		249, 081	
11. 00 12. 00	01100 CAFETERI A 01200 MAI NTENANCE OF PERSONNEL	0	0		247, 186	247, 186 0	11. 00 12. 00
13. 00	01300 NURSING ADMINISTRATION	309, 537	18, 761	328, 298	-123	328, 175	
14.00	01400 CENTRAL SERVICES & SUPPLY	0	34, 445	34, 44!		34, 445	1
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	572, 921 1, 669	689, 842 132, 921	1, 262, 763 134, 590		664, 675 134, 587	1
17. 00	01700 SOCIAL SERVICE	0	0	(o	0	17. 00
19. 00 20. 00	01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING SCHOOL	0	0	(0	0	19. 00 20. 00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRVD	0	0			0	21.00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	0	(0	0	22. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	521, 811	799, 876	1, 321, 68	7 -2, 023	1, 319, 664	30.00
31. 00	03100 INTENSIVE CARE UNIT	653, 943	106, 307	760, 250		754, 452	
32.00	03200 CORONARY CARE UNIT	0	0	(0	0	
33. 00 34. 00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0	0			0	33. 00 34. 00
40.00	04000 SUBPROVI DER - I PF	745, 294	350, 118	1, 095, 412	-296	1, 095, 116	40. 00
41. 00	04100 SUBPROVI DER - I RF	0	0	(0	0	
42. 00 43. 00	04200 SUBPROVI DER 04300 NURSERY	0	0			0	42. 00 43. 00
44.00	04400 SKILLED NURSING FACILITY	0	0	(o o	0	44. 00
45. 00 46. 00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0	0	(0	45. 00 46. 00
40.00	ANCI LLARY SERVI CE COST CENTERS		0		<i>σ</i>	0	40.00
50.00	05000 OPERATING ROOM	813, 901	694, 499	1, 508, 400	-399, 120	1, 109, 280	1
51. 00 52. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	0			0	51. 00 52. 00
53.00	05300 ANESTHESI OLOGY	O	0	· ·	o o	0	53. 00
54. 00 55. 00	05400 RADI OLOGY THERADEUT C	1, 777, 328	3, 932, 777	5, 710, 10!	-2, 464, 369	3, 245, 736 0	1
	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0	0			0	
57.00	05700 CT SCAN	0	0	(o o	0	57. 00
58. 00 59. 00	05800 MAGNETIC RESONANCE I MAGING (MRI) 05900 CARDIAC CATHETERIZATION	0	0	(0	0	58. 00 59. 00
60.00	06000 LABORATORY	939, 073	1, 151, 836	2, 090, 90	-51, 352	2, 039, 557	
60. 01	06001 BLOOD LABORATORY	0	0		o o	0	
61. 00 62. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0			0	61. 00 62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	o	0	Č	o o	0	63. 00
64.00	06400 NTRAVENOUS THERAPY	0	0	(50.40	0	0	64.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	551, 436 415, 440	102, 261 12, 738	653, 69 ⁻ 428, 178		619, 021 427, 784	
67. 00	06700 OCCUPATI ONAL THERAPY	189, 001	3, 175	192, 176		192, 176	
68.00	06800 SPEECH PATHOLOGY	35, 462	533	35, 99!		35, 995	
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	38, 159	0	38, 159		38, 159 0	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		224, 901	224, 901	71. 00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	(44, 449	44, 449	
74.00	07400 RENAL DIALYSIS	0	0		2, 827, 301 0 0	2, 827, 301 0	1
	07500 ASC (NON-DISTINCT PART)	0	0		o	0	
76. 97	O7697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	133, 264	22, 022	155, 286	<u> </u>	155, 286	76. 97
88. 00	08800 RURAL HEALTH CLINIC	0	0	(0	0	
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0 74, 707	0 1, 691	76, 398		0 76, 398	89. 00 90. 00
91.00	09100 EMERGENCY	1, 257, 067	211, 840			1, 448, 955	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
94. 00	OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S	0	0	(ol ol	0	94.00
	09500 AMBULANCE SERVI CES	o	0			0	
						·	

Health Financial Systems	MORGAN COUNTY			In Lie	u of Form CMS-:	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der	CCN: 150038	Peri od:	Worksheet A	
				From 01/01/2014 To 12/31/2014	Doto/Time Dro	narad.
				To 12/31/2014	Date/Time Pre 5/28/2015 1:0	
Cost Center Description	Sal ari es	Other	Total (col.	1 Reclassi fi cati		J pin
			+ col . 2)	ons (See A-6)		
			,	, ,	(col. 3 +-	
					col. 4)	
	1. 00	2. 00	3.00	4. 00	5. 00	
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0	96. 00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0	0	97. 00
99. 00 09900 CMHC	0	0		0 0	0	99. 00
99. 10 09910 CORF	0	0		0 0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0		0	0	100. 00
101.00 10100 HOME HEALTH AGENCY	0	0		0 0	0	101. 00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0		0		105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0		0		106. 00
107.00 10700 LI VER ACQUI SI TI ON	0	0		0		107. 00
108. 00 10800 LUNG ACQUI SI TI ON	0	0		0		108. 00
109.00 10900 PANCREAS ACQUISITION	0	0		0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0		0		110. 00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0		111. 00
113. 00 11300 I NTEREST EXPENSE		0		0		113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF	0	0		0		114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0		115. 00
116. 00 11600 HOSPI CE	0	0		0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	12, 043, 092	24, 030, 415	36, 073, 5	07 0	36, 073, 507	118. 00
NONREI MBURSABLE COST CENTERS			Г			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190. 00
191. 00 19100 RESEARCH	0	0		0		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	13, 598	3, 323	16, 9	21 0		192. 00
193. 00 19300 NONPAI D WORKERS	0	0		0		193. 00
200.00 TOTAL (SUM OF LINES 118-199)	12, 056, 690	24, 033, 738	36, 090, 4	28 0	36, 090, 428	J200. 00

Provi der CCN: 150038 Peri od: From 01/01/2014 To 12/31/2014

Worksheet A Date/Time Prepared: 5/28/2015 1:03 pm

			5/28/2015 1:0	3 pm
Cost Center Description	Adjustments	Net Expenses		
	(See A-8) 6.00	For Allocation 7.00		
GENERAL SERVICE COST CENTERS	0.00	7.00		
1.00 O0100 CAP REL COSTS-BLDG & FIXT	-783, 235	1, 808, 936		1.00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP	39, 088			2. 00
3.00 00300 OTHER CAP REL COSTS	0			3. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	0			4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL	-4, 322, 402			5. 00
7. 00 00700 0PERATI ON OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE	0	.,,		7. 00 8. 00
9. 00 00900 HOUSEKEEPI NG				9.00
10. 00 01000 DI ETARY	0			10.00
11. 00 01100 CAFETERI A	-13, 686			11. 00
12.00 01200 MAINTENANCE OF PERSONNEL	-87, 302			12. 00
13.00 01300 NURSING ADMINISTRATION	-6, 859	321, 316		13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	0			14. 00
15. 00 01500 PHARMACY	-3, 663			15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0		1	16.00
17. 00 01700 SOCIAL SERVICE 19. 00 01900 NONPHYSICIAN ANESTHETISTS	0	0		17. 00 19. 00
20. 00 02000 NURSI NG SCHOOL		0		20.00
21. 00 02100 &R SERVI CES-SALARY & FRINGES APPRVD	Ö	1		21.00
22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0		i e	22. 00
INPATIENT ROUTINE SERVICE COST CENTERS		•		
30. 00 03000 ADULTS & PEDI ATRI CS	0			30. 00
31. 00 03100 INTENSIVE CARE UNIT	0		•	31.00
32. 00 03200 CORONARY CARE UNIT	0	1		32.00
33. 00 03300 BURN INTENSIVE CARE UNIT	0	0		33.00
34. 00 03400 SURGI CAL INTENSI VE CARE UNIT 40. 00 04000 SUBPROVI DER - IPF	-2, 866	1, 092, 250		34. 00 40. 00
41. 00 04100 SUBPROVI DER - 1 RF	-2,000	1,072,230		41.00
42. 00 04200 SUBPROVI DER	Ö	0		42. 00
43. 00 04300 NURSERY	0	Ō		43. 00
44.00 04400 SKILLED NURSING FACILITY	0	0		44. 00
45.00 04500 NURSING FACILITY	0		l .	45. 00
46. 00 04600 OTHER LONG TERM CARE	0	0)	46. 00
ANCILLARY SERVICE COST CENTERS	0 (15	1 000 //5	1	F0 00
50. 00 05000 0PERATING ROOM 51. 00 05100 RECOVERY ROOM	-9, 615 0		l .	50. 00 51. 00
52. 00 05200 DELI VERY ROOM & LABOR ROOM		1		52.00
53. 00 05300 ANESTHESI OLOGY	0			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	-4, 457	3, 241, 279		54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0			55. 00
56. 00 05600 RADI OI SOTOPE	0	0		56. 00
57.00 05700 CT SCAN	0	0		57. 00
58. 00 05800 MAGNETIC RESONANCE MAGING (MRI)	0	0		58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	255 742	1 702 014		59.00
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY	-255, 743	1, 783, 814		60. 00 60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0		61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	Ö	0		62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00 06400 INTRAVENOUS THERAPY	0	0		64. 00
65. 00 06500 RESPI RATORY THERAPY	0	619, 021		65. 00
66. 00 06600 PHYSI CAL THERAPY	0	427, 784		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	192, 176		67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	20 150	35, 995	l .	68.00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	-38, 159 0			69. 00 70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		l		71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	Ö	44, 449		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	2, 827, 301		73. 00
74.00 07400 RENAL DIALYSIS	0	0		74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		75. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	155, 286)	76. 97
OUTPATIENT SERVICE COST CENTERS		1 -		00.00
88. 00 08800 RURAL HEALTH CLINIC	0			88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC	-50, 907	-		89. 00 90. 00
91. 00 09000 CETNTC 91. 00 09100 EMERGENCY	11, 668		·	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	11,000	1, 150, 525		92.00
OTHER REIMBURSABLE COST CENTERS				1
94.00 09400 HOME PROGRAM DIALYSIS	0	0		94. 00
95. 00 09500 AMBULANCE SERVI CES	0			95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0			96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	<u>'</u>	97. 00

Health FinancialSystemsMORGAN CORRECTRECLASSIFICATIONAND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES In Lieu of Form CMS-2552-10 MORGAN COUNTY HOSPITAL Provi der CCN: 150038

			5/28/2015	
Cost Center Description	Adjustments	Net Expenses		
		For Allocation		
	6. 00	7. 00		
99. 00 09900 CMHC	0	0		99. 00
99. 10 09910 CORF	0	0		99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0		100. 00
101.00 10100 HOME HEALTH AGENCY	0	0		101. 00
SPECIAL PURPOSE COST CENTERS				
105.00 10500 KIDNEY ACQUISITION	0	0		105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0		106. 00
107.00 10700 LIVER ACQUISITION	0	0		107. 00
108.00 10800 LUNG ACQUISITION	0	0		108. 00
109.00 10900 PANCREAS ACQUISITION	0	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0		110. 00
111.00 11100 I SLET ACQUISITION	0	0		111. 00
113.00 11300 INTEREST EXPENSE	0	0		113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF	0	0		114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		115. 00
116. 00 11600 HOSPI CE	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	-5, 528, 138	30, 545, 369		118. 00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
191. 00 19100 RESEARCH	0	0		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	16, 921		192. 00
193.00 19300 NONPALD WORKERS	0	0		193. 00
200.00 TOTAL (SUM OF LINES 118-199)	-5, 528, 138	30, 562, 290		200. 00

					5/28/2015 1:	
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
	A - DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00		<u>2, 532, 5</u> 97		1. 00
	0		0	2, 532, 597		
	B - DIETARY					
1. 00	CAFETERI A	<u>11.</u> 00	17 <u>6, 2</u> 54	7 <u>0, 9</u> 32		1. 00
	0		176, 254	70, 932		
	C - EQUIPMENT RENTAL					
1. 00	CAP REL COSTS-MVBLE EQUIP	2. 00	0	524, 366		1. 00
2.00		0.00	0	0		2. 00
3.00		0.00	0	0		3. 00
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
6. 00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8. 00		0.00	0	0		8. 00
9.00		0.00	0	0		9. 00
	0			524, 366		
4 00	D - BILLABLE MED SUPPLIES	74 00		204 204		4 00
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	224, 901		1. 00
2.00	PATI ENTS	0.00		0		2.00
		0.00	0	0		2. 00
3. 00 4. 00		0.00	0	0		3. 00
4. 00 5. 00		0. 00 0. 00	0	0		4. 00 5. 00
		0.00	0	0		
6. 00 7. 00		0.00	0	0		6. 00 7. 00
7.00				<u>0</u> 224, 901		7.00
	E - IMPLANT		<u> </u>	224, 701		-
1. 00	IMPL. DEV. CHARGED TO	72.00	0	44, 449		1.00
1.00	PATI ENTS	72.00	٥	77, 777		1.00
		+		44, 449		
	F - I NSURANCE		<u> </u>	11, 112		
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	59, 574		1.00
	0	— — ··· °+	— — o	59, 574		1
	G - CAPITAL LEASE INTEREST		-1	21, 21		
1.00	CAP REL COSTS-MVBLE EQUIP	2. 00	0	258, 474		1.00
				258, 474		
	J - BILLABLE DRUGS	· · · · · · · · · · · · · · · · · · ·	· · · · · · · · · · · · · · · · · · ·	, ,		1
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	2, 827, 301		1. 00
2.00		0.00	O	0		2. 00
3.00		0.00	O	0		3. 00
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
6.00		0.00	O	0		6. 00
7.00		0.00	0	0		7. 00
8.00		0.00	0	0		8. 00
9.00		0.00	0	0		9. 00
10.00		0.00	0	0		10.00
11. 00		0.00	0	0		11. 00
12.00		0.00	0	0		12. 00
13.00		0.00	0	0		13. 00
14.00		0.00	0	0		14. 00
15. 00		0.00	0	0		15. 00
	0		0	2, 827, 301		
500.00	Grand Total: Increases		176, 254	6, 542, 594		500.00

| Peri od: | Worksheet A-6 | From 01/01/2014 | To 12/31/2014 | Date/Time Prepared: Provider CCN: 150038

						5/28/2015 1	
		Decreases		,			
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	A - DEPRECIATION						
1.00	ADMI NI STRATI VE & GENERAL		0	<u>2, 532, 5</u> 97	9		1. 00
	0		0	2, 532, 597			
	B - DI ETARY						
1.00	DI ETARY	1000	17 <u>6, 2</u> 54	7 <u>0, 9</u> 32			1. 00
	0		176, 254	70, 932			
	C - EQUIPMENT RENTAL				T		
1. 00	ADMINISTRATIVE & GENERAL	5. 00	0	33, 202	9	1	1. 00
2.00	PHARMACY	15. 00	0	230, 046		1	2. 00
3.00	ADULTS & PEDIATRICS	30.00	0	1, 453			3. 00
4.00	INTENSIVE CARE UNIT	31.00	0	2, 719	9		4. 00
5.00	OPERATING ROOM	50.00	0	185, 833	9		5. 00
6.00	RADI OLOGY-DI AGNOSTI C	54.00	0	6, 785			6. 00
7.00	LABORATORY	60.00	0	51, 236			7. 00
8.00	RESPIRATORY THERAPY	65.00	0	13, 060			8. 00
9. 00	EMERGENCY	91.00	0	32			9. 00
	D - BILLABLE MED SUPPLIES		U _I	524, 366			
1. 00	ADULTS & PEDIATRICS	30.00	0	546	0	I	1.00
2. 00	INTENSIVE CARE UNIT	31. 00	0	2, 615			2. 00
3. 00	SUBPROVIDER - IPF	40. 00	0	2, 613	0	1	3. 00
4. 00	OPERATING ROOM	50.00	0	165, 523	0		4. 00
5. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	18, 443	0		5. 00
6. 00	RESPIRATORY THERAPY	65. 00	0	17, 810			6. 00
7. 00	EMERGENCY	91.00	0	17, 810			7. 00
7.00	n		— — —	224, 901			7.00
	E - IMPLANT		<u> </u>	224, 701			
1.00	OPERATING ROOM	50.00	0	44, 449	0		1.00
	0			44, 449			1 55
	F - INSURANCE		-1			l	
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	59, 574	9		1.00
	0			59, 574			
	G - CAPITAL LEASE INTEREST			•	<u> </u>		
1.00	ADMINISTRATIVE & GENERAL	5.00	0	258, 474	9		1. 00
				258, 474			İ
	J - BILLABLE DRUGS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	10, 710	0		1. 00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	780	0		2. 00
3.00	DI ETARY	10.00	0	131	0		3. 00
4.00	NURSING ADMINISTRATION	13. 00	0	123			4. 00
5.00	PHARMACY	15. 00	0	368, 042	0		5. 00
6. 00	MEDICAL RECORDS & LIBRARY	16. 00	0	3	0		6. 00
7.00	ADULTS & PEDIATRICS	30.00	0	24	0		7. 00
8.00	INTENSIVE CARE UNIT	31.00	0	464	0		8. 00
9.00	SUBPROVI DER - I PF	40. 00	0	9	0		9. 00
10.00	OPERATING ROOM	50.00	0	3, 315	0		10. 00
11. 00	RADI OLOGY-DI AGNOSTI C	54. 00	0	2, 439, 141	0		11. 00
12.00	LABORATORY	60.00	0	116			12. 00
13.00	RESPI RATORY THERAPY	65. 00	0	3, 806			13. 00
14.00	PHYSI CAL THERAPY	66.00	0	394			14. 00
15. 00	EMERGENCY	91.00	9	243	<u> </u>	1	15. 00
F00 00	U Consideration De		0	2, 827, 301		1	F00 00
500.00	Grand Total: Decreases		176, 254	6, 542, 594	l	I	500. 00

 SPITAL
 In Lieu of Form CMS-2552-10

 Provider CCN: 150038
 Period: Worksheet A-7

 From 01/01/2014
 Part I

 To 12/23/2014
 Part I

					o 12/31/2014	Date/Time Pre 5/28/2015 1:0	pared:
				Acqui si ti ons		372072013 1.0	5 piii
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2. 00	3.00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	Γ BALANCES					
1.00	Land	1, 769, 000	0	(0	0	1. 00
2.00	Land Improvements	934, 000	0	(0	0	2. 00
3.00	Buildings and Fixtures	18, 240, 000	0	(0	0	3. 00
4.00	Building Improvements	0	0	(0	0	4. 00
5.00	Fixed Equipment	43,000	0	(0	0	5. 00
6.00	Movable Equipment	11, 785, 000	1, 217, 300	(1, 217, 300	51, 300	6. 00
7.00	HIT designated Assets	0	0	(0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	32, 771, 000	1, 217, 300	(1, 217, 300	51, 300	8. 00
9.00	Reconciling Items	0	0	(0	0	9. 00
10.00	Total (line 8 minus line 9)	32, 771, 000	1, 217, 300	(1, 217, 300	51, 300	10. 00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	1, 769, 000	0				1. 00
2.00	Land Improvements	934, 000	0				2. 00
3.00	Buildings and Fixtures	18, 240, 000	0				3. 00
4.00	Building Improvements	0	0				4. 00
5.00	Fixed Equipment	43, 000	0				5. 00
6.00	Movable Equipment	12, 951, 000	0				6. 00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	33, 937, 000	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	33, 937, 000	0				10. 00

Heal th	Financial Systems	MORGAN COUNT	MORGAN COUNTY HOSPITAL			In Lieu of Form CMS-2552-10			
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150038	Peri od:	Worksheet A-7			
					From 01/01/2014 To 12/31/2014		nared·		
					12, 01, 2011	5/28/2015 1:0			
	SUMMARY OF CAPITAL								
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see			
	, , , , , , , , , , , , , , , , , , ,				instructions)				
		9. 00	10.00	11. 00	12.00	13. 00			
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUN	N 2, LINES 1 a	nd 2					
1.00	CAP REL COSTS-BLDG & FLXT	0	0)	0 0	0	1.00		
2.00	CAP REL COSTS-MVBLE EQUIP	0	0)	0 0	0	2. 00		
3.00	Total (sum of lines 1-2)	0	0		0 0	0	3. 00		
		SUMMARY 0	F CAPITAL						
	Cost Center Description	Other	Total (1) (sum	-					
		Capi tal -Relate	of cols. 9						
		d Costs (see	through 14)						
		instructions)							
		14. 00	15. 00						
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUN	IN 2, LINES 1 a	nd 2					
1.00	CAP REL COSTS-BLDG & FLXT	0	0	1			1. 00		
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	1			2. 00		
3.00	Total (sum of lines 1-2)	0	0	1			3. 00		

Health Financial Systems	MORGAN COUNT	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 01/01/2014 To 12/31/2014	Worksheet A-7 Part III Date/Time Prep 5/28/2015 1:03	
	COM	PUTATION OF RAT	TI 0S	ALLOCATION OF	OTHER CAPITAL	·
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
		Leases	for Ratio (col. 1 - col 2)	instructions)		
	1.00	2.00	3.00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS					
1.00 CAP REL COSTS-BLDG & FLXT	20, 986, 000		20, 986, 00		0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	12, 951, 000		12, 951, 00		0	2.00
3.00 Total (sum of lines 1-2)	33, 937, 000		33, 937, 00		0	3. 00
	ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL					
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Relate				
		d Costs	through 7)	0.00	10.00	
DADT III DECONOLILATION OF CARLTAL COCTO OF	6. 00	7. 00	8. 00	9. 00	10. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	INTERS	1 0	1	0 1, 808, 936	0	1. 00
2.00 CAP REL COSTS-BLDG & FIXT	0	0		0 1, 808, 936 0 821, 928	0	2. 00
3.00 Total (sum of lines 1-2)	0	0		0 2, 630, 864	0	3. 00
3.00 Total (Suil Of Titles 1-2)	U	<u> </u>	L JMMARY OF CAPI		U	3.00
		30	DIVINIART OF CAFT	IAL		
Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
		,		d Costs (see	through 14)	
				instructions)		
	11. 00	12. 00	13. 00	14. 00	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		1	1			
1.00 CAP REL COSTS-BLDG & FIXT	0	1	1	0	1, 808, 936	1.00
2. 00 CAP REL COSTS-MVBLE EQUIP	0	1		0	821, 928	2.00
3.00 Total (sum of lines 1-2)	0	0	1	0 0	2, 630, 864	3. 00

					o 12/31/2014		
				Expense Classification on	Worksheet A	5/28/2015 1: 03	3 pm
				To/From Which the Amount is			
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4.00	Wkst. A-7 Ref. 5.00	
1. 00	Investment income - CAP REL	1.00		CAP REL COSTS-BLDG & FLXT	1.00	5.00	1. 00
	COSTS-BLDG & FIXT (chapter 2)						
2. 00	Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2. 00
3.00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00	0	3. 00
	(chapter 2)						
4. 00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4. 00
5.00	Refunds and rebates of		0		0.00	О	5. 00
	expenses (chapter 8)				0.00		
6. 00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6. 00
7. 00	Tel ephone servi ces (pay		0		0.00	0	7. 00
	stations excluded) (chapter 21)						
8. 00	Television and radio service		0		0.00	0	8. 00
	(chapter 21)						
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	0 -2, 458, 564		0.00	0	9. 00 10. 00
10.00	adj ustment	A-0-2	-2, 430, 304			ď	10.00
11. 00	Sale of scrap, waste, etc.		0		0.00	0	11. 00
12. 00	(chapter 23) Related organization	A-8-1	1, 132, 203			0	12. 00
12.00	transactions (chapter 10)	7.01	1, 102, 200			Ĭ	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee		0		0. 00 0. 00	0	14. 00 15. 00
	and others	1	· ·				
16. 00	Sale of medical and surgical supplies to other than		0		0.00	0	16. 00
	patients						
17. 00	Sale of drugs to other than		0		0.00	0	17. 00
18. 00	patients Sale of medical records and		0		0.00	0	18. 00
40.00	abstracts						40.00
19. 00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19. 00
20. 00	Vending machines		0		0.00	0	20.00
21. 00	Income from imposition of interest, finance or penalty		0		0.00	0	21. 00
	charges (chapter 21)						
22. 00	Interest expense on Medicare		0		0.00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments						
23. 00	Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65.00		23. 00
	therapy costs in excess of						
24. 00	limitation (chapter 14) Adjustment for physical	A-8-3	0	 PHYSICAL THERAPY	66. 00		24. 00
	therapy costs in excess of						
25. 00	limitation (chapter 14) Utilization review -		0	UTILIZATION REVIEW-SNF	114. 00		25. 00
23.00	physicians' compensation		O	THE ZATION REVIEW SWI	114.00		23.00
26. 00	(chapter 21) Depreciation - CAP REL		2	CAD DEL COSTS DIDO 9 FLYT	1 00	0	26. 00
26.00	COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	U	26.00
27. 00	Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19. 00		28. 00
29. 00	Physicians' assistant		0		0.00	0	
30. 00	Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30.00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	instructions) Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
51.00	pathology costs in excess of		O		00.00		550
33 00	limitation (chapter 14) CAH HIT Adjustment for		0		0.00	0	32 00
32. 00	Depreciation and Interest		0		0.00	o o	32. 00
33. 00	MISC INTEREST EXPENSE	В		CAP REL COSTS-MVBLE EQUIP	2.00	9	
33. 01	PUBLIC RELATIONS	A	-325, /07	ADMINISTRATIVE & GENERAL	5.00	Ol	33. 01

From 01/01/2014 | To 12/31/2014 | Date/Time Prepared:

				10 12/31/2014	5/28/2015 1:0	
			Expense Classification o	n Worksheet A	0,20,2010 110	<u>р</u>
			To/From Which the Amount is			
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	1.00	2. 00	3. 00	4. 00	5. 00	
33. 02 PUBLIC RELATIONS	A	-2, 866	SUBPROVIDER - IPF	40.00	0	33. 02
33. 03 PUBLIC RELATIONS	A	-33	CLINIC	90.00	0	33. 03
33. 04 MI SCELLANEOUS I NCOME	В	-13, 921	ADMINISTRATIVE & GENERAL	5. 00	0	33. 04
33. 05 MI SCELLANEOUS I NCOME	В	-13, 686	CAFETERI A	11. 00	0	33. 05
33.06 MISCELLANEOUS INCOME	В	-87, 302	MAINTENANCE OF PERSONNEL	12. 00	0	33. 06
33. 07 MI SCELLANEOUS I NCOME	В	-4, 655	NURSING ADMINISTRATION	13.00	9	33. 07
33. 08 MI SCELLANEOUS I NCOME	В	-3, 663	PHARMACY	15. 00	0	33. 08
33. 09 MISCELLANEOUS INCOME	В	-4, 457	RADI OLOGY-DI AGNOSTI C	54.00	0	33. 09
33. 10 HAF	A	-2, 770, 152	ADMINISTRATIVE & GENERAL	5. 00	0	33. 10
33.11 NONALLOW PATIENT PHONES	A	-18, 929	ADMINISTRATIVE & GENERAL	5. 00	0	33. 11
33.12 NONALLOW PHONE DEPR	A	-872	CAP REL COSTS-MVBLE EQUIP	2. 00	9	33. 12
33. 13 DEPR EXPENSE	A	-889, 996	CAP REL COSTS-BLDG & FIXT	1.00	9	33. 13
33. 14		0		0.00	0	33. 14
33. 15		0		0.00	0	33. 15
33. 16		0		0.00	0	33. 16
33. 17		0		0.00	0	33. 17
33. 18		0		0.00	0	33. 18
33. 19		0		0.00	0	33. 19
33. 20		0		0.00	0	33. 20
33. 21		0		0.00	0	33. 21
33. 22		0		0.00	0	33. 22
33. 23		0		0.00	0	33. 23
33. 24		0		0.00	0	33. 24
33. 25		0		0.00	0	33. 25
50.00 TOTAL (sum of lines 1 thru 49)	-5, 528, 138				50.00
(Transfer to Worksheet A,						
column 6, line 200.)						

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

⁽²⁾ Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

						5/28/2015 1:0	
	Li ne No.	Cost Center	Expense Ite	ems	Amount of	Amount	
					Allowable Cost	Included in	
						Wks. A, column	
						5	
	1. 00	2. 00	3. 00		4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH	RELATED OR	GANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:						
1. 00			HO ALLOCATIONS		106, 761	0	1.00
2.00	2. 00	CAP REL COSTS-MVBLE EQUIP	HO ALLOCATIONS		105, 498	0	2.00
3.00	5. 00	ADMINISTRATIVE & GENERAL	HO ALLOCATIONS		1, 657, 199	2, 918, 769	3.00
3.02	13. 00	NURSING ADMINISTRATION	HO ALLOCATIONS		0	2, 204	3. 02
4.00	16. 00	MEDICAL RECORDS & LIBRARY	SHARED EMPLOYEES		987	987	4.00
4.01	30.00	ADULTS & PEDIATRICS	SHARED EMPLOYEES		4, 214	4, 214	4. 01
4.02	31.00	INTENSIVE CARE UNIT	SHARED EMPLOYEES		51, 210	51, 210	4. 02
4.03	40. 00	SUBPROVIDER - IPF	SHARED EMPLOYEES		6, 314	6, 314	4. 03
4.04	5. 00	ADMINISTRATIVE & GENERAL	BLOOMINGTON ADMIN A	ALLOCATION	353, 797	0	4.04
4.05	50.00	OPERATING ROOM	SHARED EMPLOYEES		300, 250	300, 250	4.05
4.06	54.00	RADI OLOGY-DI AGNOSTI C	SHARED EMPLOYEES		25, 413	25, 413	4.06
4.07	65. 00	RESPI RATORY THERAPY	SHARED EMPLOYEES		21, 157	21, 157	4.07
4.08	66. 00	PHYSI CAL THERAPY	SHARED EMPLOYEES		36, 016	36, 016	4. 08
4.09	76. 97	CARDIAC REHABILITATION	SHARED EMPLOYEES		4, 685	4, 685	4.09
4. 10	91.00	EMERGENCY	BLOOMINGTON EMER AL	LOCATI ONS	1, 853, 325	23, 404	4. 10
5.00	0		0		4, 526, 826	3, 394, 623	5. 00

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

1100 110	That have been posted to not kind of the animal in that of 2, the amount arrowable should be that dated in condimination 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 RELATED ORGANIZATION(S) AND/OR HOME OFFICE:										

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

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

	Comort under tritio mini		
6.00	В	0.00 I U HEALTH 100.00	6. 00
7.00		0.00	7.00
8.00		0.00	8. 00
9.00		0.00	9.00
10.00		0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

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

	F:		MODOAN	00111171/ 110/	SDI TAI			6.5. 046	0550 40
	Financial Syste			COUNTY HOS				u of Form CMS-	
STATEME	ENT OF COSTS OF	SERVICES FROM	// RELATED ORGANIZATIONS AND) HOME	Provider CCN:	150038	Peri od:	Worksheet A-8	3-1
OFFICE	COSTS						From 01/01/2014	5	
							To 12/31/2014	Date/Time Pre	epared:
								5/28/2015 1:0)3 pm
		Wkst. A-7 Ref.							
	Adjustments								
	(col. 4 minus								
	col. 5)*								
	6. 00	7. 00							
	A. COSTS INCUR	RED AND ADJUST	TMENTS REQUIRED AS A RESUL	T OF TRANS	ACTIONS WITH RE	ELATED 0	RGANIZATIONS OR (CLAI MED	
	HOME OFFICE CO	STS:							
1.00	106, 761		9						1. 00
2.00	105, 498	(9						2. 00
3.00	-1, 261, 570		ó						3. 00
3. 02			0						3. 02
	-2, 204		U						
4.00	0	(0						4. 00
4.01	0	(0						4. 01
4.02	0	(0						4. 02
4.03	0	(o						4. 03
4.04	353, 797	(o						4. 04
4. 05	1		مًا						4. 05
4. 06			0						4. 06
4 07	1 ()		()						4 07

* 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.

4. 08

4.09

4. 10

5.00

Deleted Organization(a)	
Rel ated Organization(s)	
and/or Home Office	
Type of Business	
6. 00	
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6.00	HEALTHCARE	6.00
7.00		7.00
7. 00 8. 00		8.00
9.00		9.00
10.00		10.00
9. 00 10. 00 100. 00		100.00

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

0

0

0

0

1, 829, 921

1, 132, 203

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

4.08

4.09

4.10

5.00

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT

					-	To 12/31/2014	Date/Time Pre 5/28/2015 1:0	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	•
		I denti fi er	Remuneration	Component	Component		ider Component	
				·	·		Hours	
	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	7. 00	
1.00	5. 00	ADMINISTRATIVE & GENERAL	285, 920	285, 920	C	0	0	1. 00
2.00	50. 00	OPERATING ROOM	9, 615		C	0	0	2.00
3.00	60.00	LABORATORY	255, 743	255, 743	C	0	0	3.00
4.00	69. 00	ELECTROCARDI OLOGY	38, 159	38, 159	C	0	0	4.00
5.00	90. 00	CLINIC	50, 874	50, 874	C	0	0	5. 00
6.00	91. 00	EMERGENCY	1, 818, 253	1, 818, 253	C	0	0	6.00
7.00	0. 00		0	0	C	0	0	7. 00
8.00	0.00		0	0	C	0	0	8. 00
9.00	0.00		0	0	C	0	0	9. 00
10.00	0.00		0	0	C	0	0	10.00
200.00			2, 458, 564	2, 458, 564	C)	o	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE		Component	of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8. 00	9. 00	12. 00	13.00	14. 00	
1.00		ADMINISTRATIVE & GENERAL	0	0	_	1	0	1. 00
2.00		OPERATING ROOM	0			•	0	2. 00
3.00		LABORATORY	0	0	_	1	0	3. 00
4.00		ELECTROCARDI OLOGY	0	0	C	0	0	4. 00
5.00		CLINIC	0	0	C	0	0	5. 00
6.00		EMERGENCY	0	0	C	0	0	6. 00
7.00	0. 00		0	0	C	0	0	7. 00
8.00	0. 00		0	0	C	0	0	8. 00
9.00	0. 00		0	0	C	0	0	9. 00
10.00	0. 00		0	0	C	0	0	10.00
200.00			0	0	C	0	0	200. 00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		ldenti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1. 00	2. 00	14 15. 00	16. 00	17. 00	18. 00		
1. 00		ADMI NI STRATI VE & GENERAL	15.00	10.00				1. 00
2. 00		OPERATING ROOM		0	_			2. 00
3. 00		LABORATORY		0	_	7,0.0		3. 00
4. 00		ELECTROCARDI OLOGY		0	_	1		4. 00
5.00		CLI NI C		0				5. 00
6. 00		EMERGENCY		J 0				6. 00
7. 00	0.00	EWERGENCT				1,010,233	1	7. 00
8. 00	0.00							7. 00 8. 00
8. 00 9. 00	0.00							
] 0] 0		l ~		9. 00 10. 00
10.00	0. 00				_	1		200. 00
200. 00	I		1	0	C	2, 458, 564		200.00

Health Financial Systems MORGAN COUNTY HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 150038 Peri od: Worksheet B From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/28/2015 1:03 pm CAPITAL RELATED COSTS Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Subtotal Cost Center Description for Cost **BENEFITS** DEPARTMENT All ocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1 00 1, 808, 936 00100 CAP REL COSTS-BLDG & FLXT 1, 808, 936 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 821, 928 821, 928 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 3, 435, 377 4,629 2,896 3, 442, 902 4.00 00500 ADMINISTRATIVE & GENERAL 5, 996, 629 5 00 5 352 252 111, 400 69, 712 5 00 463 265 7.00 00700 OPERATION OF PLANT 1, 698, 575 206, 978 129, 524 102, 673 2, 137, 750 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 70, 362 3, 871 2, 422 2,659 79, 314 8.00 00900 HOUSEKEEPI NG 507, 149 128, 265 635, 414 9.00 9.00 C 01000 DI ETARY 46, 348 29 004 51, 925 249, 081 376, 358 10 00 10 00 11.00 01100 CAFETERI A 233, 500 22, 217 13, 903 51, 503 321, 123 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 -87, 302 -87, 302 12.00 01300 NURSING ADMINISTRATION 321, 316 3, 556 90, 449 417, 546 13.00 2.225 13.00 13, 570 8, 492 56, 507 14.00 01400 CENTRAL SERVICES & SUPPLY 34, 445 14 00 15.00 01500 PHARMACY 661,012 10, 330 6, 464 167, 412 845, 218 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 134, 587 35,808 22, 408 488 193, 291 16.00 01700 SOCIAL SERVICE 17.00 0 C 0 0 0 17.00 19 00 01900 NONPHYSICIAN ANESTHETISTS 0 C 0 0 0 19 00 02000 NURSING SCHOOL 0 0 0 20.00 20.00 0 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 0 0 0 O 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 22.00 0 0 INPATIENT ROUTINE SERVICE COST CENTERS 152, 477 1, 875, 482 30.00 03000 ADULTS & PEDIATRICS 1, 319, 664 248, 088 155, 253 30.00 03100 INTENSIVE CARE UNIT 754, 452 71, 290 191, 087 1, 061, 441 31.00 31.00 44.612 32 00 03200 CORONARY CARE UNIT 0 C 0 0 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 33.00 0 03400 SURGICAL INTENSIVE CARE UNIT 34.00 0 34.00 04000 SUBPROVI DER - I PF 40.00 1, 092, 250 38, 185 23, 896 217, 781 1, 372, 112 40.00 04100 SUBPROVIDER - IRF 41.00 0 0 41.00 C 0 04200 SUBPROVI DER 42.00 0 42.00 0 43.00 04300 NURSERY 0 Ω 0 0 43.00 04400 SKILLED NURSING FACILITY 0 0 44 00 0 Λ 44 00 45.00 04500 NURSING FACILITY 0 0 0 0 45.00 04600 OTHER LONG TERM CARE 46.00 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1, 500, 990 50.00 1,099,665 100, 565 62, 932 237, 828 51.00 05100 RECOVERY ROOM C 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 05300 ANESTHESI OLOGY 53 00 0 0 53 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 3, 241, 279 156, 012 97,630 519, 347 4, 014, 268 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 56.00 05600 RADI OI SOTOPE 0 56.00 0 0 0 05700 CT SCAN 57 00 0 O 0 57 00 Ω 0 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 0 58.00 05900 CARDIAC CATHETERIZATION 59.00 59.00 0 0 60.00 06000 LABORATORY 1, 783, 814 45, 465 28, 451 274, 405 2, 132, 135 60.00 06001 BLOOD LABORATORY 60.01 0 0 60 01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0 61.00 61.00 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 63.00 63.00 0 0 06400 I NTRAVENOUS THERAPY 64.00 0 0 0 64 00 65.00 06500 RESPIRATORY THERAPY 619, 021 12,550 7,853 161, 134 800, 558 65.00 66.00 06600 PHYSI CAL THERAPY 427, 784 39, 605 24, 784 121, 395 613, 568 66.00 06700 OCCUPATIONAL THERAPY 192, 176 7, 702 55, 228 267, 414 67 00 67 00 12, 308 68.00 06800 SPEECH PATHOLOGY 35, 995 10, 362 46, 357 68.00 06900 ELECTROCARDI OLOGY 69.00 17,778 11, 125 11, 150 40,053 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 0 C 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 224, 901 71.00 224, 901 C 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 44, 449 0 0 44, 449 72.00 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73 00 2,827,301 0 2, 827, 301 73.00 07400 RENAL DIALYSIS 0 74.00 0 74.00 0 0 0

Λ

<u>18</u>, 198

38, 574

51, 902

155, 286

25, 491

1, 460, 623

0

11, 388

24, 139

32, 480

38, 941

21, 830

367, 325

Λ 75 00

0 88.00

0 89.00

76.97

90.00

91.00

92.00 0

223, 813

110,034

1, 912, 330

09000 CLI NI C

09100 EMERGENCY

75.00

76.97

88.00

89.00

90.00

91.00

07500 ASC (NON-DISTINCT PART)

07697 CARDIAC REHABILITATION

08800 RURAL HEALTH CLINIC

OUTPATIENT SERVICE COST CENTERS

08900 FEDERALLY QUALIFIED HEALTH CENTER

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

Health Financial Systems	MORGAN COUNTY HOSPITAL			In Lieu of Form CMS-2552-10		
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CCN: 150038		Peri od: Worksheet B From 01/01/2014 To 12/31/2014 Part I Date/Time Prepare 5/28/2015 1:03 pm		
		CAPITAL RE	LATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
	0	1. 00	2. 00	4. 00	4A	
OTHER REIMBURSABLE COST CENTERS			.1			
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0		0	0	/ 00
95. 00 09500 AMBULANCE SERVICES 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0			0	0	95. 00 96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-RENTED	0			0	0	97.00
99. 00 09900 CMHC	0	0			0	99.00
99. 10 09910 CORF	0			0 0	o o	99. 10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	Ö		0 0	o o	100.00
101.00 10100 HOME HEALTH AGENCY	0	Ö		o o	l	101. 00
SPECIAL PURPOSE COST CENTERS			•	-		
105. 00 10500 KIDNEY ACQUISITION	0	0)	0 0	0	105. 00
106.00 10600 HEART ACQUISITION	0	0		0 0	0	106. 00
107.00 10700 LIVER ACQUISITION	0	0		0 0	0	107. 00
108.00 10800 LUNG ACQUISITION	0	0)	0		108. 00
109. 00 10900 PANCREAS ACQUISITION	0	0)	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0)	0	•	110. 00
111. 00 11100 SLET ACQUI SI TI ON	0	0)	0	0	111.00

30, 545, 369

30, 562, 290

16, 921

1, 309, 227

4, 208

495, 501

1, 808, 936

113. 00

114. 00

0 115.00

0 116.00

0 191.00

0 193. 00

0 200. 00

0 201. 00

6, 841 190. 00

516, 395 192. 00

30, 562, 290 202. 00

30, 039, 054 118. 00

0

0

0

0

0

3, 438, 929

3, 442, 902

3, 973

819, 295

2,633

821, 928

113.00 11300 INTEREST EXPENSE

193. 00 19300 NONPALD WORKERS

116. 00 11600 HOSPI CE

191. 00 19100 RESEARCH

118.00

200.00

201.00

202.00

114.00 11400 UTILIZATION REVIEW-SNF

115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)

SUBTOTALS (SUM OF LINES 1-117)
NONREI MBURSABLE COST CENTERS

190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN

Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118-201)

192.00 19200 PHYSICIANS' PRIVATE OFFICES

| Period: | Worksheet B | From 01/01/2014 | Part | To 12/31/2014 | Date/Time Prepared: | 5/28/2015 1:03 pm Provi der CCN: 150038

				''	0 12/31/2014	5/28/2015 1:0	
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE			
		5. 00	7. 00	8. 00	9. 00	10. 00	
	GENERAL SERVICE COST CENTERS	1		_			
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUI P						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	E 004 430					4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	5, 996, 629					5.00
7.00	00700 OPERATION OF PLANT	519, 991	2, 657, 741				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	19, 292	6, 924		700 070		8. 00
9.00	00900 HOUSEKEEPI NG	154, 559	02.000	ή	789, 973	E7E E00	9.00
10.00	01000 DI ETARY	91, 546			24, 705	575, 508	10.00
11. 00	01100 CAFETERI A	78, 111	39, 737		11, 842	0	11.00
12.00	01200 MAI NTENANCE OF PERSONNEL	0	, 250		4 005	0	12.00
13.00	01300 NURSI NG ADMI NI STRATI ON	101, 565	6, 359		1, 895	0	13.00
14.00	1	13, 745	24, 271		7, 233	0	14.00
15. 00	1	205, 593	18, 476		5, 506	0	15.00
16.00	1 1	47, 016	64, 046		19, 086	0	16.00
17. 00	1 I	0			0	0	17.00
19. 00 20. 00	· · · · · · · · · · · · · · · · · · ·	0			0	0	19. 00 20. 00
	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0			0	0	21.00
21. 00 22. 00		0			0	0	21.00
22.00	INPATIENT ROUTINE SERVICE COST CENTERS	U		<u> </u>	U	U	22.00
30. 00		456, 196	443, 731	12, 518	132, 237	138, 867	30.00
31. 00	1 1	258, 187	127, 509		37, 999	83, 856	31.00
32. 00	1 1	250, 107	127, 309	7,870	37, 999	03, 630	32.00
33. 00	· ·	0			0	0	33.00
34. 00	03400 SURGI CAL INTENSI VE CARE UNIT	0			0	0	34.00
40. 00	04000 SUBPROVIDER - I PF	333, 755	68, 298	15, 463	20, 354	352, 785	40.00
41. 00	04100 SUBPROVIDER - I RF	333, 733	00, 290	15, 403	20, 334	352, 765	41.00
41.00	1	0			0	0	42.00
43. 00	1 1	0			0	0	42.00
44. 00	1 1	0			0	0	44. 00
45. 00	1 1	0			0	0	45.00
46. 00	1 1	0			0	0	46. 00
40.00	ANCILLARY SERVICE COST CENTERS	U		,	U	U	40.00
50. 00		365, 104	179, 871	12, 821	53, 603	0	50.00
51. 00		303, 104	177,071	12,021	33, 003	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0			0	0	52.00
53. 00		0			0	0	53.00
54. 00	1 1	976, 431	279, 044	14, 437	83, 158	0	54.00
55. 00		770, 431	279,044	14, 437	03, 130	0	55. 00
56. 00	05600 RADI OI SOTOPE	0			0	0	56.00
57. 00	05700 CT SCAN	0			0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0			0	0	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0			0	0	59.00
60. 00	06000 LABORATORY	518, 625	81, 318		24, 234	0	60.00
60. 01	06001 BLOOD LABORATORY	310,023	01,310		24, 234	0	60. 01
61. 00	· ·			7	0	O	61.00
62. 00	1 1	0	ر		0	0	1
63. 00	1 1	0			0	0	63.00
64. 00	06400 I NTRAVENOUS THERAPY	0			0	0	64. 00
65. 00	06500 RESPIRATORY THERAPY	194, 729	22, 446	2, 238	6, 689	0	65. 00
66. 00		149, 246	70, 838			0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	65, 046	22, 013		6, 560	0	67. 00
68. 00	+ I	11, 276	22,013		0, 300	0	68. 00
69. 00	1 1	9, 743	31, 797		9, 476	0	69. 00
70. 00	1	7, 745	31,777		7, 470	0	70.00
71. 00	1	54, 705			0	0	71.00
71.00		10, 812			0	0	72.00
73. 00	1	687, 718	Č		0	0	73. 00
74. 00		007,710	Č		0	0	74. 00
75. 00		0	Č		0	0	75. 00
76. 97		54, 441	32, 550	o o	9, 700	0	76. 97
70. 77	OUTPATIENT SERVICE COST CENTERS	34,441	32, 330	,, ,	7, 700	0	10. 77
88. 00		n	^		n	0	88. 00
89. 00	1 1				0	0	89. 00
90.00	1 1	26, 765	68, 994		20, 561	0	90.00
91.00	1 1	465, 159	92, 833		27, 665	0	91.00
92. 00	1 1	405, 157	72,000	37, 347	27,003		92.00
12.00	OTHER REIMBURSABLE COST CENTERS			<u> </u>			, /2.00
94. 00		n	^)	n	0	94.00
95. 00	1 1				0	0	95. 00
96. 00	1 1				0	0	96.00
97. 00	· ·	n	r		n	0	97. 00
99. 00	1 1	o o	r		n	0	1
	1 1 s	1			<u> </u>		1 00

			10	0 12/31/2014	5/28/2015 1:03 pm
Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY
	& GENERAL	PLANT	LINEN SERVICE		
	5.00	7. 00	8. 00	9. 00	10. 00
99. 10 09910 CORF	0	0	0	0	0 99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0 100.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0 101.00
SPECIAL PURPOSE COST CENTERS					
105.00 10500 KIDNEY ACQUISITION	0	0	0	0	0 105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0	0	0	0 106. 00
107.00 10700 LIVER ACQUISITION	0	0	0	0	0 107. 00
108.00 10800 LUNG ACQUISITION	0	0	0	0	0 108. 00
109. 00 10900 PANCREAS ACQUISITION	0	0	0	0	0 109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0 110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0	0	0	0 111.00
113. 00 11300 I NTEREST EXPENSE					113. 00
114.00 11400 UTILIZATION REVIEW-SNF					114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0 115. 00
116. 00 11600 HOSPI CE	0	0	0	0	0 116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	5, 869, 356	1, 763, 954	104, 398	523, 614	575, 508 118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 664	7, 526	0	2, 243	0 190. 00
191. 00 19100 RESEARCH	0	0	0	0	0 191. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	125, 609	886, 261	1, 132	264, 116	0 192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0	0 193. 00
200.00 Cross Foot Adjustments					200. 00
201.00 Negative Cost Centers	0	0	0	0	0 201. 00
202.00 TOTAL (sum lines 118-201)	5, 996, 629	2, 657, 741	105, 530	789, 973	575, 508 202. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2014 | Part | | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Tim Provi der CCN: 150038

			10	12/31/2014	Date/lime Pre 5/28/2015 1:0	
Cost Center Description	CAFETERI A	MAINTENANCE OF	NURSI NG	CENTRAL	PHARMACY	, p
		PERSONNEL	ADMI NI STRATI ON	SERVICES &		
	11. 00	12. 00	13.00	SUPPLY 14. 00	15. 00	
GENERAL SERVICE COST CENTERS	11.00	12.00	13.00	14.00	13.00	
1.00 O0100 CAP REL COSTS-BLDG & FLXT						1. 00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5. 00
7.00 O0700 OPERATION OF PLANT						7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG						8. 00 9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A	450, 813					11. 00
12. 00 01200 MAINTENANCE OF PERSONNEL	0	-87, 302				12.00
13.00 01300 NURSING ADMINISTRATION	14, 167	0	541, 532			13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0	0	101, 756		14.00
15. 00 01500 PHARMACY	20, 614	0	0	1, 200	1, 096, 607	15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	125	0	0	26	0	16.00
17. 00 01700 SOCI AL SERVI CE 19. 00 01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	17. 00 19. 00
20. 00 02000 NURSI NG SCHOOL	0	0	0	0	0	20.00
21. 00 02100 &R SERVI CES-SALARY & FRINGES APPRVD	0	Ö	Ö	Ö	0	21. 00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	31, 993	0	- ,	926	0	30. 00
31. 00 03100 I NTENSI VE CARE UNI T	32, 702	0	,	8, 389	0	31. 00
32. 00 03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00 03300 BURN INTENSIVE CARE UNIT 34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	33. 00 34. 00
40. 00 04000 SUBPROVI DER - 1 PF	49, 335	0	125, 998	3, 685	0	40.00
41. 00 04100 SUBPROVI DER - IRF	47, 555	0	123, 770	3, 003	0	41. 00
42. 00 04200 SUBPROVI DER	0	Ö	Ö	Ö	0	42. 00
43. 00 04300 NURSERY	0	0	О	0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00 04500 NURSING FACILITY	0	0	0	0	0	45. 00
46.00 O4600 OTHER LONG TERM CARE	0	0	0	0	0	46. 00
ANCILLARY SERVICE COST CENTERS	2/ 044		(0.010	22.004	0	FO 00
50. 00 05000 OPERATING ROOM 51. 00 05100 RECOVERY ROOM	26, 944 0	0	68, 812	22, 004	0	50. 00 51. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	Ö	Ö	Ö	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	95, 733	0	0	20, 311	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
56. 00 05600 RADI 0I SOTOPE	0	0	0	0	0	56. 00
57. 00 05700 CT SCAN	0	0	0	0	0	57. 00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	47, 128	0	0	11, 412	0	59. 00 60. 00
60. 01 06001 BLOOD LABORATORY	47, 120	0	0	11, 412	0	60.00
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				Ŭ.	Ŭ	61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	О	0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64. 00
65. 00 06500 RESPI RATORY THERAPY	26, 083	0	0	4, 022	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	15, 743	l .	0	1, 141	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	9, 200	l .	0	149	0	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	1, 440	0	0	21	0	68. 00 69. 00
70. 00 07000 ELECTROCARDI OLOGT	0	0	0	0	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	Ö	0	0	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	Ö	Ö	Ö	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	1, 096, 607	73. 00
74.00 07400 RENAL DI ALYSI S	0	0	0	0	0	74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON	7, 663	0	0	480	0	76. 97
OUTPATIENT SERVICE COST CENTERS				ام		00.00
88. 00 08800 RURAL HEALTH CLINIC 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	88. 00 89. 00
90. 00 09000 CLINIC	4, 621		11, 802	٥	0	90.00
91. 00 09100 EMERGENCY	66, 444		169, 693	27, 846	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	00, 744		107,075	27, 540	O	92. 00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94. 00
95. 00 09500 AMBULANCE SERVICES	0	0	0	o	0	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	<u> </u>	J 0	0	0	97. 00

SPITAL In Lieu of Form CMS-2552-10
Provider CCN: 150038 | Period: | Worksheet B | From 01/01/2014 | Part I

			To		Date/Time Pre 5/28/2015 1:0	
Cost Center Description	CAFETERI A	MAINTENANCE OF		CENTRAL	PHARMACY	
		PERSONNEL	ADMI NI STRATI ON	SERVI CES &		
				SUPPLY		
	11. 00	12.00	13. 00	14. 00	15. 00	
99. 00 09900 CMHC	0	0	0	0	0	
99. 10 09910 CORF	0	0	0	0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100. 00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0	0	0	0	105. 00
106.00 10600 HEART ACQUISITION	0	0	0	0	0	106. 00
107.00 10700 LIVER ACQUISITION	0	0	0	0	0	107. 00
108.00 10800 LUNG ACQUISITION	0	0	0	0	0	108. 00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110. 00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0	111. 00
113.00 11300 INTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	O	0	115. 00
116. 00 11600 HOSPI CE	0	0	0	O	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	449, 935	0	541, 532	101, 612	1, 096, 607	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
191. 00 19100 RESEARCH	0	0	0	0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	878	0	0	144	0	192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0	0	193. 00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	-87, 302	0	О	0	201.00
202.00 TOTAL (sum lines 118-201)	450, 813	-87, 302	541, 532	101, 756	1, 096, 607	202. 00

Provi der CCN: 150038

				0 12/31/2014	5/28/2015 1:0	
					I NTERNS & RESI DENTS	
Cost Center Description	MEDI CAL	SOCIAL SERVICE		NURSING SCHOOL		
	RECORDS & LI BRARY		ANESTHETI STS		Y & FRINGES	
	16. 00	17. 00	19. 00	20. 00	21. 00	
1. 00 O0100 CAP REL COSTS-BLDG & FIXT	1		I			1. 00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5. 00
7.00 00700 0PERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00 00900 LAUNDRY & LINEN SERVICE 9. 00 00900 HOUSEKEEPING						9. 00
10. 00 01000 DI ETARY						10. 00
11. 00 01100 CAFETERI A						11.00
12. 00 01200 MAI NTENANCE OF PERSONNEL						12.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY						13. 00 14. 00
15. 00 01500 PHARMACY						15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	323, 590					16. 00
17. 00 01700 SOCIAL SERVICE	0	0				17. 00
19. 00 01900 NONPHYSI CI AN ANESTHETI STS	0	0	C			19. 00
20. 00 02000 NURSI NG SCHOOL 21. 00 02100 1&R SERVI CES-SALARY & FRI NGES APPRVD		0	C	0	0	20. 00 21. 00
22. 00 02200 &R SERVI CES-OTHER PRGM COSTS APPRVD		0				22. 00
INPATIENT ROUTINE SERVICE COST CENTERS		_			_	
30. 00 03000 ADULTS & PEDI ATRI CS	13, 183	l .	•		-	30.00
31. 00 03100 I NTENSI VE CARE UNI T	6, 842		1	_	-	31.00
32.00 03200 CORONARY CARE UNIT 33.00 03300 BURN INTENSIVE CARE UNIT	0	1	C	_	0	32. 00 33. 00
34. 00 03400 SURGICAL INTENSIVE CARE UNIT		0		_	0	34. 00
40. 00 04000 SUBPROVI DER - 1 PF	15, 146	0	C	0	0	40.00
41. 00 04100 SUBPROVI DER - I RF	0	0	C	0	0	41. 00
42. 00 04200 SUBPROVI DER	0	0	C	0	0	42.00
43.00 04300 NURSERY 44.00 04400 SKILLED NURSING FACILITY		0		0	0	43. 00 44. 00
45. 00 04500 NURSING FACILITY	0	_	1	_	Ö	45. 00
46.00 OTHER LONG TERM CARE	0	0	C	0	0	46. 00
ANCILLARY SERVICE COST CENTERS 50. 00 OPERATING ROOM	24 222	l 0	l c	0	0	EO 00
50.00 05000 OPERATING ROOM 51.00 05100 RECOVERY ROOM	34, 222	0		_	0	50. 00 51. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	Ö	ď	0	Ö	52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	C	0	0	53.00
54. 00 05400 RADI OLOGY -DI AGNOSTI C	75, 873		C	0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C 56. 00 05600 RADI OI SOTOPE	0	0	C	0	0	55. 00 56. 00
57. 00 05700 CT SCAN		0		0	0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	C	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	C	0	0	59. 00
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY	36, 069	0	C	0	0	60. 00 60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				0		61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	c	0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	C	0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	4 405	0		0	0	64. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY	4, 695 6, 358	l .		0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	972		d	0	0	67. 00
68.00 06800 SPEECH PATHOLOGY	273		C	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	7, 453	l .	C	0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS	3, 384	0		0	0	70. 00 71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	534	Ö		0	Ö	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	56, 476	l .	C	0	0	73.00
74. 00 07400 RENAL DIALYSIS	0	0	C	0	0	74.00
75. 00 O7500 ASC (NON-DISTINCT PART) 76. 97 O7697 CARDIAC REHABILITATION	1, 518	0	C	0	0	75. 00 76. 97
OUTPATIENT SERVICE COST CENTERS	1, 310	0	1	0	0	70. 97
88. 00 08800 RURAL HEALTH CLINIC	0	0	C	0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	_	C	0	0	89. 00
90. 00 09000 CLI NI C	376		C	0	0	90.00
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART)	60, 216	0	1	0	0	91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS			1			/Z. UU
94. 00 09400 HOME PROGRAM DIALYSIS	0					94. 00
95. 00 09500 AMBULANCE SERVI CES	0	0	C	0	0	95. 00

			1	0 12/31/2014	Date/IIme Pre 5/28/2015 1:0	
					INTERNS &	
					RESI DENTS	
Cost Center Description		SOCIAL SERVICE		NURSING SCHOOL		
	RECORDS &		ANESTHETI STS		Y & FRINGES	
	LI BRARY 16. 00	17. 00	19. 00	20. 00	21. 00	
96. OO 09600 DURABLE MEDI CAL EQUI P-RENTED	16.00	17.00	19.00	20.00	21.00	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD		0	0	0	0	97. 00
99. 00 09900 CMHC		0	0	0	0	99.00
99. 10 09910 CORF	o	0	0	0	0	99. 10
100.00 10000 &R SERVICES-NOT APPRVD PRGM	l ol	0	0	0	0	100.00
101.00 10100 HOME HEALTH AGENCY	o	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0	0	0	0	105. 00
106.00 10600 HEART ACQUISITION	0	0	0	0		106. 00
107.00 10700 LIVER ACQUISITION	0	0	0	0		107. 00
108.00 10800 LUNG ACQUISITION	0	0	0	0		108. 00
109. 00 10900 PANCREAS ACQUISITION	0	0	0	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0		110. 00
111.00 11100 SLET ACQUISITION	0	0	0	0	0	111. 00
113.00 11300 INTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0		115. 00
116. 00 11600 HOSPI CE	0	0	0	0		116. 00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	323, 590	0	0	0	0	118. 00
NONREI MBURSABLE COST CENTERS		ما	0		0	100 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 191.00 19100 RESEARCH	0	0	0	0		190. 00 191. 00
192.00 19200 PHYSLCIANS' PRIVATE OFFICES	0	0	0	0		191.00
193. 00 19300 NONPALD WORKERS	0	0	0	0		192.00
200.00 Cross Foot Adjustments	١	U				200. 00
201.00 Negative Cost Centers	0	0	0	0		201. 00
202.00 TOTAL (sum lines 118-201)	323, 590	0	0	0		202. 00
202.00 101712 (36111 111103 110 201)	323, 370	٧	1	۱	O	202.00

					1	o 12/31/2014	Date/lime Prepared: 5/28/2015 1:03 pm
		Cost Center Description	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS	Subtotal	Intern & Residents Cost & Post Stepdown	Total	, 3, 20, 2013 1. 03 piii
			22.00	24. 00	Adjustments 25.00	26. 00	
	GENER	AL SERVICE COST CENTERS	22.00	24.00	25.00	20.00	
1.00		CAP REL COSTS-BLDG & FIXT					1. 00
2. 00	1	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7. 00
8.00		LAUNDRY & LINEN SERVICE					8.00
9. 00	1	HOUSEKEEPI NG					9. 00
10.00		DIETARY					10.00
11. 00 12. 00		CAFETERIA MAINTENANCE OF PERSONNEL					11. 00 12. 00
13. 00	1	NURSING ADMINISTRATION	1				13. 00
14. 00	1	CENTRAL SERVICES & SUPPLY					14. 00
15. 00	1	PHARMACY					15. 00
16.00	01600	MEDICAL RECORDS & LIBRARY					16. 00
17. 00		SOCIAL SERVICE					17. 00
19. 00		NONPHYSICIAN ANESTHETISTS					19. 00
20. 00		NURSI NG SCHOOL					20. 00
21. 00		I &R SERVI CES-SALARY & FRI NGES APPRVD					21.00
22. 00		I &R SERVICES-OTHER PRGM COSTS APPRVD I ENT ROUTINE SERVICE COST CENTERS	0				22. 00
30. 00		ADULTS & PEDIATRICS	0	3, 186, 841	Ο	3, 186, 841	30.00
31. 00		INTENSIVE CARE UNIT	l o	1, 708, 114		1, 708, 114	31. 00
32.00	03200	CORONARY CARE UNIT	0	0		0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	33.00
34. 00		SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.00
40. 00	1	SUBPROVIDER - I PF	0	2, 356, 931	0	2, 356, 931	40.00
41.00	1	SUBPROVIDER - IRF	0	0	0	0	41.00
42. 00 43. 00	1	SUBPROVI DER NURSERY		0	0	0	42. 00 43. 00
44. 00	1	SKILLED NURSING FACILITY		0	0	0	44. 00
45. 00		NURSING FACILITY		0	1	0	45. 00
46.00	1	OTHER LONG TERM CARE	0	0	0	0	46. 00
		LARY SERVICE COST CENTERS				 	
50. 00		OPERATI NG ROOM	0	2, 264, 371	1	2, 264, 371	50.00
51.00	1	RECOVERY ROOM	0	0	0	0	51.00
52. 00 53. 00	1	DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY		0	0	0	52. 00 53. 00
54. 00	1	RADI OLOGY-DI AGNOSTI C		5, 559, 255	0	5, 559, 255	54. 00
55. 00		RADI OLOGY-THERAPEUTI C		0, 337, 233		0, 337, 233	55. 00
56. 00	1	RADI OI SOTOPE	o	0	Ō	0	56. 00
57.00	05700	CT SCAN	0	0	0	0	57.00
58. 00	1	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58. 00
59. 00	1	CARDI AC CATHETERI ZATI ON	0	0	0	0	59. 00
60.00		LABORATORY	0	2, 850, 921	0	2, 850, 921	60.00
60. 01 61. 00	1	BLOOD LABORATORY PBP CLINICAL LAB SERVICES-PRGM ONLY		0	0	0	60. 01 61. 00
62. 00	1	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62. 00
63.00		BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	I NTRAVENOUS THERAPY	0	0	0	0	64. 00
65. 00	1	RESPI RATORY THERAPY	0	1, 061, 460		1, 061, 460	65. 00
66. 00	1	PHYSI CAL THERAPY	0	882, 709		882, 709	66. 00
67.00		OCCUPATIONAL THERAPY	0	371, 354		371, 354	67. 00
68. 00 69. 00		SPEECH PATHOLOGY ELECTROCARDI OLOGY		59, 367 98, 522		59, 367 98, 522	68. 00 69. 00
70. 00	1	ELECTROCARDIOCOGI		70, 322		70, 322	70.00
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS		282, 990		282, 990	71. 00
72. 00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	55, 795		55, 795	72. 00
73. 00		DRUGS CHARGED TO PATIENTS		4, 668, 102	0	4, 668, 102	73. 00
74. 00		RENAL DI ALYSI S	0	0	1	0	74. 00
75. 00		ASC (NON-DISTINCT PART)	0	0		0	75. 00
76. 97		CARDI AC REHABI LITATI ON] 0	330, 165	0	330, 165	76. 97
88. 00		TIENT SERVICE COST CENTERS RURAL HEALTH CLINIC		0	0	0	88. 00
89. 00		FEDERALLY QUALIFIED HEALTH CENTER		0	•	0	89. 00
90. 00		CLINIC		243, 153		243, 153	90.00
91. 00	09100	EMERGENCY	0	2, 856, 733	1	2, 856, 733	91. 00
92. 00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0		92. 00

Health Financial Systems	MORGAN COUNTY		450000		u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CCN		eriod: rom 01/01/2014	Worksheet B Part I
				o 12/31/2014	
					5/28/2015 1:03 pm
	INTERNS &				
	RESI DENTS				
Cost Center Description	SERVI CES-OTHER		Intern &	Total	
	PRGM COSTS	Resi	idents Cost		
			& Post		
			Stepdown		
			djustments_		
	22. 00	24. 00	25. 00	26. 00	
OTHER REIMBURSABLE COST CENTERS					
94.00 O9400 HOME PROGRAM DIALYSIS	0	0	0	0	94. 00
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	97. 00
99. 00 09900 CMHC	0	0	0	0	99. 00
99. 10 09910 CORF	0	0	0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	100. 00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS					
105.00 10500 KIDNEY ACQUISITION	0	0	0	0	105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0	0	0	106. 00
107.00 10700 LIVER ACQUISITION	0	0	0	0	107. 00
108.00 10800 LUNG ACQUISITION	0	0	0	0	108. 00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	110. 00
111.00 11100 ISLET ACQUISITION	0	0	0	0	111. 00
113.00 11300 INTEREST EXPENSE					113. 00
114.00 11400 UTILIZATION REVIEW-SNF					114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	115. 00
116. 00 11600 HOSPI CE	0	0	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	28, 836, 783	0	28, 836, 783	118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	18, 274	0	18, 274	190. 00
191. 00 19100 RESEARCH	0	0	0	1	191. 00
102 00 10200 DUVCLCLANCE DRIVATE OFFICES		1 704 525	0	1 704 525	100.00

1, 794, 535

-87, 302 30, 562, 290

1, 794, 535 0 0

-87, 302 30, 562, 290 191. 00 192. 00 193. 00 200. 00 201. 00 202. 00

191.00 19100 RESEARCH
192.00 19200 PHYSICIANS' PRIVATE OFFICES
193.00 19300 NONPAID WORKERS
200.00 Cross Foot Adjustments
201.00 Negative Cost Centers
202.00 TOTAL (sum lines 118-201)

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2014 | Part II | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Ti Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 150038

				lo	12/31/2014	Date/lime Pre 5/28/2015 1:0	
			CAPI TAL REI	LATED COSTS			•
	Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		0	1. 00	2. 00	2A	4. 00	
	GENERAL SERVICE COST CENTERS						
1. 00 2. 00 4. 00 5. 00 7. 00 8. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	0 0	4, 629 111, 400 206, 978 3, 871	69, 712 129, 524	7, 525 181, 112 336, 502 6, 293	7, 525 1, 013 225 6	1. 00 2. 00 4. 00 5. 00 7. 00 8. 00
9. 00 10. 00 11. 00	00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A	0	46, 348 22, 217	0 29, 004	75, 352 36, 120	280 114 113	9. 00 10. 00 11. 00
12. 00 13. 00 14. 00	01200 MAINTENANCE OF PERSONNEL 01300 NURSI NG ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	0	22, 217 0 3, 556 13, 570	0 2, 225	5, 720 5, 781 22, 062	0 198 0	12. 00 13. 00 14. 00
15. 00 16. 00 17. 00	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	0 0	10, 330 35, 808	6, 464	16, 794 58, 216 0	366 1 0	15. 00 16. 00 17. 00
19. 00 20. 00 21. 00	01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING SCHOOL 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0 0	0	0 0	0	0 0 0	19. 00 20. 00 21. 00
22. 00	O2200 I &R SERVICES-OTHER PRGM COSTS APPRVD I NPATI ENT ROUTI NE SERVICE COST CENTERS) O	0	ıj 0 ₁	O _I	0	22. 00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0	248, 088 71, 290		403, 341 115, 902	333 418	30.00
32. 00 33. 00 34. 00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0 0 0	32. 00 33. 00 34. 00
40. 00 41. 00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	0	38, 185 0	23, 896 0	62, 081 0	476 0	40. 00 41. 00
42. 00 43. 00 44. 00	04200 SUBPROVI DER 04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY	0	0	0	0	0 0 0	42. 00 43. 00 44. 00
45. 00 46. 00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0	0	0	0	0	45. 00 46. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0	100, 565	62, 932	163, 497	520	50.00
51. 00	05100 RECOVERY ROOM	Ö	0	0	0	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52. 00
53. 00 54. 00	05300 ANESTHESI OLOGY	0	156 012	97, 630	0 253, 642	0 1, 132	53. 00 54. 00
55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	0	156, 012 0	97, 630	253, 642	1, 132	55. 00
56. 00	05600 RADI OI SOTOPE	Ö	Ö	Ö	o	0	56. 00
57. 00	05700 CT SCAN	0	0	0	O	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0	0	0	58. 00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	45, 465	28, 451	73, 916	0 600	59. 00 60. 00
60. 01	06001 BLOOD LABORATORY	Ö	0	0	0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		_	_	0	_	61.00
62. 00 63. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	62. 00 63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	Ö	Ö	Ö	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	0	12, 550		20, 403	352	65. 00
66.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	39, 605		64, 389	265	66.00
67. 00 68. 00	06800 SPEECH PATHOLOGY	0	12, 308	7, 702	20, 010 0	121 23	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	17, 778	11, 125	28, 903	24	69.00
70. 00		0	0	0	o	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	72. 00 73. 00
74. 00	07400 RENAL DIALYSIS	0	Ö	Ö	ő	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0	О	0	75. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	18, 198	11, 388	29, 586	85	76. 97
99 00	OUTPATIENT SERVICE COST CENTERS	O	0		ام	0	00 00
88. 00 89. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER) O		O O	0	88. 00 89. 00
90.00	09000 CLINIC	Ö	38, 574	24, 139	62, 713	48	90.00
91. 00	09100 EMERGENCY	o	51, 902		84, 382	803	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92. 00
94. 00	OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S	0	0	0	0	0	94. 00
	1	<u>'</u>		, o _l	<u> </u>		

			То	12/31/2014	Date/Time Pre 5/28/2015 1:0	
		CAPI TAL REI	ATED COSTS		1 37 207 2013 1.0	J piii
		0/11 / ///2 ///2	21125 00010			
Cost Center Description	Di rectly	BLDG & FLXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	Assigned New				BENEFI TS	
	Capi tal				DEPARTMENT	
	Related Costs					
	0	1.00	2.00	2A	4. 00	
95. 00 09500 AMBULANCE SERVI CES	0	0	0	0	0	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97. 00
99. 00 09900 CMHC	0	0	0	0	0	99. 00
99. 10 09910 CORF	0	0	0	0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0	0	0	0	105. 00
106.00 10600 HEART ACQUISITION	0	0	0	0		106. 00
107.00 10700 LIVER ACQUISITION	0	0	0	0	0	107. 00
108.00 10800 LUNG ACQUISITION	0	0	0	0		108. 00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110. 00
111. 00 11100 I SLET ACQUI SI TI ON	0	0	0	0	0	111. 00
113.00 11300 INTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115. 00
116. 00 11600 HOSPI CE	0	0	0	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	1, 309, 227	819, 295	2, 128, 522	7, 516	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4, 208	2, 633	6, 841		190. 00
191. 00 19100 RESEARCH	0	0	0	0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	495, 501	0	495, 501		192. 00
193.00 19300 NONPALD WORKERS	0	0	0	0	0	193. 00
200.00 Cross Foot Adjustments				0		200. 00
201.00 Negative Cost Centers		0	0	0		201. 00
202.00 TOTAL (sum lines 118-201)	0	1, 808, 936	821, 928	2, 630, 864	7, 525	202. 00

Provi der CCN: 150038

						5/28/2015 1:0	
	Cost Center Description	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
		5. 00	7. 00	8. 00	9. 00	10.00	
4 00	GENERAL SERVI CE COST CENTERS			I			
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00	00500 ADMI NI STRATI VE & GENERAL	182, 125					5. 00
7.00	00700 OPERATION OF PLANT	15, 794	352, 521				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	586	918	7, 803			8. 00
9.00	00900 HOUSEKEEPI NG	4, 694	10.004	0	4, 974	00.200	9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	2, 781 2, 372	10, 996 5, 271		156 75	89, 399 0	10. 00 11. 00
12. 00	01200 MAI NTENANCE OF PERSONNEL	0	0, 2, 1	ő	0	0	12. 00
13.00	01300 NURSING ADMINISTRATION	3, 085	844	0	12	0	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	417	3, 219	0	46	0	14. 00
15.00	01500 PHARMACY	6, 244	2, 451	0	35	0	15.00
16. 00 17. 00	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	1, 428	8, 495 0	0	120 0	0	16. 00 17. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	Ö	ő	0	0	19. 00
20.00	02000 NURSI NG SCHOOL	0	0	0	0	0	20. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22. 00
30. 00	O3000 ADULTS & PEDIATRICS	13, 856	58, 856	926	833	21, 572	30.00
31. 00	03100 NTENSI VE CARE UNI T	7, 842	16, 913	1	239	13, 026	ı
32.00	03200 CORONARY CARE UNIT	0	0	0	0	0	32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	10 127	0 050	0	120	0 E4 001	34.00
40. 00 41. 00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	10, 137	9, 059	1, 143	128 0	54, 801 0	40. 00 41. 00
42. 00	04200 SUBPROVI DER	0	Ö	ő	o	0	42. 00
43.00	04300 NURSERY	0	0	0	0	0	43.00
44. 00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
45. 00	04500 NURSING FACILITY	0	0	0	0	0	45. 00
46. 00	04600 OTHER LONG TERM CARE ANCI LLARY SERVICE COST CENTERS	0	0	0	0	0	46. 00
50. 00	05000 OPERATI NG ROOM	11, 089	23, 858	948	338	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	29, 647	37, 012	1, 067	524 0	0	54. 00 55. 00
56. 00	05600 RADI OI SOTOPE	0	Ö	ő	0	0	56. 00
57. 00	05700 CT SCAN	0	0	0	0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0	0	0	58. 00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	15, 752	10, 786	0	0 153	0	59. 00 60. 00
60. 00	06001 BL00D LABORATORY	15, 752	10, 780	0	153	0	60.00
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				Ü	· ·	61.00
62. 00		0	0	0	0	0	
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	5, 915	2, 977	0 165	42	0	64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	4, 533	9, 396	1		0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	1, 976	2, 920		41	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	342	0	_	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	296	4, 218	0	60	0	69.00
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 662	0	0	0	0	70. 00 71. 00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	328	0	0	0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	20, 888	0	ő	0	0	73. 00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
76. 97	07697 CARDI AC REHABILITATION	1, 654	4, 317	0	61	0	76. 97
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	n	Ω	n	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	o o	Ö	Ö	0	0	89. 00
90.00	09000 CLI NI C	813	9, 151	0	129	0	90.00
91.00	09100 EMERGENCY	14, 128	12, 313	2, 555	174	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92. 00
94. 00	09400 HOME PROGRAM DIALYSIS	n	Ω	n	n	0	94. 00
95. 00	09500 AMBULANCE SERVICES	Ö	Ö	Ö	ő	0	95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
99. 00	09900 CMHC	1 0	0	'I U	ı U	0	99. 00

			To	12/31/2014	Date/Time Prepared: 5/28/2015 1:03 pm
Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DIETARY
0000 00mm 2000m pt on	& GENERAL	PLANT	LINEN SERVICE	11000EREEL THO	5.2.7
	5. 00	7.00	8. 00	9. 00	10.00
99. 10 09910 CORF	0	0	0	0	0 99.10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0 100. 00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0 101. 00
SPECIAL PURPOSE COST CENTERS					
105.00 10500 KIDNEY ACQUISITION	0	0	0	0	0 105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0	0	0	0 106. 00
107. 00 10700 LIVER ACQUISITION	0	0	0	0	0 107. 00
108.00 10800 LUNG ACQUISITION	0	0	0	0	0 108. 00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0 109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0 110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0	0	0	0 111.00
113.00 11300 INTEREST EXPENSE					113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF					114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0 115. 00
116. 00 11600 H0SPI CE	0	0	0	0	0 116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	178, 259	233, 970	7, 719	3, 299	89, 399 118. 00
NONREI MBURSABLE COST CENTERS					
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	51	998	0	14	0 190. 00
191. 00 19100 RESEARCH	0	0	0	0	0 191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	3, 815	117, 553	84	1, 661	0 192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	O	0 193. 00
200.00 Cross Foot Adjustments					200.00
201.00 Negative Cost Centers	0	0	0	0	0 201.00
202.00 TOTAL (sum lines 118-201)	182, 125	352, 521	7, 803	4, 974	89, 399 202. 00

Provi der CCN: 150038

					12/31/2014	5/28/2015 1:0	
	Cost Center Description	CAFETERI A	MAINTENANCE OF		CENTRAL	PHARMACY	
			PERSONNEL	ADMI NI STRATI ON	SERVI CES & SUPPLY		
		11. 00	12. 00	13.00	14.00	15. 00	
1 00	GENERAL SERVICE COST CENTERS						1 00
1. 00 2. 00	OO100 CAP REL COSTS-BLDG & FIXT OO200 CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL						5. 00
7.00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY	40.054					10.00
11.00	01100 CAFETERIA	43, 951	i .				11.00
12. 00 13. 00	O1200 MAI NTENANCE OF PERSONNEL O1300 NURSI NG ADMI NI STRATI ON	1, 381	Ί `	1			12. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	1,301		0 11, 301	25, 744		14. 00
15. 00	01500 PHARMACY	2, 010		o o	303	28, 203	1
16.00	01600 MEDICAL RECORDS & LIBRARY	12	2	o o	7	0	16. 00
17. 00	01700 SOCIAL SERVICE	C) (0	0	0	17. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	C		0	0	0	
20.00	02000 NURSI NG SCHOOL	C		0	0	0	
21. 00 22. 00	O2100 I &R SERVICES-SALARY & FRINGES APPRVD O2200 I &R SERVICES-OTHER PRGM COSTS APPRVD	C	1	1	0	0	
22.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		/	<u> </u>	<u> </u>	0	22.00
30. 00	03000 ADULTS & PEDI ATRI CS	3, 119) (1, 705	234	0	30.00
31.00	03100 INTENSIVE CARE UNIT	3, 188	3	1, 743	2, 122	0	31. 00
32. 00	03200 CORONARY CARE UNIT	C) (0	0	0	32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	C	1	0	0	0	
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0		1 1	0	0	
40.00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	4, 810		7 -7 -7	932 0	0	
41. 00 42. 00	04200 SUBPROVI DER				0	0	42.00
43. 00	04300 NURSERY				0	0	43. 00
44. 00	04400 SKILLED NURSING FACILITY	Ċ		ol o	o	0	44. 00
45.00	04500 NURSING FACILITY	C		o	0	0	1
46.00	04600 OTHER LONG TERM CARE	C) (o o	0	0	46. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	2, 627	1		5, 567	0	
51. 00 52. 00	O5100 RECOVERY ROOM O5200 DELIVERY ROOM & LABOR ROOM	C	1	1	0	0	
53. 00	05300 ANESTHESI OLOGY				0	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	9, 332		ol o	5, 139	0	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	C		o	0	0	55. 00
56.00	05600 RADI OI SOTOPE	C) (0	o	0	56. 00
57. 00	05700 CT SCAN	C		0	0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	C		0	0	0	
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	4, 595	1		2, 887	0	59. 00 60. 00
60. 00	06001 BLOOD LABORATORY	4, 595			2, 00 /	0	60.00
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		1		ŏ	Ü	61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	C		o	О	0	1
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	C		0	0	0	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	C		0	0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	2, 543		0	1, 018	0	
66. 00 67. 00	O6600 PHYSI CAL THERAPY O6700 OCCUPATI ONAL THERAPY	1, 535 897	l .		289 38	0	
68. 00	06800 SPEECH PATHOLOGY	140	l .		30 5	0	68.00
69. 00	06900 ELECTROCARDI OLOGY				0	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	C		o o	Ö	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C		o o	o	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	C) (0	0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	C		0	0	28, 203	1
74. 00	07400 RENAL DIALYSIS	C		0	0	0	
75. 00 76. 97	O7500 ASC (NON-DISTINCT PART) O7697 CARDIAC REHABILITATION	C 747	1	1	121	0	1
10.71	OUTPATIENT SERVICE COST CENTERS	, , , , ,		را <u>ا</u>	121	0	, 3. 7/
88. 00	08800 RURAL HEALTH CLINIC	C		0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	C) (o o	o	0	89. 00
90. 00	09000 CLI NI C	451	l .	246	0	0	
91.00	09100 EMERGENCY	6, 478	8	3, 542	7, 046	0	91.00
92. 00	O9200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92. 00
94. 00	09400 HOME PROGRAM DIALYSIS) (n	0	94. 00
95. 00	09500 AMBULANCE SERVICES			ol ol	ő	0	
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	C		ol o	o	0	1
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	<u> </u>) (o o	o	0	97. 00

| In Lieu of Form CMS-2552-10 | Provider CCN: 150038 | Period: | Worksheet B | From 01/01/2014 | Part II | To 1/21/2014 | Part II | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagation | Propagatio Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

			To	12/31/2014	Date/Time Prepared 5/28/2015 1:03 pm	
Cost Center Description	CAFETERI A	MAINTENANCE OF	NURSI NG	CENTRAL	PHARMACY	
		PERSONNEL	ADMI NI STRATI ON	SERVICES &		
				SUPPLY		
	11. 00	12.00	13. 00	14. 00	15. 00	
99. 00 09900 CMHC	C	0	0	0	0 99.	
99. 10 09910 CORF	C	0	0	0	0 99.	
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	C	0	0	0	0 100.	
101.00 10100 HOME HEALTH AGENCY	C	0	0	0	0 101.	00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	C	0	0	0	0 105.	00
106. 00 10600 HEART ACQUI SI TI ON	C	0	0	0	0 106.	00
107. 00 10700 LIVER ACQUISITION	C	0	0	0	0 107.	00
108.00 10800 LUNG ACQUISITION	C	0	0	0	0 108.	00
109.00 10900 PANCREAS ACQUISITION	C	0	0	0	0 109.	00
110.00 11000 INTESTINAL ACQUISITION	C	0	0	0	0 110.	00
111.00 11100 ISLET ACQUISITION	C	0	0	0	0 111.	00
113. 00 11300 I NTEREST EXPENSE					113.	00
114.00 11400 UTILIZATION REVIEW-SNF					114.	00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	C	0	0	0	0 115.	00
116. 00 11600 HOSPI CE	C	0	0	0	0 116.	00
118.00 SUBTOTALS (SUM OF LINES 1-117)	43, 865	0	11, 301	25, 708	28, 203 118.	00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	0	0	0	0 190.	00
191. 00 19100 RESEARCH	C	0	0	0	0 191.	00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	86	0	0	36	0 192.	00
193. 00 19300 NONPALD WORKERS	C	0	0	0	0 193.	00
200.00 Cross Foot Adjustments					200.	00
201.00 Negative Cost Centers	C	0	0	0	0 201.	
202.00 TOTAL (sum lines 118-201)	43, 951	0	11, 301	25, 744	28, 203 202.	00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 150038

				'	0 12/31/2014	5/28/2015 1:0	
						INTERNS &	
						RESI DENTS	
	Cost Center Description	MEDI CAL	SOCIAL SERVICE		NURSING SCHOOL	SERVI CES-SALAR	
		RECORDS & LI BRARY		ANESTHETI STS		Y & FRINGES	
		16. 00	17. 00	19.00	20.00	21.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 7. 00	OO5OO ADMINISTRATIVE & GENERAL OO7OO OPERATION OF PLANT						5. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8.00
9. 00	00900 HOUSEKEEPING						9. 00
10. 00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A						11. 00
12. 00	01200 MAI NTENANCE OF PERSONNEL						12. 00
13.00	01300 NURSI NG ADMI NI STRATI ON						13.00
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY						14.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	68, 279					15. 00 16. 00
17. 00	01700 SOCIAL SERVICE	00,277	1				17. 00
	01900 NONPHYSICIAN ANESTHETISTS	0	1				19. 00
20.00	02000 NURSI NG SCHOOL	0	0		0		20. 00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRVD	0		1		0	21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	0	0				22. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	2.702				ı	20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	2, 783 1, 444		•			30. 00 31. 00
32. 00	03200 CORONARY CARE UNIT	0	1	1			32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	Ö	1	1			33. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0				34.00
40.00	04000 SUBPROVI DER - I PF	3, 197	0				40. 00
41. 00	04100 SUBPROVI DER - I RF	0	0				41. 00
42.00	04200 SUBPROVI DER	0	1				42.00
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY		0				43. 00 44. 00
45. 00	04500 NURSING FACILITY			•			45. 00
46. 00	04600 OTHER LONG TERM CARE	0		•			46. 00
	ANCILLARY SERVICE COST CENTERS		•		-	•	
50.00	05000 OPERATING ROOM	7, 223					50. 00
51.00	05100 RECOVERY ROOM	0	0				51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	15, 993	-				53. 00 54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0					55. 00
56.00	05600 RADI OI SOTOPE	0	0				56. 00
57.00	05700 CT SCAN	0	0				57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0				58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	7 (12					59.00
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	7, 613	0				60. 00 60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		٥				61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0				62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0				63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	0				64. 00
65. 00	06500 RESPI RATORY THERAPY	991	0				65. 00
66. 00 67. 00	06600 PHYSI CAL THERAPY	1, 342 205					66.00
68. 00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	58	ł .				67. 00 68. 00
	06900 ELECTROCARDI OLOGY	1, 573					69. 00
	07000 ELECTROENCEPHALOGRAPHY	0					70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	714	0				71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	113	0				72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	11, 921	0				73. 00
	07400 RENAL DIALYSIS	0	0				74.00
75. 00 76. 97	07500 ASC (NON-DISTINCT PART) 07697 CARDIAC REHABILITATION	0 320	0				75. 00 76. 97
70. 77	OUTPATIENT SERVICE COST CENTERS	320	0				70. 97
88. 00	08800 RURAL HEALTH CLINIC	0	0				88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	Ö	1	1			89. 00
90.00	09000 CLI NI C	79					90. 00
91.00	09100 EMERGENCY	12, 710	0				91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
94. 00	OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS	0	0				94. 00
95.00	09500 AMBULANCE SERVICES	0					95.00
		1 0	1 0	I .	1	I .	, , , , , , ,

				0 12/31/2014	5/28/2015 1:0	
					INTERNS &	
					RESI DENTS	
Cost Center Description	MEDI CAL	SOCIAL SERVICE	NONPHYSI CI AN	NURSING SCHOOL	SERVI CES-SALAR	
	RECORDS &		ANESTHETI STS		Y & FRINGES	
	LI BRARY					
	16. 00	17. 00	19. 00	20. 00	21. 00	
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0				96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0				97. 00
99. 00 09900 CMHC	0	0				99. 00
99. 10 09910 CORF	0	0				99. 10
100.00 10000 I &R SERVI CES-NOT APPRVD PRGM	0	0				100.00
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	U	U				101. 00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0				105. 00
106. 00 10600 HEART ACQUISITION	0	0				106. 00
107. 00 10700 LI VER ACQUI SI TI ON	0	0				107. 00
108. 00 10800 LUNG ACQUISITION	0	0				108. 00
109. 00 10900 PANCREAS ACQUISITION	0	0				109. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0				110. 00
111.00 11100 SLET ACQUISITION	0	0				111. 00
113.00 11300 INTEREST EXPENSE						113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0				115. 00
116. 00 11600 HOSPI CE	0	0				116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	68, 279	0	C	0	0	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190. 00
191. 00 19100 RESEARCH	0	0				191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0				192. 00
193.00 19300 NONPALD WORKERS	0	0				193. 00
200.00 Cross Foot Adjustments			0	0		200. 00
201.00 Negative Cost Centers	0	0	C	0		201. 00
202.00 TOTAL (sum lines 118-201)	68, 279	0	l c	0	0	202. 00

45. 00 O4500 OHREN LORD TERM CARE	34. 00 40. 00 41. 00 42. 00 43. 00	03300 BURN I NIENSIVE CARE UNI I 03400 SURGI CAL I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF 04200 SUBPROVI DER 04300 NURSERY	14	9, 393 0 0	0 0 0	0 0 149, 393 0 0		33. 00 34. 00 40. 00 41. 00 42. 00 43. 00
A				0	0	0		44. 00 45. 00
SOLO 05000	46. 00	04600 OTHER LONG TERM CARE		0	0	0		46. 00
51.00 OSTOO RECOVERY ROOM LABOR ROOM O O O O O O O O O	50.00		21	7 102	0	217 102		50. 00
10		1 1	21					51. 00
S3.00 05300 ANESTHESI OLOGY 0 0 0 0 0 0 0 0 0				Ö	Ö	0		52. 00
55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 0 0 0		1 1	İ	o	o	0		53. 00
55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 0 0 0			35	3, 488	0	353, 488		54.00
57.00 05700 CT SCAN 0 0 0 0 0 0 0 0 0	55.00			0	0	0		55.00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 0 0 0 0 0 0	56.00	05600 RADI OI SOTOPE		0	0	0		56.00
59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 0 0 0 0		05700 CT SCAN		0	0	0		57.00
60. 00 06000 LABORATORY 116, 302 0 116, 302 0 06001 BLOOD LABORATORY 0 0 0 0 0 0 0 0 0				0	0	0		58. 00
60. 01 06001 BLOOD LABORATORY 61. 00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1 1		0	0	0		59. 00
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1 1	11	6, 302	0	116, 302		60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 0 0 0 0		1 1		O	O	0		60. 01
63. 00		1 1			0	0		61.00
64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0	0	0		62. 00 63. 00
65. 00 06500 RESPIRATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY 70. 00 06700 0CUPATI ONAL THERAPY 82. 230 0 82. 230 83. 230 86. 00 06800 SPEECH PATHOLOGY 86. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY 70. 00 07000 ELECTROENCEPHALOGRAPHY 70. 00 07000 ELECTROENCEPHALOGRAPHY 70. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 71. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 73. 00 07300 DRUGS CHARGED TO PATI ENTS 74. 00 07400 RENAL DI ALYSI S 75. 00 07500 ASC (NON-DI STI NCT PART) 76. 07 07697 CARDI AC REHABI LI TATI ON 77. 07697 CARDI AC REHABI LI TATI ON 78. 00 08800 RURAL HEALTH CLI NI C 79. 00 08900 FEDERALLY QUALI FI ED HEALTH CENTER 79. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 79. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)		1		0	0	0		64. 00
66. 00 06600 PHYSICAL THERAPY 82, 230 0 82, 230 67. 00 06700 0CCUPATI ONAL THERAPY 26, 208 0 26, 208 68. 00 06800 SPEECH PATHOLOGY 568 0 568 0 568 0 69. 00 06900 ELECTROCARDI OLOGY 35, 074 0 35, 074 0 35, 074 0 07000 ELECTROCARDI OLOGY 35, 074 0 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 2, 376 0 2, 376 0 2, 376 0 07200 IMPL. DEV. CHARGED TO PATI ENTS 441 0 441 0 441 0 07200 IMPL. DEV. CHARGED TO PATI ENTS 61, 012 0 61,		1 1	1	4 406	0	34 406		65. 00
67. 00 06700 OCCUPATIONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY 68. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DIALYSIS 75. 00 07500 ASC (NON-DISTINCT PART) 76. 97 07697 CARDI AC REHABILITATION 77. 00 08800 RURAL HEALTH CLINIC 78. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 79. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 10 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 10 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 10 0 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1			0			66. 00
68. 00		1 1			0			67. 00
70. 00		1 1			0			68. 00
71. 00	69.00	06900 ELECTROCARDI OLOGY	3	5, 074	0	35, 074		69. 00
72. 00	70.00	07000 ELECTROENCEPHALOGRAPHY		0	0	0		70.00
73. 00	71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		2, 376	0	2, 376		71.00
74. 00					0			72.00
75. 00			6	1	0			73. 00
76. 97 07697 CARDÍAC REHABILITATION 36, 891 0 36, 891 0 36, 891 0 0 36, 891 0 0 36, 891 0 0 36, 891 0 0 0 0 0 0 0 0 0					0			74. 00
SERVICE COST CENTERS SERVICE COST CENTERS				-1	-	ŭ		75. 00
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89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 90. 00 0 90. 00 0 90. 00 0 90. 00 0 90. 00 0 90. 00	00 00			٥	0			88. 00
90. 00 09000 CLI NI C 73, 630 0 73, 630 91. 00 09100 EMERGENCY 144, 131 0 144, 131 92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 0 0 0 0 0 0 0 0 0			i i		0			89. 00
91. 00 09100 EMERGENCY 144, 131 0 144, 131 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 0			7	-1	0	ŭ		90.00
92.00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 0		1 1			0			91. 00
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MCRI F32 - 7. 2. 157. 2	MCRI F32	2 - 7.2.157.2						

Health Financial Systems	MORGAN COUNTY	/ HUSDITAI		Inlio	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	WORGAN COUNTY		CCN: 150038	Peri od: From 01/01/2014 To 12/31/2014	Worksheet B Part II
Cost Center Description	I NTERNS & RESI DENTS SERVI CES-OTHER PRGM COSTS	Subtotal	Intern & Residents Cos & Post Stepdown Adjustments	;	
	22. 00	24. 00	25. 00	26. 00	
0THER REIMBURSABLE COST CENTERS 94. 00		0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	94. 00 95. 00 96. 00 97. 00 99. 00 99. 10 100. 00 101. 00
SPECIAL PURPOSE COST CENTERS			<u>, </u>		105 00
105. 00 10500 KI DNEY ACQUISITION 106. 00 10600 HEART ACQUISITION 107. 00 10700 LI VER ACQUISITION 108. 00 10800 LUNG ACQUISITION 109. 00 10900 PANCREAS ACQUISITION 111. 00 11100 INTESTINAL ACQUISITION 113. 00 11300 INTEREST EXPENSE 114. 00 11400 UTILIZATION REVIEW-SNF 115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 116. 00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	0	0 0 0 0 0 0 0 0 0 0 0		0 2,004,215	105. 00 106. 00 107. 00 108. 00 109. 00 110. 00 111. 00 113. 00 114. 00 115. 00 116. 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		7, 904	ı	0 7, 904	190, 00
191.00 19100 RESEARCH 192.00 19200 PHYSICIANS' PRIVATE OFFICES 193.00 19300 NONPAID WORKERS 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118-201)	0 0	7, 904 618, 745 0 0 0 2, 630, 864		0 0 0 0 618, 745 0 0 0 0 0 0 0 0 0	191. 00 191. 00 192. 00 193. 00 200. 00 201. 00 202. 00

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03000 ADULTS & PEDIATRICS

03100 INTENSIVE CARE UNIT

03300 BURN INTENSIVE CARE UNIT

04400 SKILLED NURSING FACILITY

ANCILLARY SERVICE COST CENTERS

05200 DELIVERY ROOM & LABOR ROOM

05800 MAGNETIC RESONANCE IMAGING (MRI)

06100 PBP CLINICAL LAB SERVICES-PRGM ONLY

06300 BLOOD STORING, PROCESSING & TRANS.

06200 WHOLE BLOOD & PACKED RED BLOOD CELLS

07100 MEDICAL SUPPLIES CHARGED TO PATIENTS

07200 IMPL. DEV. CHARGED TO PATIENTS

03400 SURGICAL INTENSIVE CARE UNIT

03200 CORONARY CARE UNIT

04000 SUBPROVI DER - I PF

04100 SUBPROVIDER - IRF

04500 NURSING FACILITY

05000 OPERATING ROOM

05100 RECOVERY ROOM

05300 ANESTHESI OLOGY

05600 RADI OI SOTOPE

06000 LABORATORY

06001 BLOOD LABORATORY

06400 I NTRAVENOUS THERAPY

06500 RESPIRATORY THERAPY

06700 OCCUPATI ONAL THERAPY

07000 ELECTROENCEPHALOGRAPHY

07300 DRUGS CHARGED TO PATIENTS

07500 ASC (NON-DISTINCT PART)

07697 CARDIAC REHABILITATION

06600 PHYSI CAL THERAPY

06800 SPEECH PATHOLOGY

07400 RENAL DIALYSIS

06900 ELECTROCARDI OLOGY

05700 CT SCAN

04600 OTHER LONG TERM CARE

05400 RADI OLOGY-DI AGNOSTI C

05500 RADI OLOGY-THERAPEUTI C

05900 CARDIAC CATHETERIZATION

04200 SUBPROVI DER

04300 NURSERY

Health Financial Systems	MORGAN COUNT	Y HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
				From 01/01/2014 To 12/31/2014	Date/Time Prep 5/28/2015 1:03	pared: 3 pm
	CAPITAL RE	LATED COSTS				
Cost Center Description	BLDG & FLXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
			SALARI ES)			
	1. 00	2.00	4. 00	5A	5. 00	
OTHER REIMBURSABLE COST CENTERS		1			0	04.00
94. 00 09400 HOME PROGRAM DI ALYSI S 95. 00 09500 AMBULANCE SERVI CES				0	0	' 00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED					1 0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD					0	1
99. 00 09900 CMHC				0 0	0	1
99. 10 09910 CORF				0 0	0	
100.00 10000 1&R SERVICES-NOT APPRVD PRGM	0	l o		0 0	l 0	100.00
101.00 10100 HOME HEALTH AGENCY	0	o c		0 0	0	101. 00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0)	0 0	0	105. 00
106.00 10600 HEART ACQUI SI TI ON	0	0)	0		106. 00
107.00 10700 LIVER ACQUISITION	0	0		0		107. 00
108.00 10800 LUNG ACQUISITION	0	0)	0	0	108. 00

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821, 928

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24, 129, 727 118. 00

113. 00

114. 00

109.00 10900 PANCREAS ACQUISITION

111.00 11100 | SLET ACQUISITION

113.00 11300 INTEREST EXPENSE

116. 00 11600 HOSPI CE

191. 00 19100 RESEARCH

193. 00 19300 NONPALD WORKERS

Part I)

Part II)

11)

118.00

200.00

201.00

202.00

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204.00

205.00

110.00 11000 INTESTINAL ACQUISITION

114.00 11400 UTILIZATION REVIEW-SNF

115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)

SUBTOTALS (SUM OF LINES 1-117)
NONREI MBURSABLE COST CENTERS

190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN

Cross Foot Adjustments

Cost to be allocated (per Wkst. B,

Cost to be allocated (per Wkst. B,

Unit cost multiplier (Wkst. B, Part

Unit cost multiplier (Wkst. B, Part I)

Negative Cost Centers

192.00 19200 PHYSICIANS' PRIVATE OFFICES

Heal th	Financial Systems	MORGAN COUNT	Y HOS	SPI TAL		In Lie	u of Form CMS-2	2552-10
COST A	ALLOCATION - STATISTICAL BASIS			Provi der		Peri od:	Worksheet B-1	
						rom 01/01/2014 o 12/31/2014	Date/Time Pre	pared:
							5/28/2015 1:0	3 pm
	Cost Center Description	OPERATION OF PLANT		UNDRY & N SERVICE	HOUSEKEEPI NG	DI ETARY (MEALS SERVED)	CAFETERIA (PAID HOURS)	
		(SQUARE FEET)		OUNDS OF	(SQUARE TELT)	(WLALS SERVED)	(FAID HOURS)	
		()		AUNDRY)				
	T	7. 00		8. 00	9. 00	10. 00	11. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT		l					1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP							2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT							4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL							5. 00
7.00	00700 OPERATION OF PLANT	141, 257		10 052				7.00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	368		19, 853 0	140, 889			8. 00 9. 00
10. 00	01000 DI ETARY	4, 406		0	4, 406			10.00
11. 00	01100 CAFETERI A	2, 112		0	2, 112	2 0	309, 553	
12.00	01200 MAI NTENANCE OF PERSONNEL	0		0	(_	0	12.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	338 1, 290		0	338 1, 290		9, 728 0	
15. 00	01500 PHARMACY	982		Ö	982		14, 155	
16. 00	01600 MEDICAL RECORDS & LIBRARY	3, 404		0	3, 404		86	16. 00
17. 00	01700 SOCIAL SERVICE	0		0	C	0	0	17. 00
19. 00 20. 00	01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG SCHOOL	0		0			0	19. 00 20. 00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRVD	0		0			0	21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0		0	Č	o o	0	22. 00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDI ATRI CS	23, 584		2, 355	23, 584		21, 968	
31. 00 32. 00	03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT	6, 777		1, 443	6, 777	657	22, 455 0	31. 00 32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0		0			0	33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	0		0	C	o	0	34. 00
40. 00	04000 SUBPROVI DER - I PF	3, 630		2, 909	3, 630	2, 764	33, 876	
41.00	04100 SUBPROVI DER – I RF	0		0		0	0	41.00
42. 00 43. 00	04200 SUBPROVI DER 04300 NURSERY	0		0			0	42. 00 43. 00
44. 00	04400 SKILLED NURSING FACILITY	0		0			0	44. 00
45.00	04500 NURSING FACILITY	0		0	C	o	0	45. 00
46. 00	04600 OTHER LONG TERM CARE	0		0	(0	0	46. 00
50. 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM	9, 560	I	2, 412	9, 560	ol ol	18, 501	50. 00
51. 00	05100 RECOVERY ROOM	7, 300		2, 412	7, 500		10, 301	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		0	C	o	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0		0	(0	0	
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	14, 831		2, 716	14, 831	0	65, 735 0	1
56. 00	05600 RADI OLOGY - THERAPEUTI C	0		0			0	56. 00
	05700 CT SCAN	0		Ö	d	o o	0	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0	C	0	0	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0		0	4 22	-	0	
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	4, 322 0		0	4, 322		32, 361 0	
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY			Ŭ		, 	O	61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0	C	0	0	62. 00
63. 00		0		0	C	0	0	63.00
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	1, 193		0 421	(1, 193		0 17, 910	64.00
66. 00	06600 PHYSI CAL THERAPY	3, 765		885	3, 765		10, 810	
67. 00	1 1	1, 170		0	1, 170		6, 317	1
68. 00	06800 SPEECH PATHOLOGY	0		0	C	_	989	
69. 00	06900 ELECTROCARDI OLOGY	1, 690		0	1, 690	0	0	
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0			0	70. 00 71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0			0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0		0	C	o	0	73. 00
	07400 RENAL DIALYSIS	0		0	C	0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0		0	1 720	0	0	
76. 97	O7697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	1, 730		U	1, 730	0	5, 262	76. 97
88. 00		0		0	(ol	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	C	0	0	89. 00
90.00	09000 CLINIC	3, 667		0	3, 667		3, 173	
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	4, 934		6, 499	4, 934	0	45, 624	91. 00 92. 00
72. UU	OTHER REIMBURSABLE COST CENTERS							72.00
94.00	09400 HOME PROGRAM DIALYSIS	0		0	C		0	
95. 00	09500 AMBULANCE SERVI CES	0		0	C		0	
96. 00	09600 DURABLE MEDI CAL EQUI P-RENTED	0		0	(0	0	96. 00

Health Financial Systems	MORGAN COUNT	Y HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		'eri od:	Worksheet B-1	
				rom 01/01/2014	5	
				o 12/31/2014	Date/Time Pre 5/28/2015 1:0	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	JS PIII
cost center bescription		LINEN SERVICE		(MEALS SERVED)	(PAID HOURS)	
	(SQUARE FEET)	(POUNDS OF	(SQS/IKE TEET)	(MERLES SERVED)	(1711 10 1100110)	
	(040/11/2 / 221)	LAUNDRY)				
	7. 00	8. 00	9. 00	10.00	11. 00	
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	C		0	97. 00
99. 00 09900 CMHC	o	0		o	0	99. 00
99. 10 09910 CORF	o	0	l c	o	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	o	0	l c	o	0	100.00
101.00 10100 HOME HEALTH AGENCY	o	0	l c	o	0	101.00
SPECIAL PURPOSE COST CENTERS				'		
105. 00 10500 KIDNEY ACQUISITION	0	0	C	0	0	105. 00
106. 00 10600 HEART ACQUISITION	o	0	C	o	0	106. 00
107.00 10700 LIVER ACQUISITION	o	0	C	o	0	107. 00
108.00 10800 LUNG ACQUISITION	o	0	C	o	0	108.00
109.00 10900 PANCREAS ACQUISITION	o	0	C	o	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	o	0	C	o	0	110.00
111.00 11100 ISLET ACQUISITION	0	0	C	0	0	111. 00
113.00 11300 I NTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	C	0	0	115. 00
116. 00 11600 HOSPI CE	0	0	C	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	93, 753	19, 640	93, 385	4, 509	308, 950	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	400	0	400	0		190. 00
191. 00 19100 RESEARCH	0	0	C	1 4		191. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	47, 104	213	47, 104	. 0		192. 00
193. 00 19300 NONPALD WORKERS	0	0	C	0	0	193. 00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. B,	2, 657, 741	105, 530	789, 973	575, 508	450, 813	202. 00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	18. 814933	5. 315569				1
204.00 Cost to be allocated (per Wkst. B,	352, 521	7, 803	4, 974	89, 399	43, 951	204. 00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	2. 495600	0. 393039	0. 035304	19. 826791	0. 141982	205. 00
11)						1

	Financial Systems LLOCATION - STATISTICAL BASIS	MORGAN COUN		CCN: 150038 P	In Lie eriod:	u of Form CMS-2 Worksheet B-1	
C031 F	ILLUCATION - STATISTICAL BASIS		Provider		rom 01/01/2014	Date/Time Pre	pared:
	Cost Center Description	MAINTENANCE OF	NURSI NG	CENTRAL	PHARMACY	5/28/2015 1: 0 MEDI CAL	3 pm
	·	PERSONNEL	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	
		(NUMBER HOUSED)	(NURSI NG	SUPPLY (COSTED	REQUIS.)	LI BRARY (GROSS	
			HOURS)	REQUIS.)		CHARGES)	
	GENERAL SERVICE COST CENTERS	12. 00	13.00	14. 00	15. 00	16. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 4. 00	OO200 CAP REL COSTS-MVBLE EQUIP OO400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7. 00
8. 00 9. 00	O0800 LAUNDRY & LI NEN SERVI CE O0900 HOUSEKEEPI NG						8. 00 9. 00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11.00
12. 00 13. 00	O1200 MAI NTENANCE OF PERSONNEL O1300 NURSI NG ADMI NI STRATI ON		0 145, 597				12. 00 13. 00
14. 00	01400 CENTRAL SERVI CES & SUPPLY		0 143,377	524, 835			14. 00
15.00	01500 PHARMACY		0	6, 187	100	404 754 500	15. 00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE			134	0	104, 751, 503 0	
19. 00	01900 NONPHYSI CI AN ANESTHETI STS			0	0	0	19. 00
20.00	02000 NURSI NG SCHOOL			0	0	0	20.00
21. 00 22. 00	02100 &R SERVI CES-SALARY & FRINGES APPRVD 02200 &R SERVI CES-OTHER PRGM COSTS APPRVD			0	0	0	21. 00 22. 00
22.00	INPATIENT ROUTINE SERVICE COST CENTERS		-1		<u> </u>		
30.00	03000 ADULTS & PEDIATRICS	1	21, 968	4, 775		4, 267, 732	1
31. 00 32. 00	03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT		0 22, 455 0 0	43, 267 0	0	2, 215, 024 0	
33. 00	03300 BURN INTENSIVE CARE UNIT			0	0	0	33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT		0 0	10.004	0	4 003 334	34.00
40. 00 41. 00	04000 SUBPROVI DER		0 33, 876 0 0	19, 004 0	0	4, 903, 336 0	
42.00	04200 SUBPROVI DER			0	0	0	42. 00
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY			0	0	0	43. 00 44. 00
45.00	04500 NURSING FACILITY			0	0	0	45. 00
46. 00	04600 OTHER LONG TERM CARE		0 0	0	0	0	46. 00
50. 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM		18, 501	113, 494	0	11, 078, 583	50.00
51. 00	05100 RECOVERY ROOM		0	0	0	0	51.00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY			0	0	0	52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C			104, 759	0	24, 557, 877	ı
55.00	05500 RADI OLOGY-THERAPEUTI C			0	0	0	55. 00
	05600			0	0	0	
	05800 MAGNETIC RESONANCE I MAGING (MRI)			0	0	0	
59.00	05900 CARDI AC CATHETERI ZATI ON		0	0	0	0	59.00
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY			58, 859 0	0	11, 676, 463 0	1
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY			· ·		· ·	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS			0	0	0	
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY			0	0	0	63. 00 64. 00
65.00	06500 RESPI RATORY THERAPY			20, 746	0	1, 519, 876	65. 00
66. 00 67. 00	O6600 PHYSI CAL THERAPY O6700 OCCUPATI ONAL THERAPY			5, 884 766	0	2, 058, 371 314, 702	1
68. 00	06800 SPEECH PATHOLOGY			108		88, 519	1
69. 00	06900 ELECTROCARDI OLOGY			0	0	2, 412, 802	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			0	0	0 1, 095, 560	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS			0	0	172, 776	72. 00
	07300 DRUGS CHARGED TO PATIENTS		0	0	100	18, 283, 030	
74. 00 75. 00	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)			0	0	0	
76. 97	07697 CARDI AC REHABILITATION			2, 474	0	491, 360	
00.00	OUTPATIENT SERVICE COST CENTERS						00.00
88. 00 89. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER		0 0	0	0	0	88. 00 89. 00
90.00	09000 CLI NI C		3, 173	0	0	121, 737	90.00
91.00	09100 EMERGENCY		45, 624	143, 636	0	19, 493, 755	
92. 00	O9200 OBSERVATI ON BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
	09400 HOME PROGRAM DIALYSIS	1	0	0		0	
95.00	09500 AMBULANCE SERVI CES	(이	0	0	0	95. 00

Health Financial Systems	MORGAN COUNT	Y HOSPITAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
				From 01/01/2014 Fo 12/31/2014	Date/Time Pre	narod:
				Γο 12/31/2014	5/28/2015 1:0	
Cost Center Description	MAINTENANCE OF	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	, p
	PERSONNEL	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	
	(NUMBER		SUPPLY	REQUIS.)	LI BRARY	
	HOUSED)	(NURSI NG	(COSTED		(GROSS	
		HOURS)	REQUI S.)		CHARGES)	
	12.00	13. 00	14. 00	15. 00	16. 00	
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	(0	0	
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	(0	0	1 , , , , , ,
99. 00 09900 CMHC	0	0	(0	0	1 , , , , , ,
99. 10 09910 CORF	0	0	(0	0	
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0	(0		100.00
101. 00 10100 HOME HEALTH AGENCY	0	0	(0	0	101. 00
SPECIAL PURPOSE COST CENTERS			<u> </u>	ol ol	0	105 00
105.00 10500 KIDNEY ACQUISITION 106.00 10600 HEART ACQUISITION	0	0		0		105. 00 106. 00
107. 00 10700 LI VER ACQUI SI TI ON	0	0				106.00
107. 00 10700 ETVER ACQUISITION 108. 00 10800 LUNG ACQUISITION	0	0				107.00
109. 00 10900 PANCREAS ACQUISITION	0	0				108.00
110. 00 11000 NTESTINAL ACQUISITION	0	0				1109.00
111. 00 11100 SLET ACQUISITION	0	0				111.00
113. 00 11300 NTEREST EXPENSE		U	'		U	113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF	•					114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	,		0	115. 00
116. 00 11600 HOSPI CE	0	0	l '			116.00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	0	145, 597	524, 09	100	104, 751, 503	
NONREI MBURSABLE COST CENTERS		143, 377	324, 07.	5 100	104, 731, 303	1110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	0	190. 00
191. 00 19100 RESEARCH	0	0				191. 00
192. 00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	74:	0		192. 00
193. 00 19300 NONPALD WORKERS	0	0		ol		193. 00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. B,	-87, 302	541, 532	101, 75	1, 096, 607	323, 590	202. 00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 000000	3. 719390	0. 19388:	10, 966. 070000	0. 003089	203. 00
204.00 Cost to be allocated (per Wkst. B,	0	11, 301	25, 74	1 28, 203	68, 279	204. 00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	0. 000000	0. 077618	0. 04905	282. 030000	0. 000652	205. 00
						1

Provi der CCN: 150038

| Peri od: | Worksheet B-1 | From 01/01/2014 | To 12/31/2014 | Date/Time Prepared:

						0 12/31/2014	Date/lime Pre 5/28/2015 1:0 RESIDENTS	
		Cost Center Description	SOCIAL SERVICE	NONDHYSLCLAN	NUIDSI NG SCHOOL	SERVI CES-SALAR	SEDVI CES_OTHED	
		cost center bescription	SOCIAL SERVICE	ANESTHETI STS	NORST NO SCHOOL	Y & FRI NGES	PRGM COSTS	
			(TIME SPENT)	(ASSIGNED TIME)	(ASSIGNED TIME)	(ASSI GNED TIME)	(ASSIGNED TIME)	
			17. 00	19. 00	20.00	21.00	22. 00	
1 00		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT			1			1. 00
1. 00 2. 00		CAP REL COSTS-BLDG & FIXT						2. 00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	1	ADMINISTRATIVE & GENERAL						5. 00
7. 00 8. 00	1	OPERATION OF PLANT LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00		HOUSEKEEPI NG						9. 00
10. 00	1	DI ETARY						10. 00
11. 00 12. 00	1	CAFETERIA MAINTENANCE OF PERSONNEL						11. 00 12. 00
13. 00	1	NURSING ADMINISTRATION						13. 00
14. 00	1	CENTRAL SERVICES & SUPPLY						14. 00
15.00	1	PHARMACY						15. 00
16. 00 17. 00		MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	0					16. 00 17. 00
19. 00	1	NONPHYSICIAN ANESTHETISTS	0	O				19. 00
20. 00	1	NURSI NG SCHOOL	0					20. 00
21. 00 22. 00	1	I&R SERVICES-SALARY & FRINGES APPRVD I&R SERVICES-OTHER PRGM COSTS APPRVD	0			0	0	21. 00 22. 00
22.00		I ENT ROUTINE SERVICE COST CENTERS	U				0	22.00
30.00	03000	ADULTS & PEDIATRICS	0		C		0	30. 00
31.00	1	INTENSIVE CARE UNIT	0		C	0	0	31.00
32. 00 33. 00	1	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0			0	0	32. 00 33. 00
34. 00	1	SURGICAL INTENSIVE CARE UNIT	0			o	0	34. 00
40. 00	1	SUBPROVI DER - I PF	0		C	0	0	40. 00
41. 00 42. 00	1	SUBPROVI DER	0			0	0	41. 00 42. 00
43. 00	1	NURSERY	0			0	0	43. 00
44.00	04400	SKILLED NURSING FACILITY	0		c	0	0	44. 00
45. 00 46. 00	1	NURSING FACILITY OTHER LONG TERM CARE	0		C		0	45. 00 46. 00
40.00		LARY SERVICE COST CENTERS	0			<u> </u>		40.00
50.00	1	OPERATI NG ROOM	0	O			0	50. 00
51. 00 52. 00	1	RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	51. 00 52. 00
53. 00	1	ANESTHESI OLOGY	0	0		0	0	53. 00
54.00	1	RADI OLOGY-DI AGNOSTI C	0	0	o c	0	0	54. 00
55. 00	1	RADI OLOGY-THERAPEUTI C	0	0	O	0	0	55. 00
56. 00 57. 00	1	RADI OI SOTOPE CT SCAN	0	0		0	0	56. 00 57. 00
58. 00		MAGNETIC RESONANCE IMAGING (MRI)	0	O	C	o	0	58. 00
	1	CARDI AC CATHETERI ZATI ON	0	0	C	0	0	59.00
60. 00 60. 01	1	LABORATORY BLOOD LABORATORY	0	0		0	0	60. 00 60. 01
61. 00	1	PBP CLINICAL LAB SERVICES-PRGM ONLY					· ·	61. 00
62.00		WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	C	0	0	62.00
63. 00 64. 00	1	BLOOD STORING, PROCESSING & TRANS. INTRAVENOUS THERAPY	0	0		0	0	63. 00 64. 00
65. 00		RESPI RATORY THERAPY	0	Ö	ď	o	0	65. 00
66. 00	1	PHYSI CAL THERAPY	0	0	C	0	0	66. 00
67. 00 68. 00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	0	0		0	0	67. 00 68. 00
69. 00	1	ELECTROCARDI OLOGY	0	0		o	0	69. 00
70. 00	1	ELECTROENCEPHALOGRAPHY	0	O	o c	0	0	70. 00
71. 00 72. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	71. 00 72. 00
73. 00	1	DRUGS CHARGED TO PATTENTS	0	0		0	0	73. 00
74. 00	07400	RENAL DIALYSIS	0	0	d	O	0	74. 00
75. 00	1	ASC (NON-DISTINCT PART)	0	0	-	0	0	75. 00
76. 97		CARDIAC REHABILITATION TIENT SERVICE COST CENTERS	0	0	<u> </u>	0	0	76. 97
88. 00	08800	RURAL HEALTH CLINIC	0	O	C	0	0	88. 00
89.00		FEDERALLY QUALIFIED HEALTH CENTER	0	0	O C	0	0	89. 00
90. 00 91. 00		CLINIC EMERGENCY	0				0	90. 00 91. 00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
04.00	OTHER	REIMBURSABLE COST CENTERS						04.00
94. 00	107400	HOME PROGRAM DIALYSIS	0	0	<u> </u>	0	0	94. 00

| Peri od: | Worksheet B-1 | From 01/01/2014 | To 12/31/2014 | Date/Time Prepared:

			'	0 12/31/2014	5/28/2015 1:03 pm
				INTERNS &	RESI DENTS
Cost Center Description	SOCI AL SERVI CE	NONPHYSICIAN	NURSING SCHOOL	SERVI CES-SALAR	SERVI CES-OTHER
		ANESTHETI STS		Y & FRINGES	PRGM COSTS
	(TIME SPENT)	(ASSI GNED	(ASSI GNED	(ASSI GNED	(ASSI GNED
		TIME)	TIME)	TIME)	TIME)
	17. 00	19. 00	20.00	21. 00	22. 00
95. 00 09500 AMBULANCE SERVICES	0	C	0	0	0 95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	C	0	0	0 96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	C	0	0	0 97.00
99. 00 09900 CMHC	0	C	0	0	0 99.00
99. 10 09910 CORF	0	C	0	0	0 99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	l c	0	0	0 100. 00
101.00 10100 HOME HEALTH AGENCY	0	C	0	0	0 101. 00
SPECIAL PURPOSE COST CENTERS		•			
105. 00 10500 KIDNEY ACQUISITION	0	C	0	0	0 105. 00
106. 00 10600 HEART ACQUISITION	0	l c	0	0	0 106. 00
107. 00 10700 LIVER ACQUISITION	0		0	0	0 107. 00
108.00 10800 LUNG ACQUISITION	0) 0	0	0 108.00
109. 00 10900 PANCREAS ACQUISITION	0			0	0 109. 00
110.00 11000 INTESTINAL ACQUISITION	0			0	0 110.00
111. 00 11100 SLET ACQUISITION	0			0	0 111. 00
113. 00 11300 NTEREST EXPENSE					113. 00
114.00 11400 UTILIZATION REVIEW-SNF					114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0		ol o	0	0 115.00
116. 00 11600 HOSPI CE	0			0	0 116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	l c		0	0 118.00
NONREI MBURSABLE COST CENTERS			-		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C) 0	0	0 190, 00
191. 00 19100 RESEARCH	0	l c		0	0 191. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0			0	0 192. 00
193. 00 19300 NONPALD WORKERS	0	ĺ		0	0 193. 00
200.00 Cross Foot Adjustments					200.00
201.00 Negative Cost Centers					201. 00
202.00 Cost to be allocated (per Wkst. B,	0			0	0 202. 00
Part I)					0 202. 00
203.00 Unit cost multiplier (Wkst. B, Part I	0.000000	0. 000000	0. 000000	0.000000	0. 000000 203. 00
204.00 Cost to be allocated (per Wkst. B,	0	l c	0	0	0 204. 00
Part II)					
205.00 Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000	0.000000	0. 000000	0. 000000 205. 00
)					

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2014 | Part | To 12/31/2014 | Date/Time Prepared: | 5/28/2015 1:03 pm Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provi der CCN: 150038

		Ti +I	e XVIII	Hospi tal	5/28/2015 1:0 PPS	3 pm
			L XVIII	Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26) 1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			0.00			
30. 00 03000 ADULTS & PEDIATRICS	3, 186, 841	l e	3, 186, 841		3, 186, 841	30. 00
31. 00 03100 I NTENSI VE CARE UNIT	1, 708, 114	i .	1, 708, 114	0	1, 708, 114	31.00
32. 00 03200 CORONARY CARE UNIT	C)	0	0	0	32.00
33.00 03300 BURN INTENSIVE CARE UNIT 34.00 03400 SURGICAL INTENSIVE CARE UNIT				0	0	33. 00 34. 00
40. 00 04000 SUBPROVI DER - PF	2, 356, 931	'	2, 356, 931	0	2, 356, 931	40.00
41. 00 04100 SUBPROVI DER - RF	2,000,70		2,000,701	0	0	41. 00
42. 00 04200 SUBPROVI DER	C		c	0	0	42. 00
43. 00 04300 NURSERY	C		C	0	0	43. 00
44. 00 04400 SKILLED NURSING FACILITY	C		0	0	0	44.00
45.00 04500 NURSING FACILITY 46.00 04600 OTHER LONG TERM CARE)		0	0	45. 00 46. 00
ANCILLARY SERVICE COST CENTERS		/		,, 0	0	40.00
50. 00 05000 OPERATI NG ROOM	2, 264, 371		2, 264, 371	0	2, 264, 371	50.00
51.00 05100 RECOVERY ROOM	C		0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	C		C	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	C 550 255) -	C 550 355	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C	5, 559, 255		5, 559, 255		5, 559, 255 0	54. 00 55. 00
56. 00 05600 RADI 0I SOTOPE)			0	56.00
57. 00 05700 CT SCAN				Ö	Ö	57.00
58.00 05800 MAGNETIC RESONANCE MAGING (MRI)	C		C	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	C		C	0	0	59. 00
60. 00 06000 LABORATORY	2, 850, 921		2, 850, 921	0	2, 850, 921	60.00
60. 01 06001 BLOOD LABORATORY				0	0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS				0	0	61. 00 62. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.				Ö	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	C		C	0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	1, 061, 460	I .	1, 061, 460		1, 061, 460	65. 00
66. 00 06600 PHYSI CAL THERAPY	882, 709	l e	882, 709		882, 709	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	371, 354	l .	371, 354		371, 354	1
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	59, 367 98, 522	l .	59, 367 98, 522		59, 367 98, 522	68. 00 69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	70, 322	1	70, 322		0, 322	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	282, 990		282, 990	0	282, 990	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	55, 795		55, 795	0	55, 795	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	4, 668, 102	2	4, 668, 102	. 0	4, 668, 102	73. 00
74.00 07400 RENAL DIALYSIS 75.00 07500 ASC (NON-DISTINCT PART)				0	0	74.00
75. 00 07500 ASC (NON-DISTINCT PART) 76. 97 07697 CARDIAC REHABILITATION	330, 165		330, 165	0	0 330, 165	75. 00 76. 97
OUTPATIENT SERVICE COST CENTERS	000,100	1	1 000, 100		000, 100	70.77
88. 00 08800 RURAL HEALTH CLINIC	C)	C	0		88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	C		0	0	0	1
90. 00 09000 CLI NI C	243, 153	l .	243, 153		243, 153	
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART)	2, 856, 733 1, 138, 828		2, 856, 733		2, 856, 733 1, 138, 828	91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS	1, 130, 020)	1, 138, 828	1	1, 130, 020	92.00
94. 00 09400 HOME PROGRAM DIALYSIS	C		C	0	0	94. 00
95. 00 09500 AMBULANCE SERVICES	C		c	0	0	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	C		C	0	0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	C)	C	0	0	97. 00
99. 00 09900 CMHC)			0	99.00
99. 10 09910 CORF 100. 00 10000 I &R SERVI CES-NOT APPRVD PRGM						99. 10 100. 00
101. 00 10100 HOME HEALTH AGENCY						101.00
SPECIAL PURPOSE COST CENTERS		1		1		
105. 00 10500 KIDNEY ACQUISITION	C	l l	C			105. 00
106. 00 10600 HEART ACQUISITION	C	1	C			106. 00
107. 00 10700 LIVER ACQUISITION	C		0			107.00
108.00 10800 LUNG ACQUISITION 109.00 10900 PANCREAS ACQUISITION						108. 00 109. 00
110. 00 11000 NTESTINAL ACQUISITION			0			1109.00
111. 00 11100 SLET ACQUISITION						111.00
113. 00 11300 I NTEREST EXPENSE						113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)						115.00
116.00 11600 HOSPICE 200.00 Subtotal (see instructions)	29, 975, 611) 	29, 975, 611	0		116.00
200. 00 Journal (See Histilactions)	27, 7/3, 011	1	7 £3, 375, UTI		27, 773, 011	1200.00

Health Fin	ancial Systems	MORGAN COUNT	MORGAN COUNTY HOSPITAL			In Lieu of Form CMS-2552-10		
COMPUTATIO	ON OF RATIO OF COSTS TO CHARGES			Provi der	CCN: 150038	Peri od:	Worksheet C	
						From 01/01/2014 To 12/31/2014	Part Date/Time Pre	nared·
						10 12/01/2011	5/28/2015 1:0	
				Ti tl	e XVIII	Hospi tal	PPS	
						Costs		
	Cost Center Description	Total Cost	Ther	apy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,		Adj .		Di sal I owance		
		Part I, col.						
		26)						
		1.00		2.00	3. 00	4. 00	5. 00	
201.00	Less Observation Beds	1, 138, 828	3		1, 138, 8	28	1, 138, 828	201.00
202.00	Total (see instructions)	28, 836, 783		0	28, 836, 78	33 0	28, 836, 783	202. 00

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provi der CCN: 150038

					5/28/2015 1:0	3 pm
			e XVIII	Hospi tal	PPS	
Cost Center Description	Inpati ent	Charges Outpatient	Total (col. 6	Cost or Other	TEFRA	
Cost center beserretron	Impatrent	outputtent	+ col . 7)	Ratio	Inpati ent	
			Í		Rati o	
	6. 00	7. 00	8. 00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	1, 689, 328		1, 689, 328			30. 00
31. 00 03100 NTENSIVE CARE UNIT	2, 215, 024		2, 215, 024	ł		31.00
32. 00 03200 CORONARY CARE UNIT	0					32.00
33.00 03300 BURN INTENSIVE CARE UNIT 34.00 03400 SURGICAL INTENSIVE CARE UNIT	0					33. 00 34. 00
40. 00 04000 SUBPROVI DER - PF	4, 903, 336		4, 903, 336			40.00
41. 00 04100 SUBPROVI DER - I RF	0		1, 700, 000	ó		41.00
42. 00 04200 SUBPROVI DER	o					42.00
43. 00 04300 NURSERY	o					43.00
44.00 04400 SKILLED NURSING FACILITY	0)		44. 00
45.00 04500 NURSING FACILITY	0		()		45. 00
46. 00 04600 OTHER LONG TERM CARE	0		()		46. 00
ANCILLARY SERVICE COST CENTERS	4/7 /22	10 (10 052	11 070 50	0.204202	0.000000	
50.00 05000 OPERATING ROOM 51.00 05100 RECOVERY ROOM	467, 632 0	10, 610, 952	11, 078, 58 ²		0. 000000 0. 000000	50. 00 51. 00
52. 00 05200 DELI VERY ROOM & LABOR ROOM		0		0. 000000	0. 000000	52.00
53. 00 05300 ANESTHESI OLOGY		0		0.000000	0. 000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 193, 383	23, 364, 494	24, 557, 877		0. 000000	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	(0. 000000	0.000000	55. 00
56. 00 05600 RADI 0I SOTOPE	o	0	(0.000000	0. 000000	56. 00
57.00 05700 CT SCAN	0	0	(0. 000000	0. 000000	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	(0. 000000	0. 000000	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	(0. 000000	0. 000000	59. 00
60. 00 06000 LABORATORY	2, 084, 583	9, 591, 880	11, 676, 463		0. 000000	60.00
60. 01 06001 BLOOD LABORATORY	0	0	(0.000000	0.000000	60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		0.000000	0.000000	61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0. 000000 0. 000000	0. 000000 0. 000000	62. 00 63. 00
64. 00 06400 INTRAVENOUS THERAPY	0	0		0. 000000	0. 000000	64.00
65. 00 06500 RESPI RATORY THERAPY	742, 591	777, 285	1, 519, 876		0. 000000	65.00
66. 00 06600 PHYSI CAL THERAPY	112, 986	1, 945, 385			0. 000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	13, 839	300, 864			0. 000000	67. 00
68. 00 06800 SPEECH PATHOLOGY	12, 500	76, 019			0.000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	466, 002	1, 946, 800	2, 412, 802	0. 040833	0. 000000	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	(0. 000000	0. 000000	70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	255, 164	840, 396			0. 000000	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	5, 898	166, 878			0.000000	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DIALYSIS	2, 965, 292	15, 317, 738	18, 283, 030		0.000000	73.00
74. 00 07400 RENAL DIALYSIS 75. 00 07500 ASC (NON-DISTINCT PART)	0	0		0. 000000 0. 000000	0. 000000 0. 000000	74. 00 75. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	315	491, 045	491, 360		0. 000000	76. 97
OUTPATIENT SERVICE COST CENTERS	313	471,043	471, 300	0.071941	0.00000	70. 77
88. 00 08800 RURAL HEALTH CLINIC	ol	0				88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	Ö	0				89. 00
90. 00 09000 CLI NI C	o	121, 737	121, 737	1. 997363	0. 000000	90.00
91. 00 09100 EMERGENCY	933, 617	18, 560, 137	19, 493, 754	0. 146546	0. 000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	391, 463	2, 186, 941	2, 578, 404	0. 441679	0. 000000	92. 00
OTHER REIMBURSABLE COST CENTERS			1			
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0			0.000000	94. 00
95. 00 09500 AMBULANCE SERVI CES	0	0			0.000000	95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0	(0. 000000 0. 000000	0. 000000 0. 000000	96. 00 97. 00
99. 00 09900 CMHC	0	0		0.000000	0.000000	99.00
99. 10 09910 CORF		0				99. 10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	l o	0		ó		100.00
101.00 10100 HOME HEALTH AGENCY	o	0				101. 00
SPECIAL PURPOSE COST CENTERS	<u>'</u>					
105. 00 10500 KIDNEY ACQUISITION	0	0	()		105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0	()		106. 00
107.00 10700 LIVER ACQUISITION	0	0	(107. 00
108. 00 10800 LUNG ACQUI SITI ON	0	0	()		108. 00
109. 00 10900 PANCREAS ACQUISITION	0	0	()		109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0				110.00
111. 00 11100 ISLET ACQUISITION 113. 00 11300 INTEREST EXPENSE	0	0		ή		111. 00 113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	_	0	1			115.00
116. 00 11600 HOSPI CE		0				116.00
200.00 Subtotal (see instructions)	18, 452, 953	86, 298, 551	104, 751, 504	ı		200. 00
201.00 Less Observation Beds		,				201. 00
	,					

Health Financial Systems					In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES			Provi der		Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Pre 5/28/2015 1:0	
			Ti tl	e XVIII	Hospi tal	PPS	
		Ch	narges				
Cost Center Description	I npati ent	0ut	pati ent	Total (col. (Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Ratio	
	6. 00		7. 00	8.00	9. 00	10.00	
202.00 Total (see instructions)	18, 452, 953	8	6, 298, 551	104, 751, 50	4		202. 00

Title XVIII

		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
32. 00 03200 CORONARY CARE UNIT				32.00
33.00 03300 BURN INTENSIVE CARE UNIT				33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT				34.00
40. 00 04000 SUBPROVI DER - PF				40. 00
41. 00 04100 SUBPROVI DER - I RF				41. 00
42. 00 04200 SUBPROVI DER				42.00
43. 00 04300 NURSERY				43. 00
44. 00 04400 SKI LLED NURSI NG FACI LI TY				44. 00
				45. 00
46. 00 O4600 OTHER LONG TERM CARE				46. 00
ANCI LLARY SERVI CE COST CENTERS	0.004000			50.00
50. 00 05000 OPERATI NG ROOM	0. 204392			50.00
51.00 05100 RECOVERY ROOM	0. 000000			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 226374			54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000			55. 00
56. 00 05600 RADI 0I SOTOPE	0. 000000			56.00
57. 00 05700 CT SCAN	0. 000000			57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59. 00
60. 00 06000 LABORATORY	0. 244160			60.00
60. 01 06001 BLOOD LABORATORY	0. 000000			60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000			62. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000			64. 00
	1			
65. 00 06500 RESPIRATORY THERAPY	0. 698386			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 428839			66.00
67. 00 06700 0CCUPATI ONAL THERAPY	1. 180014			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 670670			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 040833			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 258306			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 322933			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 255324			73.00
74. 00 07400 RENAL DI ALYSI S	0. 000000			74.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000			75. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 671941			76. 97
OUTPATIENT SERVICE COST CENTERS				
88. 00 08800 RURAL HEALTH CLINIC				88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER				89. 00
90. 00 09000 CLI NI C	1. 997363			90.00
91. 00 09100 EMERGENCY	0. 146546			91.00
1 I	0. 140340			92.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 44 16 / 9			92.00
OTHER REIMBURSABLE COST CENTERS	0.000000			04.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0.000000			94.00
95. 00 09500 AMBULANCE SERVI CES	0.000000			95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0. 000000			96. 00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0. 000000			97. 00
99. 00 09900 CMHC				99. 00
99. 10 09910 CORF				99. 10
100.00 10000 1&R SERVICES-NOT APPRVD PRGM				100. 00
101.00 10100 HOME HEALTH AGENCY				101. 00
SPECIAL PURPOSE COST CENTERS				
105.00 10500 KIDNEY ACQUISITION				105. 00
106.00 10600 HEART ACQUISITION				106. 00
107. 00 10700 LIVER ACQUISITION				107. 00
108.00 10800 LUNG ACQUISITION				108. 00
109. 00 10900 PANCREAS ACQUISITION				109. 00
110.00 11000 INTESTINAL ACQUISITION				110.00
111. 00 11100 I SLET ACQUISITION				111.00
I I				
113. 00 11300 I NTEREST EXPENSE				113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF				114.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)				115. 00
116. 00 11600 HOSPI CE				116. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 150038	Peri od: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Pre 5/28/2015 1:0	pared:
		Ti t	le XIX	Hospi tal	Cost	3 piii
Cost Center Description	Total Cost (from Wkst. B, Part I, col.	Therapy Limit	Total Costs	Costs RCE Di sal I owance	Total Costs	
	26)	0.00	2.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3. 00	4. 00	5. 00	
30. 00 03000 ADULTS & PEDIATRICS	3, 186, 841		3, 186, 84	1 0	3, 186, 841	30.00
31.00 03100 INTENSIVE CARE UNIT	1, 708, 114		1, 708, 11	4 0	1, 708, 114	31.00
32. 00 03200 CORONARY CARE UNIT	0			0	0	32. 00
33. 00 03300 BURN INTENSIVE CARE UNIT	0			0	0	33.00
34.00 03400 SURGI CAL INTENSIVE CARE UNIT 40.00 04000 SUBPROVI DER - I PF	2, 356, 931		2, 356, 93	11 0	0 2, 356, 931	34. 00 40. 00
41. 00 04100 SUBPROVI DER - I RF	2, 330, 731		2, 330, 70	0 0	2, 330, 731	41.00
42. 00 04200 SUBPROVI DER	0			0 0	0	42.00
43. 00 04300 NURSERY	0			0 0	0	43. 00
44. 00 04400 SKI LLED NURSI NG FACI LI TY	0			0	0	44. 00
45.00 04500 NURSING FACILITY 46.00 04600 OTHER LONG TERM CARE	0			0 0	0	45. 00 46. 00
ANCI LLARY SERVI CE COST CENTERS				0		1 40.00
50. 00 05000 OPERATI NG ROOM	2, 264, 371		2, 264, 37	'1 0	2, 264, 371	50.00
51. 00 05100 RECOVERY ROOM	0			0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0			0	0	52. 00 53. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	5, 559, 255		5, 559, 25	5 0	5, 559, 255	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0		5, 551, 25	0 0	0	55. 00
56. 00 05600 RADI OI SOTOPE	0			0 0	0	56. 00
57. 00 05700 CT SCAN	0			0 0	0	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 59.00 05900 CARDIAC CATHETERIZATION	0			0	0	58. 00 59. 00
60. 00 06000 LABORATORY	2, 850, 921		2, 850, 92	1 0	2, 850, 921	60.00
60. 01 06001 BLOOD LABORATORY	0		2,000,72	0 0	0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0			0	0	61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0			0 0	0	62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 64. 00 06400 INTRAVENOUS THERAPY	0			0	0	63. 00 64. 00
65. 00 06500 RESPI RATORY THERAPY	1, 061, 460	0	1, 061, 46	0 0	1, 061, 460	65.00
66. 00 06600 PHYSI CAL THERAPY	882, 709		882, 70		882, 709	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	371, 354	0	371, 35	0	371, 354	67. 00
68. 00 06800 SPEECH PATHOLOGY	59, 367	0	59, 36		59, 367	68. 00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	98, 522		98, 52	0	98, 522 0	69. 00 70. 00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	282, 990		282, 99	0 0	282, 990	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	55, 795	i .	55, 79		l	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	4, 668, 102		4, 668, 10	0	.,,	
74. 00 07400 RENAL DI ALYSI S	0			0 0	0	74.00
75. 00 07500 ASC (NON-DISTINCT PART) 76. 97 07697 CARDIAC REHABILITATION	330, 165		330, 16	0	0 330, 165	75. 00 76. 97
OUTPATIENT SERVICE COST CENTERS	330, 103		330, 10	0	330, 103	70.97
88. 00 08800 RURAL HEALTH CLINIC	0			0 0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0	0	89. 00
90. 00 09000 CLI NI C	243, 153		243, 15		243, 153	
91.00 09100 EMERGENCY 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART)	2, 856, 733 1, 138, 828		2, 856, 73 1, 138, 82		2, 856, 733 1, 138, 828	91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS	1, 130, 020		1, 130, 62	.5	1, 130, 020	72.00
94.00 09400 HOME PROGRAM DIALYSIS	0			0 0	0	94. 00
95. 00 09500 AMBULANCE SERVICES	0			0	0	95. 00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0			0 0	0	96.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 99. 00 09900 CMHC	0			0	0	97. 00 99. 00
99 10 09910 CORE				o l	1 0	99 10

Heal th Fina	ncial Systems	MORGAN COUNTY HOSPITAL In L					
COMPUTATI ON	OF RATIO OF COSTS TO CHARGES		Provi de	r CCN: 150038	Peri od: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Pre 5/28/2015 1:0	
			T	tle XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limi Adj.	t Total Costs	RCE Di sal I owance	Total Costs	
		1.00	2.00	3.00	4. 00	5. 00	
201.00	Less Observation Beds	1, 138, 828		1, 138, 8	28	1, 138, 828	201. 00
202.00	Total (see instructions)	28, 836, 783		0 28, 836, 7	83 0	28, 836, 783	202.00

Health Financial Systems	MORGAN COUNT	Y HOSPI TAL		In Lieu of Form CMS-2552			
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der		Period: From 01/01/2014	Worksheet C Part I		
					Date/Time Pre 5/28/2015 1:0	pared: 3 pm	
		Ti t	le XIX	Hospi tal	Cost		
	Charges						
Cost Center Description	Inpatient	Outpati ent		6 Cost or Other	TEFRA		

				Ti t	le XIX	Hospi tal	Cost	<u>o piii</u>
				Charges		·		
		Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
					+ col . 7)	Ratio	Inpati ent	
			(00	7.00	0.00	0.00	Ratio	
	LNDAT	IENT ROUTINE SERVICE COST CENTERS	6. 00	7. 00	8. 00	9. 00	10. 00	
30. 00		ADULTS & PEDIATRICS	1, 689, 328		1, 689, 328			30. 00
31. 00	1	INTENSIVE CARE UNIT	2, 215, 024		2, 215, 024			31.00
32.00		CORONARY CARE UNIT	0		C			32. 00
33.00	03300	BURN INTENSIVE CARE UNIT	o		C			33. 00
34.00	1	SURGICAL INTENSIVE CARE UNIT	0		C			34. 00
40. 00		SUBPROVI DER - I PF	4, 903, 336		4, 903, 336			40. 00
41. 00		SUBPROVIDER - I RF	0					41.00
42. 00 43. 00		SUBPROVI DER NURSERY	0					42. 00 43. 00
44. 00	1	SKILLED NURSING FACILITY						44. 00
45. 00		NURSING FACILITY	Ö		C			45. 00
46.00		OTHER LONG TERM CARE	0		C			46. 00
		LARY SERVICE COST CENTERS	,					
50. 00		OPERATING ROOM	467, 632	10, 610, 952	11, 078, 584		0. 000000	
51.00		RECOVERY ROOM	0	0	0	0.000000	0.000000	
52. 00 53. 00	1	DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	0	0		0.000000	0. 000000 0. 000000	
54. 00		RADI OLOGY-DI AGNOSTI C	1, 193, 383	23, 364, 494	24, 557, 877	0. 000000 0. 226374	0.000000	1
55. 00		RADI OLOGY-THERAPEUTI C	1, 175, 505	23, 304, 474	24, 337, 077	0. 000000	0. 000000	
56. 00	1	RADI OI SOTOPE	o	0		0. 000000	0. 000000	
57.00	05700	CT SCAN	o	0	C	0.000000	0. 000000	
58. 00		MAGNETIC RESONANCE IMAGING (MRI)	0	0	C	0. 000000	0. 000000	
59. 00		CARDI AC CATHETERI ZATI ON	0	0	C	0. 000000	0. 000000	
60.00		LABORATORY	2, 084, 583	9, 591, 880	11, 676, 463		0.000000	
60. 01	1	BLOOD LABORATORY	0	0	0	0.000000	0.000000	
61. 00 62. 00		PBP CLINICAL LAB SERVICES-PRGM ONLY WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0. 000000 0. 000000	0. 000000 0. 000000	1
63.00		BLOOD STORING, PROCESSING & TRANS.	0	0		0. 000000	0. 000000	
64. 00		I NTRAVENOUS THERAPY	Ö	0		0. 000000	0. 000000	
65. 00		RESPI RATORY THERAPY	742, 591	777, 285	1, 519, 876		0. 000000	
66.00	06600	PHYSI CAL THERAPY	112, 986	1, 945, 385	2, 058, 371	0. 428839	0. 000000	66. 00
67. 00		OCCUPATI ONAL THERAPY	13, 839	300, 864	314, 703	1. 180014	0. 000000	67. 00
68. 00		SPEECH PATHOLOGY	12, 500	76, 019			0. 000000	
69. 00	1	ELECTROCARDI OLOGY	466, 002	1, 946, 800			0.000000	
70.00		ELECTROENCEPHALOGRAPHY	0	040.204	1	0.000000	0.000000	
71. 00 72. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS	255, 164 5, 898	840, 396 166, 878			0. 000000 0. 000000	
73. 00		DRUGS CHARGED TO PATIENTS	2, 965, 292	15, 317, 738			0. 000000	
74. 00		RENAL DIALYSIS	0	0		0. 000000	0. 000000	
75.00	07500	ASC (NON-DISTINCT PART)	o	0	C	0. 000000	0. 000000	75. 00
76. 97		CARDIAC REHABILITATION	315	491, 045	491, 360	0. 671941	0.000000	76. 97
		TIENT SERVICE COST CENTERS	I al		Г .			
88. 00 89. 00		RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	0	0			0. 000000 0. 000000	
		CLINIC	0	121, 737				
		EMERGENCY	933, 617					
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)	391, 463				0. 000000	
	OTHER	REIMBURSABLE COST CENTERS						
94. 00		HOME PROGRAM DIALYSIS	0	0		0. 000000	0. 000000	
95. 00	1	AMBULANCE SERVI CES	0	0		0. 000000	0. 000000	
96.00	1	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	0.000000	1
97. 00 99. 00	1	DURABLE MEDICAL EQUIP-SOLD	0	0		0. 000000	0. 000000	97. 00 99. 00
99. 00	1	•	0	0				99. 00
	1	I&R SERVICES-NOT APPRVD PRGM	Ö	0	Ö			100.00
	1	HOME HEALTH AGENCY	Ö	0				101. 00
		AL PURPOSE COST CENTERS			1			
		KIDNEY ACQUISITION	0	0	C			105. 00
		HEART ACQUISITION	0	0				106. 00
		LIVER ACQUISITION	0	0	0			107. 00
	1	LUNG ACQUISITION PANCREAS ACQUISITION	0	0				108. 00 109. 00
		INTESTINAL ACQUISITION	٥	0	"			1109.00
		ISLET ACQUISITION	o o	0	Ö			111.00
		INTEREST EXPENSE		· ·]			113. 00
		UTILIZATION REVIEW-SNF						114. 00
	1	AMBULATORY SURGICAL CENTER (D. P.)	0	0	0			115. 00
	1	HOSPI CE	0	0 000 55	0			116. 00
200. 00 201. 00		Subtotal (see instructions)	18, 452, 953	86, 298, 551	104, 751, 504			200. 00 201. 00
201.00	וי	Less Observation Beds			1			1201.00

Health Financial Systems		In Lieu of Form CMS-2552-10				
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der		Peri od:	Worksheet C	
				From 01/01/2014	Part I	
				To 12/31/2014	Date/Time Pre	
					5/28/2015 1:0	3 pm
		Ti t	le XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
· ·			+ col. 7)	Rati o	I npati ent	
					Rati o	
	6.00	7. 00	8. 00	9. 00	10.00	
202 00 Total (see instructions)	18 452 953	86 298 551	104 751 50	4		202 00

					5/28/2015 1:03 pm
		1	Title XIX	Hospi tal	Cost
Cos	t Center Description	PPS Inpatient			
		Rati o 11.00			
I NPATI ENT	ROUTINE SERVICE COST CENTERS	11.00			
	ILTS & PEDIATRICS				30.00
1 1	ENSIVE CARE UNIT				31. 00
1 1	ONARY CARE UNIT				32. 00
33. 00 03300 BUR	N INTENSIVE CARE UNIT				33.00
34. 00 03400 SUR	GICAL INTENSIVE CARE UNIT				34.00
	PROVIDER - IPF				40. 00
	SPROVIDER - IRF				41.00
42. 00 04200 SUB					42.00
43. 00 04300 NUR					43.00
1 1	LLED NURSING FACILITY				44. 00
1 1	SING FACILITY				45. 00 46. 00
	IER LONG TERM CARE / SERVICE COST CENTERS				46.00
	RATING ROOM	0. 000000			50.00
1 1	OVERY ROOM	0. 000000			51.00
1 1	IVERY ROOM & LABOR ROOM	0. 000000			52.00
1 1	STHESI OLOGY	0. 000000			53. 00
1 1	I OLOGY-DI AGNOSTI C	0. 000000			54. 00
55. 00 05500 RAD	I OLOGY-THERAPEUTI C	0. 000000			55. 00
56. 00 05600 RAD	I OI SOTOPE	0. 000000			56.00
57. 00 05700 CT		0. 000000			57. 00
1 1	NETIC RESONANCE IMAGING (MRI)	0. 000000			58. 00
1 1	RDI AC CATHETERI ZATI ON	0. 000000			59. 00
60. 00 06000 LAB		0.000000			60.00
1 1	OD LABORATORY	0.000000			60. 01
	CLINICAL LAB SERVICES-PRGM ONLY DLE BLOOD & PACKED RED BLOOD CELLS	0. 000000 0. 000000			61.00
1 1	OD STORING, PROCESSING & TRANS.	0. 000000			62. 00 63. 00
	RAVENOUS THERAPY	0. 000000			64. 00
	PI RATORY THERAPY	0. 000000			65. 00
	SI CAL THERAPY	0. 000000			66. 00
	UPATI ONAL THERAPY	0. 000000			67. 00
68. 00 06800 SPE	ECH PATHOLOGY	0. 000000			68. 00
69. 00 06900 ELE	CTROCARDI OLOGY	0. 000000			69. 00
70. 00 07000 ELE	CTROENCEPHALOGRAPHY	0. 000000			70.00
1 1	ICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.00
	L. DEV. CHARGED TO PATIENTS	0. 000000			72. 00
1 1	IGS CHARGED TO PATIENTS	0. 000000			73. 00
1 1	IAL DIALYSIS	0.000000			74.00
	(NON-DISTINCT PART)	0.000000			75. 00
76. 97 07697 CAR	DIAC REHABILITATION IT SERVICE COST CENTERS	0. 000000			76. 97
	AL HEALTH CLINIC	0. 000000			88. 00
	DERALLY QUALIFIED HEALTH CENTER	0. 000000			89. 00
90. 00 09000 CLI		0. 000000			90.00
91. 00 09100 EME		0. 000000			91. 00
1 1	SERVATION BEDS (NON-DISTINCT PART)	0. 000000			92. 00
OTHER REI	MBURSABLE COST CENTERS				
	IE PROGRAM DIALYSIS	0. 000000			94. 00
i i	SULANCE SERVICES	0. 000000			95. 00
	ABLE MEDICAL EQUIP-RENTED	0. 000000			96. 00
1 1	ABLE MEDICAL EQUIP-SOLD	0. 000000			97. 00
99. 00 09900 CMH					99. 00
99. 10 09910 COR					99. 10
1 1	SERVICES-NOT APPRVD PRGM				100.00
	IE HEALTH AGENCY PURPOSE COST CENTERS				101.00
105. 00 10500 KID					105. 00
106. 00 10600 HEA					105.00
107. 00 10700 LI V					107. 00
107.00 10700 LTV					108. 00
1 1	ICREAS ACQUISITION				109. 00
1 1	ESTINAL ACQUISITION				110. 00
111. 00 11100 I SL					111. 00
113. 00 11300 I NT					113. 00
1 1	LIZATION REVIEW-SNF				114. 00
1 1	SULATORY SURGICAL CENTER (D. P.)				115. 00
116.00 11600 HOS	SPI CE				116. 00
	total (see instructions)				200. 00
1 1	s Observation Beds				201. 00
202. 00 Tot	al (see instructions)				202. 00

Health Financial Systems	MORGAN COUNT	Y HOSPITAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	L COSTS			Peri od: From 01/01/2014 To 12/31/2014	Date/Time Pre 5/28/2015 1:0	epared: 03 pm
			e XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col 2)		Per Diem (col. 3 / col. 4)	
	1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			•	-		
30.00 ADULTS & PEDIATRICS 31.00 INTENSIVE CARE UNIT 32.00 CORONARY CARE UNIT 33.00 BURN INTENSIVE CARE UNIT 34.00 SUBGICAL INTENSIVE CARE UNIT 40.00 SUBPROVIDER - IPF 41.00 SUBPROVIDER - IRF 42.00 SUBPROVIDER 43.00 NURSERY 44.00 SKILLED NURSING FACILITY 45.00 NURSING FACILITY 200.00 Total (lines 30-199) Cost Center Description		Inpatient Program Capital Cost (col. 5 x col.	507, 55 163, 40 149, 39 820, 35	04 657 0	248. 71 0. 00 0. 00 0. 00 54. 05 0. 00 0. 00 0. 00 0. 00	31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 42. 00 43. 00 44. 00
	6. 00	7. 00				
30.00 ADULTS & PEDIATRICS 31.00 INTENSIVE CARE UNIT 32.00 CORONARY CARE UNIT 33.00 BURN INTENSIVE CARE UNIT 34.00 SURGICAL INTENSIVE CARE UNIT 40.00 SUBPROVIDER - IPF 41.00 SUBPROVIDER - IRF 42.00 SUBPROVIDER 43.00 NURSERY 44.00 SKILLED NURSING FACILITY 45.00 NURSING FACILITY 200.00 Total (lines 30-199)	536 408 0 0 0 2, 314 0 0 0 0 0 0 3, 258	101, 474 0 0 0 125, 072 0 0 0				30. 00 31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 42. 00 43. 00 44. 00 45. 00 200. 00

Health Financial Systems	MORGAN COUNT	Y HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS			Period: From 01/01/2014 To 12/31/2014	Worksheet D Part II Date/Time Pre 5/28/2015 1:0	pared: 3 pm
			e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,		(col . 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS		1	1			
50. 00 05000 OPERATI NG ROOM	217, 103				2, 887	
51. 00 05100 RECOVERY ROOM	0	_	0.00000		0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.00000		0	52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	0.00000		0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	353, 488	24, 557, 877			9, 850	54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0.00000		0	55. 00
56. 00 05600 RADI 0I SOTOPE	0	0	0.00000		0	56. 00
57.00 05700 CT SCAN	0	0	0.00000	0 0	0	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0.00000	0 0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0.00000	0 0	0	59. 00
60. 00 06000 LABORATORY	116, 302	11, 676, 463	0.00996	914, 181	9, 105	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0.00000	0 0	0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0. 00000	0 0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0. 00000		0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	0. 00000	0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	34, 406	1, 519, 876	1		9, 410	65. 00
66. 00 06600 PHYSI CAL THERAPY	82, 230		0. 03994		1, 188	
67. 00 06700 OCCUPATI ONAL THERAPY	26, 208		1		541	67.00
68.00 06800 SPEECH PATHOLOGY	568		1		22	68. 00
69. 00 06900 ELECTROCARDI OLOGY	35, 074	l ·	1		3, 947	
70. 00 07000 ELECTROENCEPHALOGRAPHY	00,07	2, 112, 002	0.00000		0, 7.17	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 376	1, 095, 560			330	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	441	172, 776			8	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	61, 012				3, 784	
74. 00 07400 RENAL DI ALYSI S	01,012	10, 200, 000	0. 00000		0,701	74.00
75. 00 07500 ASC (NON-DISTINCT PART)			0.00000		0	75.00
76. 97 07697 CARDI AC REHABI LI TATI ON	36, 891	491, 360	1		0	76. 97
OUTPATIENT SERVICE COST CENTERS	30,071	171,000	0.07007	,	<u> </u>	70.77
88. 00 08800 RURAL HEALTH CLINIC	0	0	0.00000	0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	_	0. 00000		0	89.00
90. 00 09000 CLI NI C	73, 630	_	1		0	90.00
91. 00 09100 EMERGENCY	144, 131		1		3, 740	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	181, 378				17, 109	
OTHER REI MBURSABLE COST CENTERS	101, 370	2,370,404	0.0705	243, 221	17, 107	72.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0		0.00000	0	0	94. 00
95. 00 09500 AMBULANCE SERVICES			0.00000			95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED			0. 00000	0	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD			0.00000		0	97.00
200.00 Total (lines 50-199)	1, 365, 238	95, 943, 816		4, 510, 628	_	200.00
200.00 [10tal (11165 30-199)	1, 300, 238	70,743,610	1	4, 310, 628	01, 921	1200.00

Health Financial Systems	MORGAN COUNT				eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COST	TS Provi der		Peri od: From 01/01/2014 To 12/31/2014	Worksheet D Part III Date/Time Pre 5/28/2015 1:0	pared: 3 pm
			e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School		All Other	Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos		1 through 3,	
					minus col. 4)	
	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0	0	
31.00 03100 INTENSIVE CARE UNIT	0	0		0	0	31. 00
32. 00 03200 CORONARY CARE UNIT	0	0		0	0	
33.00 03300 BURN INTENSIVE CARE UNIT	0	0		0	0	
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0		0	0	
40. 00 04000 SUBPROVI DER - I PF	0	0		0	0	1
41. 00 04100 SUBPROVI DER - I RF	0	0		0	0	
42. 00 04200 SUBPROVI DER	0	0		0	0	1 .2.00
43. 00 04300 NURSERY	0	0		0	0	
44.00 04400 SKILLED NURSING FACILITY	0	0		0	0	1
45.00 04500 NURSING FACILITY	0	0		0	0	
200.00 Total (lines 30-199)	0	0		0	0	200. 00
Cost Center Description	Total Patient		Inpati ent	I npati ent		
	Days	5 ÷ col. 6)	Program Days			
				Pass-Through		
				Cost (col. 7 x		
				col . 8)		
INDATI FAT DOUTING OFFICE OOCT OFFITEDS	6. 00	7. 00	8. 00	9. 00		
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1 (02	0.00	53			20.00
30. 00 03000 ADULTS & PEDI ATRI CS	1, 693				1	30.00
31. 00 03100 I NTENSI VE CARE UNI T 32. 00 03200 CORONARY CARE UNI T	657	0. 00 0. 00				31. 00 32. 00
	0	0.00		0		
33. 00 03300 BURN INTENSIVE CARE UNIT	0			0		33.00
34. 00 03400 SURGICAL INTENSIVE CARE UNIT	0			0		34.00
40. 00 04000 SUBPROVI DER - 1 PF 41. 00 04100 SUBPROVI DER - 1 RF	2, 764	0. 00 0. 00				40.00
41. 00 04100 SUBPROVI DER - I RF 42. 00 04200 SUBPROVI DER	0	0.00		0		41. 00 42. 00
+ I	0	0.00		0 0		
43.00 04300 NURSERY 44.00 04400 SKILLED NURSING FACILITY	0	0.00		0 0	1	43. 00 44. 00
45. 00 04400 SKILLED NORSING FACILITY 45. 00 04500 NURSING FACILITY	0	0.00		0 0	1	45.00
200.00 Total (lines 30-199)	5, 114	ł	3, 25	-		200.00
200.00 1010 (11105 30-177)	5, 114	I	3, 20	0	I	1200.00

Heal th Fi	nancial Systems	MORGAN	COUNTY HOS	SPI TAL		In Lieu of Form CMS-2552-		
APPORTI OF THROUGH	MENT OF INPATIENT/OUTPATIENT OSTS	ANCILLARY SERVICE OTHER	R PASS	Provider CCN:	150038	From 01/01/2014	Worksheet D Part IV	

				Т	o 12/31/2014	Date/Time Pre 5/28/2015 1:0	
			Ti tl	e XVIII	Hospi tal	PPS	<u> </u>
	Cost Center Description	Non Physician Nur			All Other	Total Cost	
	'	Anesthetist	3		Medi cal	(sum of col 1	
		Cost			Education Cost	through col.	
						4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATING ROOM	0	0	0	0	0	
51. 00	05100 RECOVERY ROOM	0	0	0	0	0	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0	O	0	0	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
56. 00	05600 RADI 01 S0T0PE	0	0	0	0	0	56. 00
57. 00	05700 CT SCAN		0	0	0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON		0	0	0	0	59. 00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63. 00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	O	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	o	0	0	0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	o	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
76. 97	07697 CARDI AC REHABILITATION	0	0	0	0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
90.00	09000 CLI NI C	0	0	0	0	0	90.00
91. 00	09100 EMERGENCY	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						
94. 00	09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94. 00
95. 00	09500 AMBULANCE SERVI CES						95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	
97. 00	09700 DURABLE MEDI CAL EQUI P-SOLD	0	O	1 0	0	0	97. 00
200.00	Total (lines 50-199)	0	0	0	0	0	200. 00

Health Financial Systems	MORGAN COUNTY HO	SPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 150038	Peri od:	Worksheet D
THROUGH COSTS			From 01/01/2014	Part IV

THROUG	H COSTS					To 12/31/2014	Date/Time Pre 5/28/2015 1:0	pared: 3 pm
				Ti tl	e XVIII	Hospi tal	PPS	
	Cost Center Description	Total	Total	Charges	Ratio of Cost	Outpati ent	I npati ent	
		Outpati ent	(from	Wkst. C,	to Charges	Ratio of Cost	Program	
		Cost (sum of	Part	I, col.	(col. 5 ÷ col.	to Charges	Charges	
		col. 2, 3 and		8)	7)	(col. 6 ÷ col.		
		4)				7)		
		6. 00		7. 00	8. 00	9. 00	10.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	1	1, 078, 584			147, 326	50.00
51.00	05100 RECOVERY ROOM	0		0	0.000000	0. 000000	0	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		0	0.000000	0.000000	0	52.00
53.00	05300 ANESTHESI OLOGY	0		0	0. 000000	0. 000000	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0) 2	4, 557, 877	0.000000	0. 000000	684, 322	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0		0	0. 000000	0.000000	0	55. 00
56.00	05600 RADI 0I SOTOPE	0		0	0.000000	0.000000	0	56.00
57.00	05700 CT SCAN	0		0	0. 000000	0. 000000	0	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0	0. 000000		0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0		0	0. 000000		0	59. 00
60.00	06000 LABORATORY			1, 676, 463			914, 181	60.00
60. 01	06001 BLOOD LABORATORY		í i	1,070,100	0. 000000		0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		Ί	O	0.00000	0.000000	O	61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0	0. 000000	0.000000	0	62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.			0	0.000000		0	63.00
64. 00	06400 INTRAVENOUS THERAPY		1	0			0	64.00
	l l	1	1	Ü			-	
65. 00	06500 RESPI RATORY THERAPY	0		1, 519, 876			415, 687	65.00
66.00	06600 PHYSI CAL THERAPY	0	1	2, 058, 371	0.000000		29, 746	
67.00	06700 OCCUPATI ONAL THERAPY	0	1	314, 703			6, 496	
68.00	06800 SPEECH PATHOLOGY	0	1	88, 519			3, 391	
69. 00	06900 ELECTROCARDI OLOGY	0	1	2, 412, 802	0.000000		271, 484	69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	1		0. 000000		0	70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		1, 095, 560	•		152, 121	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0		172, 776	0. 000000		3, 047	
	07300 DRUGS CHARGED TO PATIENTS	0		8, 283, 030	•		1, 133, 822	
	07400 RENAL DI ALYSI S	0		0	0. 000000		0	
	07500 ASC (NON-DISTINCT PART)	0		0	0.00000		0	
76. 97	07697 CARDIAC REHABILITATION	0		491, 360	0.000000	0. 000000	0	76. 97
	OUTPAȚIENT SERVICE COST CENTERS	_				_		
88. 00	08800 RURAL HEALTH CLINIC	0		0	0. 000000	0.000000	0	88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0.000000	0. 000000	0	89. 00
90.00	09000 CLI NI C	0		121, 737	0.000000	0.000000	0	90.00
91.00	09100 EMERGENCY	0	1	9, 493, 754	0.000000	0.000000	505, 784	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		2, 578, 404	0. 000000	0.000000	243, 221	92.00
	OTHER REIMBURSABLE COST CENTERS							1
94.00	09400 HOME PROGRAM DIALYSIS	0		0	0.000000	0.000000	0	94.00
95.00	09500 AMBULANCE SERVICES							95.00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	ol	0	0. 000000	0. 000000	0	
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD			0			0	
200.00	l l			5, 943, 816		0.00000	4, 510, 628	
	, (' '	.,	1	1	., 5.5, 526	,

Health Financial Systems MORGAN COUNTY HOSPITAL In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

MORGAN COUNTY HOSPITAL

In Lieu of Form CMS-2552-10
Provider CCN: 150038
From 01/01/2014
To 12/31/2014
Vorksheet D
Part IV
Date/Time Prepared:
5/28/2015 1:03 pm

Title Valid Hospital PPS						12,01,201	5/28/2015 1:	03 pm
Program Pass-Through Costs (col. 8 x col. 10)				Ti tl	e XVIII	Hospi tal		•
Program Pass-Through Costs (col. 8 x col. 10)		Cost Center Description	I npati ent	Outpati ent	Outpati ent			
Costs (col. 8 x col. 10) x col. 12)			Program	Program	Program			
X COI. 10)			Pass-Through	Charges	Pass-Through	h		
ANCILLARY SERVICE COST CENTERS			Costs (col. 8		Costs (col.	9		
ANCI LLARY SERVICE COST CENTERS			x col. 10)		x col. 12)			
50.00 05000 0FERATI NC ROOM			11.00	12.00	13.00			
51.00 05100 RECOVERY ROOM 0 0 0 0 52.00 0520 05200 DELI VERY ROOM LABOR ROOM 0 0 0 0 52.00 05200 DELI VERY ROOM LABOR ROOM 0 0 0 0 0 53.00 05400 05400 05400 05400 05400 ADII OLOGY - DI AGNOSTI C 0 0 0 0 0 0 0 0 0		ANCILLARY SERVICE COST CENTERS						
52.00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 0 53.00	50.00	05000 OPERATI NG ROOM	0	3, 346, 973		0		50.00
53.00 05300 ANESTHESI OLOGY 0 0 0 53.00	51.00	05100 RECOVERY ROOM	0	0	1	0		51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 6, 825, 921 0 55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 0 0 0	52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	1	0		52.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	53.00	05300 ANESTHESI OLOGY	0	0)	0		53. 00
56. 00 05700 05700 CT SCAN 0 0 0 0 0 0 57. 00 0570 05700 CT SCAN 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	54.00	05400 RADI OLOGY-DI AGNOSTI C	0	6, 825, 921		0		54. 00
57. 00 05700 CT SCAN 0 0 0 0 0 0 57. 00	55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	1	0		55.00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 0 0 0 59. 00 05900 057900 05790 057900 05790 057900 057900 057900 057900 057900 057900 057900	56.00	05600 RADI OI SOTOPE	0	0	1	0		56. 00
59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 0 0 0 0	57.00	05700 CT SCAN	0	0	1	0		57.00
60. 00 0.000 0.000 0.000 0.000 0.000 0.000 0.00 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000	58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	1	0		58. 00
60. 01 06001 06001 06001 06001 06001 060000 060000 060000 060000 060000 0600000 0600000000	59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0)	0		59. 00
61.00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 61.00 62.00 63.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 63.00 06.00 STORI NG, PROCESSI NG & TRANS. 0 0 0 0 0 63.00 06.00 STORI NG, PROCESSI NG & TRANS. 0 0 0 0 0 06.00 O 0 06.00 O 0 06.00 O 0 06.00 O 0 06.00 O 0	60.00	06000 LABORATORY	0	1, 534, 748		0		60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 63.00 63.00 06300 BLOOD STORIN NG, PROCESSI NG & TRANS. 0 0 0 0 0 64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 65.00 06500 RESPI RATORY THERAPY 0 589,976 0 0 0 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 0 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 67.00 06700 OCUPATI ONAL THERAPY 0 0 0 0 68.00 06800 SPECH PATHOLOGY 0 0 0 0 69.00 06900 ELECTROCARDI OLOGY 0 653,825 0 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 196,173 0 0 72.00 07200 IMPL DEV. CHARGED TO PATI ENTS 0 57,134 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 5,483,664 0 73.00 74.00 07400 RENAL DI ALYSI S 0 0 0 0 75.00 07500 ASC (NON-DI STI NCT PART) 0 0 0 0 76.97 07697 CARDI AC REHABI LI TATI ON 0 238,182 0 0 76.97 07697 CARDI AC REHABI LI TATI ON 0 27,733,409 0 91.00 09000 EDERRALLY QUALI FIED HEALTH CENTER 0 0 57,133 0 90.00 09000 CLINIC COST CENTERS 0 0 0 91.00 09100 BMERGENCY 0 2,783,409 0 91.00 91.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 852,923 0 0THER REI MBURSABLE COST CENTERS 0 0 0 0THER REI MBURSABLE COST CENTERS 0 0 0 0 0THER REI MBURSABLE COST CENTERS 0 0 0 0 0THER REI MBURSABLE COST CENTERS 0 0 0 0 0 0THER REI MBURSABLE COST CENTERS 0 0 0 0 0 0THER REI MBURSABLE COST CENTERS 0 0 0 0 0 0THER REI MBURSABLE COST CENTERS 0 0 0 0 0 0 0THER REI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 0THER REI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0	60. 01	06001 BLOOD LABORATORY	0	0)	0		60. 01
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0 64. 00 64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 65. 00 06500 RESPI RATORY THERAPY 0 589, 976 0 0 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 68. 00 06800 SPECH PATHOLOGY 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 70. 00 07000 ELECTROCARDI OLOGY 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 196, 173 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 57, 134 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 57, 134 0 74. 00 07300 DRUGS CHARGED TO PATI ENTS 0 5, 483, 664 0 75. 00 07500 ASC (NON-DI STI NCT PART) 0 0 0 76. 97 07697 CARDI AC REHABI LI TATI ON 0 238, 182 0 76. 97 07697 CARDI AC REHABI LI TATI ON 0 238, 182 0 90. 00 09000 CLUINI C 0 0 90. 00 09000 CLUINI C 0 0 91. 00 09000 DEMERGENCY 0 2, 783, 409 0 91. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 852, 923 0 91. 00 07400 REIMBURSABLE COST CENTERS	61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 0 0 0	62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0)	0		62. 00
65. 00 06500 RESPIRATORY THERAPY 0 589, 976 0 66. 00 66. 00 66. 00 6600 PHYSI CAL THERAPY 0 0 0 0 0 66. 00 67. 00 0600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 67. 00 06. 00 0 0 0 0 0 0 0 0 0	63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0)	0		63.00
66.00 06600 PHYSICAL THERAPY 0 0 0 0 0 67.00 67.00 67.00 66.00 67.00 06700 0CCUPATIONAL THERAPY 0 0 0 0 0 0 67.00 68.00 6800 SPEECH PATHOLOGY 0 0 0 0 0 0 68.00 69	64.00	06400 I NTRAVENOUS THERAPY	0	0)	0		64. 00
67. 00 06700 OCCUPATIONAL THERAPY 0 0 0 0 0 68. 00 68. 00 6800 SPEECH PATHOLOGY 0 0 0 0 0 68. 00 69. 00 0 0 68. 00 69. 00 0 0 0 68. 00 69. 00 0 0 0 0 0 0 68. 00 69. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	65.00	06500 RESPIRATORY THERAPY	O	589, 976		0		65. 00
68. 00	66.00	06600 PHYSI CAL THERAPY	O	0)	0		66. 00
69. 00	67.00	06700 OCCUPATI ONAL THERAPY	O	0)	0		67. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 196, 173 0 71. 00 07200 MPL. DEV. CHARGED TO PATI ENTS 0 57, 134 0 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0 57, 134 0 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0 5, 483, 664 0 73. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 0 0 0	68.00	06800 SPEECH PATHOLOGY	O	0)	0		68. 00
71. 00	69.00	06900 ELECTROCARDI OLOGY	O	653, 825		0		69. 00
72. 00	70.00	07000 ELECTROENCEPHALOGRAPHY	0	0)	0		70. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 5, 483, 664 0 0 73. 00 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 75. 00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 76. 97 07697 CARDI AC REHABI LITATION 0 238, 182 0 88. 00 08800 RURAL HEALTH CLINI C 0 0 0 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 90. 00 09000 CLINI C 0 57, 133 0 91. 00 09100 EMERGENCY 0 2, 783, 409 0 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0 852, 923 0 94. 00 09400 HOME PROGRAM DI ALYSI S 0 0 94. 00 09400 HOME PROGRAM DI ALYSI S 0 0 94. 00 09400 HOME PROGRAM DI ALYSI S 0 0 94. 00 09400 HOME PROGRAM DI ALYSI S 0 0 95. 00 0 0 0 0 96. 00 0 0 0 0 97. 00 0 0 0 98. 00 0 0 0 99. 00 0 0 0 0 99. 00 0 0 0 99. 00 0 0 0 99. 00 0 0 0 99. 00 0 0 0 99. 00 0 0 0 99. 00 0 0 0 99. 00 0 0 0 0 99. 00 0 0 0 0 99. 00 0 0 0 0 99. 00 0 0 0 99. 00 0 0 0 99. 00 0 0 0 99. 00 0 0 0 99. 00 0	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	O	196, 173		0		71. 00
74. 00	72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	O	57, 134		0		72. 00
75. 00	73.00	07300 DRUGS CHARGED TO PATIENTS	O	5, 483, 664		0		73. 00
76. 97 O7697 CARDÍAC REHABILITATION O 238, 182 O 76. 97 OUTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 89. 00 89. 00 9000 CLINIC 0 0 57, 133 0 90. 00 9100 EMERGENCY 0 2, 783, 409 0 91. 00 91200 OBSERVATION BEDS (NON-DISTINCT PART) 0 852, 923 0 92. 00 OTHER REIMBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DIALYSIS 0 0 94. 00	74.00	07400 RENAL DIALYSIS	0	0)	0		74. 00
SECTION SUPPRINT SERVICE COST CENTERS SECTION SE	75.00	07500 ASC (NON-DISTINCT PART)	0	0)	0		75. 00
88. 00	76. 97	07697 CARDI AC REHABI LI TATI ON	0	238, 182		0		76. 97
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 0 0		OUTPATIENT SERVICE COST CENTERS						
90. 00	88. 00	08800 RURAL HEALTH CLINIC	0	0		0		88. 00
91. 00 09100 EMERGENCY 0 2, 783, 409 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 0 852, 923 0 92. 00 00 00 00 00 00 00 00	89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0)	0		89. 00
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0 852, 923 0 92. 00	90.00	09000 CLI NI C	0	57, 133		0		90.00
OTHER REI MBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DI ALYSI S 0 0 0 94. 00	91.00	09100 EMERGENCY	0	2, 783, 409	1	0		91. 00
94. 00 09400 HOME PROGRAM DI ALYSI S 0 0 0 94. 00	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	852, 923		0		92. 00
95 ON TOPSON AMBIJIANCE SERVICES	94.00	09400 HOME PROGRAM DIALYSIS	0	0	1	0		94.00
	95.00	09500 AMBULANCE SERVI CES						95. 00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 96. 00	96.00		0	0	1	0		96. 00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 97. 00	97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0)	0		97. 00
200.00 Total (lines 50-199) 0 22,620,061 0 200.00	200.00	Total (lines 50-199)	0	22, 620, 061		0		200. 00

From 01/01/2014 Part V Date/Time Prepared: 12/31/2014 5/28/2015 1:03 pm Title XVIII Hospi tal PPS Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 204392 3, 346, 973 684, 095 50.00 51.00 05100 RECOVERY ROOM 0.000000 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 0.000000 52 00 0 0 0 53.00 05300 ANESTHESI OLOGY 0.000000 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 226374 6, 825, 921 0 1, 545, 211 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0 0 55.00 C 0 05600 RADI OI SOTOPE 0 56.00 0.000000 C 0 56.00 57.00 05700 CT SCAN 0.000000 0 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 58.00 0.000000 0 0 58.00 0 0 05900 CARDI AC CATHETERI ZATI ON 59 00 59 00 0.000000 0 60.00 06000 LABORATORY 0. 244160 1, 534, 748 374, 724 60.00 06001 BLOOD LABORATORY 0.000000 0 0 60.01 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0.000000 0 0 0 0 0 0 0 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62 00 0.000000 Ω 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 C 0 0 63.00 06400 I NTRAVENOUS THERAPY 0.000000 64.00 64.00 06500 RESPIRATORY THERAPY 0.698386 589, 976 0 412, 031 65.00 65.00 0 06600 PHYSI CAL THERAPY 66.00 0.428839 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 1. 180014 67.00 0 0 06800 SPEECH PATHOLOGY 0 68.00 0.670670 0 68.00 06900 ELECTROCARDI OLOGY 0 69.00 0.040833 653, 825 26, 698 69.00 οĺ 07000 ELECTROENCEPHALOGRAPHY 0 70.00 0.000000 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0. 258306 196, 173 0 0 50, 673 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 0. 322933 57, 134 0 18, 450 72.00 07300 DRUGS CHARGED TO PATIENTS 5, 483, 664 0 2, 319 73.00 0.255324 1, 400, 111 73.00 0 74.00 07400 RENAL DIALYSIS 0.000000 0 74.00 07500 ASC (NON-DISTINCT PART) 0.000000 0 75.00 75.00 07697 CARDIAC REHABILITATION 76. 97 0.671941 238, 182 160, 044 76. 97 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0.000000 O 89.00 09000 CLINIC 90.00 90.00 1.997363 57, 133 0 114, 115 0 09100 EMERGENCY 0 91.00 0.146546 2, 783, 409 0 407, 897 91.00 852<u>,</u> 923 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.441679 0 376, 718 92.00 OTHER REIMBURSABLE COST CENTERS 94 00 09400 HOME PROGRAM DIALYSIS 0.000000 0 94 00 0 95.00 09500 AMBULANCE SERVICES 0.000000 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 0 0 96.00 0 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0.000000 97.00 0 0 200.00 Subtotal (see instructions) 22, 620, 061 2, 319 5, 570, 767 200.00 201.00 Less PBP Clinic Lab. Services-Program 0 201.00 Only Charges

0

2.319

22, 620, 061

5, 570, 767 202. 00

202.00

Net Charges (line 200 +/- line 201)

 Heal th Financial
 Systems
 MORGAN COUNT

 APPORTIONMENT OF
 MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST
 MORGAN COUNTY HOSPITAL

Provi der CCN: 150038

				5/28/2015 1:03 pm
		Title XVIII	Hospi tal	PPS
	Costs			
Cost Center Description	Cost	Cost		
		imbursed		
		vices Not		
		bject To		
		& Coins.		
		ee inst.)		
	6. 00	7. 00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	O	0		50.00
51.00 05100 RECOVERY ROOM	l ol	ol		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	o	0		52.00
53. 00 05300 ANESTHESI OLOGY	o o	0		53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C		0		54.00
	١	٦		
55. 00 05500 RADI OLOGY-THERAPEUTI C	١	0		55. 00
56. 00 05600 RADI 0I SOTOPE	0	0		56. 00
57. 00 05700 CT SCAN	0	0		57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	l ol	0		58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	l ol	o		59.00
60. 00 06000 LABORATORY	O	0		60.00
60. 01 06001 BLOOD LABORATORY	0	0		60. 01
		9		
	- 1			61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63. 00
64.00 06400 INTRAVENOUS THERAPY	0	0		64. 00
65. 00 06500 RESPI RATORY THERAPY		0		65.00
66. 00 06600 PHYSI CAL THERAPY	l ol	0		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	l ol	0		67. 00
68. 00 06800 SPEECH PATHOLOGY	o o	0		68. 00
69. 00 06900 ELECTROCARDI OLOGY	o o	ol		69. 00
	1	·		
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	592		73. 00
74.00 07400 RENAL DIALYSIS		0		74. 00
75.00 07500 ASC (NON-DISTINCT PART)	l ol	0		75. 00
76. 97 07697 CARDIAC REHABILITATION	l ol	o		76. 97
OUTPATIENT SERVICE COST CENTERS	· ·	-		
88. 00 08800 RURAL HEALTH CLINIC	0	0		88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	o o	o o		89. 00
		0		90.00
91. 00 09100 EMERGENCY	0	O		91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92. 00
OTHER REIMBURSABLE COST CENTERS				
94.00 09400 HOME PROGRAM DIALYSIS	0	0		94.00
95. 00 09500 AMBULANCE SERVICES	0			95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	o	o		96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	o	ol		97. 00
200.00 Subtotal (see instructions)	o o	592		200.00
201.00 Less PBP Clinic Lab. Services-Program		3,2		201. 00
9]			201.00
Only Charges	0	592		202.00
202.00 Net Charges (line 200 +/- line 201)	ı Y	247		202. 00

Heal th	Financial Systems	MORGAN COUNT	Y HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORT	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS		CCN: 150038 t CCN: 15S038	Peri od: From 01/01/2014 To 12/31/2014	Worksheet D Part II Date/Time Pre 5/28/2015 1:0	pared:
			Ti tl	e XVIII	Subprovi der - I PF	5/28/2015 1: 0 PPS	3 pm
	Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
	, , , , , , , , , , , , , , , , , , ,		(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
	T	1. 00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	0.17.100	11 070 50		. = l		
50. 00	05000 OPERATI NG ROOM	217, 103		1		0	
51.00	05100 RECOVERY ROOM	0				0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0				0	
53.00	05300 ANESTHESI OLOGY	0		0.00000		0	
54.00	05400 RADI OLOGY - DI AGNOSTI C	353, 488	24, 557, 877	•		604	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0		0.00000		0	
56.00	05600 RADI OI SOTOPE	0	1			0	
57. 00 58. 00	05700 CT SCAN	0	0	1 0,0000		0	
59.00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION			0.00000		0	
60.00	06000 LABORATORY	116, 302		1			60.00
60. 00	06001 BLOOD LABORATORY	110, 302	1	0.00000		4,731	
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0		0.00000	0	U	61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	,	0. 00000	0	0	1
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0		1		0	
64. 00	06400 I NTRAVENOUS THERAPY	0	· ·	1		0	1
65. 00	06500 RESPIRATORY THERAPY	34, 406	1	1		2, 321	1
66. 00	06600 PHYSI CAL THERAPY	82, 230				2, 163	1
67. 00	06700 OCCUPATI ONAL THERAPY	26, 208				134	
68. 00	06800 SPEECH PATHOLOGY	568		1		39	1
69. 00	06900 ELECTROCARDI OLOGY	35, 074	2, 412, 802	•		90	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	1			0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 376	1, 095, 560			23	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	441	172, 776	0. 00255	52 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	61, 012	18, 283, 030	0.00333	37 778, 974	2, 599	73. 00
74.00	07400 RENAL DI ALYSI S	0	C	0.00000	00	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	C	0.00000	00	0	75. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	36, 891	491, 360	0. 07507	79 0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0				0	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	1			0	1
90.00	09000 CLI NI C	73, 630		•		0	
91. 00	09100 EMERGENCY	144, 131	19, 493, 754	•		0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2, 578, 404	0.00000	00 0	0	92.00
04.00	OTHER REIMBURSABLE COST CENTERS O9400 HOME PROGRAM DIALYSIS	0		0.0000	00 0	0	04.00
94. 00 95. 00	09500 AMBULANCE SERVICES		C	0.00000		0	94. 00 95. 00
96. 00	09600 DURABLE MEDI CAL EQUI P-RENTED	0		0. 00000	0 0	0	
97.00	09700 DURABLE MEDICAL EQUIP-RENTED			1		0	1
200.00		1, 183, 860	1		1, 477, 138		200. 00
_55.50	1.000. (1.1.00.00.177)	., 100, 000	1 ,5, , 15, 516	1	., ., ,, ,,	12,704	,_00.00

Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERV THROUGH COSTS	MORGAN COUNTY /I CE OTHER PASS	Provi der	CCN: 150038	Peri od: From 01/01/2014		
		Component	CCN: 15S038	To 12/31/2014	Date/Time Pre 5/28/2015 1:0	
		Ti tl	e XVIII	Subprovi der - I PF	PPS	
Cost Center Description	Non Physician N Anesthetist	ursing School	Allied Healt	h All Other Medical	Total Cost (sum of col 1	
	Cost			Education Cost	`	
	1.00	2.00	2.00	4.00	4)	
ANCILLARY SERVICE COST CENTERS	1. 00	2. 00	3. 00	4. 00	5. 00	
50. 00 05000 OPERATING ROOM	0	0		0 0	0	50.00
51.00 05100 RECOVERY ROOM	o	0		0 0	0	51.00
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	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	
56. 00 05600 RADI 0I SOTOPE 57. 00 05700 CT SCAN	0	0		0 0	0	
58. 00 05700 CT 3CAN 58. 00 05800 MAGNETIC RESONANCE MAGING (MRI)	0	0		0 0	0	
59. 00 05900 CARDIAC CATHETERIZATION	Ö	0			Ö	
60. 00 06000 LABORATORY	o	0		0 0	0	
60. 01 06001 BLOOD LABORATORY	O	0		0 0	0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0	0	
63.00 06300 BLOOD STORING, PROCESSING & TRANS. 64.00 06400 INTRAVENOUS THERAPY	0	0		0 0	0	
65. 00 06500 RESPIRATORY THERAPY	0	0		0 0	0	
66. 00 06600 PHYSI CAL THERAPY	Ö	0		0 0	0	
67. 00 06700 OCCUPATI ONAL THERAPY	ō	0		0 0	0	
68.00 06800 SPEECH PATHOLOGY	o	0		0 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	
72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS 73.00 O7300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	
74. 00 07400 RENAL DI ALYSI S	0	0		0 0	0	
75. 00 07500 ASC (NON-DISTINCT PART)	ő	0		0 0	0	
76. 97 07697 CARDI AC REHABI LI TATI ON	o	0		0 0	0	
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0	0		0 0	0	
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	
90. 00 09000 CLI NI C	0	0		0 0	0	
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 0	0	
OTHER REIMBURSABLE COST CENTERS	U U	0		<u> </u>	0	72.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0		0 0	0	94. 00
95. 00 09500 AMBULANCE SERVICES		_				95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0	
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0	0	
200.00 Total (lines 50-199)	Ol	0	1	0 0		200.00

APPORT	Financial Systems IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	MORGAN COUNT RVICE OTHER PAS		CCN: 150038	Peri od:	worksheet D	
THROUG	H COSTS		Componen	t CCN: 15S038	From 01/01/2014 To 12/31/2014	Part IV Date/Time Pre 5/28/2015 1:0	pared:
			Ti tl	e XVIII	Subprovider -	PPS	о р
	Cost Center Description	Total	Total Charges		t Outpatient	Inpati ent	
		Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
		Cost (sum of	Part I, col.	(col . 5 ÷ col		Charges	
		col . 2, 3 and	8)	7)	(col. 6 ÷ col.		
		4) 6. 00	7. 00	8.00	7) 9. 00	10.00	
	ANCILLARY SERVICE COST CENTERS	0.00	7.00	0.00	7.00	10.00	
50.00	05000 OPERATI NG ROOM	0	11, 078, 584	0.00000	0. 000000	0	50.00
51.00	05100 RECOVERY ROOM	0	(0.00000	0. 000000	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	(0. 00000	0. 000000	0	52.00
53.00	05300 ANESTHESI OLOGY	0	(0.00000	0. 000000	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	24, 557, 877	0.00000	0. 000000	41, 946	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	(0.00000		0	
56. 00	05600 RADI OI SOTOPE	0	(0	56.00
57.00	05700 CT SCAN	0	(0.0000		0	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0				0	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0				0	
60.00	06000 LABORATORY	0	11, 676, 463	•		474, 973	
60. 01	06001 BLOOD LABORATORY	0	(0.00000	0. 000000	0	1
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY			0.0000	0 000000	0	61.00
62. 00 63. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	0	(1		0	
64. 00	06400 I NTRAVENOUS THERAPY			1		0	
65. 00	06500 RESPIRATORY THERAPY			1		102, 547	
66. 00	06600 PHYSI CAL THERAPY		, , , , , , , , , , , , , , , , , , , ,	•		54, 150	
67. 00	06700 OCCUPATI ONAL THERAPY		,	1		1, 615	
68. 00	06800 SPEECH PATHOLOGY					6, 097	
69. 00	06900 ELECTROCARDI OLOGY					6, 207	
70.00	07000 ELECTROENCEPHALOGRAPHY	0		1		0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1, 095, 560	0. 00000	0. 000000	10, 629	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	172, 776	0.00000	0. 000000	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	18, 283, 030	0.00000	0. 000000	778, 974	73.00
74. 00	07400 RENAL DIALYSIS	0	(0.00000	0. 000000	0	74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0		0.00000		0	75. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	491, 360	0.00000	0. 000000	0	76. 97
	OUTPATIENT SERVICE COST CENTERS		1				
88. 00	08800 RURAL HEALTH CLINIC	0				0	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	l .			0	
90.00	09000 CLINIC	0				0	
91.00	09100 EMERGENCY	0				0	
92. 00	09200 OBSERVATI ON BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0	2, 578, 404	0.00000	0. 000000	0	92.00
94. 00	09400 HOME PROGRAM DIALYSIS	0		0. 00000	0. 000000	0	94. 00
95.00	09500 AMBULANCE SERVICES			0.00000	0.00000	0	95.00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0		0. 00000	0. 000000	0	
97. 00	09700 DURABLE MEDICAL EQUI P-SOLD		l .	1		0	
	, ,	1	1	1 0.00000	3, 333300		

Health Financial Systems	MORGAN COUNTY HOS	SPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 150038 Component CCN: 15S038	From 01/01/2014	Date/Time Prepared:
				5/28/2015 1:03 pm
		Title XVIII	Subprovi der -	PPS

			11 11	e xviii	I PF	PPS	
Cost Center	Description	Inpati ent	Outpati ent	Outpati ent	1111		
COST CENTER	beser i per on	Program	Program	Program			
		Pass-Through	Charges	Pass-Through			
		Costs (col. 8	orial ges	Costs (col. 9			
		x col . 10)		x col . 12)			
		11.00	12. 00	13.00			
ANCI LLARY SERVI CE	COST CENTERS						
50. 00 05000 OPERATING R	ROOM	0	0	(50. 00
51. 00 05100 RECOVERY RO	OOM	o	0				51.00
52. 00 05200 DELI VERY RO	OOM & LABOR ROOM	o	0				52. 00
53. 00 05300 ANESTHESI OL	.OGY	o	0				53.00
54. 00 05400 RADI OLOGY-D	OLAGNOSTI C	o	0				54.00
55. 00 05500 RADI OLOGY-T	HERAPEUTI C	o	0				55. 00
56. 00 05600 RADI 0I SOTOP	E	o	0				56. 00
57.00 05700 CT SCAN		o	0				57. 00
58.00 05800 MAGNETIC RE	SONANCE IMAGING (MRI)	o	0				58. 00
59. 00 05900 CARDI AC CAT	HETERI ZATI ON	o	0				59. 00
60. 00 06000 LABORATORY		O	0	(60.00
60. 01 06001 BL00D LABOR	RATORY	O	0	(60. 01
61. 00 06100 PBP CLINICA	L LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD	& PACKED RED BLOOD CELLS	O	0	(62. 00
63. 00 06300 BLOOD STORI	NG, PROCESSING & TRANS.	O	0	(63. 00
64. 00 06400 I NTRAVENOUS	THERAPY	0	0	(64. 00
65. 00 06500 RESPI RATORY	THERAPY	0	0	(65. 00
66.00 06600 PHYSI CAL TH		0	0	(66. 00
67. 00 06700 OCCUPATI ONA	L THERAPY	0	0	(67. 00
68.00 06800 SPEECH PATH	IOLOGY	0	0	(68. 00
69. 00 06900 ELECTROCARD	OLOGY	0	0	(69. 00
70. 00 07000 ELECTROENCE	PHALOGRAPHY	0	0	(70. 00
71.00 07100 MEDICAL SUP	PPLIES CHARGED TO PATIENTS	0	0	(71. 00
72.00 07200 I MPL. DEV.	CHARGED TO PATIENTS	0	0	(72. 00
73. 00 07300 DRUGS CHARG	SED TO PATIENTS	0	0	(73. 00
74.00 07400 RENAL DIALY		0	0	(74. 00
75. 00 07500 ASC (NON-DI		0	0	(75. 00
76. 97 07697 CARDI AC REH		0	0	()		76. 97
OUTPATIENT SERVIC				1			
88. 00 08800 RURAL HEALT		0	0				88. 00
	DUALIFIED HEALTH CENTER	0	0	1			89. 00
90. 00 09000 CLI NI C		0	0	(90.00
91. 00 09100 EMERGENCY		0	0	1			91. 00
	I BEDS (NON-DISTINCT PART)	0	0	()		92. 00
OTHER REIMBURSABL					\		
94. 00 09400 HOME PROGRA		0	0	(ון		94. 00
95. 00 09500 AMBULANCE S			_]			95.00
	DI CAL EQUI P-RENTED	0	0	1			96.00
97. 00 09700 DURABLE MED		0	0	(97. 00
200.00 Total (line	25 30-179)	l O	0	(기		200. 00

 Heal th Financial APPORTIONMENT OF MEDICAL,
 OTHER HEALTH SERVICES AND VACCINE COST
 MORGAN COUNTY HOSPITAL
 Provi der CCN: 150038 Title XIX

			Ti t	le XIX	Hospi tal	Cost	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	F	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not	(,	
		Part I, col. 9		Subject To	Subject To		
		1 41 6 1, 661.		Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1. 00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY CERVICE COCT CENTERS	1.00	2.00	3.00	4.00	3.00	
	ANCILLARY SERVICE COST CENTERS	0.204202		1 070 100	0		F0 00
	05000 OPERATI NG ROOM	0. 204392	l .		0		50. 00
	05100 RECOVERY ROOM	0. 000000	l	_	-	_	51. 00
	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0	_			52. 00
53. 00	05300 ANESTHESI OLOGY	0. 000000	0	_	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 226374	0	2, 839, 533	0	0	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0	0	0	0	55. 00
56. 00	05600 RADI 0I S0T0PE	0. 000000	0	0	0	0	56. 00
57. 00	05700 CT SCAN	0. 000000	0	0	0	0	57. 00
	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	0		0		58. 00
	05900 CARDI AC CATHETERI ZATI ON	0. 000000	ľ	ľ	0	_	59.00
	06000 LABORATORY	0. 244160	0	_	0	_	60.00
		1	-		0	0	•
	06001 BLOOD LABORATORY	0. 000000	0	0		_	60. 01
1	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000	_	0	0		61. 00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0	_	0	_	62.00
	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0	0	0	_	63. 00
	06400 I NTRAVENOUS THERAPY	0. 000000	0	0	0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	0. 698386	0	109, 251	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 428839	0	236, 249	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	1. 180014	0	35, 981	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 670670	0	24, 637	0	0	68. 00
	06900 ELECTROCARDI OLOGY	0. 040833	0		0	0	69. 00
	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0	0	0		70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 258306	0	_	_	_	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 322933	0	13, 699	0		72.00
	07300 DRUGS CHARGED TO PATIENTS	0. 322733		1, 150, 890	-	0	73.00
			0			_	
	07400 RENAL DIALYSIS	0. 000000	l .	0	0		74.00
	07500 ASC (NON-DISTINCT PART)	0. 000000			0		75. 00
	07697 CARDI AC REHABI LI TATI ON	0. 671941	0	3, 634	0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0. 000000	l .			0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	89. 00
90. 00	09000 CLI NI C	1. 997363	0	40, 195	0	0	90.00
91. 00	09100 EMERGENCY	0. 146546	0	2, 384, 631	0	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 441679	0	275, 092	0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS	•		<u> </u>			1
	09400 HOME PROGRAM DIALYSIS	0. 000000		0			94.00
	09500 AMBULANCE SERVICES	0. 000000					95. 00
	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000				0	96. 00
1	09700 DURABLE MEDICAL EQUIP-RENTED	0. 000000	l e	0	0	_	97. 00
200.00		0.000000		_	0	_	200.00
1	Subtotal (see instructions)			9, 638, 442			•
201. 00	Less PBP Clinic Lab. Services-Program			0	0		201. 00
202 02	Only Charges		_	0 (20 440	_	_	202 00
202. 00	Net Charges (line 200 +/- line 201)	I .	0	9, 638, 442	0	0	202. 00

 Heal th Financial
 Systems
 MORGAN COUNT

 APPORTIONMENT OF
 MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST
 MORGAN COUNTY HOSPITAL

Provi der CCN: 150038

					5/28/2015 1:0	3 pm
		Ti t	le XIX	Hospi tal	Cost	
	Costs	;				
Cost Center Description	Cost	Cost				
3000 Conton 20001 ptron		Rei mbursed				
		ervi ces Not				
		Subject To				
		ed. & Coins.				
		(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	220, 357	0				50.00
51.00 05100 RECOVERY ROOM	o	0				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	o	0				52. 00
53. 00 05300 ANESTHESI OLOGY	0	0				53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	642, 796	0				
	042, 790	ū				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	O O	0				55. 00
56. 00 05600 RADI 0I SOTOPE	0	0				56. 00
57. 00 05700 CT SCAN	0	0				57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	O	0				58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	ol	0				59. 00
60. 00 06000 LABORATORY	278, 405	0				60.00
60. 01 06001 BLOOD LABORATORY	270, 403	0				60. 01
l +		U				
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0					61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0				62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	O	0				63. 00
64. 00 06400 INTRAVENOUS THERAPY	0	0				64. 00
65. 00 06500 RESPI RATORY THERAPY	76, 299	0				65.00
66. 00 06600 PHYSI CAL THERAPY	101, 313	0				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	42, 458	0				67. 00
68. 00 06800 SPEECH PATHOLOGY	16, 523	0				68. 00
69. 00 06900 ELECTROCARDI OLOGY	8, 207	0				69. 00
70. 00 07000 ELECTROCARD OLOGT	0, 207	0				70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	27, 199	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	4, 424	0				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	293, 850	0				73. 00
74. 00 07400 RENAL DI ALYSI S	0	0				74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0				75.00
76. 97 07697 CARDIAC REHABILITATION	2, 442	0				76. 97
OUTPATIENT SERVICE COST CENTERS	<u> </u>					
88. 00 08800 RURAL HEALTH CLINIC	0	0				88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				89. 00
	-					
	80, 284	0				90.00
91. 00 09100 EMERGENCY	349, 458	0				91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	121, 502	0				92. 00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0				94. 00
95. 00 09500 AMBULANCE SERVICES	O					95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	O	0				96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD		0	•			97. 00
200.00 Subtotal (see instructions)	2, 265, 517	0				200. 00
	2, 203, 317	U				200.00
9	١					201.00
Only Charges	2 2/5 517	_				202 00
202.00 Net Charges (line 200 +/- line 201)	2, 265, 517	0	l			202. 00

Health Financial Systems	MORGAN COUNTY HOSPITAL	In Lieu of Form CMS-2552-1		
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 150038	From 01/01/2014	Worksheet D-1 Date/Time Pre	pared:
			5/28/2015 1:0	
	Title XVIII	Hospi tal	PPS	
0 1 0 1 0 1 1				

				5/28/2015 1:0	3 pm
		Title XVIII	Hospi tal	PPS	
	Cost Center Description				
				1. 00	
	PART I - ALL PROVIDER COMPONENTS				
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,			1, 693	1. 00
2.00	Inpatient days (including private room days, excluding swing-be			1, 693	
3.00	Private room days (excluding swing-bed and observation bed days). If you have only pr	ivate room days,	0	3. 00
	do not complete this line.			4 000	
4.00	Semi-private room days (excluding swing-bed and observation bed			1, 088	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room	days) through Decembe	r 31 of the cost	0	5. 00
	reporting period		04 6 11	0	, 00
6. 00	Total swing-bed SNF type inpatient days (including private room	days) after December	31 OF the cost	0	6. 00
7 00	reporting period (if calendar year, enter 0 on this line)	daya) +brayab Dagambar	21 of the cost	0	7 00
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	days) till ought becember	31 OF THE COST	U	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room)	days) after December 2	1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	days) arter becember 5	i or the cost	O	0.00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing_hed and	536	9. 00
7. 00	newborn days)	the frogram (exeruating	Swifig bed and	550	7. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only	v (including private r	nom davs)	0	10. 00
	through December 31 of the cost reporting period (see instructi			-	
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl		oom davs) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, ent				
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12.00
	through December 31 of the cost reporting period	3 .	,		
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	e room days)	0	13.00
	after December 31 of the cost reporting period (if calendar yea	r, enter O on this lin	e)		
14.00	Medically necessary private room days applicable to the Program	(excluding swing-bed	days)	0	14.00
15. 00	Total nursery days (title V or XIX only)			0	15.00
16.00	Nursery days (title V or XIX only)			0	16.00
	SWI NG BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to services	through December 31 o	f the cost	0. 00	17. 00
	reporting period				
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost				18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services	0.00	19. 00		
20.00	reporting period	0.00	20.00		
20. 00	Medicaid rate for swing-bed NF services applicable to services	arter becember 31 of t	ne cost	0.00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions)			3, 186, 841	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	21 of the cost report	ing ported (line	3, 180, 841	22. 00
22.00	5 x line 17)	31 of the cost report	ing perrou (irne	U	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 3	1 of the cost reportin	n neriod (line 6	0	23. 00
23.00	x line 18)	To the cost reportin	g perrou (Triic o	O	23.00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	na period (line	0	24. 00
21100	7 x line 19)	5. 5. t 555t . spo. t.	ng por ou (i i io	· ·	21.00
25.00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25. 00
	x line 20)	, ,	` `		
26.00	Total swing-bed cost (see instructions)			0	26.00
27. 00	General inpatient routine service cost net of swing-bed cost (ine 21 minus line 26)		3, 186, 841	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	
29. 00	Private room charges (excluding swing-bed charges)			0	
30.00	Semi -private room charges (excluding swing-bed charges)			0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷	ine 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00			
34. 00	Average per diem private room charge differential (line 32 minu		tions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x line	31)		0. 00	
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36. 00		
37. 00	General inpatient routine service cost net of swing-bed cost an	a private room cost di	rrerentiai (iine	3, 186, 841	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS	TMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see i			1, 882. 36	38. 00
39. 00	Program general inpatient routine service cost per drem (see 1	,		1, 008, 945	
40. 00	Medically necessary private room cost applicable to the Program	•		1, 008, 745	40. 00
	Total Program general inpatient routine service cost (line 39 +	•		1, 008, 945	
	1	,	ı	., 555, 710	

	Financial Systems	MORGAN COUNT				eu of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi d	er CCN: 150038	Peri od: From 01/01/2014	Worksheet D-1	
					To 12/31/2014	Date/Time Pre	
			Ti	tle XVIII	Hospi tal	5/28/2015 1: 0: PPS	3 pm
	Cost Center Description	Total	Total	Average Per	<u> </u>	Program Cost	
		Inpatient Cost	Inpatient Da	aysDiem (col. 1	÷	(col. 3 x col.	
		1.00	2. 00	col . 2) 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)	0	2.00		00 0		42. 00
	Intensive Care Type Inpatient Hospital Units						
43. 00 44. 00	INTENSIVE CARE UNIT	1, 708, 114	6	2, 599.			1
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0 0		•	00 0		
46. 00		l o			00 0	_	•
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	, line 200)			1, 243, 639	48. 00
49. 00	Total Program inpatient costs (sum of lines			tions)		3, 313, 331	
F0 00	PASS THROUGH COST ADJUSTMENTS			WI+ D	D II	2/2 1/7	
50. 00	Pass through costs applicable to Program inpa	atient routine	services (Ti	rom wkst. D, Su	m or Parts I and	262, 167	50.00
51. 00	Pass through costs applicable to Program inp	atient ancillar	y services ((from Wkst. D,	sum of Parts II	61, 921	51.00
E2 00	and IV)	EO and E1)				224 022	E2 00
52. 00 53. 00	Total Program excludable cost (sum of lines ! Total Program inpatient operating cost exclu		lated non-r	nhysician anest	hetist and	324, 088 2, 989, 243	1
- 5. 50	medical education costs (line 49 minus line		2.25, 11011	. ,		2, 737, 213] - 5. 00
E 4 .00	TARGET AMOUNT AND LIMIT COMPUTATION					1	1 54 00
	Program discharges Target amount per discharge					0.00	
56. 00	Target amount (line 54 x line 55)					0.00	1
57. 00		ing cost and ta	rget amount	(line 56 minus	line 53)	0	
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	0.00					
39.00	market basket	porting period	ending 1996,	upuateu anu c	onipounded by the	0.00	39.00
60.00							
61. 00	If line 53/54 is less than the lower of lines					0	61. 00
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		S (TITIES 54	x 60), Of 1% 0	i the target		
	Relief payment (see instructions)	•				0	62. 00 63. 00
63. 00	63.00 Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST						
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of 1	the cost report	ina period (See	0	64. 00
	instructions)(title XVIII only)	· ·					
65. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts after Decemb	er 31 of the	e cost reportin	g period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routing	ne costs (line	64 plus line	e 65)(title XVI	II only). For	0	66. 00
	CAH (see instructions)						
67. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through	December 3	1 of the cost r	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routing	e costs after D	ecember 31 d	of the cost rep	orting period	0	68. 00
	(line 13 x line 20)						
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU					0	69. 00
70. 00	Skilled nursing facility/other nursing facility						70.00
71. 00	Adjusted general inpatient routine service c	,	ine 70 ÷ lir	ne 2)			71. 00
72. 00 73. 00	Program routine service cost (line 9 x line)		(line 14 v	lino 2E)			72.00
74.00	Medically necessary private room cost applications and program general inpatient routine services.						73. 00 74. 00
75. 00	Capital-related cost allocated to inpatient	•		,	Part II, column		75. 00
74 00	26, line 45)	no 2)					74 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minus	s line 77)					78. 00
79. 00	Aggregate charges to beneficiaries for excess				nuo 11 70)		79.00
80. 00 81. 00	Total Program routine service costs for compa Inpatient routine service cost per diem limi		ust limitati	on (iine /8 mi	nus iine 79)		80. 00 81. 00
82. 00	Inpatient routine service cost limitation ()				82.00
83. 00	Reasonable inpatient routine service costs (s)				83. 00
84. 00 85. 00	Program inpatient ancillary services (see in:		ns)				84. 00 85. 00
	Utilization review - physician compensation Total Program inpatient operating costs (sum						86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST	<u> </u>				
87.00	Total observation bed days (see instructions	•	line 2)			605	1
88. 00 89. 00	Adjusted general inpatient routine cost per of Observation bed cost (line 87 x line 88) (see		1111C 2)			1, 882. 36 1, 138, 828	
	(30)					., .55,526	

Health Financial Systems	MORGAN COUNT	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2014		
				To 12/31/2014	Date/Time Prep 5/28/2015 1:03	
			201111			3 PIII
			e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	507, 558	3, 186, 841	0. 15926	7 1, 138, 828	181, 378	90.00
91.00 Nursing School cost	0	3, 186, 841	0.00000	0 1, 138, 828	0	91.00
92.00 Allied health cost	0	3, 186, 841	0.00000	0 1, 138, 828	0	92.00
93.00 All other Medical Education	0	3, 186, 841	0.00000	0 1, 138, 828	0	93.00

Health Financial Systems	MORGAN COUNTY HOSPITAL	In Lie	eu of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 1500		Worksheet D-1
	Component CCN: 15SG	From 01/01/2014 To 12/31/2014	Date/Time Prepared: 5/28/2015 1:03 pm
	Title XVIII	Subprovi der -	PPS
		IDE	

		TI LIE AVIII	I PF	FF3	
	Cost Center Description			4.00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,			2, 764	1. 00
2.00	Inpatient days (including private room days, excluding swing-bed Private room days (excluding swing-bed and observation bed days)			2, 764	2. 00
3. 00	do not complete this line.	i. II you have only pri	vate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation bed	days)		2, 764	4.00
5.00	Total swing-bed SNF type inpatient days (including private room	days) through December	31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room	days) after December 3	21 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	days) arter becomber a	or or the cost	Ö	0.00
7.00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room of	Mays) after December 21	of the cost	0	8. 00
8.00	reporting period (if calendar year, enter 0 on this line)	lays) arter becember 31	or the cost	U	8.00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	2, 314	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII only	, (including private re	om days)	0	10. 00
10.00	through December 31 of the cost reporting period (see instruction		Joili days)	U	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only	(including private ro	oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, ent Swing-bed NF type inpatient days applicable to titles V or XIX		room days)	0	12. 00
12.00	through December 31 of the cost reporting period	only (including private	e room days)	U	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13.00
14. 00	after December 31 of the cost reporting period (if calendar year		, i	0	14. 00
15. 00	Medically necessary private room days applicable to the Program Total nursery days (title V or XIX only)	(excluding Swing-bed C	lays)	0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
47.00	SWING BED ADJUSTMENT		2.11	0.00	47.00
17. 00	Medicare rate for swing-bed SNF services applicable to services reporting period	through December 31 of	tne cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of t	he cost	0.00	18.00
19. 00	reporting period	through Docombon 21 of	the cost	0.00	19. 00
19.00	Medicaid rate for swing-bed NF services applicable to services reporting period	ini dugir becelliber 31 di	the cost	0.00	19.00
20. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of th	ne cost	0. 00	20.00
21. 00	reporting period Total general inpatient routine service cost (see instructions)			2, 356, 931	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	31 of the cost reporti	ng period (line	2, 333, 731	22. 00
	5 x line 17)				
23. 00	Swing-bed cost applicable to SNF type services after December 3' x line 18)	or the cost reporting	period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December :	31 of the cost reportin	ng period (line	0	24.00
25 00	7 x line 19)	-6 +1++:		0	25 00
25. 00	Swing-bed cost applicable to NF type services after December 31 x line 20)	or the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			0	
27. 00	General inpatient routine service cost net of swing-bed cost (I) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	ne 21 minus line 26)		2, 356, 931	27. 00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed cha	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)		3 ,	0	
30.00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ 1	ino 20)		0. 000000	30.00
31. 00 32. 00	Average private room per diem charge (line 29 ÷ line 3)	THE 20)		0.00000	
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 minus		i ons)	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)	31)		0.00	35. 00 36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and	d private room cost dif	ferential (line	2, 356, 931	
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST	MENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see in			852. 72	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 3	3)		1, 973, 194	39. 00
40.00	Medically necessary private room cost applicable to the Program	•		1 072 104	40.00
41. 00	Total Program general inpatient routine service cost (line 39 +	1111e 40)	I	1, 973, 194	41.00

	Financial Systems	MORGAN COUNTY F				u of Form CMS-2	
COMPUT	TATION OF INPATIENT OPERATING COST		Provider CCN: 1	F	eriod: rom 01/01/2014	Worksheet D-1	
			Component CCN:			Date/Time Pre 5/28/2015 1:0 PPS	
			litie xvii	I	Subprovider - IPF	PPS	
	Cost Center Description	Total Inpatient Costlnp	Total Aver patient Days Diem	age Per (col. 1 ÷	Program Days	Program Cost (col. 3 x col.	
		1.00		01 . 2) 3. 00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)	0	0	0.00	4. 00		42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	O	O	0. 00	0	0	43.00
44. 00	CORONARY CARE UNIT	0	0	0.00		0	1
45. 00	BURN INTENSIVE CARE UNIT	0	o	0.00	0	0	
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)	0	0	0. 00	0	0	46. 00 47. 00
	Cost Center Description		<u>'</u>				
48. 00	Program inpatient ancillary service cost (Wk	st. D-3. col. 3. I	ine 200)			1. 00 428, 188	48. 00
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS					2, 401, 382	1
50. 00	Pass through costs applicable to Program inp	atient routine sem	rvices (from Wkst.	D, sum o	of Parts I and	125, 072	50. 00
51. 00		atient ancillary s	services (from Wks	st. D, sur	m of Parts II	12, 704	51.00
52. 00	Total Program excludable cost (sum of lines					137, 776	1
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		ted, non-physiciar	anesthe	tist, and	2, 263, 606	53.00
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
55. 00	Target amount per discharge						55. 00
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and targe	at amount (line E	4 minus li	no E2)	0	
58.00	Bonus payment (see instructions)	ing cost and targe	et amount (iine so	o IIII IIUS I I	ne 53)	0	1
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0. 00	59. 00
60. 00	60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						60.00
61. 00	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target						61. 00
62. 00	amount (line 56), otherwise enter zero (see instructions) 2.00 Relief payment (see instructions)						62. 00
							63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through December	er 31 of the cost	reporti n	g period (See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after December	31 of the cost re	eporting	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)(tit	tle XVIII	onl v). For	0	66. 00
	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin						67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	· ·		,	0 .	0	
	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient			ж. торо.	ing porrou		69. 00
	PART III - SKILLED NURSING FACILITY, OTHER N	URSING FACILITY, A	AND ICF/MR ONLY			0	1
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of			ne 37)			70. 00 71. 00
71.00	Program routine service cost (line 9 x line	•	5 /0 ÷ IIIIe 2)				72.00
73.00	Medically necessary private room cost applic	able to Program (I)			73.00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient			eet B, Pa	rt II, column		74. 00 75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li						76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for exces	,	vi der records)				79. 00
80.00	Total Program routine service costs for comp		t limitation (line	e 78 minus	s line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I						81. 00 82. 00
83. 00	Reasonable inpatient routine service costs (see instructions)					83. 00
84.00	Program inpatient ancillary services (see in		\				84. 00 85. 00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						86.00
	PART IV - COMPUTATION OF OBSERVATION BED PAS	S THROUGH COST				=	1
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	•	ne 2)			0 0. 00	87. 00 88. 00
	Observation bed cost (line 87 x line 88) (se	•	*				89.00

Health Financial Systems	MORGAN COUNTY HOSPITAL			In Lieu of Form CMS-2552-1		2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
		Component	CCN: 15S038	From 01/01/2014 To 12/31/2014		
		Ti tl	e XVIII	Subprovi der - I PF	PPS	
Cost Center Description	Cost 1.00	Routine Cost (from line 27)	col umn 1 ÷ col umn 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions) 5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (OST					
90.00 Capital-related cost	149, 393	2, 356, 931	0. 06338	5 0	0	90.00
91.00 Nursing School cost	0	2, 356, 931			0	91. 00
92.00 Allied health cost	0	2, 356, 931			0	
93.00 All other Medical Education	0	2, 356, 931	0. 00000	0 0	0	93. 00

Health Financial Systems	ORGAN COUNTY HOSPITAL		In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Peri od:	Worksheet D-3	
			From 01/01/2014	D-+- /T: D	
			To 12/31/2014	Date/Time Pre 5/28/2015 1:0	
	Ti tl	e XVIII	Hospi tal	PPS	o piii
Cost Center Description		Ratio of Cos		Inpati ent	
·		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
INDATION DOUTING CERVILOR COCT CENTERS		1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1	873, 963	I	20.00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT			1, 271, 006		30.00
32. 00 03200 CORONARY CARE UNIT			1, 271, 000		32.00
33. 00 03300 BURN INTENSIVE CARE UNIT			0		33.00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T			0		34.00
40. 00 04000 SUBPROVI DER - I PF			0		40.00
41. 00 04100 SUBPROVI DER - RF			0		41. 00
42. 00 04200 SUBPROVI DER			0		42. 00
43. 00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS		,			
50. 00 05000 OPERATING ROOM		0. 20439	147, 326	30, 112	50.00
51.00 05100 RECOVERY ROOM		0.00000	0 0	0	51.00
52.00 O5200 DELIVERY ROOM & LABOR ROOM		0.00000		0	52. 00
53. 00 05300 ANESTHESI OLOGY		0.00000		0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 22637			1
55. 00 05500 RADI OLOGY-THERAPEUTI C		0.00000		0	55. 00
56. 00 05600 RADI 01 SOTOPE		0.00000		0	56. 00
57. 00 05700 CT SCAN		0.00000		0	57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0.00000		0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.00000		0	59.00
60. 00 06000 LABORATORY		0. 24416		223, 206	
60. 01 06001 BLOOD LABORATORY		0.00000		0	60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.00000		0	61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 00000 0. 00000		0	62. 00 63. 00
64. 00 06400 INTRAVENOUS THERAPY		0.00000		0	64.00
65. 00 06500 RESPI RATORY THERAPY		0. 69838		290, 310	1
66. 00 06600 PHYSI CAL THERAPY		0. 42883			
67. 00 06700 OCCUPATI ONAL THERAPY		1. 18001			
68. 00 06800 SPEECH PATHOLOGY		0. 67067		2, 274	
69. 00 06900 ELECTROCARDI OLOGY		0. 04083			
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.00000		0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 25830		39, 294	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 32293	3, 047	984	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 25532	1, 133, 822	289, 492	73.00
74. 00 07400 RENAL DI ALYSI S		0.00000	0 0	0	74. 00
75.00 07500 ASC (NON-DISTINCT PART)		0.00000		-	75. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON		0. 67194	1 0	0	76. 97
OUTPATIENT SERVICE COST CENTERS					
88. 00 08800 RURAL HEALTH CLINIC		0.00000		0	
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000		0	
90. 00 09000 CLI NI C		1. 99736		74 121	90.00
91. 00 09100 EMERGENCY		0. 14654			
92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS		0. 44167	243, 221	107, 426	92.00
94. 00 09400 HOME PROGRAM DI ALYSI S		0.00000	0	0	94. 00
95. 00 09500 AMBULANCE SERVICES		0.00000	,5		95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED		0. 00000	00	0	
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD		0. 00000		Ö	97. 00
200.00 Total (sum of lines 50-94 and 96-98)			4, 510, 628		
201.00 Less PBP Clinic Laboratory Services-Progra	m only charges (line 61)		0		201. 00
202.00 Net Charges (line 200 minus line 201)			4, 510, 628		202. 00

Health Financial Systems	MORGAN COUNTY HOSPITAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150038	Peri od: From 01/01/2014	Worksheet D-3	
	Component	CCN: 15S038	To 12/31/2014	Date/Time Prep 5/28/2015 1:03	
	Ti tl	e XVIII	Subprovi der -	PPS	
			I PF		
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	

		Title XVIII	Subprovi der -	PPS	3 piii
		II tie xviii	I PF	FFS	
	Cost Center Description	Ratio of C		I npati ent	
	COST CENTER DESCRIPTION	To Charge		Program Costs	
		To charge	_		
			Charges	(col. 1 x col.	
		1 00	2.00	2)	
LNI	DATIENT DOUTINE CEDVICE COCT CENTEDO	1.00	2. 00	3. 00	
	PATIENT ROUTINE SERVICE COST CENTERS			<u></u>	20.00
	000 ADULTS & PEDIATRICS			1	30.00
	100 I NTENSI VE CARE UNI T				31.00
	200 CORONARY CARE UNIT 300 BURN INTENSIVE CARE UNIT				32.00
					33.00
	400 SURGI CAL INTENSIVE CARE UNIT		4 102 124		34.00
	000 SUBPROVI DER - I PF		4, 103, 136	1	40.00
	100 SUBPROVI DER - I RF			1	41.00
	200 SUBPROVI DER		()	42.00
	300 NURSERY				43. 00
	CILLARY SERVICE COST CENTERS	0.00	1000		F0 00
	000 OPERATI NG ROOM	0. 204			50.00
	100 RECOVERY ROOM	0.000			51.00
1	200 DELIVERY ROOM & LABOR ROOM	0.000			52.00
1	300 ANESTHESI OLOGY	0.000		1	53. 00
	400 RADI OLOGY-DI AGNOSTI C	0. 220		1	54.00
	500 RADI OLOGY-THERAPEUTI C	0.000		1	55. 00
4	600 RADI OI SOTOPE	0.000		1	56. 00
1	700 CT SCAN	0.000		1	57. 00
	800 MAGNETIC RESONANCE I MAGING (MRI)	0.000		1	58. 00
	900 CARDI AC CATHETERI ZATI ON	0.000			59. 00
	000 LABORATORY	0. 24			60.00
1	001 BL00D LABORATORY	0.000		1	60. 01
	100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000		1	61.00
62. 00 06	200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000		0	62. 00
	300 BLOOD STORING, PROCESSING & TRANS.	0.000			63. 00
	400 I NTRAVENOUS THERAPY	0.000			64. 00
	500 RESPI RATORY THERAPY	0. 698			65. 00
	600 PHYSI CAL THERAPY	0. 428			66. 00
	700 OCCUPATI ONAL THERAPY	1. 180			1
1	800 SPEECH PATHOLOGY	0. 670			1
	900 ELECTROCARDI OLOGY	0.040		1	1
	000 ELECTROENCEPHALOGRAPHY	0.000		1	70. 00
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 258			
	200 IMPL. DEV. CHARGED TO PATIENTS	0. 32		0	72. 00
	300 DRUGS CHARGED TO PATIENTS	0. 25!			73. 00
	400 RENAL DI ALYSI S	0.000			74. 00
	500 ASC (NON-DISTINCT PART)	0.000			75. 00
	697 CARDI AC REHABI LI TATI ON	0. 67	941 (0	76. 97
	TPATIENT SERVICE COST CENTERS			1	
	800 RURAL HEALTH CLINIC	0.000		0	88. 00
	900 FEDERALLY QUALIFIED HEALTH CENTER	0.000		0	89. 00
	000 CLI NI C	1. 99		1	90.00
	100 EMERGENCY	0. 146		1	91.00
	200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 44	679 (0	92. 00
	HER REIMBURSABLE COST CENTERS				
	400 HOME PROGRAM DI ALYSI S	0.000	0000	0	
	500 AMBULANCE SERVI CES				95. 00
	600 DURABLE MEDI CAL EQUI P-RENTED	0.000		1	
	700 DURABLE MEDI CAL EQUI P-SOLD	0.000		0	97. 00
200.00	Total (sum of lines 50-94 and 96-98)		1, 477, 138		
201. 00	Less PBP Clinic Laboratory Services-Program only charges (line 61)			201. 00
202. 00	Net Charges (line 200 minus line 201)		1, 477, 138	3	202. 00

Health Financial Systems MORGAN COUNTY HO	OSPI TAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150038	Peri od:	Worksheet D-3	
			From 01/01/2014 To 12/31/2014	Date/Time Pre	nared·
			10 12/01/2011	5/28/2015 1:0	
	Ti t	le XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program Charges	Program Costs (col. 1 x col.	
			charges	2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			199, 253		30. 00
31. 00 03100 INTENSI VE CARE UNI T			208, 267		31.00
32. 00 03200 CORONARY CARE UNIT 33. 00 03300 BURN INTENSIVE CARE UNIT			0		32. 00 33. 00
34. 00 03400 SURGICAL INTENSIVE CARE UNIT			0		34. 00
40. 00 04000 SUBPROVI DER - PF			161, 434		40. 00
41. 00 04100 SUBPROVI DER - RF			0		41. 00
42. 00 04200 SUBPROVI DER			0		42. 00
43. 00 04300 NURSERY			0		43. 00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM		0. 20439	92 90, 175	18, 431	50.00
51. 00 05100 RECOVERY ROOM		0. 00000		0 10, 431	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM		0. 00000		Ö	52.00
53. 00 05300 ANESTHESI OLOGY		0.00000		0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 22637	74 141, 274	31, 981	54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C		0.00000		0	55. 00
56. 00 05600 RADI OI SOTOPE		0.00000		0	56. 00
57. 00 05700 CT SCAN		0.00000		0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 59.00 05900 CARDIAC CATHETERIZATION		0.00000		0	58. 00 59. 00
60. 00 06000 LABORATORY		0. 24416		47, 730	60.00
60. 01 06001 BLOOD LABORATORY		0.00000		0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.00000		0	61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0.00000	00	0	62. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.		0.00000		0	63. 00
64. 00 06400 I NTRAVENOUS THERAPY		0.00000		0	64.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY		0. 69838 0. 42883		38, 471 974	65. 00 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		1. 18001		325	67.00
68. 00 06800 SPEECH PATHOLOGY		0. 67067		737	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 04083		1, 841	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.00000	00	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 25830		7, 869	71. 00
72. 00 O7200 IMPL. DEV. CHARGED TO PATIENTS		0. 32293		102	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DIALYSIS		0. 25532 0. 00000		72, 826 0	73. 00 74. 00
75. 00 07500 ASC (NON-DISTINCT PART)		0.00000		0	75.00
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 67194		Ö	76. 97
OUTPATIENT SERVICE COST CENTERS			• • • • • • • • • • • • • • • • • • • •		
88. 00 08800 RURAL HEALTH CLINIC		0.00000	00 0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000		0	1
90. 00 09000 CLI NI C		1. 99736		0	90.00
91. 00 09100 EMERGENCY		0. 14654		16, 864	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS		0. 44167	79 56, 349	24, 888	92. 00
94. 00 09400 HOME PROGRAM DI ALYSI S		0. 00000	00	0	94. 00
95. 00 09500 AMBULANCE SERVI CES		0.00000	-		95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED		0. 00000	00 0	0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD		0. 00000		0	97. 00
200.00 Total (sum of lines 50-94 and 96-98)			1, 018, 182	263, 039	
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		1 010 100		201. 00
202.00 Net Charges (line 200 minus line 201)		1	1, 018, 182	I	202. 00

				From 01/01/2014 To 12/31/2014	Date/Time Pre	
		Ti tl	e XVIII	Hospi tal	5/28/2015 1: 0 PPS	JS PIII
			0	1. 00	2.00	
1 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					1 00
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurrin	g prior		0 1, 452, 916		1. 00 1. 01
1. 02	to October 1 (see instructions) DRG amounts other than outlier payments for discharges occurrin	a on or		188, 724		1. 02
1.02	after October 1 (see instructions)	g on or		100, 724		1.02
1. 03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)			0		1. 03
1.04	DRG for federal specific operating payment for Model 4 BPCI for			0		1. 04
2. 00	discharges occurring on or after October 1 (see instructions) Outlier payments for discharges. (see instructions)			16, 955		2. 00
2. 01	Outlier reconciliation amount			0		2. 01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructio	ns)		0		2. 02
3. 00 4. 00	Managed Care Simulated Payments Bed days available divided by number of days in the cost report	i na		35. 34		3. 00 4. 00
00	period (see instructions)	· ···9		00.0.]
F 00	Indirect Medical Education Adjustment		ı	0.00		- 00
5. 00	FTE count for allopathic and osteopathic programs for the most cost reporting period ending on or before 12/31/1996. (see instr			0.00		5. 00
6.00	FTE count for allopathic and osteopathic programs which meet th	e		0.00		6. 00
	criteria for an add-on to the cap for new programs in accordanc CFR 413.79(e)	e with 42				
7. 00	MMA Section 422 reduction amount to the IME cap as specified un	der 42		0.00		7. 00
7 01	CFR §412. 105(f)(1)(iv)(B)(1)	ndon 10		0.00		7 01
7. 01	ACA Section 5503 reduction amount to the IME cap as specified u CFR $\S412.105(f)(1)(iv)(B)(2)$ If the cost report straddles July			0.00		7. 01
	then see instructions.					
8. 00	Adjustment (increase or decrease) to the FTE count for allopath osteopathic programs for affiliated programs in accordance with			0.00		8. 00
	413.75(b), 413.79(c)(2)(i v), 64 FR 26340 (May 12, 1998), and 67					
0.04	(August 1, 2002).			0.00		0.01
8. 01	The amount of increase if the hospital was awarded FTE cap slot section 5503 of the ACA. If the cost report straddles July 1, 2			0.00		8. 01
	instructions.	011, 300				
8. 02	The amount of increase if the hospital was awarded FTE cap slot			0.00		8. 02
9. 00	closed teaching hospital under section 5506 of ACA. (see instru Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines			0.00		9.00
	and 8,02) (see instructions)	•				1
10. 00	FTE count for allopathic and osteopathic programs in the curren from your records	t year		0.00		10. 00
11. 00	FTE count for residents in dental and podiatric programs.			0.00		11. 00
12.00	Current year allowable FTE (see instructions)			0.00		12.00
13. 00 14. 00	Total allowable FTE count for the prior year. Total allowable FTE count for the penultimate year if that year	ended on		0. 00 0. 00		13. 00 14. 00
00	or after September 30, 1997, otherwise enter zero.	onada on		0.00		00
15. 00	Sum of lines 12 through 14 divided by 3.			0.00		15. 00
16. 00 17. 00	Adjustment for residents in initial years of the program Adjusment for residents displaced by program or hospital closur	e		0. 00 0. 00		16. 00 17. 00
18. 00	Adjusted rolling average FTE count			0.00		18. 00
19. 00	Current year resident to bed ratio (line 18 divided by line 4).			0.000000		19.00
20. 00 21. 00	Prior year resident to bed ratio (see instructions) Enter the lesser of lines 19 or 20 (see instructions)			0. 000000 0. 000000		20.00
22. 00	IME payment adjustment (see instructions)			0		22. 00
22. 01	IME payment adjustment - Managed Care (see instructions)	- 122 -6 +	In - 1404 A	0		22. 01
23. 00	Indirect Medical Education Adjustment for the Add-on for Section Number of additional allopathic and osteopathic IME FTE residen		THE IVIIVIA	0.00		23. 00
	slots under 42 Sec. 412.105 (f)(1)(iv)(C).					
24. 00 25. 00	IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -0-, then enter the lo	wor of		0. 00 0. 00		24. 00 25. 00
25.00	line 23 or line 24 (see instructions)	wei oi		0.00		25.00
26. 00	Resident to bed ratio (divide line 25 by line 4)			0. 000000		26. 00
27. 00 28. 00	IME payments adjustment factor. (see instructions) IME add-on adjustment amount (see instructions)			0. 000000		27. 00 28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions)		•	Ö		28. 01
29. 00	Total IME payment (sum of lines 22 and 28)			0		29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment			0		29. 01
30. 00	Percentage of SSI recipient patient days to Medicare Part A pat	i ent days		7.86		30. 00
21 22	(see instructions)	-				21.00
31. 00 32. 00	Percentage of Medicaid patient days (see instructions) Sum of lines 30 and 31			9. 86 17. 72		31. 00 32. 00
33. 00	Allowable disproportionate share percentage (see instructions)			4. 26		33. 00
34. 00	Disproportionate share adjustment (see instructions)			17, 484		34. 00

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT		Peri od: From 01/01/2014	Worksheet E Part A	
			To 12/31/2014	Date/Time Pre 5/28/2015 1:0	pared:
		Title XVIII	Hospi tal	PPS	у р
			Prior to October 1	On/After October 1	
		0	1.00	2. 00	
25 00	Uncompensated Care Adjustment		0.04/ 200 142	7 / 47 / 44 005	25.00
35. 00 35. 01	Total uncompensated care amount (see instructions) Factor 3 (see instructions)		9, 046, 380, 143	7, 647, 644, 885 0. 000032004	
35. 02	Hospital uncompensated care payment (If line 34 is zero,		381, 730	244, 758	
05.00	enter zero on this line) (see instructions)		005 540		05.00
35. 03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		285, 513	61, 692	35. 03
36. 00	Total uncompensated care (sum of columns 1 and 2 on line		347, 205		36. 00
	35.03)	ochonges (Lines 10 through	h 4()		
40. 00	Additional payment for high percentage of ESRD beneficiary di Total Medicare discharges on Worksheet S-3, Part I	scharges (Tries 40 tilloug	0		40.00
	excluding discharges for MS-DRGs 652, 682, 683, 684 and				
41. 00	685 (see instructions) Total ESRD Medicare discharges excluding MS-DRGs 652,		0		41.00
41.00	682, 683, 684 an 685. (see instructions)				41.00
41. 01	Total ESRD Medicare covered and paid discharges excluding		0		41. 01
42. 00	MS-DRGs 652, 682, 683, 684 an 685. (see instructions) Divide line 41 by line 40 (if less than 10%, you do not		0.00		42.00
.2. 00	qualify for adjustment)				12.00
43. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652,		0		43.00
44. 00	682, 683, 684 an 685. (see instructions) Ratio of average length of stay to one week (line 43		0. 000000		44.00
	divided by line 41 divided by 7 days)				
45. 00	Average weekly cost for dialysis treatments (see instructions)		0.00		45. 00
46. 00	Total additional payment (line 45 times line 44 times line		0		46.00
47.00	41.01)		2 022 204		47.00
47. 00 48. 00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and		2, 023, 284		47. 00
	MDH, small rural hospitals only. (see instructions)				
49. 00	Total payment for inpatient operating costs (see instructions)		2, 023, 284		49. 00
50. 00	Payment for inpatient program capital (from Wkst. L, Pt. I		133, 460		50.00
	and Pt. II, as applicable)				
51. 00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Wkst. E-4,		0		52. 00
53. 00	line 49 see instructions).				53.00
54. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies		0		54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1,		0		55. 00
56. 00	line 69) Cost of physicians' services in a teaching hospital (see		0		56. 00
30. 00	intructions)				30.00
57. 00	Routine service other pass through costs (from Wkst. D,		0		57.00
58. 00	Pt. III, column 9, lines 30 through 35). Ancillary service other pass through costs from Wkst. D,		0		58.00
	Pt. IV, col. 11 line 200)				
59. 00 60. 00	Total (sum of amounts on lines 49 through 58) Primary payer payments		2, 156, 744		59. 00 60. 00
61. 00	Total amount payable for program beneficiaries (line 59		2, 156, 744		61.00
	minus line 60)		040 574		,,,,,,,
62. 00 63. 00	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries		240, 576 1, 824		62.00
64. 00	Allowable bad debts (see instructions)		1, 000		64. 00
65.00	Adjusted reimbursable bad debts (see instructions)		650		65. 00
66. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)		1, 000		66. 00
67. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		1, 914, 994		67.00
68. 00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		68. 00
69. 00	Outlier payments reconciliation (sum of lines 93, 95 and		0		69.00
	96). (For SCH see instructions)				
70. 00 70. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) RURAL DEMONSTRATION PROJECT		0		70.00
70. 89	Pioneer ACO demonstration payment adjustment amount (see		o o		70. 89
70.00	instructions)				70.00
70. 90	HSP bonus payment HVBP adjustment amount (see instructions)		0		70. 90
70. 91	HSP bonus payment HRR adjustment amount (see instructions)		0		70. 9
70. 92 70. 93	Bundled Model 1 discount amount (see instructions) HVBP payment adjustment amount (see instructions)		0 520		70. 92 70. 93
70. 93 70. 94	HRR adjustment amount (see instructions)		0		70. 93
70. 74			0		70. 95

Heal th	Financial Systems MORGAN COU	NTY HO	ISPI TAL		In Lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 150038		eriod: rom 01/01/2014	Worksheet E Part A Date/Time Pre 5/28/2015 1:0	pared:
			Title XVIII		Hospi tal	PPS	
					Prior to	On/After	
		-	0		0ctober 1 1.00	0ctober 1 2.00	
70. 96	Low volume adjustment for federal fiscal year (yyyy)			014	308, 187	2.00	70, 96
70. 90	(Enter in column 0 the corresponding federal year for the period prior to 10/1)		2	014	306, 167		70. 96
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)		2	015	47, 109		70. 97
70. 98	Low Volume Payment-3				0		70. 98
70. 99	HAC adjustment amount (see instructions)				0		70. 99
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)				2, 270, 810		71. 00
71. 01	Sequestration adjustment (see instructions)				45, 416		71. 01
72.00	Interim payments	ı			2, 013, 169		72. 00
73.00	Tentative settlement (for contractor use only)	i			0		73. 00
74. 00	Balance due provider (Program) (line 71 minus lines 71.01 72, and 73)	,			212, 225		74. 00
75. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				312, 086		75. 00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)						
90. 00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see				0		90. 00
04 00	instructions)	-					04 00
91.00	Capital outlier from Wkst. L, Pt. I, line 2	-			0		91.00
92. 00	Operating outlier reconciliation adjustment amount (see instructions)				0		92. 00
93. 00	Capital outlier reconciliation adjustment amount (see instructions)				0		93. 00
94. 00	The rate used to calculate the time value of money (see				0.00		94. 00
95. 00	instructions) Time value of money for operating expenses (see				0		95. 00
96. 00	instructions) Time value of money for capital related expenses (see				0		96. 00
	instructions)						

	72, and 73)			l	1
75. 00	Protested amounts (nonallowable cost report items) in		312, 086		75. 00
	accordance with CMS Pub. 15-2, chapter 1, §115.2				
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see		0		90. 00
	instructions)				
91. 00	Capital outlier from Wkst. L, Pt. I, line 2		0		91. 00
92.00	Operating outlier reconciliation adjustment amount (see		0		92. 00
	instructions)				
93.00	1		0		93. 00
	instructions)				
94. 00	The rate used to calculate the time value of money (see		0.00		94. 00
	instructions)				
95. 00	Time value of money for operating expenses (see		0		95. 00
	instructions)				
96. 00	Time value of money for capital related expenses (see		0		96. 00
	instructions)				
			Prior to 10/1		
			1. 00	2. 00	
	HSP Bonus Payment Amount		T		
100.00	HSP bonus amount (see instructions)		0	0	100. 00
	HVBP Adjustment for HSP Bonus Payment				
	HVBP adjustment factor (see instructions)		0		101. 00
102.00	HVBP adjustment amount for HSP bonus payment (see instructi	i ons)	0	0	102. 00
	HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)		0. 0000	0.0000	103. 00
104.00	HRR adjustment amount for HSP bonus payment (see instruction	ons)	0	0	104. 00

In Lieu of Form CMS-2552-10

Period:	Worksheet E
From 01/01/2014	Part A Exhibit 4
To 12/31/2014	Date/Time Prepared:
5/28/2015 1:03 pm	Provi der CCN: 150038

					'	0 12/31/2014	5/28/2015 1:0	
	,				e XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3. 00	4. 00	5. 00	
1. 00	DRG amounts other than outlier	1. 00	0	0	0		0	1. 00
1. 01	payments DRG amounts other than outlier	1. 01	1, 452, 916	0	1, 452, 916	0	1, 452, 916	1. 01
1. 02	payments for discharges occurring prior to October 1 DRG amounts other than outlier	1. 02	188, 724	0	0	188, 724	188, 724	1. 02
1.02	payments for discharges occurring on or after October	1. 02	100, 724	0	O	100, 724	100, 724	1.02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1. 03	0	0	0	0	0	1. 03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0	0	0	0	1. 04
2. 00	Outlier payments for discharges (see instructions)	2. 00	16, 955	0	14, 307	2, 648	16, 955	2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	0	0	0	2. 01
3. 00	Operating outlier reconciliation	2. 01	0	0	0	0	0	3. 00
4. 00	Managed care simulated payments Indirect Medical Education Adju	3. 00	0	0	0	0	0	4. 00
5. 00	Amount from Worksheet E, Part	21. 00	0. 000000	0. 000000	0. 000000	0. 000000		5. 00
6. 00	A, line 21 (see instructions) IME payment adjustment (see	22. 00	0	0	0	0	0	6. 00
6. 01	instructions) IME payment adjustment for	22. 01	0	0	0	0	0	6. 01
	managed care (see instructions)							
	Indirect Medical Education Adju							
7. 00	IME payment adjustment factor (see instructions)	27. 00	0. 000000	0. 000000	0. 000000	0. 000000		7. 00
8.00	IME adjustment (see	28. 00	0	0	0	0	0	8. 00
8. 01	instructions) IME payment adjustment add on for managed care (see	28. 01	0	0	0	0	0	8. 01
9. 00	instructions) Total IME payment (sum of lines 6 and 8)	29. 00	0	0	0	0	0	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	0	0	0	0	0	9. 01
	Di sproporti onate Share Adjustme	ent						
10. 00	Allowable disproportionate share percentage (see	33. 00	0. 0426	0. 0426	0. 0426	0. 0426		10. 00
11. 00	<pre>instructions) Disproportionate share adjustment (see instructions)</pre>	34.00	17, 484	0	15, 474	2, 010	17, 484	11. 00
11. 01	Uncompensated care payments	36. 00	347, 205	0	285, 513	61, 692	347, 205	11. 01
	Additional payment for high per	centage of ESF						
12. 00	Total ESRD additional payment (see instructions)	46. 00	0	0	0	0	0	
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH,	47. 00 48. 00	2, 023, 284 0	0	1, 768, 210 0	255, 074 0	2, 023, 284 0	13. 00 14. 00
15.00	small rural hospitals only.) (see instructions)	40.00	2 022 204		1 7/0 210	255 074	2 022 204	15.00
15. 00	Total payment for inpatient operating costs (see instructions)	49. 00	2, 023, 284	0	1, 768, 210	255, 074	2, 023, 284	15.00
16. 00	Payment for inpatient program capital	50. 00	133, 460	0	117, 961	15, 499	133, 460	16. 00
17. 00	Special add-on payments for new technologies	54. 00	0	0	0	0	0	
17. 01 17. 02	Net organ aquisition cost Capital received from	55. 00 68. 00	0	0	0	_	0	17. 01 17. 02
18. 00	manufacturers for replaced devices for applicable MS-DRGs Capital outlier reconciliation adjustment amount (see	93. 00	0	0	0	0	0	18. 00
	instructions)							

					Ť	o 12/31/2014	Date/Time Pre 5/28/2015 1:0	
				Ti tl	e XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
		0	1.00	2.00	3.00	4. 00	5. 00	
19.00	SUBTOTAL			C	1, 886, 171	270, 573	2, 156, 744	19. 00
		W/S L, line	(Amounts from					
			L)					
		0	1.00	2.00	3.00	4. 00	5. 00	
20.00	Capital DRG other than outlier	1. 00	131, 229	C	116, 134	15, 095	131, 229	20.00
20. 01	Model 4 BPCI Capital DRG other	1. 01	0		C	0	0	20. 01
	than outlier							
21.00	Capital DRG outlier payments	2. 00	2, 231		1, 827	404	2, 231	21.00
21. 01	Model 4 BPCI Capital DRG	2. 01	0	(o c	0	0	21. 01
	outlier payments							
22.00	Indirect medical education	5. 00	0.0000	0.0000	0.0000	0.0000		22. 00
	percentage (see instructions)							
23.00	Indirect medical education	6. 00	0	(C	0	0	23. 00
	adjustment (see instructions)							
24.00	Allowable disproportionate	10.00	0.0000	0.0000	0.0000	0.0000		24. 00
	share percentage (see							
	instructions)							
25.00	Di sproporti onate share	11. 00	0		C	0	0	25. 00
	adjustment (see instructions)							
26.00	Total prospective capital	12.00	133, 460	C	117, 961	15, 499	133, 460	26. 00
	payments (see instructions)							
		W/S E, Part A	(Amounts to E,					
		line	Part A)					
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
27.00	Low volume adjustment factor				0. 163393	0. 174107		27. 00
28.00	Low volume adjustment	70. 96			308, 187		308, 187	28. 00
	(transfer amount to Wkst. E,							
	Pt. A, line)							
29.00	Low volume adjustment	70. 97				47, 109	47, 109	29. 00
	(transfer amount to Wkst. E,							
	Pt. A, line)							
100.00	Transfer low volume		Y					100.00
	adjustments to Wkst. E, Pt. A.							

Health Financial Systems	MORGAN COUNTY HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150038	From 01/01/2014	Worksheet E Part B Date/Time Prepared: 5/28/2015 1:03 pm
-	T' 11 \0/111	11 1 1	DDC

Next B				10 12/31/2014	5/28/2015 1:0	
Dear S	-		Title XVIII	Hospi tal		o piii
Next 8 - MeDICAL AND OTHER REALTH SERVICES 1.00 Medical and other services (see Instructions) 5.70 / 7.0			II ti o XVIII	nospi tui	113	
Next 8 - MeDICAL AND OTHER REALTH SERVICES 1.00 Medical and other services (see Instructions) 5.70 / 7.0					1.00	
Medical and other services (see instructions)		PART B - MEDICAL AND OTHER HEALTH SERVICES				
Medical and other services relieoursed under OPPS (see instructions) 5,707, 767 2,00	1.00				592	1.00
PS payments			ons)		5, 570, 767	2.00
0.001 Fire payment (see instructions) 0.000 5.00		· ·	,			•
Enter the fixes pital specific payment to cost ratio (see instructions) 0.000 5.00		1 ' 3				1
Line 2 times line 5 No. Sum of line 3 pius line 4 divided by line 6 0.00 7.00 8.00 I ransitional corridor payment (see instructions) 10. 10 ransitional payment (see instructions) 10. 10 ransitional payment (see instructions) 10. 10 ransitional payment (see instructions) 10. 10 ransitional payment (see instructions) 10. 10 ransitional payment (see instructions) 10. 10 ransitional payment (see instructions) 10 ransitional payment (see instructions) 10 ransitional payment (see instructions) 10 ransitional payment (see instructions) 10 ransitional payment (see instructions) 10 ransitional payment (see instructions) 10 ransitional payment (see instructions) 10 ransitional payment (see instructions) 10 ransitional payment (see instructions) 10 ransitional payment (see instructions) 10 ransi		, , , , , , , , , , , , , , , , , , , ,	ions)		l	
2.00 Sum of Tine 3 plus line 4 divided by line 6 0.00 7.00					ł	•
1 1 1 1 2 2 2 3 3 3 3 3 3 3						
		'			l	•
0.00 Organ acquisitions 0.10.00 0.00			col 13 line 200			1
1.00 Total cost (sun of lines 1 and 10) (see instructions) 592 11.00			, 66 10, 11.16 200			
COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges Reasonable charges Cost of Charges					1	
Reasonable charges	11.00				072	11.00
2.00 Ancil lary service charges 2,319 12.00 10.10						
13.00 Organ acquisition charges (from West. D-4, Pt. 111, line 69, col. 4) 0 Total reasonable to charges (sum or lines 12 and 13) 2,319 14. 00 Coustomary charges 0 15. 00 Aggregate amount actually collected from patients 1able for payment for services on a charge basis 0 16. 00 Amounts that would have been realized from patients 1able for payment for services on a chargebasis 0 16. 00 Amounts that would have been rade in accordance with 42 CFR \$413.13(e) 0 10. 00	12 00				2 319	12 00
14.00 Total reasonable charges (sum of lines 12 and 13) 13.00			1 4)		1	1
Customery_charges			,			ł
15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 16.00					2,017	
16. 00 Amounts that would have been realized from patients I able for payment for services on a chargebasis had such payment been made in accordance with 42 CFR \$413.13(e) 17.00 17.00 17.00 18.10 of file 15 to line 16 (not to exceed 1.000000) 17.00 18.00	15. 00		vment for services on a	charge basis	0	15. 00
had such payment been made in accordance with 42 CFR \$413.13(e)					l e	•
17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 2.0000000 17.00 18.00 19.00 Excess of customary charges see instructions) 2.319 18.00 19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see 1.727 19.00		· ·				
18. 00 Total customary charges (see instructions) 2. 319 18. 00	17. 00				0.000000	17. 00
19. 00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see 1,727 19. 00 1.727 19. 00 1					l .	•
instructions			if line 18 exceeds lin	ne 11) (see	l	1
20. 00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 0 20. 00 1 1 1 1 1 1 1 1 1				, (***	·	
Instructions	20.00	· ·	if line 11 exceeds lin	ne 18) (see	0	20.00
22.00 Interns and residents (see instructions) 0.20.00 23.00 23.00 23.00 23.00 25.00 70 total prospective payment (sum of lines 3, 4, 8 and 9) 23.00 23.				, ,		
23. 00 Cost of physicians' services in a teaching hospital (see instructions) 23. 00 23. 00 24. 00 Total prospective payment (sum of lines 3, 4, 8 and 9) 24. 00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 25. 00 Deductible sand coin surance (for CAH, see instructions) 813, 983 26. 00 27. 00 Subtotal ((lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23) (for CAH, see instructions) 2, 937, 630 27. 00 CAH, see instructions) 28. 00 Direct graduate medical education payments (from Wkst. E-4, line 50) 0 28. 00 29. 00	21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		592	21. 00
Total prospective payment (sum of lines 3, 4, 8 and 9) 2, 751,021 24, 00	22.00	Interns and residents (see instructions)			0	22. 00
COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance (For CAH, see instructions) 0 25. 00 26. 00 Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions) 813, 983 26. 00 27. 00 Subtotal ((lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23) (for 2, 937, 630 27. 00 28. 00 Direct graduate medical education payments (from Wkst. E-4, line 50) 0 28. 00 29. 00 SebB direct medical education costs (from Wkst. E-4, line 36) 0 29. 00 30. 00 Subtotal (sum of lines 27 through 29) 2, 937, 630 30. 00 31. 00 Primary payer payments 2, 567 31. 00 32. 00 Subtotal (line 30 minus line 31) 2, 935, 643 32. 00 33. 00 Composite rate ESBO (From Wkst. 1-5, line 11) 0 33. 00 34. 00 Allowable bad debts (see instructions) 1, 000 34. 00 35. 00 Allowable bad debts (see instructions) 1, 000 36. 00 36. 00 Allowable bad debts (see instructions) 1, 000 36. 00 37. 00 Subtotal (see instructions) 2, 935, 713 37. 00 38. 00 OTHER ADJUSTIMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39. 00 39. 90 OTHER ADJUSTIMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39. 99 40. 00 Subtotal (see instructions) 2, 935, 713 40. 00 40. 01 Sequestration adjustment (see instructions) 2, 935, 713 40. 00 40. 01 Sequestration adjustment (see instructions) 2, 935, 713 40. 00 40. 01 Sequestration adjustment (see instructions) 0 90. 00 40. 00 The triangle and the second and subtractives only 10 40. 00 41. 00 The triangle and subtractives only 10 40. 00 42. 00 The triangle and subtractives only 10 40. 00 43. 00 Sala ance due provider/program (see instructions) 0 90. 00 40. 00 The triangle and subtractives only 0 90. 00 40. 00 The triangle and subtractions 0 90. 00 40. 00 The triangle and subtractions 0 90. 00 40. 00 The triangle and subtractions 0 90. 00 40. 00 The triangle and subtractions 0 90. 00 40.	23.00	Cost of physicians' services in a teaching hospital (see instru-	ctions)		0	23. 00
COMPUTATION OF REIMBURSEMENT SETTLEMENT	24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	ŕ		3, 751, 021	24. 00
26.00 Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions) 813,983 26.00 27.00 Subtotal ((lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23) (for CAH, see instructions) 2,937,630 27.00 28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 0 29.00 29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 0 29.00 31.00 Primary payer payments 2, 237, 630 30.00 32.00 Subtotal (line 30 minus line 31) 2, 935, 063 31.00 Primary payer payments 2, 935, 063 32.00 Subtotal (line 30 minus line 31) 2, 935, 063 32.00 Composite rate ESRD (from Wkst. I-5, line 11) 0 34.00 Allowable bad debts (see instructions) 1, 000 35.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 1, 000 36.00 MSUbtotal (see instructions) 2, 935, 713 39.00 MSP-LCC reconciliation amount from PS&R 0 0 0THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.99		COMPUTATION OF REIMBURSEMENT SETTLEMENT				
27.00 Subtotal ((lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23) (for CAH, see instructions) 28.00 28.00 29.00 29.00 28.00 29.00 28.00 29.00	25.00	Deductibles and coinsurance (for CAH, see instructions)			0	25. 00
CAH, see instructions	26.00	Deductibles and Coinsurance relating to amount on line 24 (for	CAH, see instructions)		813, 983	26. 00
28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) ESRD direct medical education costs (from Wkst. E-4, line 36) 0 28.00 29.00 30.00 Subtotal (sum of lines 27 through 29) 2,937,630 30.00 31.00 Primary payer payments 2,567 31.00 2,935,063 32.00 2,935,063 32.00 2,935,063 32.00 2,935,063 32.00 2,935,063 32.00 32.00 2,935,063 32.00 32.0	27.00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) plu	us the sum of lines 22	and 23} (for	2, 937, 630	27. 00
29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 0 29.00 30.00		CAH, see instructions)				
30. 00 Subtotal (sum of lines 27 through 29) 2,937,630 30. 00 31. 00 Primary payer payments 2,567 31. 00 2,935,043 32. 00 32. 00 32. 00 32. 00 32. 00 32. 00 32. 00 32. 00 33.	28. 00	Direct graduate medical education payments (from Wkst. E-4, line	e 50)		0	28. 00
31.00 Primary payer payments 2,567 31.00 Subtotal (line 30 minus line 31) 2,935,063 32.00 AlLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Allowable bad debts (see instructions) 1,000 34.00 Allowable bad debts (see instructions) 650 35.00 Adjusted reimbursable bad debts (see instructions) 1,000 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 1,000 36.00 37.00 Subtotal (see instructions) 2,935,713 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 39.00 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 0 39.50 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.98 39.99 Acceleration adjustment (see instructions) 58,714 40.01 41.00 Interim payments 2,876,289 41.00 42.00 Tentative settlement (for contractors use only) 42.00 Tentative settlement (for contractors use only) 710 810 ECOMPLETED BY CONTRACTOR 710 7	29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
32.00 Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	30.00	Subtotal (sum of lines 27 through 29)			2, 937, 630	30. 00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33. 00 Composite rate ESRD (from Wkst. I - 5, I in e 11) 0 33. 00 34. 00 All lowable bad debts (see instructions) 1,000 34. 00 35. 00 Adjusted reimbursable bad debts (see instructions) 650 35. 00 36. 00 All owable bad debts for dual eligible beneficiaries (see instructions) 1,000 36. 00 37. 00 Subtotal (see instructions) 2,935,713 37. 00 38. 00 MSP-LCC reconciliation amount from PS&R 0 38. 00 39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39. 00 39. 90 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39. 90 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 98 40. 00 Subtotal (see instructions) 2,935,713 40. 00 40. 01 Sequestration adjustment (see instructions) 2,876,289 41. 00 41. 00 Interim payments 2,876,289 41. 00 42. 00 Tentative settlement (for contractors use only) 41. 00 44. 00 Fortested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 175 44. 00 50. BE COMPLETED BY CONTRACTOR 0 90. 00 91. 00 Outlier reconciliation adjustment amount (see instructions) 0 91. 00 92. 00 The rate used to calculate the Time Value of Money 0. 00 92. 00 93. 00 Time Value of Money (see instructions) 0 93. 00	31. 00				2, 567	31.00
33.00 Composite rate ESRD (from Wkst. I-5, line 11) 33.00 34.00 34.00 Allowable bad debts (see instructions) 1,000 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 1,000 35.00 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 1,000 36.00 37.00 Subtotal (see instructions) 2,935,713 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 39.95 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.50 39.98 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.00 Subtotal (see instructions) 2,935,713 40.00 40.01 Sequestration adjustment (see instructions) 2,935,713 40.00 40.01 Sequestration adjustment (see instructions) 2,876,289 41.00 41.00 Interim payments 2,876,289 41.00 42.00 Tentative settlement (for contractors use only) 37.00 43.0	32.00				2, 935, 063	32. 00
34.00			S)			
35.00 Adjusted reimbursable bad debts (see instructions) 35.00 36.00 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 1,000 36.00 37.00 38.00 MSP-LCC reconciliation amount from PS&R 2,935,713 37.00 39.00 MSP-LCC reconciliation amount from PS&R 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 0 39.90 39.90 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.00 Subtotal (see instructions) 2,935,713 40.00 40.01 Sequestration adjustment (see instructions) 2,935,713 40.00 41.00 Interim payments 2,876,289 41.00 42.00 43.00 Balance due provider/program (see instructions) 44.00 Fortested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 175 44.00 1515.2 10.00 10.						ł
36. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 1,000 36. 00 37. 00 Subtotal (see instructions) 2,935,713 37. 00 38. 00 MSP-LCC reconciliation amount from PS&R 0 38. 00 39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39. 00 39. 50 Pioneer ACO demonstration payment adjustment (see instructions) 0 39. 90 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 99 40. 01 Sequestration adjustment (see instructions) 2, 935, 713 40. 00 40. 01 Sequestration adjustment (see instructions) 2, 935, 713 40. 00 41. 00 Interim payments 2, 876, 289 41. 00 42. 00 Tentative settlement (for contractors use only) 0 42. 00 43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 175 44. 00 41. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 175 44. 00 90. 00 Original outlier a					1, 000	34. 00
37. 00 Subtotal (see instructions) 38. 00 MSP-LCC reconciliation amount from PS&R 99. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39. 50 Pioneer ACO demonstration payment adjustment (see instructions) 99. 89 Partial or full credits received from manufacturers for replaced devices (see instructions) 99. 99 RECOVERY OF ACCELERATED DEPRECIATION 90. 00 Subtotal (see instructions) 10 39. 99 11 Payments 12, 935, 713 12 Payments 13 Payments 14 Payments 15 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 175 15 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 175 11 Protested amounts (see instructions) 12 Protested amounts (see instructions) 13 Payments 14 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 175 15 Protested amounts (see instructions) 15 Protested amounts (see instructions) 16 Protested amounts (see instructions) 17 Protested amounts (see instructions) 18 Partial or full credits received from manufacturers for replaced devices (see instructions) 19 Partial or full credits received from manufacturers for replaced devices (see instructions) 10 99. 00 43. 00 10 Subtotal (see instructions) 10 99. 00 11 Protested amounts (nonal outles of manufacturers for replaced devices (see instructions) 10 99. 00 11 Protested amounts (see instructions) 10 99. 00 11 Protested amounts (see instructions) 12 Protested amounts (see instructions) 13 Protested amounts (see instructions) 14 Protested amounts (see instructions) 15 Protested amounts (see instructions) 16 Protested amounts (see instructions) 17 Protested amounts (see instructions) 18 Partial or full credits received from manufacturers for replaced devices (see instructions) 19 Partial or full credits received from manufacturers for replaced devices (see instructions) 20 Page (see instructions) 21 Page (see instructions) 22 Page (see instructions) 23 Page (see instructions) 24		1 3				
38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 0 39.50 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.99 40.00 Subtotal (see instructions) 2, 935, 713 40.00 40.01 Sequestration adjustment (see instructions) 58, 714 40.01 41.00 Interim payments 2, 876, 289 41.00 42.00 Tentative settlement (for contractors use only) 58alance due provider/program (see instructions) 710 43.00 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 175 44.00 41.00 Original outlier amount (see instructions) 0 90.00 42.00 The rate used to calculate the Time Value of Money (see instructions) 0 93.00 43.00 Time Value of Money (see instructions) 0 93.00		Allowable bad debts for dual eligible beneficiaries (see instruc	ctions)		1, 000	36. 00
39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.50 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 RECOVERY OF ACCELERATED DEPRECIATION 40.00 Subtotal (see instructions) 40.01 Sequestration adjustment (see instructions) 41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 175 Si15.2 TO BE COMPLETED BY CONTRACTOR 90.00 Outlier reconciliation adjustment amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions)	37. 00	Subtotal (see instructions)			2, 935, 713	37. 00
39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.98 RECOVERY OF ACCELERATED DEPRECIATION 39.99 40.00 Subtotal (see instructions) 40.01 Sequestration adjustment (see instructions) 41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 71.00 Outlier reconciliation adjustment amount (see instructions) 72.00 The rate used to calculate the Time Value of Money 73.00 Time Value of Money (see instructions) 74.00 Outlier of Money (see instructions) 75.00 Outlier reconciliation adjustment amount (see instructions) 76.00 Outlier of Money (see instructions) 77.00 Outlier of Money (see instructions) 78.00 Outlier of Money (see instructions) 79.00 Outlier of Money (see instructions) 79.00 Outlier of Money (see instructions) 79.00 Outlier of Money (see instructions)	38. 00				0	38. 00
39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.98 RECOVERY OF ACCELERATED DEPRECIATION 40.00 Subtotal (see instructions) 50.39.99 40.00 Subtotal (see instructions) 50.39.99 40.00 Sequestration adjustment (see instructions) 50.00 Sequestration adjustment (see instructions) 60.01 Interim payments 70.00 Tentative settlement (for contractors use only) 80.00 Balance due provider/program (see instructions) 710 43.00 710 43.00 711 43.00 711 43.00 711 75 44.00 711 75 75 75 75 75 75 75 75 75 75 75 75 75	39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			l .	1
39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 99 40. 00 Subtotal (see instructions) 2, 935, 713 40. 00 40. 01 5 58, 714 40. 01 1 1 1 1 1 1 1 1 1	39. 50				0	39. 50
40.00 Subtotal (see instructions) 40.01 Sequestration adjustment (see instructions) 41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Bal ance due provider/program (see instructions) 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 175 44.00 41.00 Original outlier amount (see instructions) 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money 10.00 Original outlier of Money (see instructions) 11.00 Original outlier amount (see instructions) 12.935, 713 40.00 42.00 42.00 43.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 175 44.00 90.00 Original outlier amount (see instructions) 12.935, 713 40.00 91.00 Original outlier amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 175 44.00 91.00 Original outlier amount (see instructions) 10.00 Original outlier amount (see instructions) 11.00 Outlier reconciliation adjustment amount (see instructions) 12.935, 713 40.00 92.00 Original outlier amounts (see instructions) 13.00 Original outlier amount (see instructions) 14.00 Original outlier amount (see instructions) 15.00 Original outlier amount (see instructions) 16.00 Original outlier amount (see instructions) 17.00 Original outlier amount (see instructions) 18.00 Original outlier amount (see instructions) 19.00 Original outlier amount (see instructions)	39. 98	Partial or full credits received from manufacturers for replaced	d devices (see instruct	i ons)	0	39. 98
40.01 Sequestration adjustment (see instructions) 41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\frac{5115.2}{10 \text{ BE COMPLETED BY CONTRACTOR}}{\text{Original outlier amount (see instructions)}} 90.00 Outlier reconciliation adjustment amount (see instructions) 91.00 The rate used to calculate the Time Value of Money 92.00 Time Value of Money (see instructions) 10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
41.00 Interim payments 2, 876, 289 41.00 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 175 43.00 44.00 Original outlier amount (see instructions) 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Og 42.00 95.00 Og 90.00 96.00 Og 90.00 97.00 Og 90.00	40.00	Subtotal (see instructions)			2, 935, 713	40. 00
42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 175 44.00 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions)	40. 01	Sequestration adjustment (see instructions)			58, 714	40. 01
43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 175 44.00 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Time Value of Money (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions) 98.00 Outlier reconciliation adjustment amount (see instructions) 99.00 Outlier reconciliation adjustment amount (see instructions)	41.00	Interim payments			2, 876, 289	41. 00
44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 93.00 To See The Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 175 44.00 44.00 45.00 Fig. 100 45.00 Fig. 100 45.00 Fig. 100 45.00 Fig. 1	42.00	Tentative settlement (for contractors use only)			0	42. 00
\$115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions)	43.00	Balance due provider/program (see instructions)			710	43.00
TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions)	44.00		e with CMS Pub. 15-2, c	chapter 1,	175	44. 00
90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 90.00 91.00 92.00 93.00						
91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 91.00 92.00 93.00						
92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0.00 92.00 93.00						
93.00 Time Value of Money (see instructions) 0 93.00					l	1
		1			l	
94.00 Total (sum of lines 91 and 93) 0 94.00					l .	1
	94.00	Total (sum of lines 91 and 93)		ļ	ı O	94.00

Health Financial Systems MOANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

						5/28/2015 1:03	3 pm
			tle XVIII		Hospi tal	PPS	
		Inpat	Inpatient Part A		Par	t B	
		mm/dd/yyy	/ Amo	ount	mm/dd/yyyy	Amount	
		1.00	2.	00	3. 00	4. 00	
1.00	Total interim payments paid to provider		2,	013, 169		2, 876, 289	1. 00
2.00	Interim payments payable on individual bills, either			0		0	2. 00
	submitted or to be submitted to the contractor for						
	services rendered in the cost reporting period. If none,						
3. 00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment						3. 00
3.00	amount based on subsequent revision of the interim rate						3.00
	for the cost reporting period. Also show date of each						
	payment. If none, write "NONE" or enter a zero. (1)						
	Program to Provider						
3. 01	ADJUSTMENTS TO PROVIDER			0		0	3. 01
3.02				0		0	3. 02
3.03				0		o	3. 03
3.04				0		0	3. 04
3.05				0		0	3. 05
	Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM			0		0	3. 50
3. 51				0		0	3. 51
3. 52				0		0	3. 52
3.53				0		0	3. 53
3.54	Cultural (1 in 2 01 2 40 minus 1 in			0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0		0	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		2	013, 169		2, 876, 289	4. 00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as			013, 109		2, 070, 209	4.00
	appropriate)						
	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			_1			
5. 01	TENTATI VE TO PROVI DER			0		0	5. 01
5. 02 5. 03				0		0	5. 02 5. 03
5.03	Provider to Program			U		U	5. 03
5. 50	TENTATI VE TO PROGRAM			0		0	5. 50
5. 51	TENTATI VE TO TROOKAW			0			5. 51
5. 52				0		o o	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0		Ö	5. 99
	5. 50-5. 98)						
6.00	Determined net settlement amount (balance due) based on						6. 00
	the cost report. (1)						
6. 01	SETTLEMENT TO PROVIDER			212, 225		710	6. 01
6. 02	SETTLEMENT TO PROGRAM			0		0	6. 02
7. 00	Total Medicare program liability (see instructions)		2,	225, 394		2, 876, 999	7. 00
					Contractor	NPR Date	
			0		Number 1.00	(Mo/Day/Yr)	
8. 00	Name of Contractor		U		1.00	2. 00	8. 00
0.00	maine or contractor	l		l		ı l	0.00

Health Financial Systems MOANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Inpatient Part A			Ti tl	e XVIII	Subprovi der -	PPS	
1.00 10tal Interim payments paid to provider 1.00 2.00 3.00 4.00 1.00			Inpatien	t Part A		t B	
1.00 10tal Interim payments paid to provider 1.00 2.00 3.00 4.00 1.00			mm/dd/vvvv	Amount	mm/dd/vvvv	Amount	
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.							
Submitted or to be Submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 Use 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)	1.00	Total interim payments paid to provider		1, 880, 491		0	1. 00
Services rendered in the cost reporting period. If none, write "NONE" or enter a zero.	2.00			C)	0	2. 00
Write "NONE" or enter a zero							
List separately each retroactive Lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)							
amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	3 00						3 00
payment. If none, write "NONE" or enter a zero. (1)	0.00						0.00
Program to Provider							
ADJUSTMENTS TO PROVIDER							
3.02 0						T	
3.03 0		ADJUSTMENTS TO PROVIDER					
3.04 0							
ADJUSTMENTS TO PROGRAM				١ - `	1		
Provider to Program ADJUSTMENTS TO PROGRAM 0 0 3.50 3.51 3.52 0 0 0 3.51 3.52 0 0 0 3.51 3.52 3.53 3.54 0 0 0 3.53 3.54 3.99 3.50-3.98 0 0 0 3.53 3.54 3.99 3.50-3.98 0 0 0 3.59 3.50-3.98 0 0 0 3.59 3.50-3.98 0 0 0 3.59 3.50-3.98 0 0 0 0 3.59 3.50-3.98 0 0 0 0 0 0 0 0 0							
3.51 0	0.00	Provider to Program			1		0.00
3.52 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.53 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.59 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.59 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.59 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.59 Subtotal (sum of lines 1, 2, and 3.99) 1,880,491 O 4.00	3.50	ADJUSTMENTS TO PROGRAM		C)	0	3. 50
3.53 3.54 3.54 3.54 3.54 3.54 3.54 3.54 3.54 3.55 3.57 3.98 3.50-3.98 3.50							
3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 1,880,491 0 4.00 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR							
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)					1		
3.50-3.98 Total interim payments (sum of lines 1, 2, and 3.99 1,880,491 0 4.00		Subtatal (sum of lines 2 01 2 40 minus sum of lines		·	1	1	
1,880,491 0 4.00	3. 99	· ·			,	U	3. 99
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR	4.00	1 2 2 2 2 2 2		1, 880, 491		o	4. 00
TO BE COMPLETED BY CONTRACTOR				, ,			
List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider			Г	Г			
Write "NONE" or enter a zero. (1) Program to Provider	5.00						5. 00
Program to Provider							
TENTATI VE TO PROVI DER							
Description Description	5. 01			C)	0	5. 01
Provider to Program	5.02						5. 02
TENTATI VE TO PROGRAM 0	5.03			()	0	5. 03
5.51 5.52 5.52 5.53 5.55	F F0				\		F F0
Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.52 0		TENTATIVE TO PROGRAM					
Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)				١ - `	1		
5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 1,880,492 Contractor Number (Mo/Day/Yr) 0 1.00 2.00		Subtotal (sum of lines 5.01-5.49 minus sum of lines		1			
the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions) 1,880,492 Contractor Number (Mo/Day/Yr) 0 1. 00 2. 00							
6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 1 0 6.01 0 0 6.02 7.00 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	6.00						6. 00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00						_	
7.00 Total Medicare program liability (see instructions) 1,880,492 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00]			
Contractor NPR Date Number (Mo/Day/Yr) 0 1.00 2.00		· ·		١ - `	1		
Number (Mo/Day/Yr) 0 1.00 2.00	7.00	Tiotal medicale program frability (see first detroits)		1, 000, 472	_		7.00
8.00 Name of Contractor 8.00			()	1. 00	2. 00	
	8.00	Name of Contractor					8. 00

Heal th	u of Form CMS-2	2552-10					
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 150038 Period: From 01/01/2014							
	From 01/01/2014 Part II To 12/31/2014 Date/Time Prepa 5/28/2015 1:03						
		Title XVIII	Hospi tal	PPS	<u>5 piii </u>		
				1. 00			
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORT						
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULAT						
1.00	Total hospital discharges as defined in AARA §4102 from Wk	14	540 944	1. 00 2. 00			
2.00							
3.00							
4.00							
5.00							
6.00							
7.00	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	5)		686, 000	8. 00		
9.00	Sequestration adjustment amount (see instructions)	13, 720	9.00				
10.00					10.00		
	10. 00 Calculation of the HIT incentive payment after sequestration (see instructions) 672, 280 INPATIENT HOSPITAL SERVICES UNDER PPS & CAH						
30.00	0.00 Initial/interim HIT payment adjustment (see instructions)				30.00		
31.00	1.00 Other Adjustment (specify)						
32. 00	32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions) 333,933						

Health Financial Systems	MORGAN COUNTY HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150038		Worksheet E-3
		From 01/01/2014	
	Component CCN: 15SO38	To 12/31/2014	
			5/28/2015 1:03 pm
	Title XVIII	Subprovi der -	PPS
		I PF	

	IPF		
		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS	1.00	
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	2, 059, 221	1.00
2.00	Net IPF PPS Outlier Payments	0	2.00
3.00	Net IPF PPS ECT Payments	0	3. 00
4. 00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4. 00
4. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4. 01
5.00	New Teaching program adjustment. (see instructions)	0.00	5. 00
6. 00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6. 00
7. 00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7. 00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8. 00
9.00	Average Daily Census (see instructions)	7. 572603	
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0. 000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11. 00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	2, 059, 221	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13. 00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14. 00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15. 00
16.00	Subtotal (see instructions)	2, 059, 221	16. 00
17.00	Primary payer payments	0	17. 00
18.00	Subtotal (line 16 less line 17).	2, 059, 221	18. 00
19.00	Deducti bl es	133, 664	19. 00
20.00	Subtotal (line 18 minus line 19)	1, 925, 557	20.00
21.00	Coinsurance	6, 688	21. 00
22.00	Subtotal (line 20 minus line 21)	1, 918, 869	22. 00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	23. 00
24.00	Adjusted reimbursable bad debts (see instructions)	0	24. 00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	25. 00
26.00	Subtotal (sum of lines 22 and 24)	1, 918, 869	26. 00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27. 00
28.00	Other pass through costs (see instructions)	0	28. 00
29.00	Outlier payments reconciliation	0	29. 00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30. 50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30. 50
30. 99	Recovery of Accelerated Depreciation	0	30. 99
31.00	Total amount payable to the provider (see instructions)	1, 918, 869	31.00
31. 01	Sequestration adjustment (see instructions)	38, 377	31. 01
32.00	Interim payments	1, 880, 491	32. 00
33.00	Tentative settlement (for contractor use only)	0	33. 00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)	1	34. 00
35. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35. 00
	TO BE COMPLETED BY CONTRACTOR	•	
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	0	50.00
	Outlier reconciliation adjustment amount (see instructions)	0	
52. 00	, , ,		52. 00
	Time Value of Money (see instructions)		53. 00

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

Period: Worksheet G From 01/01/2014 To 12/31/2014 Date/Time Prepared: 5/28/2015 1:03 pm

					5/28/2015 1:0	3 pm
		General Fund	Speci fi c	Endowment Fund		
		1 00	Purpose Fund	2.22		
	AUDDENT AGGETG	1.00	2. 00	3. 00	4. 00	
1 00	CURRENT ASSETS	2 100 027	,			1 00
1.00	Cash on hand in banks	3, 190, 037			0	
2.00	Temporary investments	0		-		
3.00	Notes recei vable	2 225 041	1	0	0	
4.00	Accounts receivable	3, 225, 941		0		1
5. 00 6. 00	Other receivable Allowances for uncollectible notes and accounts receivable	1, 547, 195			0	
7. 00	Inventory	498, 508	1			
8. 00	Prepai d expenses	512, 013			0	
9. 00	Other current assets	312,013			0	1
10. 00	Due from other funds			,	0	
11. 00	Total current assets (sum of lines 1-10)	8, 973, 694	1	-	1	1
11.00	FI XED ASSETS	0, 773, 074		<u>, </u>		11.00
12. 00	Land	2, 703, 239) (0	0	12. 00
13. 00	Land improvements	2,703,237			1	
14. 00	Accumul ated depreciation		1	o o		
15. 00	Bui I di ngs	18, 240, 372		-	l ő	
16. 00	Accumulated depreciation	-3, 452, 303	1	-	Ö	
17. 00	Leasehold improvements	0, 102, 000		-	o o	
18. 00	Accumulated depreciation	0		0	l o	
19. 00	Fi xed equipment	0		o o	Ō	
20. 00	Accumul ated depreciation	0		0	0	
21. 00	Automobiles and trucks	0		0	0	
22. 00	Accumul ated depreciation	0		0	0	
23. 00	Major movable equipment	12, 993, 826		0	0	
24. 00	Accumul ated depreciation	-8, 178, 955	1	0	0	
25. 00	Mi nor equi pment depreci abl e	0		0	0	25. 00
26.00	Accumulated depreciation	0		o	0	26. 00
27.00	HIT designated Assets	0) (0	0	27. 00
28. 00	Accumulated depreciation	0) (0	0	28. 00
29.00	Mi nor equi pment-nondepreci abl e	0) (0	0	29. 00
30.00	Total fixed assets (sum of lines 12-29)	22, 306, 179) (0	0	30.00
	OTHER ASSETS					1
31.00	Investments	0) (0	0	31. 00
32.00	Deposits on Leases	0)	0	0	32. 00
33.00	Due from owners/officers	0)	0	0	33. 00
34.00	Other assets	4, 459, 691	(0	0	34. 00
35. 00	Total other assets (sum of lines 31-34)	4, 459, 691		0	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	35, 739, 564	. (0	0	36. 00
	CURRENT LIABILITIES					1
37. 00	Accounts payable	1, 845, 101	1	0		1
38. 00	Salaries, wages, and fees payable	2, 889, 366	1	-	l	
39. 00	Payroll taxes payable	0)	0	0	1
40. 00	Notes and Loans payable (short term)	41, 991		0	0	
41. 00	Deferred income	0)	0	0	
42. 00	Accel erated payments	0)			42. 00
43. 00	Due to other funds	586, 463	1	0	0	
44.00	Other current liabilities	0	1	1	0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	5, 362, 921	(0	0	45. 00
44 00	LONG TERM LIABILITIES	1 ^	1			44 00
46. 00	Mortgage payable	E 001		1	0	
47. 00	Notes payable	5, 091		-	l .	1
48. 00	Unsecured Loans	04 747		-	1	
49. 00	Other long term liabilities	94, 747		-		1
50.00	Total long term liabilities (sum of lines 46 thru 49	99, 838		0 0		
51. 00	Total liabilites (sum of lines 45 and 50) CAPITAL ACCOUNTS	5, 462, 759	1	<u> </u>	0	51.00
52. 00	General fund balance	30, 276, 805				52. 00
53. 00	Specific purpose fund	30, 270, 603	'			53.00
54. 00	Donor created - endowment fund balance - restricted			1		54.00
55. 00	Donor created - endowment fund balance - restricted					55.00
56. 00	Governing body created - endowment fund balance					56.00
57. 00	Plant fund balance - invested in plant				0	1
58. 00	Plant fund balance - reserve for plant improvement,				0	
50.00	replacement, and expansion					30.00
59. 00	Total fund balances (sum of lines 52 thru 58)	30, 276, 805	i (n l	0	59. 00
60. 00	Total liabilities and fund balances (sum of lines 51 and	35, 739, 564		o o	Ö	
	59)]			

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES MORGAN COUNTY HOSPITAL

					To 12/31/201	4 Date/Time Pre 5/28/2015 1:0	
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) CHANGE IN UNRESTRICTED FUND BAL	0 -4, 138, 535 0	35, 118, 725 -703, 385 34, 415, 340		O O O	0 0 0	5. 00
7. 00 8. 00 9. 00 10. 00	Total additions (sum of line 4-9)	0 0 0	-4, 138, 535		0 0 0	0 0	8. 00 9. 00 10. 00
11. 00 12. 00 13. 00 14. 00 15. 00 16. 00	Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0 0 0 0	30, 276, 805		0 0 0 0	0 0 0 0 0 0 0 0	13. 00 14. 00 15. 00
17. 00 18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 Endowment Fund	0 30, 276, 805 Pl ant	Fund	0	0	17. 00 18. 00 19. 00
		Lindowillett Turid	Trant	Tuliu			
		6.00	7. 00	8. 00			
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) CHANGE IN UNRESTRICTED FUND BAL	0	0 0 0		0		1. 00 2. 00 3. 00 4. 00 5. 00 6. 00
7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0	0 0 0 0 0 0		0		7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00
17. 00 18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0	0		0		17. 00 18. 00 19. 00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 150038 Peri od: Worksheet G-2 From 01/01/2014 Parts I & II Date/Time Prepared: 12/31/2014 5/28/2015 1:03 pm Cost Center Description Inpati ent Outpati ent Total 1.00 2. 00 3.00 PART I - PATIENT REVENUES General Inpatient Routine Services 1.00 Hospi tal 1, 689, 328 1, 689, 328 2.00 SUBPROVIDER - IPF 4, 903, 336 4, 903, 336 2.00 SUBPROVIDER - IRF 3.00 0 3.00 0 4.00 SUBPROVI DER 0 4.00 Swing bed - SNF Swing bed - NF 5.00 0 0 5.00 6.00 0 0 6.00 SKILLED NURSING FACILITY 0 7.00 0 7.00 8.00 NURSING FACILITY 0 0 8.00 9.00 OTHER LONG TERM CARE 0 9.00 10.00 Total general inpatient care services (sum of lines 1-9) 6, 592, 664 6, 592, 664 10 00 Intensive Care Type Inpatient Hospital Services 11.00 INTENSIVE CARE UNIT 2, 215, 024 2, 215, 024 11.00 12.00 CORONARY CARE UNIT 12.00 0 0 BURN INTENSIVE CARE UNIT 13 00 0 13 00 0 SURGICAL INTENSIVE CARE UNIT 0 14.00 0 14.00 15.00 OTHER SPECIAL CARE (SPECIFY) 15.00 Total intensive care type inpatient hospital services (sum of lines 16, 00 2, 215, 024 2, 215, 024 16, 00 11 - 15) 8, 807, 688 17.00 Total inpatient routine care services (sum of lines 10 and 16) 8, 807, 688 17.00 18.00 Ancillary services 9, 253, 801 83, 989, 873 93, 243, 674 18.00 Outpatient services 391, 463 2, 308, 678 2, 700, 141 19.00 19.00 RURAL HEALTH CLINIC 20.00 0 0 0 20.00 0 21.00 FEDERALLY QUALIFIED HEALTH CENTER 0 0 21.00 22.00 HOME HEALTH AGENCY 0 22.00 0 23.00 AMBULANCE SERVICES 0 23.00 CMHC 24.00 Λ 24.00 0 24. 10 CORF 0 0 24. 10 AMBULATORY SURGICAL CENTER (D. P.) 0 0 25.00 25.00 26.00 0 26.00 HOSPI CE 0 PHYSICIAN OFFICES 118, 960 1, 460, 481 1, 579, 441 27.00 27.00 28.00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. 18, 571, 912 87, 759, 032 106, 330, 944 28.00 line 1) PART II - OPERATING EXPENSES 29.00 36, 090, 428 29 00 Operating expenses (per Wkst. A, column 3, line 200) 30.00 ADD (SPECIFY) 0 30.00 0 31.00 31.00 32.00 0 32.00 0 33.00 33.00 0 34.00 34.00 35.00 0 35.00 Total additions (sum of lines 30-35) 36, 00 0 36, 00 DEDUCT (SPECIFY) 37.00 37.00

0

0

0

36, 090, 428

38.00

39.00

40.00

41.00

42.00

43.00

38.00

39.00

40.00

41.00

42.00

43.00

Total deductions (sum of lines 37-41)

to Wkst. G-3, line 4)

Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer

Heal th	Financial Systems MORGAN COUNTY HO	SPI TAI		Inlie	u of Form CMS-2	2552-10
	ENT OF REVENUES AND EXPENSES	Provi der CCN: 1	150038	Peri od:	Worksheet G-3	1002 10
				From 01/01/2014 To 12/31/2014	Date/Time Prep 5/28/2015 1:03	
1 00		22)			1.00	1 00
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line				106, 330, 944	1.00
2.00	Less contractual allowances and discounts on patients' accounts				72, 114, 139	2. 00
3.00	Net patient revenues (line 1 minus line 2)	`			34, 216, 805	3. 00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)			36, 090, 428	4. 00
5.00	Net income from service to patients (line 3 minus line 4)				-1, 873, 623	5. 00
	OTHER I NCOME				00.000	, 00
6.00	Contributions, donations, bequests, etc				20, 000	6. 00
7.00	Income from investments		41, 384 0	7. 00 8. 00		
8.00						
9.00						
	10. 00 Purchase di scounts					
	11. 00 Rebates and refunds of expenses					
12.00	Parking lot receipts				0	12. 00 13. 00
	3.00 Revenue from laundry and linen service					
14.00	Revenue from meals sold to employees and guests				103, 566 0	14. 00 15. 00
	5.00 Revenue from rental of living quarters					
	16.00 Revenue from sale of medical and surgical supplies to other than patients					
17. 00	1		8, 120			
	Revenue from sale of medical records and abstracts		0 4, 655	18. 00		
	00 Tuition (fees, sale of textbooks, uniforms, etc.)					
	Revenue from gifts, flowers, coffee shops, and canteen					20. 00
21. 00	1		10, 678			
22. 00			475, 010			
23. 00	Governmental appropriations	372, 942				
24. 00		133, 883				
25. 00		1, 170, 238				
	Total (line 5 plus line 25)		-703, 385			
	OTHER EXPENSES (SPECIFY)		0	27. 00		
	Total other expenses (sum of line 27 and subscripts)		0	28. 00		
29. 00	Net income (or loss) for the period (line 26 minus line 28)			l	-703, 385	29.00

14.00 Carryover of accumulated capital minimum payment level over capital payment	N: 150038	Peri od: From 01/01/2014 To 12/31/2014					
CAPITAL FEDERAL AMOUNT Capital DRG other than outlier 1.01 Model 4 BPCl Capital DRG other than outlier Capital DRG outlier payments Model 4 BPCl Capital DRG outlier payments 3.00 Total inpatient days divided by number of days in the cost reporting period Number of interns & residents (see instructions) 1.00 Number of interns & residents (see instructions) 1.01 Indirect medical education percentage (see instructions) 1.02 Indirect medical education adjustment (multiply line 5 by the sum of lines 1 Percentage of SSI recipient patient days to Medicare Part A patient days (Wo 30) (see instructions) 3.00 Percentage of Medicaid patient days to total days (see instructions) 3.00 Sum of lines 7 and 8 1.00 Allowable disproportionate share percentage (see instructions) 11.00 Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01) 12.00 Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11) PART II - PAYMENT UNDER REASONABLE COST Program inpatient ancillary capital cost (see instructions) 1.00 Total inpatient program capital cost (see instructions) 3.00 Total inpatient program capital cost (line 1 plus line 2) 4.00 Capital cost payment factor (see instructions) 7.00 Program inpatient capital costs (see instructions) 8.00 Total inpatient capital costs (see instructions) 8.00 Total inpatient capital costs (see instructions) 8.00 Total inpatient capital costs (see instructions) 8.00 Total inpatient capital costs (see instructions) 8.00 Applicable exception percentage (see instructions) 8.00 Capital cost for comparison to payments (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital minimum payment level for extraordinary circumstances (see instructions) 8.00 Capital minimum payment level for extraordinary circumstances (capital minimum payment level to capital payments (line 10 plus line 7) 8.00 Current year comparison of capital minimum payment level to capital payment Worksheet L, Part III, line 14) 8.00 Carryov	VIII	Hospi tal	PPS	з рп			
CAPITAL FEDERAL AMOUNT Capital DRG other than outlier Capital DRG other than outlier Capital DRG outlier payments Model 4 BPCI Capital DRG outlier payments Model 4 BPCI Capital DRG outlier payments Total inpatient days divided by number of days in the cost reporting period Number of interns & residents (see instructions) Indirect medical education percentage (see instructions) Indirect medical education adjustment (multiply line 5 by the sum of lines 1 Percentage of SSI recipient patient days to Medicare Part A patient days (Wo 30) (see instructions) Percentage of Medicaid patient days to total days (see instructions) Percentage of Medicaid patient days to total days (see instructions) Sum of lines 7 and 8 Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01) Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11) PART II - PAYMENT UNDER REASONABLE COST Program inpatient ancillary capital cost (see instructions) Program inpatient routine capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) Total inpatient capital costs (see instructions) Program inpatient capital costs (see instructions) Program inpatient capital costs (see instructions) Program inpatient capital costs (see instructions) Or lotal inpatient capital costs (see instructions) Or lotal inpatient capital costs (see instructions) Or percentage adjustment for extraordinary circumstances (see instructions) Adjustment to capital minimum payment level for extraordinary circumstances Capital minimum payment level (line 5 plus line 7) Current year comparison of capital minimum payment level to capital payments Carryover of accumulated capital minimum payment level voer capital payment Worksheet L, Part III, I ine 14) Net comparison of accumulated capital minimum payment level voer capital payment Worksheet L, Part III, line 14)							
CAPITAL FEDERAL AMOUNT Capital DRG other than outlier Capital DRG other than outlier Capital DRG outlier payments Model 4 BPCI Capital DRG outlier payments Total inpatient days divided by number of days in the cost reporting period Number of interns & residents (see instructions) Indirect medical education percentage (see instructions) Indirect medical education adjustment (multiply line 5 by the sum of lines 1 Percentage of SSI recipient patient days to Medicare Part A patient days (Wo 30) (see instructions) Percentage of Medicaid patient days to total days (see instructions) Sum of lines 7 and 8 Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01) Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11) PART II - PAYMENT UNDER REASONABLE COST Program inpatient ancillary capital cost (see instructions) Program inpatient ancillary capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) Program inpatient capital costs (see instructions) Program inpatient capital costs (see instructions) Program inpatient capital costs (see instructions) Program inpatient capital costs (see instructions) On total inpatient program capital cost (line 1 plus line 2) Applicable exception percentage (see instructions) Adjustment to capital minimum payment level for extraordinary circumstances (see instructions) Adjustment to capital minimum payment level for extraordinary circumstances Capital minimum payment level (line 5 plus line 7) Current year comparison of capital minimum payment level to capital payments Worksheet L, Part III, line 14) Net comparison of accumulated capital minimum payment level over capital payment Worksheet L, Part III, line 14) Carryover of accumulated capital minimum payment level over capital payment			1. 00				
Capital DRG other than outlier Model 4 BPCI Capital DRG other than outlier Capital DRG outlier payments Model 4 BPCI Capital DRG outlier payments Total inpatient days divided by number of days in the cost reporting period Number of interns & residents (see instructions) Indirect medical education percentage (see instructions) Indirect medical education adjustment (multiply line 5 by the sum of lines 1 Percentage of SSI recipient patient days to Medicare Part A patient days (Wor 30) (see instructions) Percentage of Medicaid patient days to total days (see instructions) Sum of lines 7 and 8 D.00 Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01) Disproportionate share adjustment (sum of lines 1, 1.01, 2, 2.01, 6 and 11) PART II - PAYMENT UNDER REASONABLE COST Program inpatient routine capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) Program inpatient capital costs (see instructions) Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see instructions) Adjustment to capital minimum payment level for extraordinary circumstances Capital minimum payment level for extraordinary circumstances Capital minimum payment level (line 5 plus line 7) Current year comparison of capital minimum payment level to capital payments Worksheet L, Part III, line 14) Net comparison of acpital minimum payment level over capital payment Worksheet L, Part III, line 14) Net comparison of acpital minimum payment level over capital payment				+			
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Capital DRG outlier payments Model 4 BPCI Capital DRG outlier payments Total inpatient days divided by number of days in the cost reporting period Number of interns & residents (see instructions) Indirect medical education percentage (see instructions) Indirect medical education adjustment (multiply line 5 by the sum of lines 1 Percentage of SSI recipient patient days to Medicare Part A patient days (Woi 30) (see instructions) Percentage of Medicaid patient days to total days (see instructions) Sum of lines 7 and 8 Allowable disproportionate share percentage (see instructions) Sum of lines 7 and 8 Allowable disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01) Disproportionate share adjustment (sum of lines 1, 1.01, 2, 2.01, 6 and 11) PART II - PAYMENT UNDER REASONABLE COST Program inpatient routine capital cost (see instructions) Program inpatient ancillary capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs (for extraordinary circumstances (see instructions) Adjustment to capital minimum payment level for extraordinary circumstances Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applicable) Current year comparison of capital minimum payment level to capital payments Worksheet L, Part III, line 14) Net comparison of acpital minimum payment level over capital payment Worksheet L, Part III, line 14) Net comparison of acpital minimum payment level over capital payment Worksheet L, Part III, line 14) Net comparison of acpital minimum payment level over capital payment			131, 227	1			
Model 4 BPCI Capital DRG outlier payments Total inpatient days divided by number of days in the cost reporting period Number of interns & residents (see instructions) Indirect medical education percentage (see instructions) Indirect medical education adjustment (multiply line 5 by the sum of lines 1 Percentage of SSI recipient patient days to Medicare Part A patient days (Wor 30) (see instructions) Percentage of Medicaid patient days to total days (see instructions) Sum of lines 7 and 8 DOB Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01 and 1.			2, 231	1			
Total inpatient days divided by number of days in the cost reporting period Number of interns & residents (see instructions) Indirect medical education percentage (see instructions) Indirect medical education adjustment (multiply line 5 by the sum of lines 1 Percentage of SSI recipient patient days to Medicare Part A patient days (Wor 30) (see instructions) Percentage of Medicaid patient days to total days (see instructions) Sum of lines 7 and 8 Allowable disproportionate share percentage (see instructions) Sum of lines 7 and 8 Allowable disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01 total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11) PART II - PAYMENT UNDER REASONABLE COST Program inpatient routine capital cost (see instructions) Total inpatient program capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see instructions) Adjustment to capital minimum payment level for extraordinary circumstances Capital minimum payment level for extraordinary circumstances Capital minimum payment level for extraordinary circumstances Current year capital payments (from Part I, line 12, as applicable) Current year comparison of capital minimum payment level to capital payment Worksheet L, Part III, line 14) Net comparison of accumulated capital minimum payment level over capital payment Worksheet L, Part III, line 14) Net comparison of accumulated capital minimum payment level over capital payment			0				
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(if line 12 is negative, enter the amount on this line)			0				
.00 Current year allowable operating and capital payment (see instructions)			0				
.00 Current year operating and capital costs (see instructions) .00 Current year exception offset amount (see instructions)							

Provi der CCN: 150038

| In Lieu of Form CMS-2552-10 | Period: | Worksheet L-1 | From 01/01/2014 | Part | | | To 12/31/2014 | Date/Time Prepared: | 5/28/2015 1:03 pm

	Capital Related Costs				5/28/2015 1:0	3 pm	
			Capi tai Kei	atca costs			
	Cost Center Description	Extraordi nary	CAP REL	CAP REL	Subtotal	EMPLOYEE	
		Capi tal	COSTS-BLDG &	COSTS-MVBLE		BENEFITS	
		Related Costs 0	FI XT 1. 00	EQUI P 2. 00	2A	DEPARTMENT 4.00	
	GENERAL SERVICE COST CENTERS		1.00	2.00	211	1. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	0		0			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4. 00
5.00	00500 ADMI NI STRATI VE & GENERAL	0	0	0	0	0	5. 00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	0	0	0	0	0	7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG		0		0	0	9. 00
10.00	01000 DI ETARY	0	0	Ö	0	0	10.00
11. 00	01100 CAFETERI A	0	0	0	0	0	11. 00
12. 00	01200 MAI NTENANCE OF PERSONNEL	0	0	0	0	0	12. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	0	0	0	0	13.00
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	0	0	0	0	0	14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0	0	0		16. 00
17. 00	01700 SOCI AL SERVI CE	0	0	o o	0	0	17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19. 00
20. 00	02000 NURSI NG SCHOOL	0	0	0	0	0	20. 00
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD	0		0	0	0	21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	0	0	O	0	0	30.00
31. 00	03100 INTENSIVE CARE UNIT	0	0		0	0	31.00
32. 00	03200 CORONARY CARE UNIT	0	Ö	Ö	0	Ö	32. 00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40. 00	04000 SUBPROVI DER - I PF	0	0	0	0	0	40. 00
41. 00	04100 SUBPROVI DER – I RF	0	0	0	0	0	41.00
42. 00	04200 SUBPROVI DER	0	0	0	0	0	42.00
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY	0	0	0	0	0 0	43. 00 44. 00
45. 00	04500 NURSING FACILITY		0	0	0	0	45.00
46. 00	04600 OTHER LONG TERM CARE		0		0	l ő	46. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0		0	0		50.00
51. 00	05100 RECOVERY ROOM	0	0	-	0	1	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 0	52.00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY - DI AGNOSTI C	0	0	0	0	0	53. 00 54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
56. 00	05600 RADI OI SOTOPE	0	0	O	0	0	56. 00
57.00	05700 CT SCAN	0	0	0	0	0	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	1
61. 00 62. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	61.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64. 00	06400 I NTRAVENOUS THERAPY	0	0	l o	0	0	64. 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
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 0	70. 00 71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	l o	0	0	73. 00
74. 00	07400 RENAL DIALYSIS	0	0	0	0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
00.00	OUTPATIENT SERVICE COST CENTERS		_			_	00.00
88.00	08800 RURAL HEALTH CLINIC]	0	0	0	88.00
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC				0	0	89. 00 90. 00
91.00	09100 EMERGENCY	0	0		0		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				O	I	92. 00
	OTHER REIMBURSABLE COST CENTERS						
94. 00	09400 HOME PROGRAM DIALYSIS	0			0		
95. 00	09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00

Health Financial Systems MORGAN COALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

			1	o 12/31/2014	Date/Time Prepared: 5/28/2015 1:03 pm
		Capital Rel	ated Costs		37 207 2013 1: 03 piii
		oupi tui noi	atea eests		
Cost Center Description	Extraordi nary	CAP REL	CAP REL	Subtotal	EMPLOYEE
, , , , , , , , , , , , , , , , , , ,	Capi tal	COSTS-BLDG &	COSTS-MVBLE		BENEFITS
	Related Costs	FLXT	EQUI P		DEPARTMENT
	0	1. 00	2.00	2A	4. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	C	0	0 96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	C	0	0 97.00
99. 00 09900 CMHC	0	0	C	0	0 99.00
99. 10 09910 CORF	0	0	C	0	0 99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	C	0	0 100.00
101.00 10100 HOME HEALTH AGENCY	0	0	C	0	0 101. 00
SPECIAL PURPOSE COST CENTERS					
105.00 10500 KIDNEY ACQUISITION	0	0	C	0	0 105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0	C	0	0 106. 00
107.00 10700 LIVER ACQUISITION	0	0	C	0	0 107. 00
108.00 10800 LUNG ACQUISITION	0	0	C	0	0 108. 00
109.00 10900 PANCREAS ACQUISITION	0	0	C	0	0 109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	C	0	0 110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0	C	0	0 111.00
113. 00 11300 I NTEREST EXPENSE	0	0	C	0	0 113. 00
114.00 11400 UTILIZATION REVIEW-SNF	0	0	C	0	0 114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	C	0	0 115.00
116. 00 11600 H0SPI CE	0	0	C	0	0 116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	0	C	0	0 118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0	0 190. 00
191. 00 19100 RESEARCH	0	0	C	0	0 191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	C	0	0 192. 00
193. 00 19300 NONPALD WORKERS	0	0	C	0	0 193. 00
200.00 Cross Foot Adjustments					200. 00
201.00 Negative Cost Centers		0	C	0	0 201. 00
202.00 Total (sum of lines 118 and 190-201)	0	0	[c	o	0 202. 00
203.00 Total Statistical Basis		171, 963	124, 859	o	11, 782, 380 203. 00
204.00 Unit Cost Multiplier		0. 000000	0. 000000	0. 000000	0. 000000 204. 00

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

Provi der CCN: 150038 Per

Peri od: Worksheet L-1 From 01/01/2014 Part I To 12/31/2014 Date/Time Prepared:

5/28/2015 1:03 pm Cost Center Description ADMINISTRATIVE OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY & GENERAL PLANT LINEN SERVICE 9.00 10.00 5.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5 00 0 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 000000000000 0 0 9.00 0 0 0 0 0 0 0 0 0 01000 DI ETARY 0 10.00 10.00 0 0 01100 CAFETERI A 11.00 11.00 12.00 01200 MAINTENANCE OF PERSONNEL 0 0 12.00 01300 NURSING ADMINISTRATION 13.00 0 13 00 0 14.00 01400 CENTRAL SERVICES & SUPPLY 0 14.00 15.00 01500 PHARMACY 0 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 0 0 16,00 01700 SOCIAL SERVICE 0 17.00 C 0 17.00 19.00 01900 NONPHYSICIAN ANESTHETISTS 0 0 19.00 02000 NURSING SCHOOL 0 20.00 20.00 0 0 02100 I&R SERVICES-SALARY & FRINGES APPRVD 0 21.00 0 21.00 0 02200 & SERVICES-OTHER PRGM COSTS APPRVD 0 22.00 C 0 0 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 0 0 0 30.00 0 0 0 0 03100 INTENSIVE CARE UNIT 31.00 31.00 0 0 32.00 03200 CORONARY CARE UNIT 0 0 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 00000000 0 0 0 33.00 0 0 0 0 0 0 0 03400 SURGICAL INTENSIVE CARE UNIT 0 34.00 34.00 04000 SUBPROVIDER - IPF 0 40.00 0 Λ 40.00 04100 SUBPROVI DER - I RF 41.00 C 0 0 41.00 04200 SUBPROVI DER 42.00 0 0 42.00 0 04300 NURSERY 0 43.00 0 43.00 04400 SKILLED NURSING FACILITY 0 44.00 0 0 44.00 45.00 04500 NURSING FACILITY 0 0 0 45.00 04600 OTHER LONG TERM CARE 0 0 46.00 0 0 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 0 0 0 50.00 05100 RECOVERY ROOM 0 0 0 0 0 51.00 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0000000000 0 0 0 0 0 0 0 0 0 0 0 52.00 0 0 05300 ANESTHESI OLOGY 53.00 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 0 0 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 0 0 55.00 56 00 05600 RADI OI SOTOPE Ω 0 0 56 00 0 57.00 05700 CT SCAN 0 0 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0 0 59.00 0 06000 LABORATORY 0 60 00 60 00 Ω 0 60.01 06001 BLOOD LABORATORY 0 0 0 60.01 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 000000000000000 0 0 0 0 0 0 0 0 0 0 0 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 Ω 0 63.00 64.00 06400 I NTRAVENOUS THERAPY 0 0 64.00 06500 RESPIRATORY THERAPY 65.00 65.00 06600 PHYSI CAL THERAPY 0 66, 00 0 0 66,00 67 00 06700 OCCUPATI ONAL THERAPY Ω 0 0 67 00 06800 SPEECH PATHOLOGY 68.00 68.00 69 00 06900 ELECTROCARDI OLOGY 0 69.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 73.00 0 74.00 07400 RENAL DIALYSIS 0 0 74.00 0 0 75.00 07500 ASC (NON-DISTINCT PART) C 0 75.00 76. 97 07697 CARDIAC REHABILITATION 0 0 0 0 0 76. 97 OUTPATIENT SERVICE COST CENTERS 0 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89.00 89.00 0 0 0 90.00 09000 CLI NI C 0 90.00 0 0 09100 EMERGENCY 0 0 91.00 91.00 C 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 0 0 0 94.00 09500 AMBULANCE SERVICES 0 0 0 0 95.00 95 00 0 96.00 0 0 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 96.00 0 0 0 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 99. 00 09900 CMHC 0 0 99.00 ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

Total Statistical Basis

Unit Cost Multiplier

Peri od: From 01/01/2014 Part I

12/31/2014 Date/Time Prepared: 5/28/2015 1:03 pm ADMINISTRATIVE OPERATION OF Cost Center Description LAUNDRY & HOUSEKEEPI NG DI ETARY & GENERAL PLANT LINEN SERVICE 9. 00 5.00 7.00 8.00 10.00 99. 10 09910 CORF 99. 10 0 n 0 0 100.00 10000 I &R SERVI CES-NOT APPRVD PRGM 0 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 0 105.00 105.00 10500 KIDNEY ACQUISITION 0 0 0 0 0 0 0 0 0 0 0 0 0 106.00 10600 HEART ACQUISITION 0 0 0 0 0 0 0 0 0 0 0 0 106.00 107. 00 10700 LIVER ACQUISITION 0 0 107. 00 108.00 10800 LUNG ACQUISITION 0 0 0 108.00 109. 00 10900 PANCREAS ACQUISITION 0 0 109.00 0 0 110.00 11000 INTESTINAL ACQUISITION 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 0 0 111. 00 113.00 11300 INTEREST EXPENSE 0 0 0 113.00 114.00 11400 UTILIZATION REVIEW-SNF 0 0 114. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 115.00 116. 00 11600 HOSPI CE 0 0 0 116.00 SUBTOTALS (SUM OF LINES 1-117)
NONRE MBURSABLE COST CENTERS 0 118.00 0 0 118.00 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190. 00 191. 00 19100 RESEARCH 0 0 0 191.00 0 0 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 192. 00 0 193. 00 19300 NONPALD WORKERS 0 0 0 0 193. 00 200.00 200. 00 Cross Foot Adjustments 201.00 0 0 201. 00 Negative Cost Centers 0 0 0 Total (sum of lines 118 and 190-201) 202.00 0 0 202. 00

24, 652, 963

0.000000

141, 257

0.000000

19,853

0.000000

140, 889

0.000000

4, 509 203. 00

0. 000000 204. 00

203.00

204.00

Provi der CCN: 150038

			10	12/31/2014	Date/lime Pre 5/28/2015 1:0	
Cost Center Description	CAFETERIA N	MAINTENANCE OF	NURSI NG	CENTRAL	PHARMACY	ļ
		PERSONNEL	ADMI NI STRATI ON	SERVI CES & SUPPLY		
	11. 00	12.00	13. 00	14. 00	15. 00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FLXT						1. 00
2. 00 00200 CAP REL COSTS-MVBLE EQUI P						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT						5. 00 7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	1					8.00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A	0					11. 00
12.00 01200 MAINTENANCE OF PERSONNEL	0	0				12. 00
13. 00 01300 NURSING ADMINISTRATION	0	0	0	_		13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14. 00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	0	0	0	0	1
17. 00 01700 SOCIAL SERVICE		0	0	0	0	
19. 00 01900 NONPHYSI CLAN ANESTHETI STS	0	o	0	o	0	
20. 00 02000 NURSI NG SCHOOL	0	O	0	O	0	1
21.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21. 00
22. 00 02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		ما	0	ما		00.00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 NTENSIVE CARE UNIT	0 0	0	0	0	0	1
32. 00 03200 CORONARY CARE UNIT		0	0	0	0	1
33. 00 03300 BURN INTENSIVE CARE UNIT		0	0	0	0	
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T	0	o	0	o	0	1
40. 00 04000 SUBPROVI DER - I PF	0	О	0	О	0	40.00
41. 00 04100 SUBPROVI DER - I RF	0	0	0	0	0	41. 00
42. 00 04200 SUBPROVI DER	0	0	0	0	0	
43. 00 04300 NURSERY	0	0	0	0	0	1
44.00 04400 SKILLED NURSING FACILITY 45.00 04500 NURSING FACILITY	0	0	0	0	0	
46. 00 04600 OTHER LONG TERM CARE	0 0	0	0	0	0	
ANCI LLARY SERVI CE COST CENTERS	<u> </u>	<u> </u>	<u> </u>	<u> </u>		10.00
50. 00 05000 OPERATI NG ROOM	0	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	o	0	o	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	1
53. 00 05300 ANESTHESI OLOGY	0	0	0	0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	1
56. 00 05600 RADI 01 SOTOPE	0	0	0	0	0	
57. 00 05700 CT SCAN	0	ő	0	ol	0	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	O	O	0	O	0	1
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	O	0	O	0	59. 00
60. 00 06000 LABORATORY	0	0	0	0	0	1
60. 01 06001 BLOOD LABORATORY	0	0	0	0	0	
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0	0	0	0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	1
64. 00 06400 I NTRAVENOUS THERAPY		Ö	0	Ö	0	00.00
65. 00 06500 RESPIRATORY THERAPY	0	0	0	0	0	1
66. 00 06600 PHYSI CAL THERAPY	0	0	0	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	
68. 00 06800 SPEECH PATHOLOGY	0	0	0	0	0	
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	0	0	1
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		O O	0	0	0	1
73. 00 07300 DRUGS CHARGED TO PATIENTS		ol	0	ol	0	1
74. 00 07400 RENAL DI ALYSI S	0	O	0	Ö	0	1
75.00 07500 ASC (NON-DISTINCT PART)	0	O	0	o	0	75. 00
76. 97 O7697 CARDIAC REHABILITATION	0	0	0	0	0	76. 97
OUTPATIENT SERVICE COST CENTERS		_1	=1	_1		
88. 00 08800 RURAL HEALTH CLINIC		0	0	0	0	
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC		0	0	O ₁	0	
91. 00 09100 EMERGENCY		ol Ol	0	0	0	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		Ĭ	0	Ĭ	0	92.00
OTHER REIMBURSABLE COST CENTERS						1
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	
95. 00 09500 AMBULANCE SERVI CES	0	0	0	0	0	
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	O	0	O	0	97.00

Health Financial Systems	MORGAN COUNT	Y HOSPITAL		In Lie	u of Form CMS-:	2552-10
ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRC	CUMSTANCES	Provi der	CCN: 150038 F	Peri od:	Worksheet L-1	
				From 01/01/2014	Part I	
			7	Γo 12/31/2014	Date/Time Pre	
	0.4557501.4			05117041	5/28/2015 1:0	3 pm
Cost Center Description	CAFETERI A	MAINTENANCE OF		CENTRAL	PHARMACY	
		PERSONNEL	ADMI NI STRATI ON			
	44.00	40.00	40.00	SUPPLY	45.00	
00.00.00000.0000	11.00	12. 00	13. 00	14.00	15. 00	00.00
99. 00 09900 CMHC	0	0	(99. 00
99. 10 09910 CORF	0	0	(0	
100. 00 10000 I &R SERVI CES-NOT APPRVD PRGM	0	0	(100.00
101.00 10100 HOME HEALTH AGENCY	0	0	[)	0	101. 00
SPECIAL PURPOSE COST CENTERS				1		
105.00 10500 KIDNEY ACQUISITION	0	0	(이		105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0	(이		106. 00
107.00 10700 LI VER ACQUI SI TI ON	0	0	(이		107. 00
108.00 10800 LUNG ACQUISITION	0	0	(0		108. 00
109.00 10900 PANCREAS ACQUISITION	0	0	(0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	(이		110. 00
111.00 11100 I SLET ACQUI SI TI ON	0	0	(이	0	111. 00
113.00 11300 INTEREST EXPENSE	0	0	(o o	0	113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF	0	0	(o o	0	114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	(o o	0	115. 00
116. 00 11600 HOSPI CE	0	0	(0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	0	(0	0	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(0	0	190. 00
191. 00 19100 RESEARCH	0	0	(0	0	191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	(o o	0	192. 00
193.00 19300 NONPALD WORKERS	0	0	(ol ol	0	193. 00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	(ol ol	0	201.00
202.00 Total (sum of lines 118 and 190-201)	0	0		ol ol	0	202.00
203.00 Total Statistical Basis	309, 553	0	145, 597	524, 835	100	203.00
204.00 Unit Cost Multiplier	0. 000000	0. 000000			0. 000000	204.00
1	'		•	'		

Health Financial Systems MORGAN COALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES Provi der CCN: 150038

					To 12/31/2014	5/28/2015 1:0	
	Cost Center Description	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE	NONPHYSI CI AN ANESTHETI STS	NURSI NG SCHOOL	Intern & Res. I &R SERVI CES-SALAR Y & FRI NGES APPRVD	
		16. 00	17. 00	19. 00	20.00	21.00	
1 00	GENERAL SERVICE COST CENTERS		ı	1			1 00
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			•			4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00	00700 OPERATION OF PLANT			•			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11.00
12.00	01200 MAI NTENANCE OF PERSONNEL						12.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON						13. 00 14. 00
15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY						15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0					16. 00
17. 00	01700 SOCIAL SERVICE	0	0	i			17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	(19. 00
20.00	02000 NURSI NG SCHOOL	0			0		20. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0				0	21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	0	0				22. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS			ı			20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0		1			30. 00 31. 00
32. 00	03200 CORONARY CARE UNIT						32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT		Ö				33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	0	0				34. 00
40.00	04000 SUBPROVI DER - I PF	0	0				40.00
41. 00	04100 SUBPROVI DER - I RF	0	0				41.00
42. 00	04200 SUBPROVI DER	0	0				42. 00
43.00	04300 NURSERY	0	_				43.00
44. 00 45. 00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0					44. 00 45. 00
46. 00	04600 OTHER LONG TERM CARE						46. 00
10.00	ANCI LLARY SERVI CE COST CENTERS						10.00
50.00	05000 OPERATI NG ROOM	0	0				50. 00
51.00	05100 RECOVERY ROOM	0	0				51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	_				52. 00
53.00	05300 ANESTHESI OLOGY	0	0				53. 00
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	0	0				54. 00 55. 00
56. 00	05600 RADI OLOGY - THERAPEUTI C		0				56. 00
57. 00	05700 CT SCAN		0				57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0				58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0				59. 00
60.00	06000 LABORATORY	0	0				60.00
60. 01	06001 BLOOD LABORATORY	0	0				60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62. 00 63. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	0	0				62. 00 63. 00
64. 00	06400 NTRAVENOUS THERAPY						64. 00
65. 00	06500 RESPIRATORY THERAPY		Ö				65. 00
66.00	06600 PHYSI CAL THERAPY	0	0				66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0				67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0				68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	1			69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 MPL. DEV. CHARGED TO PATIENTS	0	0				71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS						73.00
74. 00	07400 RENAL DIALYSIS		0				74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0				75. 00
76. 97	07697 CARDIAC REHABILITATION	0	0				76. 97
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0				88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				89. 00
90. 00 91. 00	09000 CLI NI C 09100 EMERGENCY	0					90. 00 91. 00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1	1			91.00
,z. 00	OTHER REIMBURSABLE COST CENTERS	<u> </u>		1			12.00
94. 00	09400 HOME PROGRAM DI ALYSI S	0	0				94. 00
95.00	09500 AMBULANCE SERVICES	0	0				95. 00

Provider CCN: 150038 | Period: | Worksheet L-1 | From 01/01/2014 | Part I | To 12/21/2014 | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | P
 Heal th Financial
 Systems
 MORGAN COUNTY HOSPITAL

 ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES
 Provi

			Τ̈́	o 12/31/2014	Date/Time Pre 5/28/2015 1:0	
					Intern & Res.	<u>Б</u>
Cost Center Description	MEDI CAL	SOCIAL SERVICE	NONPHYSICIAN	NURSI NG SCHOOL	I &R	
	RECORDS &		ANESTHETI STS		SERVI CES-SALAR	
	LI BRARY				Y & FRINGES	
					APPRVD	
	16. 00	17. 00	19. 00	20.00	21. 00	
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	C	0				96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	C	0				97. 00
99. 00 09900 CMHC	C	0				99. 00
99. 10 09910 CORF	C	0				99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	C	0				100. 00
101.00 10100 HOME HEALTH AGENCY	C	0				101. 00
SPECIAL PURPOSE COST CENTERS	1					
105.00 10500 KIDNEY ACQUISITION	C	0				105. 00
106.00 10600 HEART ACQUISITION	C	0				106. 00
107.00 10700 LIVER ACQUISITION	C	0				107. 00
108.00 10800 LUNG ACQUISITION	C	0				108. 00
109.00 10900 PANCREAS ACQUISITION	C	0				109. 00
110.00 11000 INTESTINAL ACQUISITION	C	0				110. 00
111.00 11100 I SLET ACQUI SI TI ON	C	0				111. 00
113. 00 11300 I NTEREST EXPENSE	C	0				113. 00
114.00 11400 UTILIZATION REVIEW-SNF	C	0				114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	C	0				115. 00
116. 00 11600 HOSPI CE	C	0				116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	C	0	C	0	0	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	0				190. 00
191. 00 19100 RESEARCH	C	0				191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	C	0				192. 00
193.00 19300 NONPALD WORKERS	C	0				193. 00
200.00 Cross Foot Adjustments			C	0		200. 00
201.00 Negative Cost Centers	C	0	[C	0		201. 00
202.00 Total (sum of lines 118 and 190-201)	C	0	[C	0		202. 00
203.00 Total Statistical Basis	104, 751, 503		[C	0		203. 00
204.00 Unit Cost Multiplier	0. 000000	0. 000000	0.000000	0. 000000	0. 000000	204. 00

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES Provi der CCN: 150038 Peri od: Worksheet L-1 From 01/01/2014 Part I 12/31/2014 Date/Time Prepared: 5/28/2015 1:03 pm Intern & Res. Cost Center Description Subtotal Intern & Total I &R SERVI CES-OTHER Residents Cost PRGM COSTS & Post **APPRVD** Stepdown Adjustments 22.00 24.00 25.00 26.00 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 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 01100 CAFETERI A 11.00 11.00 12.00 01200 MAINTENANCE OF PERSONNEL 12.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14 00 14 00 15.00 01500 PHARMACY 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01700 SOCIAL SERVICE 17 00 17 00 19.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 02000 NURSING SCHOOL 20.00 20.00 21.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22 00 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 0 31.00 03100 INTENSIVE CARE UNIT 0 0 0 31.00 03200 CORONARY CARE UNIT 0 32 00 0 32 00 03300 BURN INTENSIVE CARE UNIT 0 33.00 33.00 03400 SURGICAL INTENSIVE CARE UNIT 0 34.00 0 0 34.00 04000 SUBPROVI DER - I PF 0 40.00 40.00 04100 SUBPROVI DER - I RF 0 41.00 0 41.00 0 42.00 04200 SUBPROVI DER 0 0 42.00 04300 NURSERY 0 43.00 43.00 0 44.00 04400 SKILLED NURSING FACILITY 0 0 44.00 04500 NURSING FACILITY 0 45.00 C 0 45 00 04600 OTHER LONG TERM CARE 0 0 46.00 46.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 0 0 50.00 0 05100 RECOVERY ROOM 0 51.00 C 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 52.00 53.00 05300 ANESTHESI OLOGY 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54.00 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 55.00 56.00 05600 RADI OI SOTOPE 0 56.00 05700 CT SCAN 0 57.00 0 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 58.00 58.00 59.00 05900 CARDIAC CATHETERIZATION 59.00 0 0 06000 LABORATORY 0 60.00 60.00 |06001|BLOOD LABORATORY 0 60.01 60.01 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 0 0 0 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 63.00 64.00 06400 I NTRAVENOUS THERAPY 0 64.00 65.00 06500 RESPIRATORY THERAPY 0 65.00 06600 PHYSI CAL THERAPY 66.00 0 0 0 66.00 67 00 06700 OCCUPATIONAL THERAPY 0 67 00 06800 SPEECH PATHOLOGY 0 68.00 68.00 06900 ELECTROCARDI OLOGY 69.00 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71 00 0 71 00 0 72.00 07200 I MPL. DEV. CHARGED TO PATIENTS 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 73.00 0 74.00 07400 RENAL DIALYSIS 0 0 74.00 07500 ASC (NON-DISTINCT PART) 0 Ω 75.00 75.00 76. 97 07697 CARDIAC REHABILITATION 0 0 0 76.97 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89.00 90.00 09000 CLI NI C 0 0 90.00 91.00 09100 EMERGENCY 0 0 ol 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DIALYSIS 0 0 0 94.00

Provider CN: 150038	Health Financial Systems	MORGAN COUNT	Y HOSPITAL		In Lie	u of Form CMS-2552-10
Second Cost Center Description Second Se	ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIR	RCUMSTANCES	Provi der	CCN: 150038	From 01/01/2014	Part I Date/Time Prepared:
95. 00 09500 AMBULANCE SERVICES 0 0 0 0 0 95. 00 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 96. 00 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 0 97. 00 99. 10 09900 CUHHC 0 0 0 0 0 99. 00 99. 10 09901 CORF 0 0 0 0 0 99. 00 100. 00 100. 00 16R SERVI CES-NOT APPRVD PRGM 0 0 0 0 0 101. 00 10100 IMPROSE COST CENTERS 0 0 0 0 0 101. 00 10100 IMPROSE COST CENTERS 0 0 0 0 0 105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 0 105. 00 106. 00 10600 HEART ACQUI SI TI ON 0 0 0 0 106. 00 107. 00 10700 LI VER ACQUI SI TI ON 0 0 0 0 107. 00 108. 00 10800 LOUNG ACQUI SI TI ON 0 0 0 0 108. 00 109. 00 10900 PANCREAS ACQUI SI TI ON 0 0 0 0 108. 00 110. 00 11000 INTESTI NAL ACQUI SI TI ON 0 0 0 0 109. 00 111. 00 11100 INTESTI NAL ACQUI SI TI ON 0 0 0 0 110. 00 111. 00 11100 INTESTI NAL ACQUI SI TI ON 0 0 0 0 110. 00 111. 00 11100 INTESTI NAL ACQUI SI TI ON 0 0 0 0 113. 00 114. 00 11400 UTI LI ZATI ON REVIEW-SNF 0 0 0 0 113. 00 115. 00 11500 AMBULANTONY SURGI CAL CENTER (D. P.) 0 0 0 0 114. 00 116. 00 11600 HOSPICE 0 0 0 0 115. 00 117. 00 11900 PANCREAS COUSTI CONTERS 0 0 0 0 115. 00 118. 00 SUBTOTALS (SUM OF LINES 1-117) 0 0 0 0 0 115. 00 119. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190. 00 119. 00 19100 RESEARCH 0 0 0 0 191. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 192. 00 193. 00 19300 NONPAID MORKERS 0 0 0 0 0 193. 00 200. 00 Cross Foot Adjustments 0 0 0 0 0 202. 00 201. 00 Total (Stati Stiti Stiti Stati Stiti Stati Stiti Cal Basi S 0 203. 00	Cost Center Description	I &R SERVI CES-OTHER PRGM COSTS APPRVD		Residents Co & Post Stepdown Adjustments	st	
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 97. 00 09700 09700 09700 09700 09700 09700 09700 09700 09700 09700 09900 CMHC 0 0 0 0 0 99. 00 099. 00 09900 CMHC 0 0 0 0 0 0 99. 00 099. 00 099. 00 099. 00 0 0 0 0 0 099. 10 000. 00 00000 188 SERVI CES-NOT APPRVD PRGM 0 0 0 0 0 0 100. 00 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101. 00 105. 00 10500 KI DNEY, ACQUI SI TI ON 0 0 0 0 0 105. 00 106. 00 106. 00 106. 00 106. 00 10700 LI VER ACQUI SI TI ON 0 0 0 0 0 107. 00 10700 LI VER ACQUI SI TI ON 0 0 0 0 0 107. 00 109. 0		22.00				
SPECIAL PURPOSE COST CENTERS 105.00 10500 KI DNEY ACQUI SI TI ON 0 0 0 0 105.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 107.00 107.00 107.00 107.00 107.00 108.00 10800 LUNG ACQUI SI TI ON 0 0 0 0 108.00 109.00 109.00 109.00 107.00 109.00 107.00 1	96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 99. 00 09900 CMHC 99. 10 09910 CORF			0 0 0 0 0 0	0 0 0 0 0 0 0 0	96.00 97.00 99.00 99.10
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107. 00 10700 LI VER ACQUI SI TI ON 0 0 0 107. 00 108. 00 10800 LUNG ACQUI SI TI ON 0 0 0 0 108. 00 109.				0	0 0	105. 00
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109. 00 10900 PANCREAS ACQUISITION 0 0 0 0 0 109. 00	107.00 10700 LIVER ACQUISITION			0	0 0	
110.00 11000 INTESTI NAL ACQUISITION 0 0 0 0 0 1110.00 111.00 1				0	0	
111.00				0	0	
113.00				0	0 0	
114.00				0	0 0	
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 0 115. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 0 0 0 0 116. 00 118. 00 0 0 0 0 0 0 0 118. 00 0 0 0 0 0 0 0 0 0				0	0 0	
116.00				0	0	
118.00 SUBTOTALS (SUM OF LINES 1-117) 0 0 0 0 0 0 0 118.00				0	0	
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 191. 00 191. 00 19100 RESEARCH 0 0 0 0 0 191. 00 192. 00 192.00 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 192. 00 193. 00 193. 00 NONRAID WORKERS 0 0 0 0 0 193. 00 200. 00 Cross Foot Adjustments 0 0 0 0 0 200. 00 200. 00 Negative Cost Centers 0 0 0 0 201. 00 202. 00 203. 00 Total (sum of lines 118 and 190-201) 0 0 0 0 0 202. 00 203. 00 Total Statistical Basis 0 0 0 0 203. 00				0	-	
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191.00 19100 RESEARCH				ol	0	100.00
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200.00 Cross Foot Adjustments 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 201.00 202.00 Total (sum of lines 118 and 190-201) 0 0 0 0 202.00 203.00 Total Statistical Basis 0 0 203.00						
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