Heal th Financi	al Systems	WABASH COUNTY HO	SPI TAL	In Lie	eu of Form CMS-2552-10
This report is	required by law (42 USC 13	95g; 42 CFR 413.20(b)). Failu cost reporting period being o	ure to report can re		FORM APPROVED OMB NO. 0938-0050
HOSPITAL AND H AND SETTLEMENT	IOSPITAL HEALTH CARE COMPLEX SUMMARY	COST REPORT CERTIFICATION	Provi der CCN: 1513	10 Peri od: From 01/01/2014 To 12/31/2014	
PART I - COST	REPORT STATUS			·	
Provi der use only	1. [ X ] Electronically file 2. [ ] Manually submitted			Date: 5/27/20	015 Time: 9:05 am
use only	3. [ 0 ] If this is an amend	ed report ed report enter the number o n. Enter "F" for full or "L"	f times the provided for low.	r resubmitted this c	ost report
Contractor use only	5. [ 1 ]Cost Report Status (1) As Submitted (2) Settled without Audi (3) Settled with Audit (4) Reopened		this Provider CCN 1		

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 WABASH COUNTY HOSPITAL (151310) 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	Admi ni strator	of Provider(s)
Title			
Date			

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	16, 239	574, 589	1	0	1.00
2.00	Subprovi der - IPF	0	0	0		0	2.00
3.00	Subprovi der - I RF	0	0	0		0	3. 00
5.00	Swing bed - SNF	0	27, 697	0		0	5. 00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9. 00
200.00	Total	0	43, 936	574, 589	1	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-MEDI CARE.

	In-State	In-State	Out-of	Out-of	Medi cai d	Other	
	Medi cai d	Medicaid	State	State	HMO days	Medi cai d	
	paid days	eligible	Medi cai d	Medicaid		days	
		unpai d	pai d days	eligible			
		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	0	0	0	0	0	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	1						
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	1 0	1 0	0	n	0		25. 00
Medicaid paid days in column 1, the in-state							20.00
Medicaid eligible unpaid days in column 2,							
out-of-state Medicaid days in column 3, out-of-state	:						
Medicaid eligible unpaid days in column 4, Medicaid							
HMO paid and eligible but unpaid days in column 5.							

care or general surgery. (see instructions)

Health Financial Systems WABASH COUNTY HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 151310 Peri od: Worksheet S-2 From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/27/2015 8:04 am Program Name Program Code Unweighted IME Unwei ghted Direct GME FTE FTE Count Count 1.00 2.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0.00 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count. 61. 20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column direct GME FTE unweighted count. 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 62 01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter N 63.00 for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions) Unwei ahted Ratio (col. 1/ Unwei ahted **FTES** FTEs in (col . 1 + col Nonprovi der Hospi tal 2)) Si te 1. 00 2.00 3.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. 64.00 Enter in column 1, if line 63 is yes, or your facility trained residents 0.000000 64.00 0.00 n the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Unwei ghted Program Name Program Code Unwei ghted Ratio (col. 3/ FTĔs FTEs in (col. 3 + col. Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 0.00 0.00 0.000000 65.00 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all

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

Health Financial Systems WABASH COUNTY HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 151310 Peri od: Worksheet S-2 From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/27/2015 8:04 am Unwei ghted Unwei ghted Ratio (col. (col. 1 + col FTEs FTEs in Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 0. 00 66.00 Enter in column 1 the number of unweighted non-primary care resident 0.00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Program Code Unwei ghted Unwei ghted Ratio (col. 3/ FTEs FTEs in (col. 3 + colNonprovi der Hospi tal 4)) Si te 1.00 2 00 3. 00 4.00 5 00 67.00 Enter in column 1, the program 0.00 0.00 0.000000 67.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS 70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? N 70.00 Enter "Y" for yes or "N" for no. If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most 71.00 0 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF Ν 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most 0 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions) 1.00 Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 80.00 N 81.00 | Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter N 81.00 Y" for yes and "N" for no. TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section N 85.00 86.00 §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.

Health Financial Systems WABASH COUNTY HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 151310 Peri od: Worksheet S-2 From 01/01/2014 Part I 12/31/2014 Date/Time Prepared: 5/27/2015 8:04 am 1. 00 2.00 128.00|If 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 (0PO), enter the 0PO 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, Ν 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: Contractor's Name: Contractor's Number: 141.00 142. 00 Street: 143. 00 Ci ty: PO Box: 142. 00 State: Zip Code: 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. Title V Part A 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) N N 155.00 155.00 Hospi tal Ν Ν Ν 156.00 Subprovi der - IPF Ν Ν Ν 156.00 157.00 Subprovi der - IRF Ν 157. 00 N Ν Ν 158. 00 SUBPROVI DER 158 00 159. 00 SNF Ν Ν Ν Ν 159.00 160.00 HOME HEALTH AGENCY Ν Ν Ν N 160. 00 161.00 CMHC 161.00 Ν Ν Ν 1.00 Multicampus 165.00 Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no. N 165.00 Name County State Zip Code CBSA FTE/Campus 0 1.00 2.00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 0.00166.00 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. 167.00 168.00| If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the 1 1 1 6 8 . 0 0 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 0.00169.00 transition factor. (see instructions)

Health Financial Systems	WABASH COUNTY HOS	WABASH COUNTY HOSPITAL			2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	Provi der CCN: 151310	Peri od:	Worksheet S-2	
			From 01/01/2014		
			To 12/31/2014		
				5/27/2015 8:0	<u>4 am</u>
			Begi nni ng	Endi ng	
			1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginner of respectively (mm/dd/yyyy)	ginning date and ending date	for the reporting	01/01/2014	12/31/2014	170. 00
				1.00	
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876  Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no.					171. 00
(see instructions)					

Health Financial Systems WABASH COUNTY HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provi der CCN: 151310 Peri od: Worksheet S-2 From 01/01/2014 Part II Date/Time Prepared: 12/31/2014 5/27/2015 8:04 am 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. Date 1.00 2.00 Home Office Costs

36.00	Were home office costs claimed on the cost report?		N		36. 00
37.00	If line 36 is yes, has a home office cost statement been pu	repared by the home office?	N		37. 00
	If yes, see instructions.				
38. 00	If line 36 is yes , was the fiscal year end of the home of	fice different from that of	N		38. 00
	the provider? If yes, enter in column 2 the fiscal year end	d of the home office.			
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	If line 36 is yes, did the provider render services to the	home office? If yes, see	N		40. 00
	instructions.				
		1.00	2.	00	
	Cost Report Preparer Contact Information				
41 00					
41.00	Enter the first name, last name and the title/position	JAKE	CARNAZZO		41. 00
41.00	held by the cost report preparer in columns 1, 2, and 3,	JAKE	CARNAZZO		41. 00
41.00		JAKE	CARNAZZO		41. 00
42. 00	held by the cost report preparer in columns 1, 2, and 3,	JAKE ALLIANT MANAGEMENT SERVICES	CARNAZZO		41. 00
	held by the cost report preparer in columns 1, 2, and 3, respectively.		CARNAZZO		
42. 00	held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report preparer.		CARNAZZO  JCARNAZZO@ALLI	ANTMANAGEMENT.	
42. 00	held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report preparer.	ALLIANT MANAGEMENT SERVICES		ANTMANAGEMENT.	42. 00

				From 01/01/2014 To 12/31/2014	Part II Date/Time Pre	
					5/27/2015 8:0	4 am
		Part B				
		Date				
		4. 00				
	PS&R Data					
16. 00	Was the cost report prepared using the PS&R	05/15/2015				16. 00
	Report only? If either column 1 or 3 is yes,					
	enter the paid-through date of the PS&R					
	Report used in columns 2 and 4 .(see					
	instructions)					
17.00	Was the cost report prepared using the PS&R					17. 00
	Report for totals and the provider's records					
	for allocation? If either column 1 or 3 is					
	yes, enter the paid-through date in columns					
	2 and 4. (see instructions)					
18.00	If line 16 or 17 is yes, were adjustments					18. 00
	made to PS&R Report data for additional					
	claims that have been billed but are not					
	included on the PS&R Report used to file					
	this cost report? If yes, see instructions.					
19.00						19. 00
	made to PS&R Report data for corrections of					
	other PS&R Report information? If yes, see					
	i nstructi ons.					
20. 00						20. 00
	made to PS&R Report data for Other? Describe					
	the other adjustments:					
21. 00	Was the cost report prepared only using the					21. 00
	provider's records? If yes, see					
	instructions.					
			3. 00	_		
	Cost Report Preparer Contact Information		3.00			
41 00	Enter the first name, last name and the title	/nosi ti on	REIMBURSEMENT MANAGER			41. 00
41.00	held by the cost report preparer in columns 1		RETWIDORSEWIENT WANAGER			41.00
	respectively.	ı, z, anu s,				
42. 00	Enter the employer/company name of the cost r	renort				42. 00
42.00	preparer.	cpoi t				72.00
43. 00	1	of the cost				43. 00
45.00	report preparer in columns 1 and 2, respective					13.00
	1. Sport property in containing a data 2, respective	. J.	ı	1		1

Provider CCN: 151310 | Period: | Worksheet S-3 | From 01/01/2014 | Part I | To 12/31/2014 | Date/Time Prepared: Heal th Fi nancial SystemsWABASHHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

				To	12/31/2014	Date/Time Prep 5/27/2015 8:04	
						I/P Days / 0/P	+ aiii
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number		Avai I abl e			
1.00		1. 00	2.00	3.00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and	30. 00	25	9, 125	41, 760. 00	0	1. 00
	Hospice days) (see instructions for col. 2					ı	
	for the portion of LDP room available beds)					ı	
2.00	HMO and other (see instructions)					ı	2. 00
3.00	HMO IPF Subprovider						3. 00
4.00	HMO IRF Subprovider					ı l	4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF					0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		25	0.105	41 7/0 00	0	6. 00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9, 125	41, 760. 00	0	7. 00
8. 00	INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT					ı	9. 00
10. 00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT					ı	11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43. 00				0	13.00
14. 00	Total (see instructions)		25	9, 125	41, 760. 00	0	14. 00
15. 00	CAH visits					0	15. 00
16.00	SUBPROVIDER - I PF						16.00
17. 00 18. 00	SUBPROVI DER - I RF SUBPROVI DER						17. 00 18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE					ı	21. 00
22. 00	HOME HEALTH AGENCY	101. 00				0	22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24. 00	HOSPI CE	116. 00	0	0		ļ	24.00
24. 10	HOSPICE (non-distinct part)	30. 00				ı	24. 10
25. 00	CMHC - CMHC						25. 00
26. 00 26. 25	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER						26. 00 26. 25
27. 00			50			ı	27. 00
28. 00	Observation Bed Days		30			0	28. 00
29. 00						-	29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32. 00
32. 01	Total ancillary labor & delivery room						32. 01
22 00	outpatient days (see instructions)						22 00
33.00	LTCH non-covered days			l l			33. 00

Provi der CCN: 151310 | Peri od: | Worksheet S-3 | Part | To | 12/31/2014 | Date/Time Prepared: | From 01/01/2014 | Date/Time Prepared: | From 01/01/2014 | Date/Time Prepared: | From 01/01/2015 | Provided Provi

				1	0 12/31/2014	5/27/2015 8:0	
		I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6.00	7. 00	8. 00	9. 00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	807	95	1, 740			1.00
2.00	HMO and other (see instructions)	404	0				2. 00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO I RF Subprovi der	0	0	400			4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	198	0	198 154			5. 00
6. 00 7. 00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation	1, 005	154 249	2, 092			6. 00 7. 00
7.00	beds) (see instructions)	1,005	249	2, 092			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		0	0			13. 00
14. 00	Total (see instructions)	1, 005	249	2, 092	0.00	240.00	
15. 00	CAH visits	0	0	0			15. 00
16. 00	SUBPROVIDER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18.00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY NURSING FACILITY						19. 00 20. 00
20. 00 21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY	2, 265	0	10, 643	0.00	15. 54	
23. 00	AMBULATORY SURGICAL CENTER (D. P. )	2,203	J	10, 043	0.00	13.34	23. 00
24. 00	HOSPI CE	0	0	0	0.00	8. 32	1
24. 10	HOSPICE (non-distinct part)	o	o	0			24. 10
25. 00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER						26. 25
27. 00	Total (sum of lines 14-26)				0.00	263. 86	
28. 00	Observation Bed Days		0	642			28. 00
29. 00	Ambul ance Tri ps	0		_			29. 00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32. 01
33 00	LTCH non-covered days	0					33. 00
55.00	1=:5:: ::5:: 55:5: 54 44.35	١	ı		I .	ı	1 55. 55

| In Lieu of Form CMS-2552-10 | Provider CCN: 151310 | Period: | Worksheet S-3 | From 01/01/2014 | Part I | To 1/21/2014 | Part I | To 1/21/2014 | Part I | Propagate: | Propa Health Financial Systems WABASI HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

					To 12/31/2014	Date/Time Pre 5/27/2015 8:0	
		Full Time Equivalents		Di s	charges	1 0, 2,, 20,0	
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions)		1		29	520	2.00
3. 00 4. 00 5. 00 6. 00 7. 00	HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)				0		3. 00 4. 00 5. 00 6. 00 7. 00
8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY						8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00	Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE	0.00	,	0 2:	39 29	520	14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00
22. 00 23. 00 24. 00 24. 10 25. 00 26. 00 26. 25	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	0. 00					22. 00 23. 00 24. 00 24. 10 25. 00 26. 00 26. 25
27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01	Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days	0. 00					27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01

Health Financial Systems	WABASH COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 151310	Peri od: Worksheet S-3 From 01/01/2014 Part IV
		To 12/31/2014 Date/Time Prepared:

	To 12/31/2014	Date/Time Prep 5/27/2015 8:04	
		Amount	
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	762, 121	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)	3, 427, 472	8. 00
9.00	Prescription Drug Plan	0	
10.00	Dental, Hearing and Vision Plan	0	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	27, 860	
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	39, 215	
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15. 00	'Workers' Compensation Insurance	162, 801	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		
17. 00	FICA-Employers Portion Only	1, 101, 087	
18. 00	Medicare Taxes - Employers Portion Only	0	18. 00
19. 00	Unempl oyment Insurance	22, 519	19. 00
20.00	State or Federal Unemployment Taxes	0	20. 00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21. 00
	instructions))		
22. 00	Day Care Cost and Allowances	0	
23. 00	Tuition Reimbursement	45, 512	
24. 00	Total Wage Related cost (Sum of lines 1 -23)	5, 588, 587	24. 00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00

Heal th	Financial Systems	WABASH COUNT	Y HOSPITAL		In lie	eu of Form CMS-2	2552-10
	BEALTH AGENCY STATISTICAL DATA				Peri od: From 01/01/2014	Worksheet S-4	
			Componen		To 12/31/2014	Date/Time Pre 5/27/2015 8:0	
					Home Health	PPS	
					Agency I		
0.00	County				WABASH	00	0.00
-	,	Title V	Title XVIII	Title XIX	0ther	Total	
	HOME HEALTH AGENCY STATISTICAL DATA	1. 00	2. 00	3.00	4. 00	5. 00	
1.00	Home Health Aide Hours	0	C		0 0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	0.00				2. 00
				Number of Em	ployees (Full Ti	me Equivarent)	
		Enter the numb	er of hours in	Staff	Contract	Total	
		your normal	l work week				
			0	1.00	2.00	3. 00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES		J	1.00	2.00	3.00	
3.00	Administrator and Assistant Administrator(s)		0.00	1			
4. 00 5. 00	Director(s) and Assistant Director(s) Other Administrative Personnel			0.0			4. 00 5. 00
6.00	Direct Nursing Service			0.0	0.00	0.00	6. 00
7. 00 8. 00	Nursing Supervisor Physical Therapy Service			0.0		l	
9. 00	Physical Therapy Supervisor			0.0		l	
10.00	Occupational Therapy Service			0.0			
11. 00 12. 00	Occupational Therapy Supervisor Speech Pathology Service			0.0			
13. 00	Speech Pathology Supervisor			0.0		l	
14.00	Medical Social Service			0.0		1	
15. 00 16. 00	Medical Social Service Supervisor Home Health Aide			0.0		l .	
17. 00	Home Health Aide Supervisor			0.0		1	
18. 00	Other (specify) HOME HEALTH AGENCY CBSA CODES			0.0	0.00	0.00	18. 00
19. 00	Enter in column 1 the number of CBSAs where				1		19. 00
	you provided services during the cost						
20. 00	reporting period. List those CBSA code(s) in column 1 serviced			15999			20. 00
	during this cost reporting period (line 20						
	contains the first code).	Full E	pi sodes				
		Wi thout	With Outliers	LUPA Epi sode		Total (cols.	
		0utliers 1.00	2. 00	3. 00	Epi sodes 4. 00	1-4) 5. 00	
04.00	PPS ACTIVITY DATA	(04				704	04.00
21. 00 22. 00	Skilled Nursing Visits Skilled Nursing Visit Charges	694 107, 686			53 15 01 2, 149	l e	
23. 00	Physical Therapy Visits	1, 013	26	) 2	25 38	1, 102	23. 00
24. 00 25. 00	Physical Therapy Visit Charges Occupational Therapy Visits	127, 763			92 4, 796 2 0	l	
26. 00	Occupational Therapy Visits  Occupational Therapy Visit Charges	208 25, 442	l .				
27. 00	Speech Pathology Visits	64	18	3	0 0		27. 00
28. 00 29. 00	Speech Pathology Visit Charges Medical Social Service Visits	8, 115	2, 519		0 0		28. 00 29. 00
30.00	Medical Social Service Visit Charges	0		1	0 0	ő	30.00
31.00	Home Health Aide Visits	97		1	0 0		31.00
32. 00 33. 00	Home Health Aide Visit Charges Total visits (sum of lines 21, 23, 25, 27,	6, 465 2, 076			0 0	6, 465 2, 297	32. 00 33. 00
	29, and 31)						
34. 00 35. 00	Other Charges Total Charges (sum of lines 22, 24, 26, 28,	140 275, 611	l .		1 6 21 6, 951	147 305, 758	
	30, 32, and 34)						
36. 00	Total Number of Episodes (standard/non outlier)	125		2	20 4	149	36. 00
37. 00	Total Number of Outlier Episodes		1		0		
38. 00	Total Non-Routine Medical Supply Charges	12	(	)	0 0	12	38. 00

	Financial Systems		WABASH COUNT				eu of Form CMS-	<u> 2552-10</u>
H0SPI 7	TAL IDENTIFICATION DATA			Provi der	CCN: 151310	Peri od:	Worksheet S-9	
				0	+ CON 151545	From 01/01/2014		
				Componer	nt CCN: 151545	To 12/31/2014	Date/Time Pre 5/27/2015 8:0	
						Hospi ce I	0,27,2010 0.0	T GIII
		Unduplicated		<u> </u>		<u>'                                    </u>		
		Days						
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
				Skilled	Nursi ng		cols. 1, 2 &	
				Nursi ng	Facility		5)	
				Facility				
		1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART I - ENROLLMENT DAYS							
1. 00	Continuous Home Care	0	0		0	0	0	1.00
2.00	Routine Home Care	7, 301	0		0	0	7, 301	
3.00	Inpatient Respite Care	50	0		0	0	50	1 0.00
4.00	General Inpatient Care	0	0		0	0	0	4.00
5. 00	Total Hospice Days	7, 351	0		0	0 0	7, 351	5. 00
	Part II - CENSUS DATA							
6.00	Number of Patients Receiving	0	0		0	0 0	0	6. 00
	Hospi ce Care							
7.00	Total Number of Unduplicated	0. 00		0.0	0			7. 00
	Continuous Care Hours Billable							
	1							

0.00

0.00

0.00

0

0.00

8. 00

9. 00

0. 00

93

0.00

93

8.00

9.00

to Medicare Average Length of Stay (line 5/line 6)

Unduplicated Census Count

1. 00	Uncompensated and indigent care cost computation Cost to charge ratio (Worksheet C, Part I line 202 column 3 divid Medicaid (see instructions for each line) Net revenue from Medicaid Did you receive DSH or supplemental payments from Medicaid? If line 3 is "yes", does line 2 include all DSH or supplemental p If line 4 is "no", then enter DSH or supplemental payments from Medicaid charges			Peri od: From 01/01/2014 To 12/31/2014	Worksheet S-10 Date/Time Prep 5/27/2015 8:04	pared:
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divid Medicaid (see instructions for each line)  Net revenue from Medicaid  Did you receive DSH or supplemental payments from Medicaid?  If line 3 is "yes", does line 2 include all DSH or supplemental p  If line 4 is "no", then enter DSH or supplemental payments from M  Medicaid charges				5/27/2015 8: 02	
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divid Medicaid (see instructions for each line)  Net revenue from Medicaid  Did you receive DSH or supplemental payments from Medicaid?  If line 3 is "yes", does line 2 include all DSH or supplemental p  If line 4 is "no", then enter DSH or supplemental payments from M  Medicaid charges		202 column	8)	1.00	
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divid Medicaid (see instructions for each line)  Net revenue from Medicaid  Did you receive DSH or supplemental payments from Medicaid?  If line 3 is "yes", does line 2 include all DSH or supplemental p  If line 4 is "no", then enter DSH or supplemental payments from M  Medicaid charges		202 column	8)		
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 3. 00	Medicaid (see instructions for each line)  Net revenue from Medicaid  Did you receive DSH or supplemental payments from Medicaid?  If line 3 is "yes", does line 2 include all DSH or supplemental p  If line 4 is "no", then enter DSH or supplemental payments from M  Medicaid charges		202 column	8)		
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 3. 00	Net revenue from Medicaid Did you receive DSH or supplemental payments from Medicaid? If line 3 is "yes", does line 2 include all DSH or supplemental p If line 4 is "no", then enter DSH or supplemental payments from M Medicaid charges	pavments fro			0. 361649	1.00
3. 00 4. 00 5. 00 5. 00 7. 00 3. 00	Did you receive DSH or supplemental payments from Medicaid? If line 3 is "yes", does line 2 include all DSH or supplemental p If line 4 is "no", then enter DSH or supplemental payments from M Medicaid charges	pavments fro				
4. 00 5. 00 6. 00 7. 00 3. 00	If line 3 is "yes", does line 2 include all DSH or supplemental p If line 4 is "no", then enter DSH or supplemental payments from M Medicaid charges	avments fro			1, 801, 570	1
5. 00 6. 00 7. 00 3. 00	If line 4 is "no", then enter DSH or supplemental payments from M Medicaid charges	avments fro			Y	3.0
5. 00   1 7. 00   1 8. 00   1	Medicaid charges		m Medicaid	i?	0,4,400	4.0
7. 00 3. 00		leai cai a			364, 622	1
3.00					7, 440, 806 2, 690, 960	
	Medicaid cost (line 1 times line 6) Difference between net revenue and costs for Medicaid program (li	ne 7 minus	sum of lir	nes 2 and 5: if	524, 768	1
	< zero then enter zero)			es 2 and 5, 11	524, 700	] 8.0
'. UU I	State Children's Health Insurance Program (SCHIP) (see instruction Net revenue from stand-alone SCHIP	ins for each	i i i ne)		0	9.0
	Stand-alone SCHIP charges				0	
	Stand-alone SCHIP cost (line 1 times line 10)				0	
	Difference between net revenue and costs for stand-alone SCHIP (I	ine 11 minu	ıs line 9:	if < zero then	0	
	enter zero)				1	]
	Other state or local government indigent care program (see instru					
	Net revenue from state or local indigent care program (Not includ			<i>'</i>		13.0
	Charges for patients covered under state or local indigent care p 10)	rogram (Not	: i ncl uded	in lines 6 or	0	14. (
	State or local indigent care program cost (line 1 times line 14)				0	
Ŀ	Difference between net revenue and costs for state or local indig 13; if < zero then enter zero)	jent care pr	ogram (lin	e 15 minus line	0	16.0
	Uncompensated care (see instructions for each line)					١
	Private grants, donations, or endowment income restricted to fund					17.0
	Government grants, appropriations or transfers for support of hos			o (oum of lines	0	
	Total unreimbursed cost for Medicaid , SCHIP and state and local 8, 12 and 16)	rnargent ca	ire program	s (sum of fines	524, 768	19.0
			Uni nsured	Insured	Total (col. 1	
		_	patients	patients	+ col . 2)	
0.00	Total initial obligation of nationts approved for -tity (-	+ 6.11	1.00	2.00	3. 00 1, 184, 675	20.0
	Total initial obligation of patients approved for charity care (a charges excluding non-reimbursable cost centers) for the entire f		1, 184, 67	5	1, 184, 6/5	20. C
	Cost of initial obligation of patients approved for charity care		428, 43	37 0	428, 437	21.0
-	times line 20)					
	Partial payment by patients approved for charity care			0 0	0	
23. 00	Cost of charity care (line 21 minus line 22)		428, 43	37 0	428, 437	23.0
					1. 00	
	Does the amount in line 20 column 2 include charges for patient d		a length c	f stay limit	N	24.0
	imposed on patients covered by Medicaid or other indigent care pr					
	If line 24 is "yes," charges for patient days beyond an indigent		am's lengt	h of stay limit	0	
	Total bad debt expense for the entire hospital complex (see instr				2, 463, 696	
	Medicare bad debts for the entire hospital complex (see instructi	,	. 07)		368, 441	
	Non-Medicare and non-reimbursable Medicare bad debt expense (line			20)	2, 095, 255	1
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt expen	ise (iine 1	times line	∠∀)	757, 747 1, 186, 184	1
	Cost of uncompensated care (line 23 column 3 plus line 29) Total unreimbursed and uncompensated care cost (line 19 plus line			,		1 30 0

Health Financial Systems	WABASH COUNTY				u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der		eriod: rom 01/01/2014	Worksheet A	
				o 12/31/2014	Date/Time Pre	
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	5/27/2015 8:0 Reclassi fi ed	4 alli
cook conton become per on	our ur roo	0 (1.10)	+ col . 2)	ons (See A-6)	Trial Balance	
			ŕ	,	(col. 3 +-	
					col . 4)	
OFWERN OFRIGO COOT OFWERN	1.00	2. 00	3. 00	4. 00	5. 00	
GENERAL SERVICE COST CENTERS		420, 227	420.227		420, 227	1 00
1.00   00100   NEW CAP REL COSTS-BLDG & FIXT 2.00   00200   NEW CAP REL COSTS-MVBLE EQUIP		428, 226			428, 226 887, 702	1.00
2.00   OO200   NEW CAP REL COSTS-MVBLE EQUIP 4.00   OO400   EMPLOYEE BENEFITS DEPARTMENT	144, 736	873, 195 327, 077			471, 813	2. 00 4. 00
5. 01   00561 OTHER ADMINISTRATIVE AND GENERAL	1, 354, 651	3, 529, 270			4, 883, 078	5. 01
5. 02 00560 BUSI NESS OFFI CE	381, 540	663, 257			1, 044, 797	5. 02
6. 00   00600 MAI NTENANCE & REPAI RS	304, 288	483, 024				6. 00
7. 00 00700 OPERATION OF PLANT	0	609, 872				7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	l ol	0	007,072		0	8. 00
9. 00   00900   HOUSEKEEPI NG	234, 336	420, 078	654, 414		654, 414	9. 00
10. 00   01000 DI ETARY	426, 825	540, 953				10.00
11. 00   01100   CAFETERI A	O	0	C			11. 00
13.00 01300 NURSING ADMINISTRATION	167, 827	58, 865	226, 692		226, 692	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	46, 602	999, 756	1, 046, 358	0	1, 046, 358	14. 00
15. 00 01500 PHARMACY	709, 879	2, 328, 824	3, 038, 703	-8, 348	3, 030, 355	15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	280, 713	226, 881	507, 594	0	507, 594	16. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	1, 536, 565	678, 206	2, 214, 771	32, 720	2, 247, 491	30. 00
43. 00 04300 NURSERY	0	0	C	0	0	43. 00
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATI NG ROOM	684, 500	909, 660			1, 618, 592	50. 00
51. 00 05100 RECOVERY ROOM	67, 133	26, 055	1		93, 188	51.00
52. 00   05200   DELI VERY ROOM & LABOR ROOM	0	0	0		0	52. 00
53. 00 05300 ANESTHESI OLOGY	880, 528	490, 524			1, 371, 052	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	756, 731	1, 288, 945			2, 061, 800	54.00
56. 00   05600   RADI OI SOTOPE	76, 762	105, 995			182, 757	56. 00
60. 00 06000 LABORATORY	679, 446	1, 285, 513			1, 964, 959	60.00
63.00 O6300 BLOOD STORING, PROCESSING & TRANS.	0 883, 202	96, 975 504, 629	96, 975 1, 387, 831		96, 975 1, 401, 971	63. 00 66. 00
69. 00   06900   ELECTROCARDI OLOGY	575, 788	325, 117			907, 090	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	373, 788		1		769, 494	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT		1, 274, 715	1, 274, 713		505, 221	72.00
73. 00 07300 DRUGS CHARGED TO PATTENTS		0	1			73.00
OUTPATIENT SERVICE COST CENTERS	<u> </u>	0		0	0	73.00
90. 00 09000 CLINIC	O	125, 189	125, 189	0	125, 189	90. 00
90. 01   09001   SENI OR CARE	138, 748	138, 578			277, 326	90. 01
91. 00 09100 EMERGENCY	857, 439	1, 580, 772			2, 460, 282	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		.,,	_,,	,,	_,,	92.00
OTHER REIMBURSABLE COST CENTERS	· · · · · · · · · · · · · · · · · · ·			<b>'</b>		
101.00 10100 HOME HEALTH AGENCY	713, 969	456, 722	1, 170, 691	2, 123	1, 172, 814	101. 00
SPECIAL PURPOSE COST CENTERS						
116. 00 11600 HOSPI CE	365, 105	337, 662				
118.00 SUBTOTALS (SUM OF LINES 1-117)	12, 267, 313	21, 114, 535	33, 381, 848	-14, 387	33, 367, 461	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	3, 467, 572	2, 332, 601	5, 800, 173	2, 535		
194.00 07950 FITNESS CENTER	0	0	0	0		194. 00
194. 01 07951 MARKETI NG	78, 696	122, 841	201, 537		201, 537	
194. 02 07952 NEW DIRECTION	0	0	C	0		194. 02
194. 03 07953 RESPI TE	0	0	C	0		194. 03
194. 04 07954 WELL CHILD CLINIC	75, 983	49, 640			137, 475	
200.00   TOTAL (SUM OF LINES 118-199)	15, 889, 564	23, 619, 617	39, 509, 181	0	39, 509, 181	J∠UU. UU

Provi der CCN: 151310

Peri od: Worksheet A From 01/01/2014 Date/Time Prepared: 5/27/2015 8:04 am

			5/27/2015 8:	04 am
Cost Center Description	Adjustments	Net Expenses		
·	(See A-8)	For Allocation		
	6.00	7.00		
GENERAL SERVICE COST CENTERS				
1.00   OO100 NEW CAP REL COSTS-BLDG & FIXT	-32, 241	395, 985		1. 00
2.00   00200 NEW CAP REL COSTS-MVBLE EQUIP	-128, 647	759, 055		2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	-1, 426	470, 387		4. 00
5.01 00561 OTHER ADMINISTRATIVE AND GENERAL	-233, 584	4, 649, 494		5. 01
5. 02   00560   BUSI NESS OFFI CE	C	1, 044, 797		5. 02
6.00 00600 MAINTENANCE & REPAIRS	-64	829, 556		6. 00
7.00 00700 OPERATION OF PLANT	-8, 613	421, 453		7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	C	0		8. 00
9. 00 00900 HOUSEKEEPI NG	C	654, 414		9. 00
10. 00 01000 DI ETARY	C	421, 462		10.00
11. 00 01100 CAFETERI A	-203, 478			11. 00
13.00 01300 NURSING ADMINISTRATION	C	1		13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	-1, 212	1		14. 00
15. 00 01500 PHARMACY	-86, 652			15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	-14, 247	1		16. 00
INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>			
30. 00 03000 ADULTS & PEDI ATRI CS	-397, 304	1, 850, 187		30.00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS	1			
50. 00 05000 OPERATING ROOM	C	1, 618, 592		50. 00
51.00 O5100 RECOVERY ROOM	C	93, 188		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	C	o		52.00
53. 00   05300   ANESTHESI OLOGY	-1, 297, 524	73, 528		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	-535	2, 061, 265		54. 00
56. 00   05600   RADI OI SOTOPE	C	182, 757		56. 00
60. 00   06000   LABORATORY	-11, 861	1, 953, 098		60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	C	96, 975		63. 00
66. 00 06600 PHYSI CAL THERAPY	C	1, 401, 971		66. 00
69. 00 06900 ELECTROCARDI OLOGY	-244, 798	662, 292		69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C	769, 494		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	C	505, 221		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	C	0		73. 00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	C	125, 189		90. 00
90. 01  09001   SENI OR CARE	C			90. 01
91. 00   09100   EMERGENCY	C	2, 460, 282		91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				92. 00
OTHER REIMBURSABLE COST CENTERS				
101.00 10100 HOME HEALTH AGENCY	C	1, 172, 814		101. 00
SPECIAL PURPOSE COST CENTERS	_			
116. 00 11600 HOSPI CE	0			116. 00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	-2, 662, 186	30, 705, 275		118. 00
NONREI MBURSABLE COST CENTERS				100.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	1		190.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	C			192. 00
194. 00 07950 FITNESS CENTER	C	1		194. 00
194. 01 07951 MARKETI NG	C			194. 01
194. 02 07952 NEW DI RECTI ON	C	1		194. 02
194. 03 07953 RESPI TE	C	1		194. 03
194. 04 07954 WELL CHILD CLINIC	2 442 194			194. 04
200.00   TOTAL (SUM OF LINES 118-199)	-2, 662, 186	36, 846, 995		200. 00

Health Financial Systems WABASH COUNTY HOSPITAL In Lieu of Form CMS-2552-10
RECLASSIFICATIONS Provider CCN: 151310 Period: Worksheet A-6
From 01/01/2014

KECEAS	STITEATIONS	110VI dei	OCIN. 131310	From 01/01/2014	WOI KSHEEL A	O		
							Date/Time Pr 5/27/2015 8	repared:
		Increases				<u>'</u>		
	Cost Center	Li ne #	Sal ary	Other				
	2. 00	3.00	4. 00	5. 00				
	A - CAFETERIA							
1.00	CAFETERI A	11. 00	240, 945	305, 371				1. 00
	TOTALS		240, 945	305, 371				
	B - TUMOR REGISTRY							
1.00	OTHER ADMINISTRATIVE AND	5. 01	0	12, 001				1. 00
	GENERAL							
	TOTALS		0	12, 001				
	E - INTEREST							
1.00	NEW CAP REL COSTS-MVBLE	2. 00	0	14, 507				1. 00
	EQUI P							
	TOTALS		0	14, 507				
	G - LAUNDRY							
1. 00	OTHER ADMINISTRATIVE AND	5. 01	0	1, 663				1. 00
	GENERAL							
2.00	MAINTENANCE & REPAIRS	6. 00	0	42, 308				2. 00
3.00	PHARMACY	15. 00	0	3, 653				3. 00
4.00	ADULTS & PEDIATRICS	30.00	0	32, 720				4. 00
5.00	OPERATING ROOM	50.00	0	24, 432				5. 00
6. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	16, 124				6. 00
7.00	PHYSI CAL THERAPY	66.00	0	14, 140				7. 00
8.00	ELECTROCARDI OLOGY	69. 00	0	6, 185				8. 00
9.00	EMERGENCY	91.00	0	22, 071				9. 00
10.00	HOME HEALTH AGENCY	101.00	0	2, 123				10. 00
11. 00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	2, 535				11. 00
12.00	WELL CHILD CLINIC	194. 04	0	11, 852				12. 00
	TOTALS		0	179, 806				
	H - IMPLANTS							
1.00	IMPL. DEV. CHARGED TO	72. 00	0	505, 221				1. 00
	PATI ENT							
	TOTALS		0	505, 221				
500.00	Grand Total: Increases		240, 945	1, 016, 906				500.00

Heal th Financial Systems WABASH COUNTY HOSPITAL In Lieu of Form CMS-2552-10
RECLASSIFICATIONS Provider CCN: 151310 Period: From 01/01/2014 To 12/31/2014 Date/Time Prepared:

						To 12/31/2014	Date/Time Pre	epared:
		Decreases					3/2//2015 8: C	)4 am
	Cost Center	Li ne #	Salary	Other	Wkst. A-7 Ref.			
	6.00	7. 00	8.00	9. 00	10.00			
	A - CAFETERIA		2.22					
1.00	DI ETARY	10.00	240, 945	305, 371	C			1. 00
	TOTALS		240, 945	305, 371				
	B - TUMOR REGISTRY							
1.00	PHARMACY	<u>15.</u> 00	0_	12, 001				1. 00
	TOTALS		0	12, 001				
	E - INTEREST							
1.00	OTHER ADMINISTRATIVE AND	5. 01	0	14, 507	9	9		1. 00
	GENERAL	+						
	TOTALS		0	14, 507				-
	G - LAUNDRY	7 00	اه	170.00/				4
1.00	OPERATION OF PLANT	7. 00	0	179, 806		)		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 6. 00		0. 00 0. 00	U	0				5. 00 6. 00
6. 00 7. 00		0.00	U	0				7.00
7. 00 8. 00		0.00	U O	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
12.00	TOTALS — — — —			179, 806	<del> </del>	<u>'</u>		12.00
	H - IMPLANTS		<u> </u>	177,000	1			-
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	505, 221				1.00
00	PATI ENTS	71.00	Ĭ	300, 221				
	TOTALS	+		505, 221		1		
500.00	Grand Total: Decreases		240, 945	1, 016, 906		1		500. 00

RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 151310 Peri od: Worksheet A-7 From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/27/2015 8:04 am Acqui si ti ons Begi nni ng Purchases Donati on Total Di sposal s and Bal ances Retirements 2.00 3.00 4. 00 1 00 5 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 1, 295, 014 0 1.00 0 2.00 Land Improvements 314, 699 0 0 2.00 3.00 15, 457, 129 2, 877, 039 3.00 Buildings and Fixtures 0 0 4.00 Building Improvements 3, 810, 773 340, 086 340, 086 0 4.00 5.00 Fixed Equipment 845, 994 22, 336 0 22, 336 5.00 0 6.00 Movable Equipment 13, 090, 166 901, 647 901, 647 0 6.00 0 7.00 HIT designated Assets 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 34, 813, 775 1, 264, 069 1, 264, 069 2, 877, 039 8.00 9.00 Reconciling Items 0 9.00 <u>34, 813, 77</u>5 Total (line 8 minus line 9) 2, 877, 039 10.00 1, 264, 069 0 1, 264, 069 10.00 Endi ng Bal ance Fully Depreci ated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 1, 295, 014 0 1.00 2.00 Land Improvements 314, 699 0 2.00 3.00 Buildings and Fixtures 12, 580, 090 0 3.00 0 4.00 Building Improvements 4, 150, 859 4.00 5.00 Fi xed Equipment 868, 330 0 5.00 Movable Equipment 0 6.00 13, 991, 813 6.00 7.00 HIT designated Assets 0 7.00

33, 200, 805

33, 200, 805

0

0

8.00

9.00

10.00

Subtotal (sum of lines 1-7)

Reconciling Items

10.00 Total (line 8 minus line 9)

8.00

9.00

Heal th	Financial Systems	WABASH COUNT	Y HOSPITAL		In Lieu of Form CMS-2552		
	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 151310	Peri od: From 01/01/2014	Worksheet A-7 Part II	
					To 12/31/2014	Date/Time Prep 5/27/2015 8:04	
		SUMMARY OF CAPITAL					
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)		
		9. 00	10.00	11. 00	12.00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FLXT	428, 226	0		0 0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	873, 195	0		0 0	ol	2.00
3.00	Total (sum of lines 1-2)	1, 301, 421	0		0 0	ol	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	(SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	428, 226				1. 00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	873, 195				2. 00
	1	1		I		,	

0 0 0

428, 226 873, 195 1, 301, 421

1. 00 2. 00 3. 00

3.00 Total (sum of lines 1-2)

Heal th	Financial Systems	WABASH COUNT	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 01/01/2014 To 12/31/2014	Worksheet A-7 Part III Date/Time Prep 5/27/2015 8:04	
		COMI	PUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col 2)	instructions)	Insurance	
		1, 00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE		2.00	3.00	4.00	3.00	
1.00	NEW CAP REL COSTS-BLDG & FLXT	217, 498	С	217, 49	0. 311654	0	1. 00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	480, 386	0	480, 38	0. 688346	0	2.00
3.00	Total (sum of lines 1-2)	697, 884		697, 88			3. 00
		ALLOCA <sup>-</sup>	TION OF OTHER (	CAPI TAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	0ther	Total (sum o	f Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)			
	DART LILL BESSELLLATION OF SARITAL SOCTO OF	6.00	7. 00	8. 00	9. 00	10.00	
1 00	PART III - RECONCILIATION OF CAPITAL COSTS CENEW CAP REL COSTS-BLDG & FIXT	INTERS 0		ı	0 395, 985	0	1. 00
1. 00 2. 00	NEW CAP REL COSTS-BLDG & FIXT	0	l ~		0 759, 055		2. 00
3.00	Total (sum of lines 1-2)	0			0 1, 155, 040		3. 00
3.00	Total (Suil of Titles 1-2)	0	SI	'L JMMARY OF CAPI		0	3.00
			30	SWIMPART OF CPATE	IAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
			instructions)	instructions	) Capi tal -Relate		
					d Costs (see instructions)	through 14)	
		11. 00	12.00	13.00	14. 00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE						
1.00	NEW CAP REL COSTS-BLDG & FLXT	0	C		0 0	395, 985	1. 00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	)	0 0	759, 055	2.00
3.00	Total (sum of lines 1-2)	0	C	)	0	1, 155, 040	3. 00

Health Financial Systems
ADJUSTMENTS TO EXPENSES WABASH COUNTY HOSPITAL In Lieu of Form CMS-2552-10 Provi der CCN: 151310 Peri od: From 01/01/2014 To 12/31/2014 Worksheet A-8 Date/Time Prepared: 5/27/2015 8:04 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted

				To/From Which the Amount is t	o be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
1. 00	Investment income - NEW CAP	1.00	2.00	3.00 NEW CAP REL COSTS-BLDG &	4. 00 1. 00	5.00	1. 00
	REL COSTS-BLDG & FIXT (chapter 2)			FIXT			
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter	В	-14, 507	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	2. 00
3. 00	Investment income - other		0		0.00	0	3. 00
4. 00	(chapter 2) Trade, quantity, and time	В	-2, 310	OTHER ADMINISTRATIVE AND	5. 01	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of		0	GENERAL	0.00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay stations excluded) (chapter		0		0.00	O	7. 00
8. 00	21) Tel evi si on and radi o servi ce (chapter 21)	В	-8, 613	OPERATION OF PLANT	7. 00	0	8. 00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	0 -91, 192		0.00	0	9. 00 10. 00
	adjustment	A-0-2	-91, 192		0.00		
11. 00	(chapter 23)		0		0. 00		
12. 00	transactions (chapter 10)	A-8-1	0			0	
13. 00 14. 00		В	0 -203, 478	CAFETERI A	0. 00 11. 00	l .	13. 00 14. 00
15. 00	Rental of quarters to employee and others		0		0.00	0	15. 00
16. 00	Sale of medical and surgical supplies to other than patients	В	-1, 212	CENTRAL SERVICES & SUPPLY	14. 00	0	16. 00
17. 00	11.	В	-86, 652	PHARMACY	15. 00	0	17. 00
18. 00	Sale of medical records and	В	-14, 247	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	abstracts Nursing school (tuition, fees, books, etc.)		0		0.00	0	19. 00
20. 00 21. 00		В	-64 0	MAINTENANCE & REPAIRS	6. 00 0. 00		20. 00 21. 00
	interest, finance or penalty charges (chapter 21)		_				
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22. 00
23. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	0	*** Cost Center Deleted ***	65. 00		23. 00
24. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
25. 00	limitation (chapter 14) Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
26. 00	(chapter 21) Depreciation - NEW CAP REL			NEW CAP REL COSTS-BLDG &	1. 00	0	26. 00
27. 00	·		0	FIXT NEW CAP REL COSTS-MVBLE	2. 00	0	27. 00
28. 00	1 3			EQUIP *** Cost Center Deleted ***	19. 00		28. 00
29. 00 30. 00	1 3	A-8-3	0	*** Cost Center Deleted ***	0. 00 67. 00		29. 00 30. 00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30. 99
31. 00	Adjustment for speech pathology costs in excess of	A-8-3	0	*** Cost Center Deleted ***	68. 00		31. 00
32. 00	limitation (chapter 14) CAH HIT Adjustment for Depreciation and Interest		0		0.00	O	32. 00

Heal th	Financial Systems		WABASH COUNT	Y HOSPI TAL	In Lie	eu of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES				Peri od:	Worksheet A-8	
					From 01/01/2014		
					To 12/31/2014	Date/Time Pre 5/27/2015 8:0	
				Expense Classification on	Worksheet A	0,27,2010 010	
				To/From Which the Amount is	to be Adjusted		
					•		
	C+ C+ D	D:- (0I- (2)	A ±	0	1: //	WI+ A 7 D-6	
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
33. 00	DEVELOPMENT	1.00	2.00	3. 00 OTHER ADMINISTRATIVE AND	4. 00	5. 00	33. 00
33.00	DEVELOPMENT	A	-159, 533	GENERAL	5.01	U	33.00
35 00	MI SC. REV	В	_33_470	OTHER ADMINISTRATIVE AND	5. 01	0	35. 00
33.00	WI SC. REV		-33, 470	GENERAL	3.01	0	33.00
37. 00			0	OENEW LE	0.00	0	37. 00
38. 00	LAB FEES	В	-11, 861	LABORATORY	60.00		•
39. 00	CARDI AC REHAB	В	-160, 798	ELECTROCARDI OLOGY	69.00	0	39. 00
40. 00	ANESTHESI A	В	-1, 297, 524	ANESTHESI OLOGY	53.00	0	40.00
42.00	PHYSICIAN RECRUIT	A	-31, 465	OTHER ADMINISTRATIVE AND	5. 01	0	42.00
				GENERAL			
43.00			0		0.00	0	43. 00
44. 00	LOBBYI NG	A	-6, 806	OTHER ADMINISTRATIVE AND	5. 01	0	44. 00
				GENERAL			
45. 00	PROPERTY TAXES	A		NEW CAP REL COSTS-BLDG &	1.00	9	45. 00
	EL TUEGO OFILTED			FIXT			
45. 01	FITNESS CENTER	В	•	EMPLOYEE BENEFITS DEPARTMENT			1 .0.0.
45. 02	MRI	В		RADI OLOGY-DI AGNOSTI C	54.00	•	45. 02
46. 00	HOSPI TALI ST	A	•	ADULTS & PEDIATRICS	30.00	•	1 .0.00
46. 01	EHR DEPRECIATION	A	•	NEW CAP REL COSTS-MVBLE	2.00	9	46. 01
47. 00			0	EQUI P	0.00	0	47. 00
50.00	TOTAL (sum of lines 1 thru 49)		-2, 662, 186		0.00	١	50.00
50.00	(Transfer to Worksheet A,		-2,002,100				30.00
	column 6 Line 200 )						

column 6, line 200.) (1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT

						To 12/31/2014	Date/Time Pre 5/27/2015 8:0	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	T GIII
		Identi fi er	Remuneration	Component	Component		ider Component	
				'	·		Hours	
	1. 00	2. 00	3.00	4. 00	5. 00	6. 00	7. 00	
1.00		ADULTS & PEDIATRICS	7, 192			0	0	1. 00
2.00	69. 00	ELECTROCARDI OLOGY	84, 000	84, 000			0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0. 00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0. 00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7. 00
8.00	0.00		0	0	0	0	0	8. 00
9.00	0.00		0	0	0	0	0	9. 00
10.00	0.00		0	0	0	0	0	10.00
200.00			91, 192	91, 192	0	)	0	200.00
	Wkst. A Line #		Unadjusted RCE		Cost of	Provi der	Physician Cost	
		l denti fi er	Limit	Unadjusted RCE		Component	of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
4.00	1.00	2.00	8.00	9.00	12. 00	13.00	14. 00	1.00
1.00		ADULTS & PEDIATRICS	0	0	_			1.00
2.00		ELECTROCARDI OLOGY	0	l				2.00
3.00	0.00		0	0	_		0	3. 00
4.00	0.00			0	0	_	0	4. 00
5. 00 6. 00	0. 00 0. 00			0		1	0	5. 00 6. 00
7. 00	0.00			0	0		0	7. 00
8. 00	0.00			0	0	0	0	8. 00
9. 00	0.00			0			0	9. 00
10.00	0.00			0	0	0	0	10. 00
200.00	0.00			0			0	
200.00	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	0	200.00
	MKSt. A LITTO "	I denti fi er	Component	Limit	Di sal I owance	naj as tilicire		
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1.00		ADULTS & PEDIATRICS	0	0	0			1. 00
2.00		ELECTROCARDI OLOGY	0	0		84, 000		2.00
3.00	0.00		0	0	0	_		3.00
4.00	0.00		0	0	_	1		4. 00
5.00	0.00		0	0	_	_		5. 00
6.00	0.00		0	0	_	0		6. 00
7.00	0.00		0	0		0		7. 00
8.00	0.00	1	0	0		0		8.00
9.00	0. 00	1	0	0				9. 00
10.00	0. 00		0	0	_			10.00
200. 00			0	0	0	91, 192		200. 00

COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 151310 Peri od: Worksheet B From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/27/2015 8:04 am CAPITAL RELATED COSTS Cost Center Description Net Expenses NEW BLDG & NEW MVBLE EMPLOYEE Subtotal for Cost FIXT **FOULP BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1 00 395, 985 1 00 00100 NEW CAP REL COSTS-BLDG & FIXT 395, 985 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 759, 055 759, 055 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 470, 387 7, 693 499 478, 579 4.00 00561 OTHER ADMINISTRATIVE AND GENERAL 5 01 4 649 494 40, 483 125 602 41, 176 4, 856, 755 5 01 5.02 00560 BUSINESS OFFICE 1,044,797 C 6,890 11, 597 1,063,284 5.02 6.00 00600 MAINTENANCE & REPAIRS 829, 556 175, 476 9, 249 1, 014, 281 6.00 7.00 00700 OPERATION OF PLANT 421, 453 80, 210 501, 663 7.00 0 00800 LAUNDRY & LINEN SERVICE 8 00 0 8 00 0 0 9.00 00900 HOUSEKEEPI NG 654, 414 6,019 7, 123 667, 556 9.00 01000 DI ETARY 421, 462 444, 829 10.00 15, 547 2, 170 5,650 10.00 01100 CAFETERI A 342, 838 4, 822 7, 324 354, 984 11.00 11.00 C 01300 NURSING ADMINISTRATION 226, 692 1, 505 13.00 O 5, 101 233, 298 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 1,045,146 16, 412 694 1, 417 1,063,669 14.00 01500 PHARMACY 2, 943, 703 15.00 14, 697 61, 404 21, 577 3, 041, 381 15.00 <u>12, 8</u>13 01600 MEDICAL RECORDS & LIBRARY 16.00 493, 347 8,533 515, 220 527 16,00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 1, 850, 187 1, 954, 426 30.00 34, 063 23, 471 46, 705 43.00 04300 NURSERY 43.00 0 ANCILLARY SERVICE COST CENTERS 1, 778, 591 50.00 05000 OPERATING ROOM 1, 618, 592 25, 777 113, 416 20, 806 50.00 93, 188 05100 RECOVERY ROOM 51.00 2, 972 0 2,041 98, 201 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 52.00 0 05300 ANESTHESI OLOGY 53 00 73.528 26, 765 100, 829 53.00 536 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 2, 061, 265 20, 745 130, 756 23, 002 2, 235, 768 54.00 05600 RADI OI SOTOPE 56, 00 182, 757 650 2, 333 185, 740 56, 00 10, 678 60.00 06000 LABORATORY 1, 953, 098 15.873 20.652 2,000,301 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 96, 975 96, 975 63.00 C 06600 PHYSI CAL THERAPY 1, 401, 971 2,633 26, 846 1, 443, 105 66.00 11.655 66,00 69.00 06900 ELECTROCARDI OLOGY 662, 292 3, 220 2, 415 17, 502 685, 429 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 769.494 769.494 71 00 71 00 0 0 72.00 07200 I MPL. DEV. CHARGED TO PATIENT 505, 221 C 0 0 505, 221 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 0 0 0 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 3. 050 90 00 09000 CLI NI C 125, 189 5,099 133, 338 90.01 09001 SENI OR CARE 277, 326 6, 443 400 4, 217 288, 386 90.01 91.00 09100 EMERGENCY 2, 460, 282 10, 305 7, 321 26, 063 2, 503, 971 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92 00 92 00 0 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 1, 172, 814 5, 988 0 21, 702 1, 200, 504 101. 00 SPECIAL PURPOSE COST CENTERS 11, 098 116.00 11600 HOSPI CE 702, 767 713, 865 116. 00 0 SUBTOTALS (SUM OF LINES 1-117) 118.00 30, 705, 275 326, 611 684, 318 368, 479 30, 451, 064 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 2, 508 2, 508 190. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 5, 802, 708 49, 437 105, 398 6, 032, 280 192. 00 74, 737 194.00 07950 FITNESS CENTER 12, 108 12, 108 194. 00 C 204, 688 194. 01 194. 01 07951 MARKETI NG 201, 537 759 0 2.392 194. 02 07952 NEW DIRECTION 0 0 194. 02 C 0 194. 03 07953 RESPITE 0 0 194. 03 C 4, 562 194. 04 07954 WELL CHILD CLINIC 137, 475 0 2, 310 144, 347 194. 04 0 200.00 200.00 Cross Foot Adjustments 201 00 Negative Cost Centers 0 201 00 202.00 TOTAL (sum lines 118-201) 36, 846, 995 395, 985 759, 055 478, 579 36, 846, 995 202. 00

Provider CCN: 151310 | Period: | Worksheet B | From 01/01/2014 | Part I | To 12/31/2014 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

COST CENTER   DISTRIPT   DISTRI					Ť	0 12/31/2014	Date/Time Pre 5/27/2015 8:0	
SENERAL SERVICE COST CENTERS   5.01   5.02   6.00   7.00   8.00		Cost Center Description	OTHER	BUSINESS	MAINTENANCE &	OPERATION OF		T GIII
GENERAL SERVICE COST CENTERS   5.01   5.02   6.00   7.00   8.00		·	ADMI NI STRATI VE	OFFI CE	REPAI RS	PLANT	LINEN SERVICE	
GENERAL SERVICE COST CENTERS 1.00 001000 (DNC APER REL COSTS-BUBG & FIXT 2.00 00200 (NEW CAR PEL COSTS-BUBG & FIXT 4.00 004000 (MEN CAR PEL COSTS-BUBG & FIXT 4.00 004000 (MEN CAR PEL COSTS-BUBG & FIXT 5.01 00500 (MEN CAR PEL COSTS-BUBG & FIXT 5.01 00500 (MEN CAR PEL COSTS-BUBG & FIXT 7.00 00500 (MEN) CAR PEL COSTS-BUBG & FIXT 7.00 00700 (PERATION OF PLANT 7.00 00700 (PERATION OF PLANT 7.00 00500 (MEN) CAR PEL COSTS-BUBG & FIXT 7.00 00500 (MEN) CAR PEL								
1.00   001000 NEW CAP REL COSTS-BUBLE COUNTY   2.00   00200 NEW CAP REL COSTS-MUBLE COUNTY   2.00   4.00   00400 NEW CAP REL COSTS-MUBLE COUNTY   2.00   4.00   00500 NEW CAP REL COSTS-MUBLE COUNTY   2.00   4.00   00500 NEW CAP REL COSTS   2.00   2		CENEDAL CEDVICE COCT CENTERS	5. 01	5. 02	6.00	7. 00	8.00	
2.00	1 00		Т					1 1 00
4.00		l l						
5.01   00561   0THER ADM IN STRATIVE AND GENERAL   4,856,755   5.02   00560 BUSINESS OFFICE   1614,428   1,224,712   5.502   6.00   00600 BUSINESS OFFICE   1614,428   1,224,712   5.502   6.00   00600 BUSINESS OFFICE   1614,284   1,224,712   5.502   6.00   00600 BUSINESS OFFICE   0   0   0   0   0   0   0   0   0								
5.02 00560 BUSINESS OFFICE		· · · · · · · · · · · · · · · · · · ·	1 856 755					
6.00   00000 MAINTENNICE & REPAIRS   153, 988   51, 100   1, 219, 375   885, 108   7.00   0.00   000   000   000   000   0.00				1 224 712				•
7. 00         007000   OPERATI ON OF PLANT         76, 162         2e, 072         281, 211         885, 108         7, 00         0 <td></td> <td>1 1</td> <td>1</td> <td></td> <td></td> <td></td> <td></td> <td>•</td>		1 1	1					•
0.000   0.0000   LAUNDRY & LINEN SERVICE   0   0   0   0   0   0   0   0   0		1 1	1			885. 108		
9.00   000000   HOLDSKEEPI NG			1				0	
11.00   01100   CAPETERIA   15, 3894   16, 764   10, 904   15, 948   0   11.00   14.00   14.00   01400   WIRST INA SIMINI STRATION   35, 419   11, 804   5, 276   4, 977   01   3.00   13.00   01300   WIRST INA SIMINI STRATION   35, 419   11, 804   5, 276   4, 977   01   3.00   13.00   13.00   01400   WENT INA SIMINI STRATION   461, 742   161, 486   50, 549   57, 539   54, 285   01   4.00   16.00   16.00   WENT INA SIMINI STRATION   78, 221   27, 423   44, 921   42, 381   0   16.00   16.00   WENT INA SIMINI STRATICS   296, 721   120, 040   119, 419   112, 666   0   30, 00   0   0   0   0   0   0   0   0			101, 348	31, 805	21, 103	19, 910	0	9. 00
13.00   01300   OURSING ADMINISTRATION   35, 419   11, 804   5, 276   4, 977   0   13, 00     14.00   01400   CENTRAL SERVICES & SUPPLY   161, 486   56, 549   57, 539   54, 285   0   14, 00     15.00   01500   PHARMACY   78, 221   27, 423   167, 395   51, 527   48, 613   0   16, 00     10.00   01500   MEDI CAL RECORDS & LI BRARY   78, 221   27, 423   44, 921   42, 381   0   16, 00     10.00   OURDI CAL RECORDS & LI BRARY   78, 221   27, 423   44, 921   42, 381   0   16, 00     10.00   OURDI CAL RECORDS & LI BRARY   78, 221   27, 423   44, 921   42, 381   0   16, 00     10.00   OURDI CAL RECORDS & LI BRARY   78, 221   27, 423   44, 921   42, 381   0   16, 00     10.00   OURDI CAL RECORDS & LI BRARY   78, 221   27, 423   44, 921   42, 381   0   16, 00     10.00   OURDI CAL RECORDS & LI BRARY   78, 221   27, 423   44, 921   42, 381   44, 921   42, 381     10.00   OURDI CAL RECORDS & LI BRARY   78, 221   27, 422   44, 921   42, 381   43, 00     10.00   OURDI CAL RECORDS & LI BRARY   78, 221   27, 422   42, 381   43, 00     10.00   OURDI CAL RECORDS & LI BRARY   78, 221   27, 422   43, 90, 370   85, 259   0   50, 00     10.00   OURDI CAL RECORDS & LI BRARY   78, 30   44, 479   79, 370   85, 259   0   50, 00     10.00   OURDI CAL RECORDS & LI BRARY   78, 30   44, 479   79, 370   87, 279   68, 616   0   52, 00     10.00   OURDI CAL RECORDS & LI BRARY   78, 30   34, 41   113, 790   72, 729   68, 616   0   54, 00     10.00   OURDI CAL RECORDS & LI BRARY   78, 30   30, 484   113, 790   72, 729   68, 616   0   54, 00     10.00   OURDI CAL RECORDS & LI BRARY   78, 30   30, 486   99, 739   37, 436   35, 319   0   60, 00     10.00   OURDI CAL RECORDS & LI BRARY   78, 30   30, 486   99, 739   37, 436   35, 319   0   60, 00     10.00   OURDI CAL RECORDS & LI BRARY   78, 30   37, 510   0   0   0   0   0     10.00   OURDI CAL RECORDS & LI BRARY   78, 30   14, 273   15, 286   0   0   0   0     10.00   OURDI CAL LI HERAPY   78, 30   37, 30   0   00, 00   0     10.00   OURDI CAL LI HERAPY   78, 30   37, 30   0   00, 00   0   0	10.00	01000 DI ETARY	67, 534	22, 147	54, 505	51, 423	0	10.00
14. 00   01400   CENTRAL SERVICES & SUPPLY   161, 1866   56, 549   57, 539   54, 285   0   14. 00     16. 00   01500   MEDICAL RECORDS & LIBRARY   78, 221   27, 423   44, 921   42, 381   0     16. 00   01500   MEDICAL RECORDS & LIBRARY   78, 221   27, 423   44, 921   42, 381   0     10. 00   03000   ADULTS & PEDIATRIC & COST CENTERS   78, 221   120, 040   119, 419   112, 666   0   30, 00     10. 00   03000   ADULTS & PEDIATRIC & COST CENTERS   70   0   0   0   0     10. 00   ADULTS & PEDIATRIC & COST CENTERS   70   0   0   0   0   0     10. 00   ADULTS & PEDIATRIC & COST CENTERS   70   0   0   0   0   0     10. 00   ADULTS & PEDIATRIC & COST CENTERS   70   0   0   0   0   0   0     10. 00   ADULTS & PEDIATRIC & COST CENTERS   70   0   0   0   0   0   0   0     10. 00   ADULTS & PEDIATRIC & COST CENTERS   70   0   0   0   0   0   0   0   0	11.00	01100 CAFETERI A	53, 894	16, 764	16, 904	15, 948	0	11. 00
15. 00   01500   PHARMACY   167, 395   51, 527   48, 613   0   15. 00     10	13.00	01300 NURSING ADMINISTRATION	35, 419	11, 804	5, 276	4, 977	0	13. 00
16. 00   01-000   MEDICAL RECORDS & LIBRARY   78, 221   27, 423   44, 921   42, 381   0   16. 00	14.00	01400 CENTRAL SERVICES & SUPPLY	161, 486	56, 549	57, 539	54, 285	0	14. 00
IMPATI ENT ROUTINE SERVICE COST CENTERS	15.00	1 1	461, 742			48, 613		15. 00
30.00   03000   ADULTS & PEDIATRICS   296, 721   120,040   119,419   112,666   0 30.00   30.00   30.00   30.00   ASURESERY   0 0 0 0 0 0   0   0   0   0   0   0	16. 00		78, 221	27, 423	44, 921	42, 381	0	16. 00
A3. 00   O4300   NURSERY   0   0   0   0   0   0   0   0   0			TT					
ANCILLARY SERVICE COST CENTERS   S			1					1
SO 00   050000   05000   05000   05000   05000   05000   05000   05000   050000   05000   0500000   050000   050000   050000   050000   050000   050000   050000   050000   0500000   050000   050000   050000   050000   0500000   050000   0500000   0500000   0500000   0500000   0500000   0500000000	43.00		0	0	0	U	0	43.00
14,909	EO 00		270 024	02 244	00.270	0E 2E0	0	E0 00
52.00   05200   05200   05200   05200   05200   05200   053000   05300   05300   05300   0530000   053000   0530000   0530000   0530000   0530000   0530000   05300000   05300000   0530000000000								
53.00   05300   AMESTHESI OLOGY   15, 308   5, 512   1, 879   1, 773   0   53.00			14, 707	•				
54.00   05400   RADI OLOGY-DI AGNOSTI C   339, 434   113, 790   72, 729   68, 616   0   54.00   65.00   05600   RADI OLOGY-DI AGNOSTI C   28, 199   9, 504   0   0   0   0   66.00   06000   LABORATORY   303, 686   99, 739   37, 436   35, 319   0   60.00   63.00   06300   BLOOD STORI ING   PROCESSI NG & TRANS.   14, 723   5, 126   0   0   0   0   69.00   06900   ELECTROCARDI OLOGY   219, 092   73, 910   9, 233   8, 710   0   69.00   06900   ELECTROCARDI OLOGY   104, 062   12, 453   11, 288   10, 650   0   0   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   76, 703   73, 581   0   0   0   0   72.00   07300   DRUGS CHARGED TO PATI ENT   76, 703   73, 581   0   0   0   0   73.00   07300   DRUGS CHARGED TO PATI ENTS   76, 703   73, 581   0   0   0   0   74.00   07300   DRUGS CHARGED TO PATI ENTS   76, 703   73, 581   0   0   0   0   75.00   07000   CLI NI C   20, 243   5, 926   10, 694   10, 090   0   75.00   09000   CLI NI C   20, 243   5, 926   10, 694   10, 090   0   75.00   09000   CLI NI C   380, 153   107, 459   36, 128   34, 085   991, 00   75.00   09000   DRUGS CHARGED TO PATI ENT   76, 703   380, 153   107, 459   36, 128   34, 085   991, 00   75.00   09000   DRUGS CHARGED TO PATI ENT   76, 703   78, 78, 78, 78, 78, 78, 78, 78, 78, 78,			15 308	-				1
56.00   05600   RADI OI SOTOPE   28, 199   9, 504   0   0   0   0   56.00   60.00   06000   LABORATORY   303, 686   99, 739   37, 436   35, 319   0   60.00   63.00   06300   BLOOD STORI NG, PROCESSI NG & TRANS.   14, 723   5, 126   0   0   0   0   0   66.00   06600   PHYSI CAL THERAPY   219, 092   73, 910   9, 233   8, 710   0   66.00   69.00   06900   ELECTROCARDI OLOGY   104, 062   12, 453   11, 288   10, 650   0   0   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   116, 825   19, 706   0   0   0   0   72.00   07200   IMPL. DEV. CHARGED TO PATI ENTS   76, 703   37, 581   0   0   0   0   73.00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   73.00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   73.00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   73.00   09000   CLI NI C   0   74.00   09000   CLI NI C   0   75.00   09000   CLI NI C   0   75.00   090001   SENONATI ON BEDS (NON-DI STI NCT PART)   0   75.00   09100   EMERGENCY   380, 153   107, 459   36, 128   34, 085   0   91.00   75.00   09200   09SERVATI ON BEDS (NON-DI STI NCT PART)   0   75.00   09100   EMERGENCY   182, 261   62, 466   20, 993   19, 806   0   75.00   09100   HEALTH AGENCY   182, 261   62, 466   20, 993   19, 806   0   75.00   09100   HOMBER BURSABLE COST CENTERS   0   0   0   75.00   09100   O   0   75.00   09100   O   0   0   75.00   09100   O   0   0   75.00   09100   O   0   75.00   09100   O   0   75.00   09100   O   0   0				·			-	1
60.00   06000   LABORATORY   303,686   99,739   37,436   35,319   0   60.00   63.00   663.00   06300   BLDOD STORI NG, PROCESSI NG & TRANS.   14,723   5,126   0   0   0   0   0   66.00   66.00   06600   PHYSI CAL THERAPY   219,092   73,910   9,233   8,710   0   66.00   66.00   06600   PHYSI CAL THERAPY   219,092   73,910   9,233   8,710   0   66.00   0   0   0   0   0   0   0   0   0				·	· ·		-	1
66. 00   06600   PHYSI CAL THERAPY   219, 092   73, 910   9, 233   8, 710   0   66. 00   69. 00   06900   ELECTROCARDIOLOGY   104, 062   12, 453   11, 288   10, 650   0   69. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   116, 825   19, 706   0   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   76, 703   37, 581   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   00   0742.00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   00   075.00   075.00   075.00   075.00   00   075.00   075.00   075.00   075.00   00   09001   SENI OR CARE   43, 783   14, 126   22, 587   21, 310   0   90. 01   09001   SENI OR CARE   43, 783   14, 126   22, 587   21, 310   0   90. 01   09100   SENI OR CARE   43, 783   107, 459   36, 128   34, 085   0   91. 00   09200   095ERVATI ON BEDS (NON-DI STI NCT PART)   92. 00   09200   095ERVATI ON BEDS (NON-DI STI NCT PART)   92. 00   010   010   O10   HOME HEALTH A GENCY   182, 261   62, 466   20, 993   19, 806   0   101. 00   0110. 00   1000   HOME HEALTH A GENCY   3, 885, 729   1, 224, 712   976, 162   655, 651   0   018. 00   SUBTOTALS (SUM OF LINES 1-117)   3, 885, 729   1, 224, 712   976, 162   655, 651   0   0192. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   381   0   8, 793   8, 296   0   100. 00   0194. 00   10900   PHYSIC LAND PRI VATE OFFI CES   915, 816   0   173, 320   163, 517   0   192. 00   0194. 01   107951   MARKETI NG   31, 076   0   2, 660   2, 509   0   194. 01   0194. 02   07952   NEW DI RECTION   0   0   0   0   0   0194. 03   07953   RESPITE   0   0   0   0   0   0   0194. 03   07953   RESPITE   0   0   0   0   0   0   020. 00   Cross Foot Adjustments   00   0   0   0   0   020. 00   0000   0000   0000   0000   0000   0000   0000   0000   020. 00   0000   0000   0000   0000   0000   0000   0000   0000   0201. 00   Negati ve Cost Centers   0   0   0   0   0   0   0201. 00   0000   0000   0000   0000   0000   0000   0000   00	60.00	06000 LABORATORY		99, 739	37, 436	35, 319	0	60.00
66. 00   06600   PHYSI CAL THERAPY   219, 092   73, 910   9, 233   8, 710   0   66. 00   69. 00   06900   ELECTROCARDI OLOGY   104, 062   12, 453   11, 288   10, 650   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   116, 825   19, 706   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   76, 703   37, 581   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   74. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   75. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   75. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   76. 00   09000   CLI NI C   0   0   77. 00   09000   CLI NI C   0   0   78. 00   09000   CLI NI C   0   0   79. 00   09000   SENI OR CARE   43, 783   14, 126   22, 587   21, 310   0   79. 00   09000   SENI OR CARE   43, 783   107, 459   36, 128   34, 085   0   79. 00   09200   08SERVATI ON BEDS (NON-DI STI NCT PART)   92. 00   79. 00   09200   08SERVATI ON BEDS (NON-DI STI NCT PART)   92. 00   70. 01   09000   FERI MBURSABLE COST CENTERS   100. 00   0   0   70. 01   09000   CLI NI C   0   0   70. 01   09000   CLI NI C   0   0   70. 01   09000	63.00	06300 BLOOD STORING, PROCESSING & TRANS.	14, 723	5, 126	0	0	0	63.00
71. 00	66.00	06600 PHYSI CAL THERAPY	219, 092	73, 910	9, 233	8, 710	0	66. 00
72. 00   07200   IMPL. DEV. CHARGED TO PATIENT   76, 703   37, 581   0   0   0   0   0   0   0   0   0	69. 00		104, 062	12, 453	11, 288	10, 650	0	1
73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   0   0   0						-		1
90. 00   09000   CLI NI C   20, 243   5, 926   10, 694   10, 090   0   90. 00     90. 01   09001   SENI OR CARE   43, 783   14, 126   22, 587   21, 310   0   90. 01     91. 00   09100   EMERGENCY   380, 153   107, 459   36, 128   34, 085   0   91. 00     92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   92. 00     01. 00   0100   HEALTH AGENCY   182, 261   62, 466   20, 993   19, 806   0     101. 00   10100   HOME HEALTH AGENCY   182, 261   62, 466   20, 993   19, 806   0     116. 00   11600   HOSPI CE   108, 379   39, 566   0   0   0     118. 00   SUBTOTALS (SUM OF LI NES 1-117)   3, 885, 729   1, 224, 712   976, 162   655, 651   0     118. 00   19000   GI FT, FLOWER, COFFEE SHOP & CANTEEN   381   0   8, 793   8, 296   0     192. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES   915, 816   0   173, 320   163, 517   0   192. 00     194. 00   07950   FI TNESS CENTER   1, 838   0   42, 448   40, 047   0   194. 00     194. 02   07952   NEW DI RECTI ON   0   0   0   0   0   0     194. 02   07953   RESPI TE   0   0   0   0   0   0     194. 03   07953   RESPI TE   0   0   0   0   0   0     194. 04   07954   WELL CHILD CLINIC   21, 915   0   15, 992   15, 088   0     201. 00   Negative Cost Centers   0   0   0   0   0   0    201. 00   Negative Cost Centers   0   0   0   0   0    201. 00   Negative Cost Centers   0   0   0   0   0    201. 00   Negative Cost Centers   0   0   0   0    201. 00   Negative Cost Centers   0   0   0   0   0    201. 00   0   0   0   0    201. 00   0   0   0   0    201. 00   0   0   0   0    201. 00   0   0   0    201. 00   0   0   0   0    201. 00   0   0   0    201. 00   0   0   0    201. 00   0   0   0    201. 00   0   0   0    201. 00   0   0   0    200. 00   0   0    200. 00   0   0   0    201. 00   0   0    200. 00   0   0    201. 00   0   0    200. 00   0   0    200. 00   0   0    200. 00   0   0    200. 00   0   0    200. 00   0   0    200. 00   0   0    200. 00   0   0    200. 00   0    200. 00   0    200. 00   0    200. 00   0    200. 00   0    200. 00   0    200. 00   0    2			1					1
90. 00	73. 00		0	0	0	0	0	73.00
90. 01	00 00		20.242	E 024	10 404	10,000	0	00 00
91. 00						· ·		
92. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART)   0THER REI MBURSABLE COST CENTERS   10100   HOME   HEALTH   AGENCY   182, 261   62, 466   20, 993   19, 806   0   101. 00   101. 00   116.				·		· ·		
101. 00   1010   HOME   HEALTH   AGENCY   182, 261   62, 466   20, 993   19, 806   0   101. 00			000, 100	107, 107	00, 120	01,000	Ĭ	
101.00   10100   HOME   HEALTH   AGENCY   182, 261   62, 466   20, 993   19, 806   0   101.00	72.00		<u> </u>					72.00
116. 00 116. 00 118. 00 SUBTOTALS (SUM OF LINES 1-117) S, 885, 729 1, 224, 712 976, 162 655, 651 0 118. 00 NONREI MBURSABLE COST CENTERS  190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 915, 816 0 173, 320 163, 517 0 192. 00 194. 00 194. 01 07950 FI TNESS CENTER 1, 838 0 42, 448 40, 047 0 194. 00 194. 01 07951 MARKETI NG 31, 076 0 2, 660 2, 509 0 194. 01 194. 02 194. 03 07952 NEW DIRECTION 0 0 0 0 0 0 0 194. 02 194. 03 07953 RESPI TE 0 0 0 0 0 0 0 194. 03 194. 04 07954 WELL CHILD CLINIC 200. 00 201. 00 Negati ve Cost Centers 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	101.00		182, 261	62, 466	20, 993	19, 806	0	101.00
118.00   SUBTOTALS (SUM OF LINES 1-117)   3,885,729   1,224,712   976,162   655,651   0   118.00   NONREI MBURSABLE COST CENTERS   190.00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   381   0   8,793   8,296   0   190.00   192.00   192.00   192.00   194.00   07950   FI TNESS CENTER   1,838   0   42,448   40,047   0   194.00   194.01   07951   MARKETING   31,076   0   2,660   2,509   0   194.01   194.02   07952   NEW DI RECTION   0   0   0   0   0   194.03   194.03   07953   RESPITE   0   0   0   0   0   0   194.03   194.04   194.04   194.04   194.05		SPECIAL PURPOSE COST CENTERS						
NONREI MBURSABLE COST CENTERS   190. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   381   0   8, 793   8, 296   0   190. 00   192. 00   192. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES   915, 816   0   173, 320   163, 517   0   192. 00   194. 00   07950   FI TNESS CENTER   1, 838   0   42, 448   40, 047   0   194. 00   194. 01   07951   MARKETI NG   31, 076   0   2, 660   2, 509   0   194. 01   194. 02   07952   NEW DI RECTI ON   0   0   0   0   0   194. 02   194. 03   07953   RESPI TE   0   0   0   0   0   194. 03   194. 04   07954   WELL CHI LD CLI NI C   21, 915   0   15, 992   15, 088   0   194. 04   200. 00   Negati ve Cost Centers   0   0   0   0   0   0   201. 00   0   0   0   0   0   0   0   0   0	116.00	11600 H0SPI CE	108, 379	39, 566	0	0	0	116. 00
190. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   381   0   8,793   8,296   0   190. 00   192. 00   192. 00   19200   194. 01   192. 00   19	118.00		3, 885, 729	1, 224, 712	976, 162	655, 651	0	118. 00
192. 00     192.00     PHYSI CI ANS' PRI VATE OFFI CES     915, 816     0     173, 320     163, 517     0     192. 00       194. 00     07950     FI TNESS CENTER     1, 838     0     42, 448     40, 047     0     194. 00       194. 01     07951     MARKETI NG     31, 076     0     2, 660     2, 509     0     194. 01       194. 02     07952     NEW DI RECTI ON     0     0     0     0     0     194. 02       194. 03     07953     RESPI TE     0     0     0     0     194. 02       194. 04     07954     WELL CHILD CLINIC     21, 915     0     15, 992     15, 088     0     194. 04       200. 00     Negati ve Cost Centers     0     0     0     0     0     0     0     0								
194. 00     07950     FITNESS CENTER     1,838     0     42,448     40,047     0   194.00       194. 01 07951     MARKETI NG     31,076     0     2,660     2,509     0   194.01       194. 02 07952     NEW DIRECTI ON     0     0     0     0     0     0   194.02       194. 03 07953     RESPI TE     0     0     0     0     0   194.02       194. 04 07954     WELL CHILD CLINIC     21,915     0     15,992     15,088     0   194.04       200. 00     Negative Cost Centers     0     0     0     0     0     0     0						· ·		
194. 01 07951 MARKETI NG				-	,			
194. 02 07952 NEW DIRECTION 0 0 0 0 194. 02 194. 03 07953 RESPITE 0 0 0 0 0 0 194. 03 194. 04 07954 WELL CHILD CLINIC 21, 915 0 15, 992 15, 088 0 194. 04 200. 00 Negative Cost Centers 0 0 0 0 0 0 0 0 201. 00				-				
194. 03 07953 RESPITE 0 0 0 0 0 194. 03 194. 04 07954 WELL CHILD CLINIC 21, 915 0 15, 088 0 194. 04 200. 00 Cross Foot Adjustments 201. 00 Negative Cost Centers 0 0 0 0 0 0 0 0 201. 00		1	1					1
194. 04 07954 WELL CHILD CLINIC     21,915     0 15,992     15,088     0 194.04       200. 00 201. 00     Cross Foot Adjustments     200.00       Negative Cost Centers     0 0 0 0     0 201.00		1				_	-	
200.00       Cross Foot Adjustments       200.00         201.00       Negative Cost Centers       0       0       0       0       0       0       201.00			21 915	-		_		1
201.00   Negative Cost Centers   0   0   0   0   201.00			2.,,10	0	, , , , 2	. 5, 000	Ĭ	
		, ,	0	0	0	O	0	
	202.00	TOTAL (sum lines 118-201)	4, 856, 755	1, 224, 712	1, 219, 375	885, 108	0	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

						o 12/31/2014	Date/Time Pre 5/27/2015 8:0	
		Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	
			9.00	10.00	11. 00	13.00	14. 00	
	GENER	AL SERVICE COST CENTERS						
1.00	1	NEW CAP REL COSTS-BLDG & FIXT						1. 00
2.00		NEW CAP REL COSTS-MVBLE EQUIP						2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01		OTHER ADMINISTRATIVE AND GENERAL						5. 01
5. 02		BUSINESS OFFICE						5. 02
6.00		MAINTENANCE & REPAIRS						6.00
7.00	1	OPERATION OF PLANT						7. 00
8.00	1	LAUNDRY & LINEN SERVICE	041 722					8. 00
9.00		HOUSEKEEPI NG DI ETARY	841, 722	400 444				9.00
10. 00 11. 00		CAFETERI A	50, 028 15, 516	690, 466 0	474, 010			10. 00 11. 00
13.00		NURSING ADMINISTRATION	4, 842	o	5, 321	1		13.00
14. 00		CENTRAL SERVICES & SUPPLY	52, 812	0	2, 801		1, 449, 141	14. 00
15. 00		PHARMACY	47, 294	0	26, 196	1	1, 449, 141	15. 00
16. 00		MEDICAL RECORDS & LIBRARY	41, 231	o	16, 977	1	0	
10.00		I ENT ROUTI NE SERVI CE COST CENTERS	71,231	<u> </u>	10, 777	٩		10.00
30. 00		ADULTS & PEDIATRICS	109, 609	373, 354	56, 075	99, 392	0	30. 00
43.00		NURSERY	0	0	C		0	43. 00
	ANCI L	LARY SERVICE COST CENTERS						
50.00		OPERATING ROOM	82, 945	149, 034	34, 238		0	
51. 00		RECOVERY ROOM	9, 564	0	2, 773	1	0	
52. 00		DELIVERY ROOM & LABOR ROOM	0	0	C	1	0	52. 00
53. 00	1	ANESTHESI OLOGY	1, 725	0	C	ή "Ι	0	
54.00	1	RADI OLOGY-DI AGNOSTI C	66, 754	23, 213	36, 532		0	54.00
56. 00		RADI OI SOTOPE	0	0	2, 651	I	0	56. 00
60.00		LABORATORY	34, 361	1, 065	37, 648		0	60. 00 63. 00
63. 00 66. 00		BLOOD STORING, PROCESSING & TRANS. PHYSICAL THERAPY	8, 474	0 118	32, 823	′I "I	0	66.00
69. 00	1	ELECTROCARDI OLOGY	10, 361	1, 065	28, 592		0	
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	10, 301	1, 065	20, 392	1	1, 449, 141	71.00
71.00		IMPL. DEV. CHARGED TO PATIENT		0	C	1	1, 449, 141	1
73. 00		DRUGS CHARGED TO PATIENTS		31, 551	C		0	
70.00		TIENT SERVICE COST CENTERS	<u> </u>	01,001		,1		7 0. 00
90.00		CLI NI C	9, 816	2, 839	C	0	0	90.00
90. 01	09001	SENI OR CARE	20, 731	10, 823	5, 961	0	0	90. 01
91.00	09100	EMERGENCY	33, 160	64, 995	40, 163	71, 190	0	91.00
92.00		OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
		REIMBURSABLE COST CENTERS				,		
101.00	-	HOME HEALTH AGENCY	19, 269	15, 850	C	0	0	101. 00
11/ 00		AL PURPOSE COST CENTERS		ما		ا	0	11/ 00
116.00	1	HOSPICE	619, 403	0 472 007	220 751			116. 00
118.00		SUBTOTALS (SUM OF LINES 1-117) MBURSABLE COST CENTERS	618, 492	673, 907	328, 751	300, 937	1, 449, 141	1118.00
190 00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	8, 071	ol	C	ol ol	0	190. 00
		PHYSICIANS' PRIVATE OFFICES	159, 079	16, 559	138, 037			192. 00
		FITNESS CENTER	38, 961	0, 337	133, 337	ol öl		194. 00
		MARKETI NG	2, 441	o	2, 484	ol		194. 01
	1	NEW DIRECTION	O	Ö	_,C	1		194. 02
	1	RESPI TE	o	o	C	o	0	194. 03
194. 04	07954	WELL CHILD CLINIC	14, 678	0	4, 738	o o	0	194. 04
200.00	)	Cross Foot Adjustments		ļ				200. 00
201.00		Negative Cost Centers	0	0	C	۱ ۱		201. 00
202.00	)	TOTAL (sum lines 118-201)	841, 722	690, 466	474, 010	300, 937	1, 449, 141	202. 00

Health Financial Systems	WABASH COUNTY	/ HOSPITAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der	F	eriod: rom 01/01/2014 o 12/31/2014	Worksheet B Part I Date/Time Pre 5/27/2015 8:0	pared:
Cost Center Description	PHARMACY	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	15. 00	16. 00	24. 00	25. 00	26. 00	
GENERAL SERVICE COST CENTERS						
1. 00   00100   NEW CAP REL COSTS-BLDG & FIXT   2. 00   00200   NEW CAP REL COSTS-MVBLE EQUI P   4. 00   00400   EMPLOYEE BENEFITS DEPARTMENT   5. 01   00561   OTHER ADMINISTRATI VE AND GENERAL   5. 02   00560   BUSI NESS OFFICE   6. 00   00600   MAI NTENANCE & REPAI RS   7. 00   00700   OPERATI ON OF PLANT   8. 00   00800   LAUNDRY & LINEN SERVICE						1. 00 2. 00 4. 00 5. 01 5. 02 6. 00 7. 00 8. 00
9. 00   00900   LAUNDRY & LINEN SERVICE 9. 00   00900   HOUSEKEEPI NG 10. 00   01000   DI ETARY 11. 00   01100   CAFETERI A						9. 00 10. 00 11. 00
13. 00   01100   CAPETERTA 13. 00   01300   NURSI NG   ADMI NI STRATI ON 14. 00   01400   CENTRAL   SERVI CES & SUPPLY						13. 00 14. 00
15. 00   01500   PHARMACY 16. 00   01600   MEDI CAL   RECORDS & LI BRARY	3, 844, 148 0	766, 374				15. 00 16. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS				'		
30. 00   03000   ADULTS & PEDI ATRI CS   43. 00   04300   NURSERY	0	56, 012 0	3, 297, 714 0		3, 297, 714 0	30. 00 43. 00
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATING ROOM 51. 00   05100   RECOVERY ROOM	0	43, 863 4, 736	2, 677, 278 159, 827	O	2, 677, 278 159, 827	51.00
52. 00   05200   DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	8, 768	135, 794	0	135, 794	
54. 00   05400   RADI OLOGY - DI AGNOSTI C	0	141, 303	3, 162, 891	0	3, 162, 891	
56. 00   05600  RADI 0I SOTOPE 60. 00   06000  LABORATORY	0	9, 077	235, 171	0	235, 171	56.00
60.00   06000   LABORATORY 63.00   06300   BLOOD STORING, PROCESSING & TRANS.	-	120, 075	2, 669, 630		2, 669, 630	1
66. 00   06600   PHYSI CAL THERAPY	0	1, 645	118, 469 1, 819, 576		118, 469 1, 819, 576	
69. 00   06900   ELECTROCARDI OLOGY		24, 111 22, 985	1, 619, 576 886, 885		886, 885	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	39, 928	2, 395, 094		2, 395, 094	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0	26, 215	2, 393, 094 645, 720		2, 393, 094 645, 720	1
73. 00 07300 DRUGS CHARGED TO PATIENTS	3, 844, 148	191, 643	4, 067, 342	0	4, 067, 342	
OUTPATIENT SERVICE COST CENTERS	3, 044, 140	171, 043	4,007,342	<u> </u>	4,007,342	73.00
90. 00 09000 CLINIC	0	5, 999	198, 945	0	198, 945	90.00
90. 01   09001   SENI OR CARE	o	4, 264	431, 971	o	431, 971	90. 01
91. 00 09100 EMERGENCY	o	65, 750	3, 337, 054	o	3, 337, 054	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				o		92.00
OTHER REIMBURSABLE COST CENTERS						
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	1, 521, 149	0	1, 521, 149	101. 00
116. 00 11600 HOSPI CE	0	0	861, 810	0	861, 810	116. 00
118. 00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	3, 844, 148	766, 374	28, 622, 320	0	28, 622, 320	118. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	28, 049	o	28. 049	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	O	7, 598, 608		7, 598, 608	
194.00 07950 FITNESS CENTER	0	o	135, 402		135, 402	
194. 01 07951 MARKETI NG	o	o	245, 858	o	245, 858	194. 01
194. 02 07952 NEW DIRECTION	0	o	0	o		194. 02
194. 03 07953 RESPI TE	0	o	0	0		194. 03
194.04 07954 WELL CHILD CLINIC	0	0	216, 758	0	216, 758	
200.00 Cross Foot Adjustments			0	0		200. 00
201.00 Negative Cost Centers	0	0	0	ı	0	201. 00
202.00   TOTAL (sum lines 118-201)	3, 844, 148	766, 374	36, 846, 995	0	36, 846, 995	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

				То	12/31/2014	Date/Time Pre 5/27/2015 8:0	
			CAPI TAL REI	ATED COSTS		372772013 0.0	4 alli
			NEW BL BO A	NEW ANDLE		5MB1 0) (55	
	Cost Center Description	Directly Assigned New	NEW BLDG & FLXT	NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
		Capi tal	1171	EQUIT		DEPARTMENT	
		Related Costs					
los	NEDAL OFFICE COOT OFFITEDS	0	1. 00	2. 00	2A	4. 00	
	NERAL SERVICE COST CENTERS  100 NEW CAP REL COSTS-BLDG & FIXT						1. 00
	200 NEW CAP REL COSTS-BUDG & TTXT						2.00
	400 EMPLOYEE BENEFITS DEPARTMENT	0	7, 693	499	8, 192	8, 192	4. 00
	561 OTHER ADMINISTRATIVE AND GENERAL	0	40, 483	125, 602	166, 085	704	5. 01
	560 BUSINESS OFFICE	0	0		6, 890	198	•
	600 MAINTENANCE & REPAIRS 700 OPERATION OF PLANT	0	0 210		175, 476	158 0	6. 00 7. 00
	800 LAUNDRY & LINEN SERVICE		80, 210 0		80, 210 0	0	8.00
1	900 HOUSEKEEPI NG	l ő	6, 019		6, 019	122	9.00
1	000 DI ETARY	O	15, 547	2, 170	17, 717	97	10.00
1	100 CAFETERI A	0	4, 822	1	4, 822	125	ı
	300 NURSI NG ADMI NI STRATI ON	0	1, 505	1	1, 505	87	13.00
1	400 CENTRAL SERVICES & SUPPLY 500 PHARMACY	0	16, 412	1	17, 106	24 369	14. 00 15. 00
	600 MEDICAL RECORDS & LIBRARY		14, 697 12, 813		76, 101 13, 340	146	1
	PATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	12,010	027	10, 010	110	10.00
30. 00 03	000 ADULTS & PEDIATRICS	0	34, 063	23, 471	57, 534	799	30. 00
	300 NURSERY	0	0	0	0	0	43. 00
	CILLARY SERVICE COST CENTERS OOO OPERATING ROOM		25 777	112 414	120 102	257	FO 00
1	100 RECOVERY ROOM		25, 777 2, 972		139, 193 2, 972	356 35	1
	200 DELIVERY ROOM & LABOR ROOM	Ö	0	1	2, 7,2	0	•
53. 00 05	300 ANESTHESI OLOGY	0	536	0	536	458	53. 00
	400 RADI OLOGY-DI AGNOSTI C	0	20, 745		151, 501	394	1
1	600 RADI OI SOTOPE	0	10 (70		650	40	ł
	000 LABORATORY 300 BLOOD STORING, PROCESSING & TRANS.	0	10, 678 0	i	26, 551 0	353 0	60. 00 63. 00
	600 PHYSI CAL THERAPY		2, 633	1	14, 288	459	ł
	900 ELECTROCARDI OLOGY	O	3, 220		5, 635	299	1
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	
	200 I MPL. DEV. CHARGED TO PATIENT	0	0		0	0	72.00
	300 DRUGS CHARGED TO PATIENTS TPATIENT SERVICE COST CENTERS	0	0	0	0	0	73. 00
	000 CLINIC		3, 050	5, 099	8, 149	0	90.00
	001 SENLOR CARE	O	6, 443		6, 843	72	•
	100 EMERGENCY	0	10, 305	1	17, 626	446	91. 00
	200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92. 00
	HER REIMBURSABLE COST CENTERS		F 000		F 000	271	101 00
	100 HOME HEALTH AGENCY ECLAL PURPOSE COST CENTERS	0	5, 988	0	5, 988	3/1	101. 00
	600 HOSPI CE	O	0	0	O	190	116. 00
118. 00	SUBTOTALS (SUM OF LINES 1-117)	0	326, 611	684, 318	1, 010, 929	6, 302	118. 00
	NREI MBURSABLE COST CENTERS						
	000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2, 508		2, 508		190. 00
	200 PHYSICIANS' PRIVATE OFFICES 950 FITNESS CENTER	0	49, 437 12, 108		124, 174 12, 108		192. 00 194. 00
	951 MARKETI NG		759		759		194. 00
	952 NEW DIRECTION		0	1	,3,		194. 02
194. 03 07	953 RESPI TE	0	0		O	0	194. 03
1	954 WELL CHILD CLINIC	0	4, 562	0	4, 562	40	194. 04
200.00	Cross Foot Adjustments		_		0	0	200.00
201. 00 202. 00	Negative Cost Centers TOTAL (sum lines 118-201)	0	0 395, 985		0 1, 155, 040		201. 00 202. 00
202.00	10171E (30111 111103 110-201)	١	375, 705	1 737, 033	1, 133, 040	0, 172	1202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

				10	0 12/31/2014	Date/lime Pre 5/27/2015 8:0	
	Cost Center Description	OTHER	BUSI NESS	MAINTENANCE &	OPERATION OF	LAUNDRY &	T GIII
	out contor boson per on	ADMI NI STRATI VE	OFFI CE	REPAI RS	PLANT	LINEN SERVICE	
		AND GENERAL					
		5. 01	5. 02	6. 00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00561 OTHER ADMINISTRATIVE AND GENERAL	166, 789					5. 01
5.02	00560 BUSINESS OFFICE	5, 544	12, 632				5. 02
6.00	00600 MAINTENANCE & REPAIRS	5, 288	527				6. 00
7. 00	00700 OPERATION OF PLANT	2, 616	269		124, 943		7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	0	_	0	0	8. 00
9. 00	00900 HOUSEKEEPI NG	3, 481	328	· ·	2, 810	0	9. 00
10.00	01000 DI ETARY	2, 319	228	· ·	7, 259	0	10.00
11. 00	01100 CAFETERI A	1, 851	173	·	2, 251	0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	1, 216	122		703	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	5, 546	583		7, 663	0	14. 00
15. 00	01500 PHARMACY	15, 858	1, 727		6, 862	0	15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	2, 686	283	6, 684	5, 982	0	16. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	10 100	1 220	17 770	1F 004	0	20.00
30. 00 43. 00	04300 NURSERY	10, 190	1, 238 0		15, 904 0	_	30. 00 43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>	U	U	U	U	43.00
50. 00	05000 OPERATING ROOM	9, 274	849	13, 447	12, 035	0	50.00
51. 00	05100 RECOVERY ROOM	512	46		1, 388	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		1, 300	0	52. 00
53. 00	05300 ANESTHESI OLOGY	526	57	_	250	Ö	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	11, 657	1, 174		9, 686	Ö	54. 00
56. 00	05600 RADI OI SOTOPE	968	98	· ·	0	Ö	56. 00
60. 00	06000 LABORATORY	10, 430	1, 029		4, 986	0	60. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	506	53		0	0	63.00
66. 00	06600 PHYSI CAL THERAPY	7, 524	762		1, 230	0	66. 00
69.00	06900 ELECTROCARDI OLOGY	3, 574	128	1, 680	1, 503	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 012	203	0	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	2, 634	388	0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	695	61	1, 591	1, 424	0	90. 00
90. 01	09001 SENI OR CARE	1, 504	146		3, 008	0	90. 01
91. 00	09100 EMERGENCY	13, 056	1, 108	5, 376	4, 811	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS				0.70/		
101.00	10100 HOME HEALTH AGENCY	6, 259	644	3, 124	2, 796	0	101. 00
11/ 0/	SPECIAL PURPOSE COST CENTERS	2 722	400		0	0	11/ 00
118.00	) 11600 HOSPICE SUBTOTALS (SUM OF LINES 1-117)	3, 722 133, 448	408 12, 632		0 92, 551		116. 00 118. 00
110.00	NONREI MBURSABLE COST CENTERS	133, 440	12, 032	140, 200	92, 551	U	110.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	13	0	1, 308	1, 171	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	31, 445	0	· ·	23, 084		192. 00
	07950 FITNESS CENTER	63	0		5, 653		194. 00
	07951 MARKETI NG	1, 067	0		354		194. 01
	207952 NEW DIRECTION	0	0		0		194. 02
	3 07953 RESPI TE	o	0		0		194. 03
	107954 WELL CHILD CLINIC	753	0	2, 380	2, 130		194. 04
200.00							200. 00
201.00		0	0	0	0	0	201. 00
202.00		166, 789	12, 632	181, 449	124, 943	0	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

				Т	o 12/31/2014	Date/Time Pre 5/27/2015 8:0	
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	4 alli
					ADMI NI STRATI ON	SERVICES &	
						SUPPLY	
CENE	DAL CEDVICE COCT CENTEDS	9. 00	10. 00	11. 00	13. 00	14. 00	
	RAL SERVICE COST CENTERS ON NEW CAP REL COSTS-BLDG & FIXT						1. 00
	NEW CAP REL COSTS-BLDG & FIXT						2.00
	O EMPLOYEE BENEFITS DEPARTMENT						4. 00
	01 OTHER ADMINISTRATIVE AND GENERAL						5. 01
	BUSINESS OFFICE						5. 02
	OO MAINTENANCE & REPAIRS						6. 00
7.00 0070	OO OPERATION OF PLANT						7. 00
8.00 0080	OO LAUNDRY & LINEN SERVICE						8. 00
	HOUSEKEEPI NG	15, 900					9. 00
	DO DI ETARY	945	36, 676				10. 00
	OO CAFETERI A	293	0	12, 030			11. 00
	OO NURSI NG ADMI NI STRATI ON	91	0			40 550	13.00
	OO CENTRAL SERVICES & SUPPLY	998	0		0	40, 553	14.00
	OO PHARMACY	893	0		I	0	15.00
	00 MEDICAL RECORDS & LIBRARY TIENT ROUTINE SERVICE COST CENTERS	779	0	431	0	0	16. 00
	00 ADULTS & PEDIATRICS	2,070	19, 831	1, 423	1, 533	0	30.00
	00 NURSERY	2,070	17,031			0	43. 00
	LLARY SERVICE COST CENTERS	<u> </u>	<u> </u>		١		10.00
	OO OPERATING ROOM	1, 567	7, 916	869	937	0	50.00
51.00 0510	OO RECOVERY ROOM	181	0		76	0	51.00
52. 00 0520	DO DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52. 00
	OO ANESTHESI OLOGY	33	0	0	0	0	53. 00
	OO RADI OLOGY-DI AGNOSTI C	1, 261	1, 233			0	54.00
	00 RADI OI SOTOPE	0	0			0	56. 00
	OO LABORATORY	649	57	955		0	60.00
	DO BLOOD STORING, PROCESSING & TRANS.	0	0			0	63. 00
	00 PHYSI CAL THERAPY	160	6		I	0	66.00
	OO ELECTROCARDIOLOGY OO MEDICAL SUPPLIES CHARGED TO PATIENTS	196 0	57 0	726 0		0 40, 553	69. 00 71. 00
	00 IMPL. DEV. CHARGED TO PATIENT		0			40, 553	71.00
	DO DRUGS CHARGED TO PATIENTS		1, 676			0	
	PATIENT SERVICE COST CENTERS	<u> </u>	., 0, 0		91		70.00
	OO CLI NI C	185	151	0	0	0	90.00
90. 01 0900	1 SENI OR CARE	392	575	151	O	0	90. 01
91. 00 0910	OO EMERGENCY	626	3, 452	1, 019	1, 099	0	91. 00
	OO OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	R REIMBURSABLE COST CENTERS		0.40				
	DO HOME HEALTH AGENCY	364	842	0	0	0	101. 00
116. 00 1160	CLAL PURPOSE COST CENTERS	0	0	0	ol		114 00
118. 00	SUBTOTALS (SUM OF LINES 1-117)	11, 683	35, 796			40, 553	116.00
	REIMBURSABLE COST CENTERS	11,003	33, 170	0, 342	4, 044	40, 555	] 110.00
	O GIFT, FLOWER, COFFEE SHOP & CANTEEN	152	0	0	o	0	190. 00
	OO PHYSICIANS' PRIVATE OFFICES	3, 006	880				192. 00
	50 FITNESS CENTER	736	0	· ·			194. 00
194. 01 0795	MARKETI NG	46	0	63	0	0	194. 01
	NEW DIRECTION	0	0	0	О	0	194. 02
194. 03 0795		0	0				194. 03
	4 WELL CHILD CLINIC	277	0	120	0	0	194. 04
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers	0	0	0			201. 00
202.00	TOTAL (sum lines 118-201)	15, 900	36, 676	12, 030	4, 644	40, 553	J202. 00

CONTROL CAPITAL RELATED CIDSTS	Health Financial Systems	WABASH COUNTY	/ HOSPITAL		In Lie	u of Form CMS	2552-10
Cost Center Description	ALLOCATION OF CAPITAL RELATED COSTS		Provi der	F	rom 01/01/2014	Part II Date/Time Pre	pared:
GENERAL SERVICE COST CENTERS	Cost Center Description		RECORDS & LI BRARY		Residents Cost & Post Stepdown Adjustments		
1.00		15. 00	16. 00	24. 00	25. 00	26. 00	
2.00				•			
9,00   00900   0015KEEPING   9,00   11.00   11	2.00   00200   NEW CAP REL COSTS-MVBLE EQUIP   00400   EMPLOYEE BENEFITS DEPARTMENT   00561   OTHER ADMINISTRATIVE AND GENERAL   00560   BUSINESS OFFICE   00600   MAINTENANCE & REPAIRS   7.00   00700   OPERATION OF PLANT						2. 00 4. 00 5. 01 5. 02 6. 00 7. 00
13.00   01300   NURSING ADMINISTRATION	9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY						9. 00 10. 00
16. 00   01600   MEDICAL RECORDS & LIBRARY   0   30, 331	13.00   01300   NURSI NG   ADMINISTRATI ON 14.00   01400   CENTRAL   SERVI CES & SUPPLY						13. 00 14. 00
IMPATI ENT ROUTI NE SERVICE COST CENTERS   0   2,214   130,506   0   130,506   0   0   0   0   0   0   0   0   0		1	30, 331				1
A3. 00   04300   NURSERY   0   0   0   0   0   0   0   33. 00		·					
SOLO   050000   050000   050000   050000   050000   050000   050000   050000   050000   050000   050000   050000   050000   050000   050000   0500000   0500000   0500000   0500000   0500000   05000000   050000000   0500000000	30. 00   03000   ADULTS & PEDI ATRI CS   43. 00   04300   NURSERY	1				•	1
51.00   05100   RECOVERY ROOM   0   187   7,017   0   7,017   51.00			1 724	100 177		100 177	E0 00
53.00   05300   AMESTHESI OLOGY   0   3.47   2, 487   0   2, 487   53.00		1				•	1
54.00   05400   RADI OLOGY-DI AGNOSTI C   0   5,586   195,240   0   195,240   54.00   65.00   05600   RADI OLSOTOPE   0   359   2,182   0   2,182   56.00   60.00   6000   LABORATORY   0   4,747   55,328   0   55,328   60.00   63.00   63.00   BLOOD STORI NG, PROCESSI NG & TRANS.   0   65   624   0   624   63.00   60.00   6000   PLECTROCARDI OLOGY   0   953   27,589   0   27,589   66.00   60.00   6000   PLECTROCARDI OLOGY   0   909   14,707   0   14,707   69.00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   1,578   46,346   0   46,346   71.00   72.00   7020   IMPL. DEV. CHARGED TO PATI ENTS   0   1,036   4,058   0   4,058   0   4,058   72.00   73.00   DRUGS CHARGED TO PATI ENTS   110,142   7,611   119,429   0   119,429   73.00   73.00   DRUGS CHARGED TO PATI ENTS   0   169   16,221   0   16,221   90.01   90.00   9000   CLINI C   0   237   12,493   0   12,493   90.00   90.00   9000   DRUGS CHARGED TO PATI ENTS   0   169   16,221   0   16,221   90.01   90.00   9000   DRUGS CHARGED TO PATI ENTS   0   2,599   51,218   0   51,218   91.00   91.00   90100   EMERGENCY   0   2,599   51,218   0   51,218   91.00	52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	C	0	0	52. 00
56. 00   05600   RADI OI SOTOPE   0   3559   2, 182   0   2, 182   56. 00	53. 00 05300 ANESTHESI OLOGY	0	347	2, 487	0	2, 487	53. 00
60. 00   06000   LABORATORY   0   4,747   55,328   0   55,328   60. 00   63. 00   06300   BLOOD STORI NG, PROCESSI NG & TRANS.   0   65   624   0   624   63. 00   64. 00   06600   PHYSI CAL THERAPY   0   953   27,589   0   27,589   66. 00   69. 00   06900   ELECTROCARDI OLOGY   0   909   14,707   0   14,707   69. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   1,578   46,346   0   46,346   77. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   1,036   4,058   0   4,058   0   73. 00   07300   DRUGS CHARGED TO PATIENTS   110,142   7,611   119,429   0   119,429   73. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   110,142   7,611   119,429   0   119,429   73. 00   74. 00   07300   DRUGS CHARGED TO PATIENTS   0   237   12,493   0   12,493   90. 00   75. 00   09000   CLI NI C   0   237   12,493   0   12,493   90. 00   76. 01   09001   SENI OR CARE   0   169   16,221   0   16,221   90. 10   77. 00   09100   DERECENCY   0   2,599   51,218   0   51,218   91. 00   78. 00   09200   DSSERVATI ON BEDS (NON-DISTINCT PART)   0   20,388   0   20,388   78. 00   00   0   0   0   0   0   0   0   79. 00   10000   HEALTH AGENCY   0   0   0   0   0   0   0   79. 00   10000   HEALTH AGENCY   0   0   0   0   0   0   0   79. 00   09000   CLI NIC   0   0   0   0   0   0   0   79. 00   09000   SUBTOTALS (SUM OF LINES 1-117)   110,142   30,331   898,330   0   898,330   118. 00   79. 00   19000   19000   HYSI CLANS* PRI VATE OFFICES   0   0   0   24,876   0   24,876   0   24,876   0   24,876   0   24,876   0   24,876   0   24,876   0   24,876   0   24,876   0   24,876   0   0   0   194,03   194,03   194,03   194,03   194,03   195,03   195,03   194,0		-					1
63.00   06300   BLOOD STORING, PROCESSING & TRANS.   0   655   624   0   624   63.00   66.00   06600   PHYSI CAL THERAPY   0   953   27.589   0   27.589   66.00   67.00   06900   ELECTROCARDI OLOGY   0   909   14,707   0   14,707   72.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   1,578   46.346   0   46,346   71.00   72.00   07200   IMPL. DEV. CHARGED TO PATIENT   0   1,036   4,058   0   4,058   72.00   73.00   07300   DRUGS CHARGED TO PATIENTS   110,142   7,611   119,429   0   119,429   79.00   07300   DRUGS CHARGED TO PATIENTS   110,142   7,611   119,429   0   119,429   79.00   09000   CLINIC   0   237   12,493   0   12,493   90.00   79.01   09001   SENIOR CARE   0   169   16,221   0   16,221   0   79.00   09000   DRERGENCY   0   2,599   51,218   0   51,218   91.00   79.00   09000   DRERGENCY   0   20,388   0   20,388   0   70   09000   DRERGENCY   0   20,388   0   20,388   70   09000   DRERGENCY   0   0   0   20,388   0   20,388   70   09000   DRERGENCY   0   0   0   0   0   71   00   01000   HOME HEALTH AGENCY   0   0   0   4,320   0   4,320   116.00   71   116.00   1059T CE   SUBTOTALS (SUM OF LINES 1-117)   110,142   30,331   898,330   0   898,330   71   116.00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   213,694   0   213,694   192.00   71   09000   00   00   0   0   0   0   0		0					1
66.00   06600   PHYSI CAL THERAPY   0   953   27, 589   0   27, 589   66.00   69.00   06900   CELECTROCARDI OLOGY   0   909   14, 707   0   14, 707   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   1, 578   46, 346   0   46, 346   71.00   72.00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   1, 036   4, 058   0   4, 058   72.00   73.00   07300   DRUGS CHARGED TO PATIENTS   110, 142   7, 611   119, 429   0   119, 429   73.00   07300   DRUGS CHARGED TO PATIENTS   110, 142   7, 611   119, 429   0   119, 429   73.00   07300   DRUGS CHARGED TO PATIENTS   110, 142   7, 611   119, 429   0   119, 429   73.00   07300   DRUGS CHARGED TO PATIENTS   110, 142   7, 611   119, 429   0   119, 429   73.00   07300   DRUGS CHARGED TO PATIENTS   10, 142   7, 611   119, 429   0   119, 429   73.00   07300   DRUGS CHARGED TO PATIENTS   10, 142   7, 611   119, 429   0   119, 429   73.00   07300   DRUGS CHARGED TO PATIENTS   10, 142   7, 611   119, 429   0   119, 429   73.00   07900   DRUGS CHARGED TO PATIENTS   0   12, 493   0   12, 493   90.00   79.00   09000   CLI NI C   0   237   12, 493   0   12, 493   90.00   79.00   09000   SENI OR CARE   0   169   16, 221   0   16, 221   90.01   79.00   09100   EMERGENCY   0   2,599   51, 218   0   51, 218   91.00   79.00   09100   EMERGENCY   0   2,599   51, 218   0   51, 218   91.00   70.00   09100   DRUGS CHARGED TO PATIENTS   0   0   0   20, 388   0   20, 388   101.00   70.00   01000   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   70.00   01000   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   70.00   01000   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   70.00   01000   DRUGS CHARGED TO PATIENTS   0   0   0   0   70.00   01000   DRUGS CHARGED TO PATIENTS   0   0   0   0   70.00   01000   DRUGS CHARGED TO PATIENTS   0   0   0   0   70.00   01000   DRUGS CHARGED TO PATIENTS   0   0   0   0   70.00   01000   DRUGS CHARGED TO PATIENTS   0   0   0   0   70.00   01000   DRUGS CHARGED TO PATIENTS   0   0   0   0   70.00   01000   DRUGS CHARGED TO PATIENTS   0   0   0   0   70.00		0				•	1
69.00   66900   ELECTROCARDIOLOGY   0   909   14, 707   0   14, 707   69.00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   1,578   46, 346   0   46, 346   71.00   72.00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   1,036   4,058   0   4,058   72.00   07300   DRUGS CHARGED TO PATIENTS   110,142   7,611   119,429   0   119,429   73.00   07300   DRUGS CHARGED TO PATIENTS   110,142   7,611   119,429   0   119,429   73.00   07300   DRUGS CHARGED TO PATIENTS   110,142   7,611   119,429   0   119,429   73.00   070000   07000   070000   070000   070000		1					
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 1,578 46,346 0 46,346 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 0 1,036 4,058 0 4,058 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 110,142 7,611 119,429 0 119,429 73. 00 0UTPATIENT SERVICE COST CENTERS  90. 00 09000 CLINIC 0 237 12,493 0 12,493 90. 00 90. 01 09001 SENI OR CARE 0 169 16,221 0 16,221 90. 01 91. 00 09100 EMERGENCY 0 2,599 51,218 0 51,218 91. 00 92. 00 09200 [OBSERVATI ON BEDS (NON-DI STINCT PART) 0 0,2,599 51,218 0 51,218 91. 00 0THER REI MBURSABLE COST CENTERS  101. 00 10100 [HOME HEALTH AGENCY 0 0 0 20,388 0 20,388 101. 00  SPECIAL PURPOSE COST CENTERS  116. 00 11600 [HOSPI CE 0 0 0 4,320 0 898,330 118. 00  NONREI MBURSABLE COST CENTERS  190. 00 19000 [GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 213,694 0 213,694 192. 00 194. 00 07950 [FI TNESS CENTER 0 0 0 24,876 0 24,876 194. 00 194. 01 07951 [MARKETI NG 0 0 0 0 2,726 0 2,726 194. 01 194. 01 07951 [MARKETI NG 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
72. 00 07200   IMPL. DEV. CHARGED TO PATIENT 0 1,036 4,058 0 4,058 72. 00 73.00   DRUGS CHARGED TO PATIENTS 110,142 7,611 119,429 0 119,429 73. 00   DRUGS CHARGED TO PATIENTS 110,142 7,611 119,429 0 119,429 73. 00   DRUGS CHARGED TO PATIENTS	· · · · · · · · · · · · · · · · · · ·	0					1
73. 00   07300   DRUGS CHARGED TO PATIENTS   110, 142   7, 611   119, 429   0   119, 429   73. 00	· · · · · · · · · · · · · · · · · · ·	1		· ·			
90. 00	· · · · · · · · · · · · · · · · · · ·	1					
90. 01	OUTPATIENT SERVICE COST CENTERS						
91. 00		1 1				•	1
92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART)   0   0THER REI MBURSABLE COST CENTERS   0   0   20, 388   0   20, 388   101. 00   0   20, 388   101. 00   0   20, 388   101. 00   0   20, 388   101. 00   0   20, 388   101. 00   0   20, 388   101. 00   0   20, 388   101. 00   0   20, 388   101. 00   0   20, 388   101. 00   0   20, 388   20   20, 20   20, 20   20, 20   20, 20   20, 20   20, 20   20, 20   20, 20   20, 20   20, 20   20, 20   20, 20   20, 20   20, 20   20, 20   20, 20   20, 20		1		· ·			
OTHER REIMBURSABLE COST CENTERS   101.00   10100   HOME   HEALTH   AGENCY   0   0   0   20, 388   0   20, 388   101.00		0	2, 599	51, 218 		51, 218	1
101. 00   10100   HOME   HEALTH   AGENCY   0   0   20, 388   0   20, 388   101. 00   SPECIAL PURPOSE COST CENTERS   116. 00   11600   HOSPI CE   0   0   0   4, 320   0   4, 320   116. 00   118. 00   SUBTOTALS (SUM OF LINES 1-117)   110, 142   30, 331   898, 330   0   898, 330   118. 00   NONREI   MBURSABLE   COST CENTERS					l o		92.00
118. 00   SUBTOTALS (SUM OF LINES 1-117)   110, 142   30, 331   898, 330   0   898, 330   118. 00   NONREI MBURSABLE COST CENTERS   190. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   5, 152   190. 00   192. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES   0   0   213, 694   192. 00   194. 00   194. 01   07950   FI TNESS CENTER   0   0   24, 876   194. 00   194. 01   07951   MARKETI NG   0   0   2, 726   0   2, 726   194. 01   194. 02   07952   NEW DIRECTION   0   0   0   0   0   194. 02   194. 03   07953   RESPI TE   0   0   0   0   0   0   194. 03   194. 04   07954   WELL CHILD CLINIC   0   0   0   0   0   0   0   0   0	101.00 10100 HOME HEALTH AGENCY	0	0	20, 388	0	20, 388	101. 00
NONREI MBURSABLE COST CENTERS   190. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   5, 152   190. 00   192. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES   0   0   213, 694   192. 00   194. 00   07950   FI TNESS CENTER   0   0   24, 876   0   24, 876   194. 00   194. 01   07951   MARKETI NG   0   0   2, 726   0   2, 726   194. 01   194. 02   07952   NEW DIRECTION   0   0   0   0   0   194. 02   194. 03   07953   RESPI TE   0   0   0   0   0   0   194. 03   194. 04   07954   WELL CHILD CLINIC   0   0   0   0   0   0   200. 00   201. 00   Negative Cost Centers   0   0   0   0   0   0   0   0   0	116. 00 11600 HOSPI CE	0	0	4, 320	0	4, 320	116. 00
192. 00   1920	NONREI MBURSABLE COST CENTERS		30, 331				
194. 00   07950   FI TNESS CENTER     0     24, 876   194. 00       194. 01   07951   MARKETI NG     0     0     2, 726   0     2, 726   194. 01       194. 02   07952   NEW DIRECTI ON     0     0     0     0     0     194. 02       194. 03   07953   RESPI TE     0     0     0     0     0     0     194. 03       194. 04   07954   WELL CHILD CLINIC     0     0     10, 262   194. 04       200. 00   Cross Foot Adjustments     0     0     0     0     0     0       201. 00   Negative Cost Centers     0     0     0     0     0     0     0		1	0				
194. 01 07951 MARKETING 0 0 2, 726 0 2, 726 194. 01 194. 02 07952 NEW DIRECTION 0 0 0 0 194. 02 194. 03 07953 RESPITE 0 0 0 0 0 0 194. 03 194. 04 07954 WELL CHILD CLINIC 0 0 10, 262 194. 04 07954 WELL CHILD CLINIC 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1 1	0				
194. 02 07952 NEW DIRECTION 0 0 0 0 194. 02 194. 03 07953 RESPITE 0 0 0 0 0 194. 03 194. 04 07954 WELL CHILD CLINIC 0 0 10, 262 194. 04 200. 00 Cross Foot Adjustments 0 0 0 0 0 0 0 0 0 0 0 200. 00 201. 00		1	0				
194. 03 07953 RESPITE 0 0 0 0 0 194. 03 194. 04 07954 WELL CHILD CLINIC 0 0 10, 262 194. 04 200. 00 Cross Foot Adjustments 0 0 0 0 0 201. 00 0 0 0 0 0 201. 00		-1	0	2, 720	0		
194. 04 07954 WELL CHILD CLINIC 0 10, 262 0 10, 262 194. 04 200. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	l o			
200.00   Cross Foot Adjustments		l ol	Ö	10, 262	l ol		
201.00         Negative Cost Centers         0         0         0         0         0         201.00           202.00         TOTAL (sum lines 118-201)         110,142         30,331         1,155,040         0         1,155,040         202.00		1		· c	o	0	200.00
202. 00   TOTAL (sum lines 118-201)   110, 142  30, 331  1, 155, 040  0  1, 155, 040 202. 00		0	O			0	201. 00
	202.00   TOTAL (sum lines 118-201)	110, 142	30, 331	1, 155, 040	o	1, 155, 040	202. 00

COST A	NLLOCATION - STATISTICAL BASIS		Provi der	F	Period: From 01/01/2014 Fo 12/31/2014	Worksheet B-1 Date/Time Pre 5/27/2015 8:0	
		CAPITAL RELA	ATED COSTS			372772015 8.0	4 alli
	Cost Center Description	NEW BLDG & FLXT (SQUARE FEET)	NEW MVBLE EQUI P (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
		1.00	2. 00	4. 00	5A. 01	5. 01	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT	126, 308	1 25/ 012				1. 00 2. 00
2. 00 4. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	2, 454	1, 256, 913 827		3		4. 00
5. 01	00561 OTHER ADMINISTRATIVE AND GENERAL	12, 913	207, 983			31, 990, 240	1
5. 02	00560 BUSINESS OFFICE	0	11, 409			.,	1
6.00	00600 MAI NTENANCE & REPAIRS	0	290, 569				6.00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	25, 585	0			501, 663 0	7. 00 8. 00
9. 00	00900 HOUSEKEEPING	1, 920	0	234, 336	-	667, 556	9. 00
10.00	01000 DI ETARY	4, 959	3, 593			444, 829	10. 00
11.00	01100 CAFETERI A	1, 538	0	240, 945		354, 984	11.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	480 5, 235	0 1, 150	10,,02,		233, 298 1, 063, 669	1
15. 00	01500 PHARMACY	4, 688	101, 678				15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	4, 087	873				16. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	10.0/5	20.077	1 52/ 5/5	-1 0	1 054 407	1 20 00
43. 00	03000 ADULTS & PEDI ATRI CS 04300 NURSERY	10, 865	38, 866 0				30. 00 43. 00
	ANCILLARY SERVICE COST CENTERS	, , , , , , , , , , , , , , , , , , , ,	-		-	_	
50.00	05000 OPERATING ROOM	8, 222	187, 804				50.00
51. 00 52. 00	O5100   RECOVERY ROOM   O5200   DELIVERY ROOM & LABOR ROOM	948	0	67, 133			51. 00 52. 00
53. 00	05300 ANESTHESI OLOGY	171	0	880, 528			
54.00	05400 RADI OLOGY-DI AGNOSTI C	6, 617	216, 518				1
56. 00	05600 RADI OI SOTOPE	0	1, 076				
60. 00 63. 00	06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.	3, 406	26, 284 0	679, 446		2, 000, 301 96, 975	1
66. 00	06600 PHYSI CAL THERAPY	840	19, 299	-	-	1, 443, 105	1
69. 00	06900 ELECTROCARDI OLOGY	1, 027	3, 999	575, 788	0		1
71. 00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	-			1
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	0	0				72. 00 73. 00
, 0. 00	OUTPATIENT SERVICE COST CENTERS	9			,		70.00
90.00	09000 CLI NI C	973	8, 444				
90. 01 91. 00	09001 SENI OR CARE 09100 EMERGENCY	2, 055 3, 287	662 12, 123				90. 01 91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 207	12, 123	037, 437		2, 303, 771	92. 00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	1, 910	0	713, 969	9 0	1, 200, 504	]101. 00 
116. 00	11600 HOSPI CE	0	0	365, 105	5 0	713, 865	116. 00
118.00	SUBTOTALS (SUM OF LINES 1-117)	104, 180	1, 133, 157				
100.00	NONREI MBURSABLE COST CENTERS	000				T 2 500	1100 00
	1900  GIFT, FLOWER, COFFEE SHOP & CANTEEN   1920  PHYSICIANS' PRIVATE OFFICES	800 15, 769	0 123, 756				190. 00 192. 00
	07950 FITNESS CENTER	3, 862	0		o o		194. 00
	07951 MARKETI NG	242	0	78, 696	0	,	
	07952 NEW DIRECTION	0	0		0		194. 02 194. 03
	07953 RESPITE   07954 WELL CHILD CLINIC	1, 455	0	75, 983	3 0	144, 347	
200.00		., .55	0	, 5, 766			200. 00
201.00							201. 00
202.00	Cost to be allocated (per Wkst. B, Part I)	395, 985	759, 055	478, 579	7	4, 856, 755	202. 00
203.00		3. 135075	0. 603904	0. 03039 <i>6</i>	5	0. 151820	203. 00
204.00	Cost to be allocated (per Wkst. B,			8, 192	2	166, 789	204. 00
205.00	Part II)   Unit cost multiplier (Wkst. B, Part			0. 000520		0. 005214	205 00
200.00				3.000320		0.003214	

1. 00	COST Center Description  ENERAL SERVICE COST CENTERS D100 NEW CAP REL COSTS-BLDG & FIXT D200 NEW CAP REL COSTS-MVBLE EQUIP D400 EMPLOYEE BENEFITS DEPARTMENT D561 OTHER ADMINISTRATIVE AND GENERAL D560 BUSINESS OFFICE MAINTENANCE & REPAIRS D700 OPERATION OF PLANT D800 LAUNDRY & LINEN SERVICE D900 HOUSEKEEPING D1000 DIETARY D1000 CAFETERIA NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY D1500 PHARMACY D1600 MEDICAL RECORDS & LIBRARY	BUSI NESS OFFI CE (ACCUM: COST)  5. 02  11, 773, 314  491, 291  250, 639  0 305, 748  212, 907 161, 156 113, 475	110, 941 25, 585 0 1, 920 4, 959	0PERATI ON OF PLANT (SQUARE FEET) 7.00	0	5/27/2015 8: 0 HOUSEKEEPI NG (SQUARE FEET) 9: 00	1. 00 2. 00 4. 00 5. 01 5. 02 6. 00 7. 00 8. 00
1. 00	D1000 NEW CAP REL COSTS-BLDG & FIXT D2000 NEW CAP REL COSTS-MVBLE EQUIP D4000 EMPLOYEE BENEFITS DEPARTMENT D5661 OTHER ADMINISTRATIVE AND GENERAL D5660 BUSINESS OFFICE D6000 MAINTENANCE & REPAIRS D7000 OPERATION OF PLANT D8000 LAUNDRY & LINEN SERVICE D9000 HOUSEKEEPING D10000 DIETARY D11000 CAFETERIA D1300 NURSING ADMINISTRATION D14000 CENTRAL SERVICES & SUPPLY D40400 PHARMACY	11, 773, 314 491, 291 250, 639 0 305, 748 212, 907 161, 156 113, 475	110, 941 25, 585 0 1, 920 4, 959	7. 00 85, 356 0 1, 920	8.00		2. 00 4. 00 5. 01 5. 02 6. 00 7. 00 8. 00
1. 00	D1000 NEW CAP REL COSTS-BLDG & FIXT D2000 NEW CAP REL COSTS-MVBLE EQUIP D4000 EMPLOYEE BENEFITS DEPARTMENT D5661 OTHER ADMINISTRATIVE AND GENERAL D5660 BUSINESS OFFICE D6000 MAINTENANCE & REPAIRS D7000 OPERATION OF PLANT D8000 LAUNDRY & LINEN SERVICE D9000 HOUSEKEEPING D10000 DIETARY D11000 CAFETERIA D1300 NURSING ADMINISTRATION D14000 CENTRAL SERVICES & SUPPLY D40400 PHARMACY	11, 773, 314 491, 291 250, 639 0 305, 748 212, 907 161, 156 113, 475	110, 941 25, 585 0 1, 920 4, 959	85, 356 0 1, 920	0		2. 00 4. 00 5. 01 5. 02 6. 00 7. 00 8. 00
1. 00	D1000 NEW CAP REL COSTS-BLDG & FIXT D2000 NEW CAP REL COSTS-MVBLE EQUIP D4000 EMPLOYEE BENEFITS DEPARTMENT D5661 OTHER ADMINISTRATIVE AND GENERAL D5660 BUSINESS OFFICE D6000 MAINTENANCE & REPAIRS D7000 OPERATION OF PLANT D8000 LAUNDRY & LINEN SERVICE D9000 HOUSEKEEPING D10000 DIETARY D11000 CAFETERIA D1300 NURSING ADMINISTRATION D14000 CENTRAL SERVICES & SUPPLY D40400 PHARMACY	491, 291 250, 639 0 305, 748 212, 907 161, 156 113, 475	110, 941 25, 585 0 1, 920 4, 959	0 1, 920	0	83 436	2. 00 4. 00 5. 01 5. 02 6. 00 7. 00 8. 00
2. 00	D200 NEW CAP REL COSTS-MVBLE EQUIP D400 EMPLOYEE BENEFITS DEPARTMENT D561 OTHER ADMINISTRATIVE AND GENERAL D5600 MAINTENANCE & REPAIRS D700 OPERATION OF PLANT D800 LAUNDRY & LINEN SERVICE D900 HOUSEKEEPING D1000 DI ETARY CAFETERIA D1300 NURSING ADMINISTRATION D400 CENTRAL SERVICES & SUPPLY PHARMACY	491, 291 250, 639 0 305, 748 212, 907 161, 156 113, 475	110, 941 25, 585 0 1, 920 4, 959	0 1, 920	0	83 426	4. 00 5. 01 5. 02 6. 00 7. 00 8. 00
5. 01 00 5. 02 00 6. 00 00 7. 00 00 8. 00 00 10. 00 01 11. 00 01 13. 00 01 14. 00 01 15. 00 01 16. 00 01	OTHER ADMINISTRATIVE AND GENERAL DESCRIPTION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING 10000 DIETARY 11000 CAFETERIA 13000 NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY	491, 291 250, 639 0 305, 748 212, 907 161, 156 113, 475	110, 941 25, 585 0 1, 920 4, 959	0 1, 920	0	83 436	5. 01 5. 02 6. 00 7. 00 8. 00
5. 02 00 6. 00 00 7. 00 00 8. 00 00 9. 00 00 11. 00 01 13. 00 01 14. 00 01 15. 00 01 16. 00 01	D560 BUSINESS OFFICE D600 MAINTENANCE & REPAIRS D700 OPERATION OF PLANT D800 LAUNDRY & LINEN SERVICE D900 DIETARY D1000 DIETARY D1100 CAFETERIA D1300 NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY D1500 PHARMACY	491, 291 250, 639 0 305, 748 212, 907 161, 156 113, 475	110, 941 25, 585 0 1, 920 4, 959	0 1, 920	0	83 436	5. 02 6. 00 7. 00 8. 00
6. 00 00 7. 00 00 8. 00 00 9. 00 00 11. 00 01 13. 00 01 14. 00 01 15. 00 01 16. 00 01	DOCOO MAINTENANCE & REPAIRS DOCOO DERATION OF PLANT DROO LAUNDRY & LINEN SERVICE HOUSEKEEPING 1000 DIETARY 1100 CAFETERIA 1300 NURSING ADMINISTRATION 1400 CENTRAL SERVICES & SUPPLY 1500 PHARMACY	491, 291 250, 639 0 305, 748 212, 907 161, 156 113, 475	110, 941 25, 585 0 1, 920 4, 959	0 1, 920	0	83 436	6. 00 7. 00 8. 00
7. 00 00 8. 00 00 9. 00 00 10. 00 01 11. 00 01 13. 00 01 14. 00 01 15. 00 01 16. 00 01	0700 OPERATION OF PLANT 0800 LAUNDRY & LINEN SERVICE 0900 HOUSEKEEPING 1000 DIETARY 1100 CAFETERIA 1300 NURSING ADMINISTRATION 1400 CENTRAL SERVICES & SUPPLY 1500 PHARMACY	250, 639 0 305, 748 212, 907 161, 156 113, 475	25, 585 0 1, 920 4, 959	0 1, 920	0	83 436	7. 00 8. 00
8. 00 00 9. 00 00 10. 00 01 11. 00 01 13. 00 01 14. 00 01 15. 00 01 16. 00 01	D800 LAUNDRY & LINEN SERVICE D900 HOUSEKEEPING 1000 DIETARY 1100 CAFETERIA 1300 NURSING ADMINISTRATION 1400 CENTRAL SERVICES & SUPPLY 1500 PHARMACY	0 305, 748 212, 907 161, 156 113, 475	0 1, 920 4, 959	0 1, 920	0	83 436	8.00
9. 00 00 10. 00 01 11. 00 01 13. 00 01 14. 00 01 15. 00 01 16. 00 01	0900 HOUSEKEEPING 1000 DIETARY 1100 CAFETERIA 1300 NURSING ADMINISTRATION 1400 CENTRAL SERVICES & SUPPLY 1500 PHARMACY	305, 748 212, 907 161, 156 113, 475	1, 920 4, 959	1, 920	Ö	83 436	
10. 00 01 11. 00 01 13. 00 01 14. 00 01 15. 00 01 16. 00 01	1000 DIETARY 1100 CAFETERIA 1300 NURSING ADMINISTRATION 1400 CENTRAL SERVICES & SUPPLY 1500 PHARMACY	212, 907 161, 156 113, 475	4, 959				9.00
11. 00 01 13. 00 01 14. 00 01 15. 00 01 16. 00 01	1100 CAFETERIA 1300 NURSING ADMINISTRATION 1400 CENTRAL SERVICES & SUPPLY 1500 PHARMACY	161, 156 113, 475			ا ۱	4, 959	•
13. 00 01 14. 00 01 15. 00 01 16. 00 01	1300 NURSING ADMINISTRATION 1400 CENTRAL SERVICES & SUPPLY 1500 PHARMACY	113, 475		1, 538		1, 538	1
14. 00 01 15. 00 01 16. 00 01	1400 CENTRAL SERVICES & SUPPLY 1500 PHARMACY	F 40 / 10		480		480	1
16. 00 01		543, 618	5, 235	5, 235	o	5, 235	14. 00
IN	1600 MEDICAL RECORDS & LIBRARY	1, 609, 153	4, 688	4, 688	0	4, 688	15. 00
		263, 618	4, 087	4, 087	0	4, 087	16. 00
	NPATIENT ROUTINE SERVICE COST CENTERS		10.0/5		1 al	10.0/5	
	3000 ADULTS & PEDIATRICS	1, 153, 966		10, 865			
	4300 NURSERY NCILLARY SERVICE COST CENTERS	0	0	0	0	0	43. 00
	5000 OPERATING ROOM	790, 814	8, 222	8, 222	ol	8, 222	50.00
	5100 RECOVERY ROOM	43, 060				948	
1	5200 DELIVERY ROOM & LABOR ROOM	0	0	0		0	
	5300 ANESTHESI OLOGY	52, 987	171	171	o	171	
54.00 05	5400 RADI OLOGY-DI AGNOSTI C	1, 093, 880	6, 617	6, 617	o	6, 617	54.00
56.00 05	5600 RADI OI SOTOPE	91, 359	0	0	0	0	56. 00
	6000 LABORATORY	958, 805	3, 406	3, 406	0	3, 406	60.00
	6300 BLOOD STORING, PROCESSING & TRANS.	49, 279	l .	0	-	0	
	6600 PHYSI CAL THERAPY	710, 508		840		840	•
	5900 ELECTROCARDI OLOGY	119, 714		1, 027		1, 027	
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS 7200 IMPL. DEV. CHARGED TO PATIENT	189, 434 361, 268	l .	0	_	0	•
	7300 DRUGS CHARGED TO PATIENTS	0	l .				
	JTPATIENT SERVICE COST CENTERS				<u> </u>		70.00
	9000 CLI NI C	56, 966	973	973	0	973	90.00
90. 01 09	9001 SENI OR CARE	135, 795	2, 055	2, 055	0	2, 055	90. 01
	9100 EMERGENCY	1, 033, 018	3, 287	3, 287	0	3, 287	
	9200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
	THER REIMBURSABLE COST CENTERS	/ 00 407	1 010	4 040	1 0	4 040	101 00
	D100 HOME HEALTH AGENCY PECIAL PURPOSE COST CENTERS	600, 497	1, 910	1, 910	0	1, 910	101. 00
	1600 HOSPI CE	380, 359	0	0	ol	0	116. 00
118. 00	SUBTOTALS (SUM OF LINES 1-117)	11, 773, 314					118.00
_	ONREI MBURSABLE COST CENTERS	,			-1		1
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	800	800	0	800	190. 00
192. 00 19	P200 PHYSICIANS' PRIVATE OFFICES	0	15, 769	15, 769	0		192. 00
194. 00 07	7950 FITNESS CENTER	0	3, 862	3, 862	0	3, 862	194. 00
	7951 MARKETI NG	0		242			194. 01
	7952 NEW DI RECTI ON	0	_	0	_		194. 02
	7953 RESPITE	0		0			194. 03
200. 00	7954 WELL CHILD CLINIC Cross Foot Adjustments	0	1, 455	1, 455	٥	1, 455	194. 04
200.00	Negative Cost Centers						200. 00 201. 00
201.00	Cost to be allocated (per Wkst. B,	1, 224, 712	1, 219, 375	885, 108		841, 722	
202.00	Part I)	1,227,112	1,217,373	555, 100		071,722	1 52.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 104024	10. 991203	10. 369605	0. 000000		
204.00	Cost to be allocated (per Wkst. B,	12, 632				15, 900	
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	0. 001073	1. 635545	1. 463787	0. 000000	0. 190565	205. 00

near tr	Financial Systems	WABASH COUNTY	' HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST A	ALLOCATION - STATISTICAL BASIS		Provi der		eri od:	Worksheet B-1	
				Fr	rom 01/01/2014 0 12/31/2014	Date/Time Pre	nared.
					7 12/31/2014	5/27/2015 8:0	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
		(MEALS	(HOURS)	ADMI NI STRATI ON	SERVICES &	(COSTED	
		SERVED)			SUPPLY	REQUIS.)	
				(DI RECT	(COSTED		
				NRSING HRS)	REQUIS.)		
		10.00	11. 00	13.00	14. 00	15. 00	
	GENERAL SERVICE COST CENTERS	, ,		,			_
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00561 OTHER ADMINISTRATIVE AND GENERAL						5. 01
5. 02	00560 BUSI NESS OFFI CE						5. 02
6.00	00600 MAINTENANCE & REPAIRS						6.00
7. 00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY	23, 350					10.00
11. 00	O1100  CAFETERI A	0	365, 853				11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	4, 107	131, 041			13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	2, 162	0	10, 000		14.00
15.00	01500 PHARMACY	0	20, 219	0	0	10, 000	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	13, 103	0	0	0	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	12, 626	43, 280	43, 280	0	0	30.00
43.00	04300 NURSERY	0	0	0	0	0	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	5, 040	26, 426	26, 426	0	0	50.00
51.00	05100 RECOVERY ROOM	O	2, 140	2, 140	o	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	o	0	0	o	0	52.00
53.00	05300 ANESTHESI OLOGY	o	0	o	o	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	785	28, 196	28, 196	o	0	54.00
56.00	05600 RADI 0I SOTOPE	0	2, 046		0	0	•
60.00	06000 LABORATORY	36	29, 058	1	0	0	
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.		0	1	0	0	
66. 00	06600 PHYSI CAL THERAPY	4	25, 334		0	0	•
69. 00	06900 ELECTROCARDI OLOGY	36	22, 068	1	0	0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	10, 000	0	•
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	l ol	0	Ö	0	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 067	0		o	10, 000	
70.00	OUTPATIENT SERVICE COST CENTERS	1,007		ı	٩	10,000	70.00
90. 00	09000 CLINIC	96	0	O	ol	0	90.00
90. 01	09001 SENI OR CARE	366	4, 601	- 1	o	0	
91. 00	09100 EMERGENCY	2. 198	30, 999		o	0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,170	30, 777	30, 777	J	O	92. 00
72.00	OTHER REIMBURSABLE COST CENTERS						/2.00
101 00	10100 HOME HEALTH AGENCY	536	0	0	o	0	101. 00
101.00	SPECIAL PURPOSE COST CENTERS	330		1 9	<u> </u>		11011.00
116 00	11600 HOSPI CE	O	0	O	ol	0	116. 00
118.00	1 1	22, 790	253, 739		10, 000	10, 000	
110.00	NONREI MBURSABLE COST CENTERS	22, 190	200, 709	131,041	10, 000[	10, 000	1110.00
100 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		0	ما	0	190. 00
		560	104 540		ol Ol		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	560	106, 540	1	- 1		
	07950 FI TNESS CENTER	0	0	0	0		194.00
	07951 MARKETI NG	0	1, 917	1	0		194. 01
	07952 NEW DIRECTION	0	0	0	0		194. 02
	07953 RESPI TE	0	0	0	0		194. 03
	07954 WELL CHILD CLINIC	0	3, 657	0	O	0	194. 04
200.00	1 1						200.00
201.00							201.00
202.00	"	690, 466	474, 010	300, 937	1, 449, 141	3, 844, 148	202. 00
	Part I)						L
		29. 570278	1. 295630	1	144. 914100	384. 414800	
203.00		1				110 110	1204 00
	Cost to be allocated (per Wkst. B,	36, 676	12, 030	4, 644	40, 553	110, 142	204.00
203. 00 204. 00	Cost to be allocated (per Wkst. B, Part II)	36, 676			·		
203.00	Cost to be allocated (per Wkst. B, Part II)	1	12, 030 0. 032882		40, 553 4. 055300	11. 014200	

Health Financial Systems	WABASH COUNTY HOSPITAL	In Lieu of Form CMS-2552-		
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 151310	Peri od: Worksheet B-1 From 01/01/2014		

COST A	LLOCATION - STATISTICAL BASIS		Provi der CCN: 151310	Peri od: From 01/01/2014	Worksheet B	
				To 12/31/2014	Date/Time Pr 5/27/2015 8:	
	Cost Center Description	MEDI CAL RECORDS & LI BRARY (GROSS REV) 16.00				
	GENERAL SERVICE COST CENTERS					
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT					1. 00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP					2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5. 01	00561 OTHER ADMINISTRATIVE AND GENERAL					5. 01
5. 02	00560 BUSI NESS OFFI CE					5. 02
6.00	00600 MAI NTENANCE & REPAI RS					6.00
7.00	00700 OPERATION OF PLANT					7. 00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE					8. 00
10.00	00900  HOUSEKEEPI NG  01000  DI ETARY					9.00
11. 00	01100 CAFETERI A					11. 00
	01300 NURSING ADMINISTRATION					13. 00
	01400 CENTRAL SERVICES & SUPPLY					14. 00
	01500 PHARMACY					15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	77, 092, 278				16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	11/012/2/0				10.00
30.00	03000 ADULTS & PEDIATRICS	5, 634, 394				30.00
43.00	04300 NURSERY	0				43. 00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	4, 412, 356				50.00
51.00	05100 RECOVERY ROOM	476, 425				51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0				52. 00
53.00	05300 ANESTHESI OLOGY	882, 026				53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	14, 214, 144				54.00
56. 00	05600 RADI OI SOTOPE	913, 080				56. 00
60.00	06000 LABORATORY	12, 078, 736				60. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	165, 427				63. 00
66. 00	06600 PHYSI CAL THERAPY	2, 425, 439				66. 00
69. 00	06900 ELECTROCARDI OLOGY	2, 312, 169				69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	4, 016, 506 2, 637, 085				71.00
	07300 DRUGS CHARGED TO PATIENTS	19, 278, 165				73.00
73.00	OUTPATIENT SERVICE COST CENTERS	17, 270, 103				73.00
90. 00	09000 CLINIC	603, 427				90.00
	09001 SENI OR CARE	428, 890				90. 01
91.00	09100 EMERGENCY	6, 614, 009				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					92. 00
	OTHER REIMBURSABLE COST CENTERS					
101.00	10100 HOME HEALTH AGENCY	0				101. 00
	SPECIAL PURPOSE COST CENTERS					
	11600 H0SPI CE	0				116. 00
118.00		77, 092, 278				118. 00
400.00	NONREI MBURSABLE COST CENTERS					100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0				190.00
	19200 PHYSICIANS' PRIVATE OFFICES  07950 FITNESS CENTER	0				192. 00 194. 00
	07950 FTTNESS CENTER 07951 MARKETI NG	0				194. 00
	07951 NARRETTING 07952 NEW DI RECTI ON					194. 01
	07953 RESPITE	o o				194. 02
	07954 WELL CHILD CLINIC	0				194. 04
200.00						200. 00
201.00	1 1					201. 00
202.00		766, 374				202. 00
	Part I)					
203.00		0. 009941				203. 00
204.00		30, 331				204. 00
	Part II)					
205.00		0. 000393				205. 00
	1 )	I I				I

Health Financial Systems	WABASH COUNTY HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 151310	Peri od: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Prepared: 5/27/2015 8:04 am

				1	To 12/31/2014	Date/Time Pre 5/27/2015 8:0	pared: 4 am
			Ti tl	e XVIII	Hospi tal	Cost	
					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)					
	ENT POUTLING OFFINIOR COOT OFFITTED	1. 00	2. 00	3. 00	4. 00	5. 00	
	ENT ROUTINE SERVICE COST CENTERS	1			.1	_	
	ADULTS & PEDIATRICS	3, 297, 714		3, 297, 714		0	
	NURSERY	0		(	0	0	43. 00
	ARY SERVICE COST CENTERS	0 (77 070					
	OPERATI NG ROOM	2, 677, 278		2, 677, 278		0	00.00
	RECOVERY ROOM	159, 827		159, 827	0	0	51.00
	DELIVERY ROOM & LABOR ROOM	0		(	0	0	52.00
	ANESTHESI OLOGY	135, 794		135, 794		0	53.00
	RADI OLOGY-DI AGNOSTI C	3, 162, 891		3, 162, 891		0	54.00
	RADI OI SOTOPE	235, 171		235, 171		0	56.00
	LABORATORY	2, 669, 630		2, 669, 630		0	60.00
1 1	BLOOD STORING, PROCESSING & TRANS.	118, 469	_	118, 469		0	63.00
	PHYSI CAL THERAPY	1, 819, 576	0	1, 819, 576		0	66.00
	ELECTROCARDI OLOGY	886, 885		886, 885		0	69.00
	MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 395, 094		2, 395, 094		0	71.00
	IMPL. DEV. CHARGED TO PATIENT	645, 720		645, 720		0	72. 00
	DRUGS CHARGED TO PATIENTS	4, 067, 342		4, 067, 342	2 0	0	73. 00
	TENT SERVICE COST CENTERS	100.045		100.04	-1		
90.00 09000 0		198, 945		198, 945		· -	
	SENI OR CARE	431, 971		431, 971		0	
	EMERGENCY	3, 337, 054		3, 337, 054		0	,
	OBSERVATION BEDS (NON-DISTINCT PART)	815, 539		815, 539	9	0	92. 00
	REI MBURSABLE COST CENTERS				.1	_	
	HOME HEALTH AGENCY	1, 521, 149		1, 521, 149	7	0	101. 00
	L PURPOSE COST CENTERS	0/4 040		0/4 044	.1		
116. 00 11600 H		861, 810		861, 810			116. 00
	Subtotal (see instructions)	29, 437, 859		27, 107,00			200.00
1 1	Less Observation Beds	815, 539		815, 539			201. 00
202. 00	Total (see instructions)	28, 622, 320	0	28, 622, 320	0	, 0	202. 00

Health Financial Systems	WABASH COUNTY HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Peri od: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Prepared: 5/27/2015 8:04 am
	Title XVIII	Hospi tal	Cost

				'	0 12/31/2014	5/27/2015 8:0	
			Ti tl	e XVIII	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpati ent	
						Ratio	
		6. 00	7. 00	8. 00	9. 00	10. 00	
	TIENT ROUTINE SERVICE COST CENTERS						
	O ADULTS & PEDI ATRI CS	3, 885, 547		3, 885, 547			30.00
	0 NURSERY	0		C			43. 00
	LLARY SERVICE COST CENTERS	1					
	O OPERATI NG ROOM	552, 767	3, 859, 589			0. 000000	
	O RECOVERY ROOM	80, 020	396, 405			0. 000000	
	O DELIVERY ROOM & LABOR ROOM	0	0	C	0.00000	0. 000000	
	O ANESTHESI OLOGY	108, 170	773, 856			0. 000000	
	O RADI OLOGY-DI AGNOSTI C	691, 750	13, 522, 394			0. 000000	
	O RADI OI SOTOPE	21, 918	891, 162			0. 000000	
	0 LABORATORY	1, 183, 249	10, 895, 487			0. 000000	
	O BLOOD STORING, PROCESSING & TRANS.	41, 362	124, 065			0. 000000	
	O PHYSI CAL THERAPY	271, 898	2, 153, 541			0. 000000	
	O ELECTROCARDI OLOGY	711, 338	1, 600, 832			0. 000000	
1	O MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 156, 102	2, 860, 404			0. 000000	
	O IMPL. DEV. CHARGED TO PATIENT	1, 776, 284	860, 801			0. 000000	
	O DRUGS CHARGED TO PATIENTS	3, 458, 737	15, 819, 428	19, 278, 165	0. 210982	0. 000000	73. 00
	ATLENT SERVICE COST CENTERS				1		1
90.00 0900		0	603, 427	· ·		0. 000000	
	1 SENI OR CARE	0	428, 890	· ·		0. 000000	
	O EMERGENCY	101, 823	6, 512, 186			0. 000000	
	O OBSERVATION BEDS (NON-DISTINCT PART)	1, 666	1, 747, 182	1, 748, 848	0. 466329	0.000000	92.00
	R REIMBURSABLE COST CENTERS						
	O HOME HEALTH AGENCY	0	960, 344	960, 344			101. 00
	IAL PURPOSE COST CENTERS						
116. 00 1160	l .	0	1, 091, 295				116. 00
200. 00	Subtotal (see instructions)	14, 042, 631	65, 101, 288	79, 143, 919			200. 00
201. 00	Less Observation Beds						201. 00
202.00	Total (see instructions)	14, 042, 631	65, 101, 288	79, 143, 919			202. 00

Health Financial Systems	WABASH COUNTY HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 1	From 01/01/2014	Worksheet C Part I Date/Time Prepared: 5/27/2015 8:04 am
	T: +L o V///	II Ilooni tol	Coot

			10 12,01,2011	5/27/2015 8:04 am
		Title XVIII	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00   03000   ADULTS & PEDI ATRI CS				30.00
43. 00 04300 NURSERY				43. 00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 000000			50. 00
51.00   05100   RECOVERY ROOM	0. 000000			51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52. 00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000			54. 00
56. 00   05600   RADI 0I SOTOPE	0. 000000			56. 00
60. 00   06000   LABORATORY	0. 000000			60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66. 00
69. 00   06900   ELECTROCARDI OLOGY	0. 000000			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.00
72.00 O7200 MPL. DEV. CHARGED TO PATIENT	0. 000000			72. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
OUTPATIENT SERVICE COST CENTERS				
90. 00   09000   CLI NI C	0. 000000			90. 00
90. 01   09001   SENI OR CARE	0. 000000			90. 01
91. 00   09100   EMERGENCY	0. 000000			91. 00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92. 00
OTHER REIMBURSABLE COST CENTERS				
101.00 10100 HOME HEALTH AGENCY				101. 00
SPECIAL PURPOSE COST CENTERS				
116. 00 11600 HOSPI CE				116. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00

Health Financial Systems	WABASH COUNT	Y H0	SPI TAL		In Lie	u of Form CMS-2	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 5/27/2015 8:04	pared:
			Ti t	le XIX	Hospi tal	PPS	
					Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Ther	apy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00		2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00		2.00	0.00	1. 00	0.00	
30. 00 03000 ADULTS & PEDI ATRI CS	3, 297, 714			3, 297, 71	4 0	3, 297, 714	30.00
43. 00 04300 NURSERY	0				0	0	43.00
ANCILLARY SERVICE COST CENTERS							1

	Total Cost from Wkst. B, Part I, col.	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	26)					
	1. 00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	3, 297, 714		3, 297, 714	0	3, 297, 714	30. 00
43. 00 04300 NURSERY	0		0	0	0	43. 00
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATI NG ROOM	2, 677, 278		2, 677, 278		2, 677, 278	
51. 00   05100   RECOVERY ROOM	159, 827		159, 827	0	159, 827	
52.00   05200   DELIVERY ROOM & LABOR ROOM	0		0	0	0	
53. 00   05300   ANESTHESI OLOGY	135, 794		135, 794		135, 794	1
54. 00   05400   RADI OLOGY-DI AGNOSTI C	3, 162, 891		3, 162, 891		3, 162, 891	
56. 00   05600   RADI OI SOTOPE	235, 171		235, 171		235, 171	
60. 00   06000   LABORATORY	2, 669, 630		2, 669, 630		2, 669, 630	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	118, 469		118, 469		118, 469	
66. 00   06600   PHYSI CAL THERAPY	1, 819, 576		1, 819, 576		1, 819, 576	1
69. 00 06900 ELECTROCARDI OLOGY	886, 885		886, 885		886, 885	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 395, 094		2, 395, 094		2, 395, 094	1
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	645, 720	1	645, 720		645, 720	1
73.00 O7300 DRUGS CHARGED TO PATIENTS	4, 067, 342		4, 067, 342	0	4, 067, 342	73. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	198, 945		198, 945		198, 945	1
90. 01   09001   SENI OR CARE	431, 971	1	431, 971		431, 971	1
91. 00   09100   EMERGENCY	3, 337, 054	1	3, 337, 054		3, 337, 054	1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	815, 539		815, 539		815, 539	92. 00
OTHER REIMBURSABLE COST CENTERS						1
101.00 10100 HOME HEALTH AGENCY	1, 521, 149		1, 521, 149		1, 521, 149	101. 00
SPECIAL PURPOSE COST CENTERS						1
116. 00 11600 H0SPI CE	861, 810		861, 810		861, 810	
200.00 Subtotal (see instructions)	29, 437, 859		29, 437, 859		29, 437, 859	
201.00 Less Observation Beds	815, 539		815, 539		815, 539	
202.00 Total (see instructions)	28, 622, 320	0	28, 622, 320	0	28, 622, 320	202. 00

Health Financial Systems	ems WABASH COUNTY HOSPITAL			In Lie	u of Form CMS-	2552-10	
COMPUTATION OF RATIO OF COSTS TO CHARGES			Provi der		From 01/01/2014	Date/Time Pre	pared:
			Ti 1	tle XIX	Hospi tal	PPS	
			Charges				
Cost Center Description	Provider CCN: 151310						
·	·		·	+ col. 7)	Ratio	I npati ent	
						Rati o	
	6. 00		7. 00	8. 00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
20 00 02000 ADULTS & DEDLATRICS	2 005 547			2 005 5/	7		7 20 00

			char ges				
	Cost Center Description	Inpatient	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	•	'	'	+ col. 7)	Ratio	Inpati ent	
				<b>'</b>		Rati o	
		6.00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	3, 885, 547		3, 885, 547			30. 00
43.00	04300 NURSERY	O		0			43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	552, 767	3, 859, 589	4, 412, 356	0. 606768	0. 000000	50.00
51.00	05100 RECOVERY ROOM	80, 020	396, 405	476, 425	0. 335471	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0. 000000	0.000000	52.00
53.00	05300 ANESTHESI OLOGY	108, 170	773, 856	882, 026	0. 153957	0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	691, 750	13, 522, 394	14, 214, 144	0. 222517	0.000000	54.00
56.00	05600 RADI OI SOTOPE	21, 918	891, 162	913, 080	0. 257558	0.000000	56. 00
60.00	06000 LABORATORY	1, 183, 249	10, 895, 487	12, 078, 736	0. 221019	0.000000	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	41, 362	124, 065	165, 427	0. 716141	0.000000	63.00
66.00	06600 PHYSI CAL THERAPY	271, 898	2, 153, 541	2, 425, 439	0. 750205	0.000000	66. 00
69.00	06900 ELECTROCARDI OLOGY	711, 338	1, 600, 832	2, 312, 170	0. 383573	0.000000	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 156, 102	2, 860, 404	4, 016, 506	0. 596313	0.000000	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	1, 776, 284	860, 801	2, 637, 085	0. 244861	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 458, 737	15, 819, 428	19, 278, 165	0. 210982	0. 000000	73. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	603, 427	603, 427	0. 329692	0.000000	90.00
90. 01	09001 SENI OR CARE	0	428, 890	428, 890	1. 007184	0.000000	90. 01
91.00	09100 EMERGENCY	101, 823	6, 512, 186	6, 614, 009	0. 504543	0.000000	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 666	1, 747, 182	1, 748, 848	0. 466329	0.000000	92. 00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0	960, 344	960, 344			101. 00
	SPECIAL PURPOSE COST CENTERS						
	11600 H0SPI CE	0	1, 091, 295				116. 00
200.00	,	14, 042, 631	65, 101, 288	79, 143, 919			200. 00
201.00	1 1						201. 00
202.00	Total (see instructions)	14, 042, 631	65, 101, 288	79, 143, 919			202. 00

Health Financial Systems	WABASH COUNTY HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 151310	From 01/01/2014	Worksheet C Part I Date/Time Prepared: 5/27/2015 8:04 am

				5/27/2015 8:04 am
		Title XIX	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
43. 00 04300 NURSERY				43. 00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 606768			50. 00
51.00   05100   RECOVERY ROOM	0. 335471			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52. 00
53. 00 05300 ANESTHESI OLOGY	0. 153957			53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 222517			54. 00
56. 00   05600   RADI 0I SOTOPE	0. 257558			56. 00
60. 00   06000   LABORATORY	0. 221019			60. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 716141			63. 00
66. 00 06600 PHYSI CAL THERAPY	0. 750205			66. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 383573			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 596313			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 244861			72. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0. 210982			73. 00
OUTPATIENT SERVICE COST CENTERS				
90. 00   09000   CLI NI C	0. 329692			90. 00
90. 01   09001   SENI OR CARE	1. 007184			90. 01
91. 00   09100   EMERGENCY	0. 504543			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 466329			92. 00
OTHER REIMBURSABLE COST CENTERS				
101.00 10100 HOME HEALTH AGENCY				101. 00
SPECIAL PURPOSE COST CENTERS				
116. 00 11600 H0SPI CE				116. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00   Total (see instructions)				202. 00

Health Financial Systems	WABASH COUNTY HOS	SPI TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE C	OST TO CHARGE RATIOS NET OF	Provi der CCN: 151310		Worksheet C
REDUCTIONS FOR MEDICALD ONLY			From 01/01/2014	

REDUCTIONS FOR MEDICALD UNLY				o 12/31/2014		
		Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	Total Cost		Operating Cost		Operating Cost	
	(Wkst. B, Part				Reduction	
	I, col. 26)	II col. 26)	Cost (col. 1 -		Amount	
			col . 2)			
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCI LLARY SERVI CE COST CENTERS						
50.00   05000   OPERATING ROOM	2, 677, 278				0	50. 00
51.00 05100 RECOVERY ROOM	159, 827	7, 017	152, 810	0	0	51. 00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	0	) C	0	0	52. 00
53. 00   05300   ANESTHESI OLOGY	135, 794		•		0	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	3, 162, 891				0	54. 00
56. 00   05600   RADI 0I SOTOPE	235, 171		•		0	56. 00
60. 00   06000   LABORATORY	2, 669, 630				0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	118, 469	l e	,		0	63.00
66. 00  06600 PHYSI CAL THERAPY	1, 819, 576	27, 589	1, 791, 987	0	0	66. 00
69. 00   06900   ELECTROCARDI OLOGY	886, 885		•		0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 395, 094			0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	645, 720		1		0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	4, 067, 342	119, 429	3, 947, 913	0	0	73. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00  09000  CLI NI C	198, 945		1		0	, , , , , ,
90. 01  09001   SENI OR CARE	431, 971	16, 221	415, 750	0	0	90. 01
91. 00   09100   EMERGENCY	3, 337, 054			0	0	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	815, 539	35, 174	780, 365	0	0	92. 00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	1, 521, 149	20, 388	1, 500, 761	0	0	101. 00
SPECIAL PURPOSE COST CENTERS						
116. 00 11600 HOSPI CE	861, 810	4, 320	857, 490	0	0	116. 00
200.00 Subtotal (sum of lines 50 thru 199)	26, 140, 145	802, 998	25, 337, 147	0	0	200. 00
201.00 Less Observation Beds	815, 539	35, 174	780, 365	0	0	201. 00
202.00 Total (line 200 minus line 201)	25, 324, 606	767, 824	24, 556, 782	2 0	0	202. 00

Health Financial Systems	WABASH COUNTY HOS	SPI TAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO REDUCTIONS FOR MEDICAID ONLY	CHARGE RATIOS NET OF	Provider CCN: 151310	From 01/01/2014	Worksheet C Part II Date/Time Prepared:

				'	0 12/01/2011	5/27/2015 8:	
				le XIX	Hospi tal	PPS	
	Cost Center Description	Cost Net of	Total Charges	Outpati ent			
		Capital and		Cost to Charge			
		Operating Cost					
		Reducti on	8)	/ col . 7)			
		6. 00	7. 00	8. 00			
	ANCILLARY SERVICE COST CENTERS						4
	05000 OPERATING ROOM	2, 677, 278		1			50.00
51. 00	05100 RECOVERY ROOM	159, 827	476, 425	•			51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000			52. 00
53. 00	05300 ANESTHESI OLOGY	135, 794		•			53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	3, 162, 891		1			54.00
56. 00	05600 RADI OI SOTOPE	235, 171		•			56. 00
60.00	06000 LABORATORY	2, 669, 630		•			60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	118, 469		•			63. 00
	06600 PHYSI CAL THERAPY	1, 819, 576					66. 00
69. 00	06900 ELECTROCARDI OLOGY	886, 885		•			69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 395, 094	4, 016, 506	•			71. 00
	07200 I MPL. DEV. CHARGED TO PATIENT	645, 720		l			72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	4, 067, 342	19, 278, 165	0. 210982			73. 00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	198, 945					90. 00
	09001 SENI OR CARE	431, 971					90. 01
	09100 EMERGENCY	3, 337, 054	6, 614, 009				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	815, 539	1, 748, 848	0. 466329			92. 00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	1, 521, 149	960, 344	1. 583963			101. 00
	SPECIAL PURPOSE COST CENTERS						
	11600 HOSPI CE	861, 810		0. 789713			116. 00
200.00	, ,	26, 140, 145		2			200. 00
201.00	1 1	815, 539	l e	1			201. 00
202.00	Total (line 200 minus line 201)	25, 324, 606	75, 258, 372	2			202. 00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS  Provider CN: 151310 Provid	Health Financial S	Svetame	WABASH COUNT	V HOSDITAI		Inlie	u of Form CMS-2	2552_10
Cost Center Description					· CCN· 151310			2332-10
Title   XVIII   Hospital   Cost   Cost   Cost   Center Description   Related Cost   (From West B. Related Cost   (From West B. Related Cost   (From West B. B. Part II, col. 26)   Total Charges   Col. 1 + col. 20	ALLOKITONWENT OF	INFATTENT ANGIELANT SERVICE CALLER	L 00313	i i ovi dei				
Cost Center Description						To 12/31/2014	Date/Time Pre	pared:
Capital Related Cost (From Wisst. B. Part II, col. 26)   Part II, col. 38)   Capital Cost (From Wisst. C. Part II, col. 20)   Part II, col. 38)   Capital Cost (Column 3 x column 4)								4 am
Rel ated Cost (From Wkst. C, Part I, col. 2)   Program (Col umn 3 x col umn 4)			1					
Column 4   Part II, col.   Col. 1 + col.   Charges   Column 4   Part II, col.   20     Charges   Column 4   Part II, col.   26     Col. 1 + col.   Charges   Column 4   Part II, col.   26   Col. 1 + col.   Charges   Column 4   Part II, col.   26   Col. 1 + col.   Charges   Column 4   Part II, col.   26   Col. 1 + col.   Charges   Column 4   Part II, col.   27   Col.   Col. 1 + col.   Charges   Column 4   Part II, col.   Col. 1 + col.   Charges   Column 4   Part II, col.   Col. 1 + col.   Charges   Column 4   Part II, col.   Col. 1 + col.   Charges   Column 4   Part II, col.   Col. 1 + col.   Charges   Column 4   Part II, col.   Col. 1 + col.   Charges   Column 4   Part II, col.   Col. 1 + col.   Charges   Column 4   Part II, col.   Col. 1 + col.   Charges   Column 4   Part II, col.   Col. 1 + col.   Charges   Column 4   Part II, col.   Col. 1 + col.   Charges   Column 4   Part II, col.   Col. 1 + col.   Charges   Column 4   Part II, col.   Col.   Charges   Column 4   Col.   Charges   Column 4   Charges	Cost	Center Description						
Part II, col. 26   1.00   2.00   3.00   4.00   5.00								
ANCI LLARY SERVI CE COST CENTERS						. Charges	column 4)	
ANCILLARY SERVICE COST CENTERS   1.00   2.00   3.00   4.00   5.00			·	8)	2)			
ANCI LLARY SERVI CE COST CENTERS  50. 00 05000   OFERATI NG ROOM   188, 177   4, 412, 356   0. 042648   171, 052   7, 295   50. 00   51. 00 05100   RECOVERY ROOM   7, 017   476, 425   0. 014728   24, 644   363   51. 00   52. 00 05200   DELI VERY ROOM & LABOR ROOM   0   0. 0000000   0   0. 52. 00   53. 00 05300   ANESTHESI OLOGY   2, 487   882, 026   0. 002820   24, 232   68   53. 00   54. 00 05400   RADI OLOGY-DI AGNOSTI C   195, 240   14, 214, 144   0. 013736   276, 914   3, 804   54. 00   56. 00 05600   RADI OLOGY-DI AGNOSTI C   195, 240   14, 214, 144   0. 013736   276, 914   3, 804   54. 00   60. 00 05600   RADI OLOGY-DI AGNOSTI C   195, 328   12, 078, 736   0. 002390   4, 583   11   56. 00   60. 00 06000   LABORATORY   55, 328   12, 078, 736   0. 004581   507, 008   2, 323   60. 00   63. 00 06300   BLOOD STORI NG, PROCESSI NG & TRANS.   624   165, 427   0. 003772   39, 422   149   63. 00   64. 00 06600   PHYSI CAL THERAPY   27, 589   2, 425, 439   0. 011375   92, 784   1, 055   66. 00   69. 00 06900   ELECTROCARDI OLOGY   14, 707   2, 312, 170   0. 006361   307, 101   1, 953   69, 00   71. 00 07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   46, 346   4, 016, 506   0. 011539   449, 682   5, 189   71. 00   72. 00 07200   IMPL. DEV. CHARGED TO PATI ENTS   40, 58   2, 637, 085   0. 001539   603, 757   929   72. 00   73. 00 07300   DRUGS CHARGED TO PATI ENTS   119, 429   19, 278, 165   0. 006195   1, 306, 285   8, 092   73. 00   90. 01 09001   SENI OR CARE   16, 221   428, 890   0. 037821   0   0   0   90. 01   90. 01 09000   DEMERGENCY   51, 218   6, 614, 009   0. 007744   2, 886   22 91, 00   92. 00 09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   35, 174   1, 748, 848   0. 020113   1, 666   34   92. 00   92. 00 09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   35, 174   1, 748, 848   0. 020113   1, 666   34   92. 00   92. 00 09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   35, 174   1, 748, 848   0. 020113   1, 666   34   92. 00				0.00	0.00	4.00	F 00	
50.00	ANOLLI ADV. C	SERVILOE COCT DENTERS	1.00	2.00	3.00	4.00	5.00	
51.00   05100   RECOVERY ROOM   7, 017   476, 425   0. 014728   24, 644   363   51.00   52.00   05200   DELI VERY ROOM & LABOR ROOM   0   0. 000000   0   0. 52.00   53.00   05300   ANESTHESI OLOGY   2, 487   882, 026   0. 002820   24, 232   68   53.00   54.00   05400   RADI OLOGY-DI AGNOSTI C   195, 240   14, 214, 144   0. 013736   276, 914   3, 804   54.00   65.00   05600   RADI OLOGY-DI AGNOSTI C   195, 240   14, 214, 144   0. 013736   276, 914   3, 804   54.00   60.00   06000   LABORATORY   55, 328   12, 078, 736   0. 004581   507, 008   2, 323   60.00   63.00   06300   BLOOD STORING, PROCESSING & TRANS.   624   165, 427   0. 003772   39, 422   149   63.00   66.00   06600   PHYSI CAL THERAPY   27, 589   2, 425, 439   0.011375   92, 784   1, 055   66.00   69.00   06900   ELECTROCARDI OLOGY   14, 707   2, 312, 170   0. 006361   307, 101   1, 953   69.00   71.00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   46, 346   4, 016, 506   0. 011539   449, 682   5, 189   71.00   73.00   07300   DRUGS CHARGED TO PATI ENTS   119, 429   19, 278, 165   0. 006195   1, 306, 285   8, 092   73.00   07300   DRUGS CHARGED TO PATI ENTS   119, 429   19, 278, 165   0. 006195   1, 306, 285   8, 092   73.00   09000   SENI OR CARE   16, 221   428, 890   0. 037821   0   0   90.01   90.01   90.01   SENI OR CARE   16, 221   428, 890   0. 037821   0   0   90.01   90.01   90.00   09200   DBSERVATI ON BEDS (NON-DI STI NCT PART)   35, 174   1, 748, 848   0. 020113   1, 666   34   92.00			100 177	4 410 05	( 0.040/	0 171 050	7 205	
S2. 00   05200   DELI VERY ROOM & LABOR ROOM   O   O   0   0   0   0   0   0   0   0	1 1				1			
53. 00			1	1	1			
54. 00			1				-	
56. 00					1			
60. 00					1			
63. 00					1			
66. 00   06600   PHYSI CAL THERAPY   27, 589   2, 425, 439   0. 011375   92, 784   1, 055   66. 00   69. 00   06900   ELECTROCARDI OLOGY   14, 707   2, 312, 170   0. 006361   307, 101   1, 953   69. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   46, 346   4, 016, 506   0. 011539   449, 682   5, 189   71. 00   72. 00   07200   MPL. DEV. CHARGED TO PATI ENT   4, 058   2, 637, 085   0. 001539   603, 757   929   72. 00   07300   DRUGS CHARGED TO PATI ENTS   119, 429   19, 278, 165   0. 006195   1, 306, 285   8, 092   73. 00   00000   CLI NI C   12, 493   603, 427   0. 020703   0   0   90. 01   09001   SENI OR CARE   16, 221   428, 890   0. 037821   0   0   90. 01   91. 00   09100   EMERGENCY   51, 218   6, 614, 009   0. 007744   2, 886   22   91. 00   92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   35, 174   1, 748, 848   0. 020113   1, 666   34   92. 00   09200   08568   0. 000000000000000000000000000000000								
69. 00   06900   ELECTROCARDI OLOGY   14, 707   2, 312, 170   0.006361   307, 101   1, 953   69. 00   71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   46, 346   4, 016, 506   0.011539   449, 682   5, 189   71. 00   72. 00   72. 00   07200   MPL. DEV. CHARGED TO PATI ENT   4, 058   2, 637, 085   0.001539   603, 757   929   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   119, 429   19, 278, 165   0.006195   1, 306, 285   8, 092   73. 00   0000   000000					1	· ·		
71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   46, 346   4, 016, 506   0. 011539   449, 682   5, 189   71. 00   72. 00   07200   MPL. DEV. CHARGED TO PATIENT   4, 058   2, 637, 085   0. 001539   603, 757   929   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   119, 429   19, 278, 165   0. 006195   1, 306, 285   8, 092   73. 00   0740					1	· ·		
72. 00   07200   IMPL. DEV. CHARGED TO PATIENT   4,058   2,637,085   0.001539   603,757   929   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   119,429   19,278,165   0.006195   1,306,285   8,092   73. 00   0000   CLI NI C   12,493   603,427   0.020703   0   0   0.000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.000000   0.000000   0.000000   0.00000000					1	· ·		
73. 00   07300   DRUGS CHARGED TO PATIENTS   119, 429   19, 278, 165   0.006195   1, 306, 285   8, 092   73. 00								
OUTPATIENT SERVICE COST CENTERS           90.00         09000 CLINIC         12,493         603,427         0.020703         0         0         90.00           90.01         09001 SENIOR CARE         16,221         428,890         0.037821         0         0         90.01           91.00         09100 EMERGENCY         51,218         6,614,009         0.007744         2,886         22         91.00           92.00         09200 OBSERVATION BEDS (NON-DISTINCT PART)         35,174         1,748,848         0.020113         1,666         34         92.00								
90. 00			119, 429	19, 278, 16	5 0. 00619	1, 306, 285	8, 092	73. 00
90. 01   09001   SENI OR CARE   16, 221   428, 890   0. 037821   0   0   90. 01   91. 00   09100   EMERGENCY   51, 218   6, 614, 009   0. 007744   2, 886   22   91. 00   92. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART)   35, 174   1, 748, 848   0. 020113   1, 666   34   92. 00								
91. 00   09100   EMERGENCY   51, 218   6, 614, 009   0.007744   2, 886   22   91. 00   92. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART)   35, 174   1, 748, 848   0.020113   1, 666   34   92. 00					1		0	
92. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART)   35, 174   1, 748, 848   0. 020113   1, 666   34   92. 00							Ĭ	
200. 00   Total (lines 50-199)   778, 290  73, 206, 733    3, 812, 016  31, 287  200. 00					1			
	200. 00   Total	(lines 50-199)	778, 290	73, 206, 73	3	3, 812, 016	31, 287	200. 00

Health Financial Systems	WABASH COUNT	V HOSPITAI		In lie	eu of Form CMS-2	2552_10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS			CCN: 151310	Peri od: From 01/01/2014 To 12/31/2014	Worksheet D Part IV	pared:
			e XVIII	Hospi tal	Cost	
Cost Center Description	Anesthetist Cost	Nursing School		Medical Education Cost	4)	
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATI NG ROOM	0	0		0	0	50. 00
51.00   05100   RECOVERY ROOM	0	0		0	0	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	
53. 00   05300   ANESTHESI OLOGY	0	0		0	0	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0		0	0	54.00
56. 00   05600   RADI 0I SOTOPE	0	0		0	0	56. 00
60. 00  06000 LABORATORY	0	0		0	0	
63.00   06300   BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	63. 00
66. 00   06600 PHYSI CAL THERAPY	0	0		0	0	66. 00
69. 00  06900 ELECTROCARDI OLOGY	0	0		0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0	0	
73.00 O7300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00   09000   CLI NI C	0	0		0	0	
90. 01  09001  SENI OR CARE	0	0		0	0	
91. 00   09100   EMERGENCY	0	0		0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0	0	
200.00   Total (lines 50-199)	0	0		0 0	0	200. 00

Heal th	Financial Systems	WABASH COUNT	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10
	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	S Provi der		Peri od:	Worksheet D	
THROUG	SH COSTS				From 01/01/2014 To 12/31/2014	Part IV Date/Time Pre	pared:
						5/27/2015 8:0	4 am
				e XVIII	Hospi tal	Cost	
	Cost Center Description	Total	Total Charges			I npati ent	
			(from Wkst. C,		Ratio of Cost		
		Cost (sum of				Charges	
		col. 2, 3 and	8)	7)	(col . 6 ÷ col .		
		4)	7.00	0.00	7)	40.00	
	ANOLLI ADV. CEDVI OF COCT OFNITEDO	6. 00	7. 00	8. 00	9. 00	10. 00	
F0 00	ANCILLARY SERVICE COST CENTERS		4 440 057	0.0000	0 000000	474 050	
50.00	05000 OPERATI NG ROOM	0	4, 412, 356			171, 052	
51.00	05100 RECOVERY ROOM	0	476, 425	1		24, 644	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0			0	52.00
53. 00	05300 ANESTHESI OLOGY	0	882, 026	1			53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	14, 214, 144				54.00
56. 00	05600 RADI OI SOTOPE	0	913, 080				56. 00
60.00	06000 LABORATORY	0	12, 078, 736	1		507, 008	60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	165, 427	1			1
66.00	06600 PHYSI CAL THERAPY	0	2, 425, 439	1			1
69. 00	06900 ELECTROCARDI OLOGY	0	2, 312, 170				69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4, 016, 506				71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	0	2, 637, 085				l
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	19, 278, 165	0.00000	0. 000000	1, 306, 285	73. 00
	OUTPATIENT SERVICE COST CENTERS	,					
90.00	09000 CLI NI C	0	603, 427	0.00000	0. 000000	0	90.00
90. 01	09001 SENI OR CARE	0	428, 890	0.00000	0. 000000	0	90. 01
91.00	09100 EMERGENCY	0	6, 614, 009	0.00000	0. 000000	2, 886	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1, 748, 848	0.00000	0. 000000	1, 666	92. 00
200.00	Total (lines 50-199)	0	73, 206, 733			3, 812, 016	200. 00

Health Financial Systems	WABASH COUNTY HO	In Lie	u of Form CMS-2552-10	
APPORTIONMENT OF INPATIENT/OUTPATIEN THROUGH COSTS	T ANCILLARY SERVICE OTHER PASS	Provider CCN: 151310		Worksheet D Part IV Date/Time Prepared: 5/27/2015 8:04 am
•		Ti +1 o V\/I I I	Hospi tal	Cost

						5/27/2015 8:0	)4 am
			Ti tl	e XVIII	Hospi tal	Cost	
Cost Center Description	I npati ent	Out	pati ent	Outpati ent			
	Program		rogram	Program			
	Pass-Through	Cl	narges	Pass-Through			
	Costs (col. 8			Costs (col. (	9		
	x col. 10)			x col. 12)			
	11. 00		12. 00	13. 00			
ANCILLARY SERVICE COST CENTERS	,			,			
50.00 05000 OPERATING ROOM	0		0		0		50.00
51.00  05100   RECOVERY ROOM	0		0	1	0		51. 00
52.00  05200   DELIVERY ROOM & LABOR ROOM	0		0		0		52. 00
53. 00   05300   ANESTHESI OLOGY	0		0		0		53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0		0		0		54.00
56. 00   05600   RADI 0I SOTOPE	0		0	)	0		56. 00
60. 00  06000  LABORATORY	0		0	)	0		60.00
63.00 O6300 BLOOD STORING, PROCESSING & TRANS.	0		0	1	0		63.00
66. 00  06600 PHYSI CAL THERAPY	0		0	1	0		66. 00
69. 00  06900  ELECTROCARDI OLOGY	0		0	1	0		69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	1	0		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0		0	1	0		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0		0		0		73. 00
OUTPATIENT SERVICE COST CENTERS							
90. 00  09000  CLI NI C	0		0	)	0		90.00
90. 01  09001   SENI OR CARE	0		0	)	0		90. 01
91. 00   09100   EMERGENCY	0		0	)	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		0	)	0		92.00
200.00   Total (lines 50-199)	0		0	)	o		200. 00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provi der CCN: 151310 Peri od: Worksheet D From 01/01/2014 Part V 12/31/2014 Date/Time Prepared: 5/27/2015 8:04 am Title XVIII Hospi tal Cost Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Rei mbursed Ratio From 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 0.606768 983, 520 0 50.00 51.00 05100 RECOVERY ROOM 0. 335471 0 77, 373 0 0 0 0 0 0 51.00 0 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 52 00 C 0 05300 ANESTHESI OLOGY 53.00 0.153957 0 133, 195 0 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 222517 4, 028, 859 0 54.00 56.00 05600 RADI OI SOTOPE 0. 257558 0 283.817 0 56.00 06000 LABORATORY 3, 691, 862 60.00 0.221019 0 60.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0. 716141 81, 481 0 63.00 06600 PHYSI CAL THERAPY 577, 045 66.00 0.750205 0 0 66.00 06900 ELECTROCARDI OLOGY 69.00 0.383573 0 612, 042 69 00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.596313 0 550, 899 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0. 244861 0 167, 937 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 6, 092, 525 0 73.00 0. 210982 152 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0. 329692 0 0 0 90.00 09001 SENI OR CARE 1. 007184 0 415, 861 0 0 90.01 90. 01 91.00 09100 EMERGENCY 0.504543 0 1, 277, 316 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 0.466329 0 328, 379 0 0 200.00 Subtotal (see instructions) 19, 302, 111 152 0 200. 00 Less PBP Clinic Lab. Services-Program 201.00 201. 00 0 0 Only Charges

0

19, 302, 111

152

0 202.00

202.00

Net Charges (line 200 +/- line 201)

Health Financial Systems	WABASH COUNTY HOSPITAL In L						2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST		Provi der	CCN: 151310	From 01/01/2014	Worksheet D Part V Date/Time Pre 5/27/2015 8:04	
			Ti tl	e XVIII	Hospi tal	Cost	
	C	osts					
Cost Center Description	Cost		Cost				

				10 12/31/2014	5/27/2015 8:04 am
		Ti tl	e XVIII	Hospi tal	Cost
·	Cos	sts		· · · · · · · · · · · · · · · · · · ·	
Cost Center Description	Cost	Cost			
	Rei mbursed	Reimbursed			
	Servi ces	Services Not			
	Subject To	Subject To			
	Ded. & Coins.	Ded. & Coins.			
	(see inst.)	(see inst.)			
	6. 00	7. 00			
ANCILLARY SERVICE COST CENTERS			ı		
50. 00   05000   OPERATI NG ROOM	596, 768				50.00
51. 00   05100   RECOVERY ROOM	25, 956	0			51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0			52. 00
53. 00   05300   ANESTHESI OLOGY	20, 506				53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	896, 490	l .			54. 00
56. 00   05600   RADI OI SOTOPE	73, 099				56. 00
60. 00   06000   LABORATORY	815, 972				60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	58, 352	l e			63. 00
66. 00 06600 PHYSI CAL THERAPY	432, 902	l e			66. 00
69. 00 06900 ELECTROCARDI OLOGY	234, 763	l e			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	328, 508	0			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	41, 121	0			72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 285, 413	32			73. 00
OUTPATIENT SERVICE COST CENTERS	_	_			
90. 00   09000   CLI NI C	0				90.00
90. 01   09001   SENI OR CARE	418, 849	0			90. 01
91. 00   09100   EMERGENCY	644, 461	0			91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	153, 133	l e			92. 00
200.00 Subtotal (see instructions)	6, 026, 293	32			200. 00
201.00 Less PBP Clinic Lab. Services-Program	0				201. 00
Only Charges					
202.00   Net Charges (line 200 +/- line 201)	6, 026, 293	32			202. 00

Health Financial Systems		WABASH	In Lieu of Form CMS-2552				
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES	AND VACCINE	COST	Provi der CCN:		Peri od: From 01/01/2014	

		Component	CCN: 15Z310 T	rom 01/01/2014 o 12/31/2014	Part V Date/Time Pre 5/27/2015 8:0	
		Ti tl	e XVIII S	wing Beds - SNF	Cost	
			Charges		Costs	
Cost Center Description		PPS Reimbursed	Cost	Cost	PPS Services	
		Services (see	Reimbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9	1	Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1. 00	2.00	3. 00	4. 00	5. 00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0. 606768	<b> </b>	C	0	0	00.00
51. 00   05100   RECOVERY ROOM	0. 335471	<b>1</b>	C	0	0	51. 00
52.00   O5200   DELI VERY ROOM & LABOR ROOM	0. 000000		C	0	0	52. 00
53. 00   05300   ANESTHESI OLOGY	0. 153957		C	0	0	00.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 222517	1	C	0	0	
56. 00   05600   RADI OI SOTOPE	0. 257558		C	0	0	00.00
60. 00   06000   LABORATORY	0. 221019		C	0	0	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 716141	1	C	0	0	63. 00
66. 00 06600 PHYSI CAL THERAPY	0. 750205	1	C	0	0	00.00
69. 00 06900 ELECTROCARDI OLOGY	0. 383573	1	C	0	0	07.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 596313	1	C	0	0	
72.00 07200 MPL. DEV. CHARGED TO PATIENT	0. 244861		C	0	0	
73.00 O7300 DRUGS CHARGED TO PATIENTS	0. 210982	0	C	0	0	73. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00  09000   CLI NI C	0. 329692		C	0	0	
90. 01   09001   SENI OR CARE	1. 007184	1	C	0	0	
91. 00   09100   EMERGENCY	0. 504543		C	0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 466329	0	C	0	0	
200.00 Subtotal (see instructions)		0	C	0	0	200. 00
201.00 Less PBP Clinic Lab. Services-Program			C	0		201. 00
Only Charges						
202.00   Net Charges (line 200 +/- line 201)		0	[ C	0	0	202. 00

Health Financial Systems	Systems WABASH COUNTY HOSPITAL					2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES	AND VACCINE COST	Provi der	CCN: 151310	Peri od:	Worksheet D	
		Componen	t CCN: 15Z310	From 01/01/2014 To 12/31/2014	Part V Date/Time Pre 5/27/2015 8:0	pared: 4 am
		Ti tl	e XVIII	Swing Beds - SNF	Cost	
	Со	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				

	Co	sts		
Cost Center Description	Cost	Cost		
	Rei mbursed	Rei mbursed		
	Servi ces	Services Not		
	Subject To	Subject To		
	Ded. & Coins.	Ded. & Coins.		
	(see inst.)	(see inst.)		
	6. 00	7. 00		
ANCILLARY SERVICE COST CENTERS				
50.00   05000   OPERATING ROOM	C	0		50.00
51.00   05100   RECOVERY ROOM	C	0		51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	C	0		52.00
53. 00   05300   ANESTHESI OLOGY	C	0		53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	C	0		54.00
56. 00   05600   RADI 0I SOTOPE	C	0		56.00
60. 00   06000   LABORATORY	C	0		60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	C	0		63.00
66. 00 06600 PHYSI CAL THERAPY	C	0		66.00
69. 00 06900 ELECTROCARDI OLOGY	C	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	C	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	C	0		73.00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	C	0		90.00
90. 01   09001   SENI OR CARE	C	0		90. 01
91. 00 09100 EMERGENCY	C	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	C	0		92.00
200.00 Subtotal (see instructions)		0	2	200.00
201.00 Less PBP Clinic Lab. Services-Program	C			201. 00
Only Charges				
202.00 Net Charges (line 200 +/- line 201)	C	0		202. 00
	•	•	•	

Health Financial Systems	WABASH COUNT	Y HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der		Peri od:	Worksheet D	
				From 01/01/2014		
				To 12/31/2014	Date/Time Prep 5/27/2015 8:04	
		Ti t	tle XIX	Hospi tal	PPS	<del>T</del> alli
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
· ·	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost		ŕ	
	Part II, col.		(col. 1 - col.			
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			•	*		
30. 00 ADULTS & PEDI ATRI CS	130, 506	10, 758	119, 74	3, 382	50. 27	30.00
43. 00 NURSERY	0			0	0.00	43.00
200.00 Total (lines 30-199)	130, 506		119, 74	2, 382		200. 00
Cost Center Description	I npati ent	Inpati ent				
· ·	Program days	Program				
		Capital Cost				
		(coi. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	95	4, 776	5			30. 00
43. 00 NURSERY	0	C				43.00
200.00 Total (lines 30-199)	95	4, 776	5			200. 00
,			1			

Health Financial Systems	WABASH COUNT	V HOSPITAI		Inlie	u of Form CMS-2	2552_10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA				Peri od:	Worksheet D	2332 10
				From 01/01/2014	Part II	
				To 12/31/2014	Date/Time Pre 5/27/2015 8:0	pared:
		Ti t	le XIX	Hospi tal	PPS	4 4111
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(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)					
	1.00	2. 00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	188, 177	4, 412, 356	0. 04264	8 38, 605	1, 646	50.00
51.00   05100   RECOVERY ROOM	7, 017	476, 425	0. 01472	8 5, 514	81	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	0	0.00000		0	52. 00
53. 00   05300   ANESTHESI OLOGY	2, 487	882, 026			22	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	195, 240	14, 214, 144			510	54. 00
56. 00   05600   RADI 0I SOTOPE	2, 182	913, 080	0. 00239	0 1, 218	3	56. 00
60. 00  06000  LABORATORY	55, 328	12, 078, 736	0. 00458	1 57, 370	263	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	624	165, 427	0. 00377	2 0	0	63. 00
66. 00  06600 PHYSI CAL THERAPY	27, 589	2, 425, 439	0. 01137	5 7, 878	90	66. 00
69. 00  06900 ELECTROCARDI OLOGY	14, 707	2, 312, 170	0. 00636	1 42, 206	268	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	46, 346	4, 016, 506	0. 01153	9 292, 688	3, 377	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	4, 058	2, 637, 085	0. 00153	9 0	0	72. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS	119, 429	19, 278, 165	0. 00619	5 205, 376	1, 272	73. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00  09000   CLI NI C	12, 493				0	90. 00
90. 01  09001  SENI OR CARE	16, 221	428, 890	0. 03782	1 0	0	90. 01
91. 00   09100   EMERGENCY	51, 218				130	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	35, 174			3 0	0	92. 00
200.00   Total (lines 50-199)	778, 290	73, 206, 733		712, 646	7, 662	200. 00

Health Financial Systems	WABASH COUNT	Y HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COST	ΓS Provi der		Peri od:	Worksheet D	
				From 01/01/2014 To 12/31/2014		nared:
				10 12/31/2014	5/27/2015 8: 0	
		Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	Nursing School			Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos		1 through 3,	
				instructions)	minus col. 4)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	-					
30. 00  03000 ADULTS & PEDIATRICS	0	0		0	0	30. 00
43. 00   04300   NURSERY	0	0	)	O	0	43.00
200.00 Total (lines 30-199)	0	0	)	O	0	200.00
Cost Center Description	Total Patient	Per Diem (col.	I npati ent	I npati ent		
	Days	5 ÷ col. 6)	Program Days	Program		
				Pass-Through		
				Cost (col. 7 x		
				col. 8)		
	6. 00	7. 00	8. 00	9. 00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	2, 382	0.00	9	5 0		30. 00
43. 00   04300 NURSERY	0	0.00	)	0		43.00
200.00 Total (lines 30-199)	2, 382		9.	5 0		200. 00
	•	•	•	•	•	•

Health Financial Systems	WABASH COUNT	Y HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS		S Provi der	CCN: 151310	Peri od: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Pre 5/27/2015 8:0	pared:
			le XIX	Hospi tal	PPS	
Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Healt	h All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
	1.00	2. 00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATI NG ROOM	0	0		0	0	50.00
51.00   05100   RECOVERY ROOM	0	0		0	0	51.00
52.00  05200   DELIVERY ROOM & LABOR ROOM	0	0		0	0	
53. 00   05300   ANESTHESI OLOGY	0	0		0	0	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0		0	0	54. 00
56. 00   05600   RADI 0I SOTOPE	0	0		0	0	56. 00
60. 00  06000  LABORATORY	0	0		0	0	60. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	63. 00
66. 00  06600 PHYSI CAL THERAPY	0	0		0	0	66. 00
69. 00  06900   ELECTROCARDI OLOGY	0	0		0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0	0	
73.00 O7300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00  09000  CLI NI C	0	0		0	0	90.00
90. 01  09001  SENI OR CARE	0	0		0	0	90. 01
91. 00   09100   EMERGENCY	0	0		0	0	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0	0	
200.00   Total (lines 50-199)	0	0		0 0	0	200. 00

Heal th	Financial Systems	WABASH COUNT	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PAS	S Provi der		Peri od:	Worksheet D	
THROUG	H COSTS				From 01/01/2014 To 12/31/2014	Part IV   Date/Time Pre	narod:
					10 12/31/2014	5/27/2015 8:0	
			Ti t	le XIX	Hospi tal	PPS	
	Cost Center Description	Total	Total Charges			I npati ent	
		Outpati ent	(from Wkst. C,		Ratio of Cost		
		Cost (sum of				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	T	T	T			
50.00	05000 OPERATING ROOM	0	4, 412, 356	1		38, 605	
51. 00	05100 RECOVERY ROOM	0	476, 425			5, 514	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.00000		0	52.00
53.00	05300 ANESTHESI OLOGY	0	882, 026	1		7, 854	53. 00
54.00	05400  RADI OLOGY-DI AGNOSTI C	0	14, 214, 144				
56.00	05600 RADI OI SOTOPE	0	913, 080			, ,	
60.00	06000 LABORATORY	0	12, 078, 736	1		57, 370	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	165, 427	1		0	63. 00
66.00	06600 PHYSI CAL THERAPY	0	2, 425, 439	0.00000	0. 000000	7, 878	66. 00
69. 00	06900 ELECTROCARDI OLOGY	0	2, 312, 170	0.00000	0. 000000	42, 206	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4, 016, 506	0.00000		292, 688	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	2, 637, 085	0.00000	0. 000000	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	19, 278, 165	0.00000	0. 000000	205, 376	73. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	603, 427	0.00000	0. 000000	0	90.00
90. 01	09001 SENI OR CARE	0	428, 890	0.00000	0. 000000	0	90. 01
91.00	09100 EMERGENCY	0	6, 614, 009	0.00000	0. 000000	16, 775	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1, 748, 848	0.00000	0. 000000	0	92.00
200.00	Total (lines 50-199)	0	73, 206, 733			712, 646	200. 00

Health Financial Systems	WABASH COUNT	Y HOS	SPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY S THROUGH COSTS	ERVICE OTHER PASS	6	Provi der	CCN: 151310	From 01/01/2014	Worksheet D Part IV Date/Time Pre 5/27/2015 8:04	
			Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	Inpatient Program Pass-Through Costs (col. 8	P	tpatient Program Charges	Outpatient Program Pass-Through Costs (col.			

		Ti t	le XIX	Hospi tal	PPS
Cost Center Description	I npati ent	Outpati ent	Outpati ent		
	Program	Program	Program		
	Pass-Through	Charges	Pass-Through		
	Costs (col. 8		Costs (col. 9		
	x col. 10)		x col. 12)		
	11. 00	12.00	13. 00		
ANCI LLARY SERVI CE COST CENTERS					
50.00   05000   OPERATI NG ROOM	0	0	0		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   05300   ANESTHESI OLOGY	0	0	0		53.00
54. 00   05400 RADI OLOGY-DI AGNOSTI C	0	0	0		54.00
56. 00   05600   RADI 0I SOTOPE	0	0	0		56.00
60. 00   06000   LABORATORY	0	0	0		60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
66. 00 06600 PHYSI CAL THERAPY	0	0	0		66. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0		69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C	0	C	0		90.00
90. 01   09001   SENI OR CARE	0	Ö	0		90. 01
91. 00 09100 EMERGENCY	0	d	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	Ó	0		92.00
200.00 Total (lines 50-199)	0	O	0		200. 00
	1			1	1

Health Financial Systems	WABASH COUNTY HOS	SPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 151310	Peri od:	Worksheet D

From 01/01/2014 | Part V To 12/31/2014 | Date/Time Prepared: 5/27/2015 8:04 am Title XIX Hospi tal PPS Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Rei mbursed Ratio From 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.) 3.00 (see inst.) 1.00 2.00 5. 00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 606768 262, 921 0 50.00 51.00 05100 RECOVERY ROOM 0. 335471 0 41, 578 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 0 52 00 0 05300 ANESTHESI OLOGY 0 0 53.00 0.153957 64, 304 0 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 222517 1, 325, 768 0 54.00 0 56.00 05600 RADI OI SOTOPE 0. 257558 0 0 56.00 24 866 06000 LABORATORY 0 0 1, 075, 454 60.00 0. 221019 0 60.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0. 716141 1, 233 0 63.00 06600 PHYSI CAL THERAPY 0 0 112, 040 66.00 0.750205 0 66.00 0 06900 ELECTROCARDI OLOGY 107, 565 69.00 69 00 0.383573 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.596313 0 385, 575 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0. 244861 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0. 210982 0 0 1, 118, 592 0 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0. 329692 0 0 99, 821 0 90.00 90. 01 09001 SENI OR CARE 1. 007184 0 0 90.01 91.00 09100 EMERGENCY 0.504543 0 0 1, 206, 646 91.00 0 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 0.466329 0 100, 202 0 200.00 Subtotal (see instructions) 0 5, 926, 565 0 200. 00 Less PBP Clinic Lab. Services-Program 201.00 0 201. 00 Only Charges

0

0

5, 926, 565

0 202.00

202.00

Net Charges (line 200 +/- line 201)

Health Financial Systems	WABASH COUNT	Y H0	SPI TAL		In Lie	u of Form CMS	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST		Provi der	CCN: 151310	Peri od: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Pre 5/27/2015 8:0	pared:
			Ti t	le XIX	Hospi tal	PPS	
	Cos	sts					
Cost Center Description	Cost Reimbursed Services Subject To	Ser	Cost imbursed vices Not bject To				

		l lit	le XIX	Hospi tal	PPS	
	Co	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7.00				
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATI NG ROOM	C	159, 532				50.00
51. 00   05100   RECOVERY ROOM	C	13, 948				51.00
52.00  05200 DELIVERY ROOM & LABOR ROOM	C	0				52.00
53. 00 05300 ANESTHESI OLOGY	C	9, 900	1			53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	C	295, 006				54.00
56. 00   05600   RADI 0I SOTOPE	C	6, 404	•			56.00
60. 00  06000   LABORATORY	C	237, 696	•			60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	C	883	•			63.00
66. 00  06600 PHYSI CAL THERAPY	C	84, 053	•			66.00
69. 00  06900  ELECTROCARDI OLOGY	C	41, 259				69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C	229, 923				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	C	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	C	236, 003				73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00  09000  CLI NI C	C	32, 910				90.00
90. 01  09001   SENI OR CARE	C	0				90. 01
91. 00   09100   EMERGENCY	C	608, 805				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	C	46, 727				92.00
200.00 Subtotal (see instructions)	0	2, 003, 049			2	200. 00
201.00 Less PBP Clinic Lab. Services-Program	C	)			2	201. 00
Only Charges						
202.00   Net Charges (line 200 +/- line 201)	C	2, 003, 049			2	202. 00

Health Financial Systems	WABASH COUNTY HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 151310	Peri od: From 01/01/2014	Worksheet D-1	
		To 12/31/2014	Date/Time Prep 5/27/2015 8:04	
	Title XVIII	Hospi tal	Cost	
Cost Center Description			1 00	

			10 12/01/2011	5/27/2015 8: 0	4 am
		Title XVIII	Hospi tal	Cost	
	Cost Center Description				
	DART I DROWNER COMPONENTS			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
1. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days,	eveluding newborn)		2, 734	1.00
2.00	Inpatient days (including private room days, excluding swing-bed days,			2, 734	
3.00	Private room days (excluding swing-bed and observation bed days		ivate room days	2, 302	3.00
0.00	do not complete this line.	). It you have only pr	i vate i com days,	١	0.00
4.00	Semi-private room days (excluding swing-bed and observation bed	days)		1, 740	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room	days) through Decembe	r 31 of the cost	198	5. 00
	reporting period				
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) through Dagambar	21 of the cost	154	7 00
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	days) through becember	31 Of the Cost	154	7. 00
8.00	Total swing-bed NF type inpatient days (including private room	davs) after December 3	1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	aaye, a. te. Beeember e		١	0.00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	807	9. 00
	newborn days)	0 1			
10.00	Swing-bed SNF type inpatient days applicable to title XVIII onl		oom days)	198	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 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		o room days)	0	12. 00
12.00	through December 31 of the cost reporting period	only (Therduring privat	e room days)	0	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	onlv (includina privat	e room davs)	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
17. 00	SWING BED ADJUSTMENT  Medicare rate for swing-bed SNF services applicable to services	through Docombor 21 o	f the cost		17. 00
17.00	reporting period	till dugit beceiliber 31 0	i the cost	  -	17.00
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	through December 31 of	the cost	132.00	19. 00
00.00	reporting period	CL D L 24 CL		100.00	00.00
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	arter becember 31 or t	ne cost	132. 00	20. 00
21. 00	Total general inpatient routine service cost (see instructions)			3, 297, 714	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ing period (line	0	22. 00
	5 x line 17)	•			
23. 00	Swing-bed cost applicable to SNF type services after December 3	1 of the cost reportin	g period (line 6	0	23. 00
04.00	x line 18)	24 6 11		00.000	04.00
24. 00	Swing-bed cost applicable to NF type services through December 7 x line 19)	31 of the cost reporti	ng period (line	20, 328	24.00
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)		F	- I	
26.00	Total swing-bed cost (see instructions)			271, 847	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (I	ine 21 minus line 26)		3, 025, 867	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		<u> </u>		
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28. 00
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000	31.00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	11116 20)		0. 00	ł
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	1
34.00	Average per diem private room charge differential (line 32 minu	s line 33)(see instruc	tions)	0.00	1
35.00	Average per diem private room cost differential (line 34 x line	31)		0.00	35. 00
36. 00				0	36. 00
37. 00	, , ,			3, 025, 867	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		I	1, 270. 30	38. 00
39. 00	Program general inpatient routine service cost per drem (see 1)  Program general inpatient routine service cost (line 9 x line 3)	•		1, 025, 132	1
40. 00	Medically necessary private room cost applicable to the Program	•		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 +			1, 025, 132	41.00

Heal th	Financial Systems	WABASH COUNT	Y HOSPITAL		In Lie	eu of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST				Period: From 01/01/2014	Worksheet D-1	
					To 12/31/2014		
				e XVIII	Hospi tal	Cost	<del> </del>
	Cost Center Description	Total Inpatient Cost	Total Inpatient Davs	Average Per	Program Days	Program Cost	
				col . 2)		4)	
42. 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5. 00	42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT		 				43. 00
44. 00	CORONARY CARE UNIT						44. 00
45.00	1						45. 00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wk					1, 200, 102	48. 00
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(	(see instructio	ons)		2, 225, 234	49. 00
50.00	Pass through costs applicable to Program inp	atient routine	services (from	m Wkst. D, sum	of Parts I and	0	50. 00
51. 00	<pre>                                    </pre>	atient ancillar	y services (fr	rom Wkst. D, s	um of Parts II	0	51. 00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				0	52. 00
53. 00	Total Program inpatient operating cost exclu	ding capital re	elated, non-phy	ysician anesth	etist, and	ő	53. 00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
	Program di scharges					0	
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	55. 00 56. 00
57. 00	Difference between adjusted inpatient operat	ing cost and ta	arget amount (I	line 56 minus	line 53)	0	57. 00
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	porting period	endi na 1996. u	updated and co	mpounded by the	0.00	58. 00 59. 00
	market basket	. 0.	9	•	,		
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line				the amount by	0.00	60. 00 61. 00
	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						
62.00 Relief payment (see instructions)						0	
63.00 Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST						0	63. 00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of the	e cost reporti	ng period (See	251, 519	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	per 31 of the o	cost reporting	period (See	0	65. 00
66. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi</pre>	ne costs (line	64 plus line 6	65)(title XVII	I only). For	251, 519	66. 00
	CAH (see instructions)	·	·		3.		
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	i becember 31 (	or the cost re	portring period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after [	December 31 of	the cost repo	rting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N		`			0	69. 00
70. 00	Skilled nursing facility/other nursing facil		•				70. 00
71. 00 72. 00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		ine 70 ÷ line	2)			71. 00 72. 00
73. 00	Medically necessary private room cost applic	abĺe to Program					73. 00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•			art II. column		74. 00 75. 00
	26, line 45)		(**************************************				
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line	,					76. 00 77. 00
78.00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		ravi dan nagan	do)			78. 00 79. 00
79. 00 80. 00	Total Program routine service costs for comp	, ,		,	us line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I		1)				81. 00 82. 00
83. 00	Reasonable inpatient routine service cost (		· .				83. 00
84. 00 85. 00	Program inpatient ancillary services (see in		nns)				84. 00 85. 00
86. 00		of lines 83 th					86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					642	87. 00
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷				1, 270. 31	88. 00
89. 00	Observation bed cost (line 87 x line 88) (se	e instructions)				815, 539	89.00

Health Financial Systems	WABASH COUNT	WABASH COUNTY HOSPITAL In Lieu of Form CM				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 5/27/2015 8:04	
		Ti tl	e XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	130, 506	3, 025, 867	0. 04313	0 815, 539	35, 174	90.00
91.00 Nursing School cost	0	3, 025, 867	0.00000	0 815, 539	0	91.00
92.00 Allied health cost	0	3, 025, 867	0.00000	0 815, 539	0	92.00
93.00 All other Medical Education	0	3, 025, 867	0.00000	0 815, 539	0	93.00

Health Financial Systems	WABASH COUNTY HOS	u of Form CMS-2	2552-10		
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 151310	From 01/01/2014		
			To 12/31/2014	Date/Time Prep 5/27/2015 8:04	pared: 4 am
		Title XIX	Hospi tal	PPS	
Cost Center Description					
				1. 00	
PART I - ALL PROVIDER COMPONENTS					
I NIDATI ENT. DAVC					

		Title XIX	Hospi tal	PPS	
	Cost Center Description			1 00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,	excluding newborn)		2, 734	1. 00
2.00	Inpatient days (including private room days, excluding swing-be			2, 382	2. 00
3.00	Private room days (excluding swing-bed and observation bed days	). If you have only pri	vate room days,	0	3. 00
4.00	do not complete this line. Semi-private room days (excluding swing-bed and observation bed	days)		1, 740	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room		31 of the cost	1, 740	5. 00
0.00	reporting period	auge, em eugn becomber	0. 0. 1 0001	170	0.00
6.00	Total swing-bed SNF type inpatient days (including private room	days) after December 3	1 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)				7.00
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	days) through December	31 OF the COST	154	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room	days) after December 31	of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	aayo, a. to. Becombe. e.		· ·	0.00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	95	9. 00
10.00	newborn days)			0	10.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl through December 31 of the cost reporting period (see instructi		olli days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl		om davs) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, ent	er 0 on this line)			
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including private	room days)	154	12.00
12 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX	only (including private	room days)	0	13. 00
13. 00	after December 31 of the cost reporting period (if calendar yea			U	13.00
14. 00	Medically necessary private room days applicable to the Program	(excluding swing-bed d	ays)	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
17 00	SWING BED ADJUSTMENT	through Documber 21 of	the cost		17 00
17. 00	Medicare rate for swing-bed SNF services applicable to services reporting period	through December 31 of	the cost		17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of t	he cost		18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	132. 00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 31 of th	a cost	132. 00	20. 00
20.00	reporting period	arter becember 31 or th	e cost	132.00	20.00
21. 00	Total general inpatient routine service cost (see instructions)			3, 297, 714	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	31 of the cost reporti	ng period (line	0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December 3	1 of the cost reporting	noried (line 4	0	23. 00
23.00	x line 18)	To the cost reporting	perrou (Trile o	U	23.00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reportin	g period (line	20, 328	24. 00
	7 x line 19)	•			
25. 00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)			271, 847	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (I	ine 21 minus line 26)		3, 025, 867	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			27 3237 333	
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed cha	rges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)	line 20)		0	30.00
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 ÷ Average private room per diem charge (line 29 ÷ line 3)	11 ne 28)		0. 000000 0. 00	31. 00 32. 00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00
34. 00	Average per diem private room charge differential (line 32 minu	s line 33)(see instruct	i ons)	0.00	34. 00
35. 00	Average per diem private room cost differential (line 34 x line			0. 00	35. 00
36. 00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost an	d private room cost dif	terential (line	3, 025, 867	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, 270. 31	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 3	•		120, 679	39. 00
40.00	Medically necessary private room cost applicable to the Program			120 (70	40.00
41.00	Total Program general inpatient routine service cost (line 39 +	TIME 40)		120, 679	41.00

Heal th	Financial Systems	WABASH COUNTY H	OSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der		eriod: rom 01/01/2014	Worksheet D-1	
				Т	o 12/31/2014	Date/Time Prep 5/27/2015 8:04	
	Cost Center Description	Total	Ti ti Total	le XIX Average Per	Hospital Program Days	PPS Program Cost	
	oust delited beschiption	Inpatient Cost Inpa		Diem (col. 1 ÷	11 ogram bays	(col. 3 x col.	
		1.00	2. 00	col . 2) 3.00	4. 00	4) 5. 00	
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0. 00	0	0	42. 00
43.00	INTENSIVE CARE UNIT						43. 00
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
46.00	SURGICAL INTENSIVE CARE UNIT						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						47. 00
40.00		-+ 0.21 2 1	1 = 200)			1.00	40.00
48. 00 49. 00	Program inpatient ancillary service cost (Wk: Total Program inpatient costs (sum of lines			ns)		296, 174 416, 853	48. 00 49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program input	atient routine ser	vices (from	Wkst D sum	of Parts I and	4, 776	50.00
			•				
51. 00	Pass through costs applicable to Program inpand IV)	atient ancillary s	services (fr	om Wkst. D, su	m of Parts II	7, 662	51. 00
52.00	Total Program excludable cost (sum of lines		سيطم ممم لمه	oioion onco+ho	tict and	12, 438	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		.ea, non-pny:	sician anestne	tist, and	404, 415	53. 00
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54. 00
55. 00	Target amount per discharge		0. 00	55. 00			
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ine 53)	0	56. 00 57. 00			
58. 00	Bonus payment (see instructions)	ŕ	0 0. 00	58. 00			
59. 00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						59. 00
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of lines	he amount by	0. 00 0	60. 00 61. 00			
01.00	which operating costs (line 53) are less than	U	01.00				
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	0	62. 00				
63. 00	Allowable Inpatient cost plus incentive payments		0	63. 00			
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	0	64. 00				
65. 00	instructions)(title XVIII only)  Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See						65. 00
66. 00	instructions)(title XVIII only)						66. 00
86.00	CAH (see instructions)						86.00
67. 00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67. 00
68. 00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period						68. 00
69. 00						20, 328	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil						70. 00
71. 00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71. 00
72. 00 73. 00	· · · · · · · · · · · · · · · · · · ·						72. 00 73. 00
74. 00 75. 00	Total Program general inpatient routine service costs (line 72 + line 73)						74. 00 75. 00
75.00	26, line 45)		ists (ITOIII W	orksneet b, Fa	it ii, corumii		
76. 00 77. 00							76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minus line 77)						78. 00
79. 00 80. 00	, , , , , , , , , , , , , , , , , , , ,						79. 00 80. 00
81. 00 82. 00	Inpatient routine service cost per diem limitation						81. 00 82. 00
82. 00 83. 00	· · · · · · · · · · · · · · · · · · ·						82.00
84. 00 85. 00	O Program inpatient ancillary services (see instructions)						84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum	of lines 83 throu					86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					642	87. 00
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷ li	ne 2)			1, 270. 31	88. 00
89.00	Observation bed cost (line 87 x line 88) (see	e instructions)				815, 539	89. UU

Health Financial Systems	al Systems WABASH COUNTY HOSPITAL In Lieu of Form CMS			u of Form CMS-2	2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2014 To 12/31/2014	Date/Time Pre	oared:
					5/27/2015 8: 0	
		Ti t	le XIX	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	130, 506	3, 025, 867	0. 04313	0 815, 539	35, 174	90.00
91.00 Nursing School cost	0	3, 025, 867	0.00000	0 815, 539	0	91.00
92.00 Allied health cost	0	3, 025, 867	0.00000	0 815, 539	0	92.00
93.00 All other Medical Education	0	3, 025, 867	0.00000	0 815, 539	0	93.00

Health Fina	ncial Systems WABASH COU	NTY HOSPITAL		In lie	u of Form CMS-2	2552-10
			CCN: 151310	Peri od:	Worksheet D-3	
				From 01/01/2014 To 12/31/2014	Date/Time Pre 5/27/2015 8:0	
		Ti tl	e XVIII	Hospi tal	Cost	
	Cost Center Description		Ratio of Cos	The state of the s	Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
	THE POLITIME OF DAY OF AGOT OF STREET		1. 00	2. 00	3. 00	
	TIENT ROUTINE SERVICE COST CENTERS			1 (04 57)		
	O ADULTS & PEDI ATRI CS			1, 681, 574		30.00
	O NURSERY					43. 00
	LLARY SERVICE COST CENTERS		0.707	171 052	100, 700	
	O OPERATI NG ROOM		0.60676		-	1
	O RECOVERY ROOM		0. 33547		8, 267	51.00
	O DELIVERY ROOM & LABOR ROOM		0.00000		0	52.00
	O ANESTHESI OLOGY		0. 1539		3, 731	53.00
•	O RADI OLOGY-DI AGNOSTI C		0. 22251		61, 618	1
•	O RADI OI SOTOPE		0. 2575		-	1
	O LABORATORY		0. 2210		-	1
	O BLOOD STORING, PROCESSING & TRANS. O PHYSICAL THERAPY		0. 71614		-	63. 00
	O ELECTROCARDI OLOGY		0. 75020		-	66. 00 69. 00
	O MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 3835 0. 5963		117, 796 268, 151	71.00
	OIMPL. DEV. CHARGED TO PATIENTS		0. 5963	·	-	72.00
	O DRUGS CHARGED TO PATIENTS		0. 24486		-	
	ATIENT SERVICE COST CENTERS		0.21090	1, 300, 203	275, 603	73.00
	O CLINI C		0. 3296	92 0	0	90.00
	1 SENLOR CARE		1. 00718		0	90.00
	O EMERGENCY		0. 50454		1, 456	
	O OBSERVATION BEDS (NON-DISTINCT PART)		0. 30432			91.00
200.00	Total (sum of lines 50-94 and 96-98)		0.4003	3, 812, 016		
201. 00	Less PBP Clinic Laboratory Services-Program only cha	argos (lino 61)		3, 612, 016		200.00
202.00	Net Charges (line 200 minus line 201)	arges (Title 01)		3, 812, 016		201.00
202.00	Tivet charges (Title 200 IIII hus Title 201)		I	3,012,010		1202.00

Health Financial Systems WABASH COUNTY HC	IAT IQ2		In lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		CCN: 151310	Peri od:	Worksheet D-3	
			From 01/01/2014		
	Component	CCN: 15Z310	To 12/31/2014		
	T: ±1	e XVIII	Contract Darda CNI	5/27/2015 8: 0	4 am
Coat Contan Decemention	11 11	Ratio of Cos	Swing Beds - SNF t Inpatient		
Cost Center Description		To Charges	Program	Inpatient Program Costs	
		10 Charges	Charges	(col. 1 x col.	
			Charges	2)	
		1.00	2. 00	3, 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	0.00	
30. 00 03000 ADULTS & PEDIATRICS			0		30.00
43. 00   04300   NURSERY					43.00
ANCILLARY SERVICE COST CENTERS			<u> </u>		
50. 00 05000 OPERATING ROOM		0. 60676	8 0	0	50.00
51. 00   05100   RECOVERY ROOM		0. 33547	1 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0.00000	0	0	52.00
53. 00   05300   ANESTHESI OLOGY		0. 15395	7 0	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 22251	7 10, 361	2, 305	54.00
56. 00   05600   RADI 0I SOTOPE		0. 25755	8 0	0	56.00
60. 00   06000   LABORATORY		0. 22101	9 42, 853	9, 471	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 71614	1 822	589	63.00
66. 00 06600 PHYSI CAL THERAPY		0. 75020	•		
69. 00   06900   ELECTROCARDI OLOGY		0. 38357	•		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 59631	•	13, 792	
72.00 07200 MPL. DEV. CHARGED TO PATLENT		0. 24486		0	72. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS		0. 21098	2 290, 954	61, 386	73. 00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C		0. 32969		0	
90. 01   09001   SENI OR CARE		1. 00718		0	90. 01
91. 00   09100   EMERGENCY		0. 50454		0	91. 00
92. 00 OBSERVATION BEDS (NON-DISTINCT PART)		0. 46632		0	92. 00
200 00 Total (sum of lines 50 04 and 06 09)		I	452 002	125 716	1200 00

135, 716 200. 00 201. 00 202. 00

452, 002

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)
200.00 Total (sum of lines 50-94 and 96-98)
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)

Net Charges (line 200 minus line 201)

202.00

Health Fina	ncial Systems WABASH COUNTY	ΗΛΟΡΙ ΤΔΙ		In lie	u of Form CMS-2	2552_10
	ANCILLARY SERVICE COST APPORTIONMENT		CCN: 151310	Peri od:	Worksheet D-3	
				From 01/01/2014 To 12/31/2014	Date/Time Pre 5/27/2015 8:0	pared:
		Ti t	le XIX	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges		Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1. 00	2. 00	3. 00	
	TIENT ROUTINE SERVICE COST CENTERS		1			
	O ADULTS & PEDI ATRI CS			157, 536		30.00
	0 NURSERY			0		43. 00
	LLARY SERVICE COST CENTERS		1			
	O OPERATI NG ROOM		0. 60676	•		1
	O RECOVERY ROOM		0. 3354	•	1, 850	1
	O DELIVERY ROOM & LABOR ROOM		0.00000		0	52. 00
	O ANESTHESI OLOGY		0. 1539	•	1, 209	53. 00
	O RADI OLOGY-DI AGNOSTI C		0. 22251	•		1
	O RADI OI SOTOPE		0. 2575!			56. 00
	0 LABORATORY		0. 2210	•		1
	O BLOOD STORING, PROCESSING & TRANS.		0. 71614		0	63. 00
	O PHYSI CAL THERAPY		0. 75020			1
	O ELECTROCARDI OLOGY		0. 3835	•		1
	O MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 5963			71.00
	O I MPL. DEV. CHARGED TO PATIENT		0. 24486		0	72. 00
	O DRUGS CHARGED TO PATIENTS		0. 21098	32 205, 376	43, 331	73. 00
	ATIENT SERVICE COST CENTERS					
	O CLI NI C		0. 32969		0	90.00
	1 SENI OR CARE		1. 00718		0	90. 01
	O EMERGENCY		0. 50454	•	8, 464	91. 00
	O OBSERVATION BEDS (NON-DISTINCT PART)		0. 46632		0	92.00
200.00	Total (sum of lines 50-94 and 96-98)	(1)		712, 646		
201. 00	Less PBP Clinic Laboratory Services-Program only charges	s (line 61)		0		201. 00
202. 00	Net Charges (line 200 minus line 201)		1	712, 646		202. 00

Health Financial Systems	WABASH COUNTY HOS	SPI TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 151310	Peri od: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 5/27/2015 8:04 am
		Ti +Lo V/////	Hospi tal	Cost

PART B. WOLGAL AND DIFFE IRAN IN SERVICES   1.00				To 12/31/2014	Date/Time Pre 5/27/2015 8:0	
Name			Title XVIII	Hospi tal		
Name					4.00	
Medical and other services (see instructions)		DART R - MEDICAL AND OTHER HEALTH SERVICES			1.00	
PS payments	1.00				6, 026, 325	1.00
0.001   Comparison   0.000	2.00	Medical and other services reimbursed under OPPS (see instructi		0	2. 00	
Finder the fixed plat   Specific payment to cost ratio (see instructions)   0.000   5.00						1
Line 2 times line 5			i ana)			1
7.00         Sum of Time 3 plus line 4 divided by line 6         0.00         7.00           8.00         Transitional corridor payment (see instructions)         0         0.00           9.00         Ancillary service other pass through costs from West. D. Pt. IV, col. 13, line 200         0         0.00           11.00         Dram acquisitions         6,026,235         11.00           12.00         Ancillary service charges         6,026,325         11.00           12.00         Ancillary service charges (from West. D4, Pt. III, line 69, col. 4)         0         12.00           14.00         Organ acquisit ion charges (from West. D4, Pt. III, line 69, col. 4)         0         13.00           15.00         Aggregate amount actually collected from patients liable for payment for services on a charge basis         0         15.00           16.00         Aggregate amount actually collected from patients liable for payment for services on a charge basis         0         15.00           17.00         Italian collected from patients liable for payment for services on a charge basis         0         15.00           18.00         About the payment feel and the payment for services on a charge basis         0         15.00           19.00         Italian collected from patients liable for payment for services on a charge basis         0         15.00           19.			1 0115)			1
Transitional corridor payment (see instructions)   0						1
10.00   Organ acquisitions   0.026, 325   11.00   Country   11.00   Total cost (sum of lines 1 and 10) (see Instructions)   0.026, 325   11.00   Country   11.00   Total cost (sum of lines 1 and 10) (see Instructions)   0.026, 325   11.00   0.000   0.000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.00000000	8.00				0	8. 00
1.00   Total cost (sum of lines 1 and 10) (see instructions)   6.026, 325   11.00			, col. 13, line 200			1
COMPUTATION OF LESSER OF COST OR CHARGES		,			_	
Reasonable charges	11.00				0, 020, 325	] 11.00
13.00   Organ acquisition charges (from West. D-4, Pt. III, line 69, col. 4)   0.   13.00   0.   14.00   Coustomary, charges (see instructions)   0.   14.00   0.   14.00   0.   14.00   0.   14.00   0.   14.00   0.   14.00   0.   14.00   0.   14.00   0.   14.00   0.   14.00   0.   14.00   0.   14.00   0.   14.00   0.   14.00   0.   14.00   0.   14.00   0.   14.00   0.   16.00   0.   16.00   0.   16.00   0.   16.00   0.   16.00   0.   16.00   16.00   0.   16.00   16.00   0.   16.00						1
14.00   Total reasonable charges (sum of lines 12 and 13)						
Customary charges			1. 4)			1
15.00   Aggregate amount actually collected from patients liable for payment for services on a charge basis   0   15.00	14.00				0	14.00
16.00   Amounts that would have been realized from patients   1 able for payment for services on a chargebasis   0   16.00   National Computation   10.00   National Computation   10.00   National Computation   10.00   National Computation   10.00   National Computational Computat	15. 00		vment for services on	a charge basis	0	15. 00
17.00   Ratio of line 15 to line 16 (not to exceed 1.000000)   17.00   18.00					0	1
18.00   Total customary charges (see instructions)   0   18.00   18.00   18.00   19.		' '				
19. 00   Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see   0   19. 00						
instructions			if line 18 exceeds li	ne 11) (see		1
instructions	17.00	, ,	TT TTHE TO EXCECUS TT	110 11) (300	Ŭ	17.00
1. 00   Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)   0. 22, 00   22, 00   Cost of physicians' services in a teaching hospital (see instructions)   0. 23, 00   24, 00	20. 00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see				20. 00
22.00   Interns and residents (see instructions)   0.20.00   23.00	21 00					21 00
23. 00   Cost of physicians' services in a teaching hospital (see instructions)						
Total prospective payment (sum of lines 3, 4, 8 and 9)		· · · · · · · · · · · · · · · · · · ·				1
25. 00   Deductibles and coinsurance (for CAH, see instructions)   32, 662   25. 00   Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)   3,128, 933   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)   0   29, 00   29, 00   ESRD direct 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, 9	24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)				24. 00
26. 00         Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)         3, 128, 933         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, 924, 993         27. 00           28. 00         Direct graduate medical education payments (from Wkst. E-4, line 50)         0         29. 00           30. 00         Subtotal (sum of lines 27 through 29)         2, 924, 993         30. 00           31. 00         Primary payer payments         2, 242, 993         30. 00           32. 00         Subtotal (line 30 minus line 31)         2, 924, 791         32. 00           34. 00         Allowable BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)         33. 00         33. 00           35. 00         Allowable bad debts (see instructions)         465, 562         34. 00           36. 00         Allowable bad debts (see instructions)         33. 3, 27         35. 00           36. 00         Allowable bad debts for dual eligible beneficiaries (see instructions)         3, 278, 578         30. 00           37. 00         MSUbtotal (see instructions)         3, 278, 578         30. 00           38. 00         MSP-LCC reconciliation amount from PS&R         0         3, 278, 578         30. 00           39. 99	05.00			22 ((2	05.00	
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)   2,924,993   27.00   28.00   29.0			CAH see instructions)			
CAH, see instructions   Direct graduate medical education payments (from Wkst. E-4, line 50)   0   28. 00   29. 00   2				and 23} (for		
29.00   ESRD diffect medical education costs (from Wkst. E-4, line 36)   0   29.00   30.00				, ,		
30.00   Subtotal (sum of lines 27 through 29)   2,924,993   30.00   21.00   Primary payer payments   242   31.00   2.924,751   3.00   2.924,751   3.00   2.924,751   3.00   2.924,751   3.00   2.924,751   3.00   2.924,751   3.00   2.924,751   3.00   2.924,751   3.00   2.924,751   3.00   2.924,751   3.00   2.924,751   3.00   2.924,751   3.00   2.924,751   3.00   3.		, , ,	e 50)			
31.00		· · · · · · · · · · · · · · · · · · ·			_	
32.00   Subtotal (ine 30 minus line 31)   ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)						1
33.00   Composite rate ESRD (from Wkst. I-5, line 11)   0   33.00   34.00   All owable bad debts (see instructions)   465,562   34.00   35.00   Adjusted reimbursable bad debts (see instructions)   353,827   35.00   36.00   All owable bad debts for dual eligible beneficiaries (see instructions)   465,562   36.00   37.00   Subtotal (see instructions)   38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   07HER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.50   99.50   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   39.99   40.00   Subtotal (see instructions)   3, 278, 578   40.00   40.00   Sequestration adjustment (see instructions)   3, 278, 578   40.01   41.00   Interim payments   2, 638, 417   41.00   42.00   Tentative settlement (for contractors use only)   574, 589   43.00   44.00   Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,						
34. 00       Allowable bad debts (see instructions)       465, 562       34. 00         35. 00       Adjusted reimbursable bad debts (see instructions)       353, 827       35. 00         36. 00       Allowable bad debts for dual eligible beneficiaries (see instructions)       465, 562       36. 00         37. 00       Subtotal (see instructions)       3, 278, 578       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       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. 00       Subtotal (see instructions)       3, 278, 578       40. 00         40. 01       Sequestration adjustment (see instructions)       65, 572       40. 01         41. 00       Interim payments       2, 638, 417       41. 00         42. 00       Tentative settlement (for contractors use only)       574, 589       43. 00         43. 00       Bal ance due provi der/program (see instructions)       574, 589 <td< td=""><td></td><td></td><td>S)</td><td></td><td>_</td><td></td></td<>			S)		_	
35. 00       Adjusted reimbursable bad debts (see instructions)       35, 827       35. 00         36. 00       Allowable bad debts for dual eligible beneficiaries (see instructions)       465, 562       36. 00         37. 00       Subtotal (see instructions)       3, 278, 578       37. 00         38. 00       MSP-LCC reconciliation amount from PS&R       0       38. 00         39. 00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       39. 00         39. 50       Pioneer ACO demonstration payment adjustment (see instructions)       0       39. 50         39. 99       Partial or full credits received from manufacturers for replaced devices (see instructions)       0       39. 90         39. 99       RECOVERY OF ACCELERATED DEPRECIATION       0       39. 98         40. 01       Subtotal (see instructions)       0       39. 98         40. 01       Sequestration adjustment (see instructions)       65, 572       40. 01         41. 00       Interim payments       2, 638, 417       41. 00         42. 00       Tentative settlement (for contractors use only)       574, 589       43. 00         44. 00       Balance due provider/program (see instructions)       574, 589       43. 00         44. 00       Si15.2       To BE COMPLETED BY CONTRACTOR       0       90. 00						1
36.00       Allowable bad debts for dual eligible beneficiaries (see instructions)       465, 562       36.00         37.00       Subtotal (see instructions)       3, 278, 578       37.00         38.00       MSP-LCC reconciliation amount from PS&R       0       38.00         39.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       39.00         39.50       Pioneer ACO demonstration payment adjustment (see instructions)       0       39.50         39.98       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)       3, 278, 578       40.00         40.01       Interim payments       2, 638, 417       41.00         41.00       Interim payments       2, 638, 417       41.00         42.00       Balance due provider/program (see instructions)       574, 589       43.00         44.00       §115.2       0       44.00         70.00       Original outlier amount (see instructions)       0       90.00         90.00       The rate used to calculate the Time Value of Money       0.00       92.00         71.00       Time Value of Money (see inst		· · · · · · · · · · · · · · · · · · ·				
38.00 MSP-LCC reconciliation amount from PS&R 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.98 RECOVERY OF ACCELERATED DEPRECIATION 39.99 RECOVERY OF ACCELERATED DEPRECIATION 39.99 AU. 00 Subtotal (see instructions) 39.99 Subtotal (see instructions) 30.278,578 AU. 00 40.01 Interim payments 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,  10.00 Protested amounts (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 Original outlier amount (see instructions) 93.00 Time Value of Money (see instructions) 93.00 Original outlier amount (see instructions) 93.00 Original outlier amount (see instructions) 93.00 Original outlier original outlier amount (see instructions) 94.00 Original outlier original outlier amount (see instructions) 95.00 Original outlier original outlier amount (see instructions) 97.00 Original outlier original original outlier original or		, ,	ctions)			
39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.00		,				
Pioneer ACO demonstration payment adjustment (see instructions)  39. 50 39. 88 Partial or full credits received from manufacturers for replaced devices (see instructions)  39. 99 RECOVERY OF ACCELERATED DEPRECIATION  39. 99 40. 00 Subtotal (see instructions)  30. 278, 578 30. 00 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,  574, 589  70 BE COMPLETED BY CONTRACTOR  70. 00 Original outlier 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 Time Value of Money (see instructions)  75. 39. 50 To BE COMPLETED BY CONTRACTOR  75. 50 To BE COMPLETED BY CONTRACTOR  76. 50 Time Value of Money (see instructions)  77. 00 Time Value of Money (see instructions)  78. 50 Time Value of Money (see instructions)  79. 00 Time Value of Money (see instructions)						
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)  30. 98 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,  574, 589 43. 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. 98 39. 98  39. 98  39. 98  39. 99  30. 39. 98  39. 99  30. 39. 99  30. 39. 99  30. 30. 30. 30. 30. 30. 30. 30. 30. 30.		, , , , ,				1
RECOVERY OF ACCELERATED DEPRECIATION   0   39.99			d devices (see instruc	tions)		1
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, 574, 589 43.00  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) 0 Utilier reconciliation adjustment amount (see instructions) 0 Utilier reconciliation adjustment amount (see instructions) 0 92.00 The rate used to calculate the Time Value of Money 1 Time Value of Money (see instructions) 0 93.00		· ·	(**************************************	,	0	
41.00   Interim payments   2,638,417   41.00   42.00   43.00   Balance due provider/program (see instructions)   574,589   43.00   44.00   Frotested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,   0   44.00   0   0   0   0   0   0   0   0   0		,				
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, 0 44.00    91.00 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)  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)  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)		, ,				1
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, 0 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)  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)		' '				
44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 \$115.2 TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 0 91.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 The rate used to calculate the Time Value of Money 0 93.00 Time Value of Money (see instructions) 0 93.00						1
TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 0 utlier reconciliation adjustment amount (see instructions) 0 utlier reconciliation adjustment amount (see instructions) 0 pl. 00 1 The rate used to calculate the Time Value of Money 0 pl. 00 1 Time Value of Money (see instructions) 0 pl. 00 1 pl		Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	chapter 1,		
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 91.00 92.00 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	90 00				0	90 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 0 93.00						
		,				
94.00   lotal (sum of lines 91 and 93)   0   94.00						
	94. 00	lotal (sum of lines 91 and 93)			0	94. 00

Health Financial Systems WAANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

					5/27/2015 8: 0	4 am
		Ti	tle XVIII	Hospi tal	Cost	
		Inpati	ent Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1. 00	Total interim payments paid to provider		1, 839, 891		2, 638, 417	1. 00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,		(		0	2. 00
3.00	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) Program to Provider					3. 00
2 01	ADJUSTMENTS TO PROVIDER	00 (00 (2014	125 500	\	0	2 01
3. 01 3. 02	ADJUSTMENTS TO PROVIDER	08/08/2014	135, 500		0	3. 01 3. 02
3. 02						3. 02
3. 03					0	3. 03
3. 04					0	3. 04
3.00	Provider to Program			)		3.05
3. 50	ADJUSTMENTS TO PROGRAM				0	3. 50
3. 51	ADJUSTIMENTS TO TROUVAIN				0	3. 51
3. 52					0	3. 52
3. 53					0	3. 53
3. 54					0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		135, 500	1	0	3. 99
	3. 50-3. 98)					
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1, 975, 391		2, 638, 417	4. 00
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5. 00
5.00	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		(	)	0	5. 01
5.02				)	0	5. 02
5.03			(	)	0	5. 03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM				0	5. 50
5. 51					0	5. 51
5. 52			(		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			D	0	5. 99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		16, 239		574, 589	6. 01
6. 02	SETTLEMENT TO PROGRAM		1 .5, 20		0,1,007	6. 02
7. 00	Total Medicare program liability (see instructions)		1, 991, 630		3, 213, 006	7. 00
	,		1, 11, 17, 000	Contractor Number	NPR Date (Mo/Day/Yr)	30
			0	1. 00	2. 00	
8. 00	Name of Contractor					8. 00
0.00	1	1		1	1	0.00

Health Financial Systems WAANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provi der CCN: 151310 | Peri od: From 01/01/2014 | Part | Part | Peri od: From 01/01/2014 | Part | Part | Peri od: 5/27/2015 8:04 am

		Ti tl	e XVIII Si	wing Beds - SNF	Cost	T GIII
			t Part A		t B	
		Tripatrici	t rait A	l di		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1. 00	Total interim payments paid to provider	11.00	353, 800		0	1. 00
2. 00	Interim payments payable on individual bills, either		0		o l	2. 00
2.00	submitted or to be submitted to the contractor for		Ĭ		J	2.00
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
5.00	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	l	l .			
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3. 02	ADJUSTIMENTS TO TROVIDER				0	3. 02
3. 02					0	3. 02
3.04			0		0	3. 04
3.05			0		0	3. 05
	Provider to Program		_		_	
3. 50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51			0		0	3. 51
3. 52			0		0	3. 52
3.53			0		0	3. 53
3.54			0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		353, 800		0	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5.01	TENTATI VE TO PROVI DER		0		0	5. 01
5.02			0		0	5. 02
5.03			0		0	5. 03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5. 52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		Ö		o	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		27, 697		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		2,,0,,		0	6. 02
7. 00	Total Medicare program liability (see instructions)		381, 497		Ö	
7.00	Trotal mode out of program traditity (see this traditions)		301, 477	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
			)	1. 00	2. 00	
8. 00	Name of Contractor			1.00	2.00	8. 00
5. 55	Tham of South dottor	I		I .		0.00

Heal th	Financial Systems WABASH COUNTY H	OSPI TAL	In Lie	u of Form CMS-2	2552-10	
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT  Provider CCN: 151310 Period: From 01/01/2014 To 12/31/2014 Part II To 12/31/2015					
		Title XVIII	Hospi tal	Cost		
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS					
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION			520	1. 00	
1.00						
2.00	00   Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12					
3.00	00   Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 404					
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-	12		1, 740		
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			79, 143, 919	5. 00	
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 li	ne 20		1, 184, 675	6. 00	
7. 00	CAH only - The reasonable cost incurred for the purchase of ce line 168	rtified HIT technology	Wkst. S-2, Pt. I	1	7. 00	
8.00	Calculation of the HIT incentive payment (see instructions)			1	8. 00	
9.00	Sequestration adjustment amount (see instructions)			ol	9. 00	
10.00	Calculation of the HIT incentive payment after sequestration (	see instructions)		1	10.00	
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instructions)	·		0	30. 00	
31.00	Other Adjustment (specify)			0	31. 00	
22 00	00 Palance due provider (line 0 (or line 10) minus line 20 and line 21) (occimatrustions)					

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

0 30.00 0 31.00 1 32.00

Health Financial Systems	1	WABASH COUNTY HOS	SPI TAL				In Lie	u of Form (	CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS		Provi der	CCN:	151310	Perio	od:	Worksheet	E-2
						From	01/01/2014		
			Component	CCN:	: 15Z310	To	12/31/2014		

		Component CCN: 15Z310	To 12/31/2014	Date/Time Pre 5/27/2015 8:0	
		Title XVIII	Swing Beds - SNF		
			Part A	Part B	
			1. 00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		254, 034	0	1. 00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2. 00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200 for Pt. A,		137, 073	0	3. 00
	Part V, cols. 6 and 7, line 202 for Pt. B) (For CAH, see instruc				
4.00	Per diem cost for interns and residents not in approved teaching	program (see		0.00	4. 00
	instructions)				
5. 00	Program days		198	0	5. 00
6.00	Interns and residents not in approved teaching program (see inst			0	1 0.00
7.00	Utilization review - physician compensation - SNF optional metho	d only	0		7. 00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		391, 107	0	
9.00	Primary payer payments (see instructions)		0	0	9. 00
10.00	Subtotal (line 8 minus line 9)		391, 107	0	10.00
11. 00	Deductibles billed to program patients (exclude amounts applicab	le to physician	0	0	11. 00
	professional services)				
12.00	Subtotal (line 10 minus line 11)		391, 107	0	
13.00	Coinsurance billed to program patients (from provider records) (	exclude coinsurance	1, 824	0	13. 00
	for physician professional services)				
	80% of Part B costs (line 12 x 80%)			0	
	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		389, 283	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
	Pioneer ACO demonstration payment adjustment (see instructions)		0	0	16. 50
16. 55	410A RURAL DEMONSTRATION PROJECT		0		16. 55
17. 00	Allowable bad debts (see instructions)		0	0	17. 00
17. 01	Adjusted reimbursable bad debts (see instructions)		0	0	
18. 00	Allowable bad debts for dual eligible beneficiaries (see instruc	tions)	0	0	18. 00
19.00	Total (see instructions)		389, 283	0	19. 00
19. 01	Sequestration adjustment (see instructions)		7, 786	0	19. 01
20.00	Interim payments		353, 800	0	20.00
21.00	Tentative settlement (for contractor use only)		o	0	21. 00
22. 00	Balance due provider/program (line 19 minus lines 19.01, 20, and	21)	27, 697	0	22. 00
23.00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub. 15-2,	o	0	23. 00
	§115. 2				

Health Financial Systems	WABASH COUNTY HOSPITAL	In Lie	eu of Form CMS-:	2552_10	
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 1513	O Period: From 01/01/2014	Worksheet E-3	pared:	
	Title XVIII	Hospi tal	Cost		
			1. 00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT					
1.00 Inpatient services			2, 225, 234	1.00	
			1		

		Title XVIII	Hospi tal	Cost			
				1.00			
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PAR	T A SERVICES - COST	REIMBURSEMENT				
1.00	Inpatient services			2, 225, 234			
2.00	Nursing and Allied Health Managed Care payment (see instructions)			0	2. 00		
3.00	Organ acqui si ti on			0	3. 00		
4.00	Subtotal (sum of lines 1 through 3)			2, 225, 234	4.00		
5.00	Primary payer payments			0	5. 00		
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			2, 247, 486	6. 00		
	COMPUTATION OF LESSER OF COST OR CHARGES						
	Reasonable charges						
7. 00	Routine service charges			0			
8.00	Ancillary service charges			0			
9. 00	Organ acquisition charges, net of revenue			0			
10. 00	Total reasonable charges			0	10. 00		
	Customary charges						
11. 00	Aggregate amount actually collected from patients liable for paym		9		11. 00		
12. 00	Amounts that would have been realized from patients liable for pa	yment for services on	a charge basis	0	12.00		
	had such payment been made in accordance with 42 CFR 413.13(e)						
13. 00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0. 000000			
14. 00	Total customary charges (see instructions)	0					
15. 00	Excess of customary charges over reasonable cost (complete only i	0	15. 00				
4, 00	instructions)				4. 00		
16. 00	, , , , , , , , , , , , , , , , , , , ,				16. 00		
17 00	instructions)		17. 00				
17. 00							
18. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT  Direct graduate medical education payments (from Worksheet E-4, I	ino 40)		0	18. 00		
19. 00	Cost of covered services (sum of lines 6, 17 and 18)	1116 47)		2, 247, 486			
20. 00	Deductibles (exclude professional component)			229, 824			
21. 00	Excess reasonable cost (from line 16)			224, 624			
22. 00	Subtotal (line 19 minus line 20 and 21)			2, 017, 662			
23. 00	Coi nsurance			2,017,002			
24. 00	Subtotal (line 22 minus line 23)			2, 017, 662			
25. 00	Allowable bad debts (exclude bad debts for professional services)	(soo instructions)		19, 229			
26. 00	Adjusted reimbursable bad debts (see instructions)	(see mistractions)		14, 614			
27. 00	Allowable bad debts for dual eligible beneficiaries (see instruct	ions)		19, 229			
28. 00	Subtotal (sum of lines 24 and 25, or line 26)	10113)		2, 032, 276			
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			2, 032, 270			
29. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0			
29. 99	Recovery of Accelerated Depreciation			0			
30.00	Subtotal (see instructions)			2, 032, 276			
30. 00	Sequestration adjustment (see instructions)			40, 646			
31. 00	Interim payments			1, 975, 391			
32. 00	Tentative settlement (for contractor use only)			1, 973, 391	32. 00		
33. 00	Balance due provider/program (line 30 minus lines 30.01, 31, and	32)		16, 239			
34.00	Protested amounts (nonallowable cost report items) in accordance		hanter 1	10, 239	34. 00		
34.00	§115. 2	WI LII GWIS FUD. 19-2, C	mapter I,	۷	34.00		
	13.10.2		'	'			

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: 5/27/2015 8:04 am Provi der CCN: 151310

					5/27/2015 8:0	4 am
		General Fund	Speci fi c	Endowment Fund	Plant Fund	
			Purpose Fund			
	AUDDENT AGGETG	1.00	2.00	3. 00	4. 00	
1 00	CURRENT ASSETS	0.052.224	1 /		0	1 00
1.00	Cash on hand in banks	9, 052, 336			0	1.00
2.00	Temporary investments	1, 752, 629	1			2.00
3.00	Notes recei vabl e Accounts recei vabl e	14 200 021	(	, i	0	3.00
4. 00 5. 00		16, 208, 031 121, 385			0	
6. 00	Other receivable Allowances for uncollectible notes and accounts receivable	-9, 609, 869			0	
7. 00	Inventory				0	7.00
8. 00	Prepai d expenses	861, 276 259, 574			0	
9. 00	Other current assets	239, 374			0	9.00
10. 00	Due from other funds	255, 434		, i	0	10.00
11. 00	Total current assets (sum of lines 1-10)	18, 900, 796	•			11.00
11.00	FIXED ASSETS	10, 900, 790		<u>)</u>	0	11.00
12. 00	Land	0		0	0	12. 00
13. 00	Land improvements				0	
14. 00	Accumulated depreciation			-		14. 00
15. 00	Bui I di ngs	33, 200, 805			Ö	15. 00
16. 00	Accumulated depreciation	-28, 304, 959		-	Ö	16. 00
17. 00	Leasehold improvements	20,001,707		-	Ö	17. 00
18. 00	Accumulated depreciation	0			ő	18. 00
19. 00	Fixed equipment	0		0	0	19. 00
20. 00	Accumulated depreciation	0		0	Ō	20.00
21. 00	Automobiles and trucks	0		0	ő	21.00
22. 00	Accumulated depreciation	0		-	ő	22. 00
23. 00	Major movable equipment	0		0	Ō	23. 00
24. 00	Accumulated depreciation	0		0	Ō	24. 00
25. 00	Mi nor equipment depreciable	l o		o o	Ō	25. 00
26. 00	Accumulated depreciation	0		0	0	26. 00
27. 00	HIT designated Assets	0		o	0	27. 00
28. 00	Accumulated depreciation	0		o	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0		o	0	29. 00
30.00	Total fixed assets (sum of lines 12-29)	4, 895, 846		o	0	30.00
	OTHER ASSETS					
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	5, 695, 042		0	0	34.00
35.00	Total other assets (sum of lines 31-34)	5, 695, 042		0	0	35. 00
36.00	Total assets (sum of lines 11, 30, and 35)	29, 491, 684	(	0	0	36. 00
	CURRENT LIABILITIES					
37.00	Accounts payable	1, 095, 389	(	0	0	37. 00
38. 00	Salaries, wages, and fees payable	0	(	0	0	38. 00
39. 00	Payroll taxes payable	1, 270, 377	(	0	0	39. 00
40.00	Notes and Loans payable (short term)	0	(	0	0	40.00
41.00	Deferred income	0	(	0	0	41.00
42.00	Accel erated payments	0				42. 00
43.00	Due to other funds	0	(	0	0	
44. 00	Other current liabilities	840, 818	(	1	0	44. 00
45. 00	Total current liabilities (sum of lines 37 thru 44)	3, 206, 584	(	0	0	45. 00
	LONG TERM LIABILITIES					
46. 00	Mortgage payable	391, 108	(	ا ا	0	
47. 00	Notes payable	0	(	0		1
48. 00	Unsecured Loans	0	(	0	0	48. 00
49. 00	Other long term liabilities	0	(	0	0	1
50. 00	Total long term liabilities (sum of lines 46 thru 49	391, 108				
51. 00	Total liabilites (sum of lines 45 and 50)	3, 597, 692	(	0	0	51.00
	CAPI TAL ACCOUNTS					
52. 00	General fund balance	25, 893, 992				52. 00
53. 00	Specific purpose fund		(			53. 00
54. 00	Donor created - endowment fund balance - restricted			0		54. 00
55.00	Donor created - endowment fund balance - unrestricted			0		55. 00
56.00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant				0	
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
	repl acement, and expansi on					l
59. 00	Total fund balances (sum of lines 52 thru 58)	25, 893, 992	•	0	0	59.00
60. 00	Total liabilities and fund balances (sum of lines 51 and	29, 491, 684		0	0	60.00
	[59]	I	I		l	I

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES In Lieu of Form CMS-2552-10 WABASH COUNTY HOSPITAL Provi der CCN: 151310 | Peri od: | Worksheet G-1 | From 01/01/2014 | To 12/31/2014 | Date/Time Prepared: | 5/37/2015 8: 04.3m

						5/27/2015 8:0	4 am
		General	Fund	Special P	urpose Fund	Endowment Fund	
		1.00	2. 00	3. 00	4. 00	5. 00	
1. 00	Fund balances at beginning of period		29, 090, 702		0		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-3, 614, 495				2. 00
3.00	Total (sum of line 1 and line 2)		25, 476, 207		0		3. 00
4.00	MI SCELLANEOUS	417, 785			O	0	4.00
5.00		0			O	0	5.00
6.00		0			)	0	6.00
7.00		0			)	0	7. 00
8.00		0			)	0	8.00
9.00		o			O	0	9. 00
10.00	Total additions (sum of line 4-9)		417, 785		0		10.00
11.00	Subtotal (line 3 plus line 10)		25, 893, 992		0		11. 00
12.00	MI SCELLANEOUS	l ol	,		)	0	12.00
13. 00		l ol				0	13. 00
14. 00		أم			)	0	14. 00
15. 00					)	l o	15. 00
16. 00					ก	0	16. 00
17. 00					n n	0	17. 00
18. 00	Total deductions (sum of lines 12-17)	١	0	· ·	0	Ĭ	18. 00
19. 00	Fund balance at end of period per balance		25, 893, 992		0		19. 00
17.00	sheet (line 11 minus line 18)		25, 675, 772				17.00
	Janeer (Trite Trimings Trite To)	Endowment Fund	PI ant	Fund			
		6.00	7. 00	8. 00			
1.00	Fund balances at beginning of period	0		(	)		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2. 00
3.00	Total (sum of line 1 and line 2)	l ol		1	)		3. 00
4.00	MI SCELLANEOUS		0				4. 00
5. 00			0				5. 00
6.00			0				6. 00
7. 00			0				7. 00
8. 00			0				8. 00
9. 00			0				9. 00
10. 00	Total additions (sum of line 4-9)		J	1	o		10. 00
11. 00	Subtotal (line 3 plus line 10)				ก		11. 00
12. 00	MI SCELLANEOUS	١	0	· ·			12. 00
13. 00	IWI SCELEANEOUS		0				13. 00
14. 00			0				14. 00
15. 00			0				15. 00
16. 00			0				16. 00
17. 00			0				16.00
17.00	Total deductions (sum of lines 12 17)		U				17.00
	Total deductions (sum of lines 12-17)						
19. 00	Fund balance at end of period per balance	١			7		19. 00
	sheet (line 11 minus line 18)			l	1		

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES WABASH COUNTY HOSPITAL In Lieu of Form CMS-2552-10 Worksheet G-2 Parts I & II Date/Time Prepared: 5/27/2015 8:04 am Provi der CCN: 151310 Peri od: From 01/01/2014 To 12/31/2014 Cost Center Description I npati ent 1.00 Outpati ent Total 2. 00 3.00 DADT I \_ DATIENT DEVENUES

	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	3, 885, 547		3, 885, 547	1.00
2.00	SUBPROVI DER - I PF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVI DER				4.00
5.00	Swing bed - SNF	l o		ol	5.00
6.00	Swing bed - NF	0		0	6. 00
7. 00	SKILLED NURSING FACILITY	1		-	7. 00
8.00	NURSING FACILITY				8. 00
9. 00	OTHER LONG TERM CARE				9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)	3, 885, 547		3, 885, 547	10. 00
. 0. 00	Intensive Care Type Inpatient Hospital Services	0,000,011		0,000,017	
11. 00	INTENSIVE CARE UNIT				11. 00
12. 00	CORONARY CARE UNIT				12.00
13. 00	BURN INTENSIVE CARE UNIT				13. 00
	SURGI CAL I NTENSI VE CARE UNI T				14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines	0		0	16. 00
. 0. 00	11-15)			Ĭ	
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	3, 885, 547		3, 885, 547	17.00
18. 00	Ancillary services	10, 155, 417	63, 051, 312	73, 206, 729	18. 00
	Outpati ent servi ces	1, 709	180, 406	182, 115	
	RURAL HEALTH CLINIC	0	0	0	20. 00
	FEDERALLY QUALIFIED HEALTH CENTER	0	o	o l	21. 00
	HOME HEALTH AGENCY	Ĭ	960, 344	960, 344	22. 00
23. 00	AMBULANCE SERVICES		,00,0	700,011	23. 00
24. 00	CMHC				24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P. )				25. 00
26. 00	, ,	0	1, 091, 295	1, 091, 295	
27. 00	OTHER (SPECIFY)	١	0	0	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	14, 042, 673	65, 283, 357	79, 326, 030	
20.00	G-3, line 1)	11,012,070	00, 200, 007	77,020,000	20.00
	PART II - OPERATING EXPENSES	L			
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		39, 509, 181		29. 00
30. 00	ADD (SPECIFY)	o	21,7221,121		30. 00
31. 00		l o			31. 00
32. 00		0			32. 00
33. 00		0			33. 00
34. 00		ا			34. 00
35. 00		0			35. 00
36. 00	Total additions (sum of lines 30-35)	1	0		36. 00
37. 00	MI SCELLANEOUS	7, 460, 317	1		37. 00
38. 00		0			38. 00
39. 00		١			39. 00
40. 00		0			40. 00
41. 00		0	1		41. 00
42. 00	Total deductions (sum of lines 37-41)		7, 460, 317		42. 00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		32, 048, 864		43. 00
	to Wkst. G-3, line 4)		32, 3.3, 301		.0.00
	1 · · · · · · · · · · · · · · · · · · ·		1	'	

Health Financial Systems WABASH COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
STATEMENT OF REVENUES AND EXPENSES Provider CCN: 151310 Period:	Worksheet G-3
From 01/ To 12/	/01/2014 /31/2014 Date/Time Prepared: 5/27/2015 8:04 am
	1.00
1.00 Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	79, 326, 030 1. 00
2.00 Less contractual allowances and discounts on patients' accounts 3.00 Net patient revenues (line 1 minus line 2)	46, 729, 406 2. 00
	32, 596, 624 3. 00
4.00 Less total operating expenses (from Wkst. G-2, Part II, line 43) 5.00 Net income from service to patients (line 3 minus line 4)	32, 048, 864 4. 00 547, 760 5. 00
5.00 Net income from service to patients (line 3 minus line 4) OTHER INCOME	547, 760 5. 00
6.00 Contributions, donations, bequests, etc	0 6.00
7.00 Uncome from investments	0 7.00
8.00 Revenues from telephone and other miscellaneous communication services	0 8.00
9.00 Revenue from television and radio service	0 9.00
10. 00 Purchase di scounts	0 10.00
11.00 Rebates and refunds of expenses	0 11.00
12. 00 Parking Lot receipts	0 12.00
13.00 Revenue from Laundry and Linen service	0 13.00
14.00 Revenue from meals sold to employees and quests	0 14.00
15.00 Revenue from rental of living quarters	0 15.00
16.00 Revenue from sale of medical and surgical supplies to other than patients	0 16.00
17.00 Revenue from sale of drugs to other than patients	0 17.00
18.00 Revenue from sale of medical records and abstracts	0 18.00
19.00 Tuition (fees, sale of textbooks, uniforms, etc.)	0 19.00
20.00 Revenue from gifts, flowers, coffee shops, and canteen	0 20.00
21.00 Rental of vending machines	0 21.00
22.00 Rental of hospital space	0 22.00
23.00 Governmental appropriations	0 23.00
24. 00 MI SCELLANEOUS	714, 550 24. 00
24. 01 MI SCELLANEOUS	745, 884 24. 01
25.00 Total other income (sum of lines 6-24)	1, 460, 434 25. 00
26.00 Total (line 5 plus line 25)	2, 008, 194 26. 00
27. 00 MI SCELLANEOUS	2, 001, 466 27. 00
27. 01 MI SCELLANEOUS	3, 621, 223 27. 01
28.00 Total other expenses (sum of line 27 and subscripts)	5, 622, 689 28. 00
29.00 Net income (or loss) for the period (line 26 minus line 28)	-3, 614, 495 29. 00

2. 00	Capital Related - Movable Equipment	0	0	0	0	2. 00
3.00	Plant Operation & Maintenance	0	0	0	0	3.00
4.00	Transportati on	0	0	O	0	4.00
5.00	Administrative and General	2, 123	200, 236	0	200, 236	5.00
	HHA REIMBURSABLE SERVICES					
6.00	Skilled Nursing Care	0	516, 777	0	516, 777	6.00
7.00	Physi cal Therapy	0	193, 190	0	193, 190	7.00
8.00	Occupational Therapy	0	36, 591	0	36, 591	8. 00
9.00	Speech Pathology	0	12, 756	0	12, 756	9.00
10.00	Medical Social Services	0	304		304	10.00
11. 00	Home Health Aide	0	159, 385	0	159, 385	11.00
	Supplies (see instructions)	0	14, 161	0	14, 161	12.00
	Drugs	0	0	0	0	13.00
14.00		0	0	0	0	14.00
	HHA NONREI MBURSABLE SERVI CES					
	Home Dialysis Aide Services	0	0	0	0	15. 00
	Respi ratory Therapy	0	0	0	0	16. 00
	Private Duty Nursing	0	0	0	0	17. 00
	Clinic	0	0	0	0	18. 00
	Health Promotion Activities	0	0	0	0	19. 00
	Day Care Program	0	0	0	0	20.00
	Home Delivered Meals Program	0	0	0	0	21. 00
	Homemaker Service	0	39, 414	0	39, 414	22.00
	All Others (specify)	0	0	0	0	23.00
24. 00	Total (sum of lines 1-23)	2, 123	1, 172, 814	0	1, 172, 814	24.00

COST A	LLOCATION - HHA GENERAL SERVICE	COST			CCN: 151310	Period: From 01/01/2014	Worksheet H-1 Part I	
				HHA CCN:	157061	To 12/31/2014	Date/Time Prep 5/27/2015 8:04	pared: 4 am
						Home Health Agency I	PPS	
			Capital Rela	ited Costs		Agency		
		Net Expenses for Cost Allocation (from Wkst. H,	BI dgs & Fixtures	Movable Equipment	PI ant Operation & Maintenance		Subtotal (cols. 0-4)	
		col . 10) 0	1. 00	2.00	3.00	4. 00	4A. 00	
	GENERAL SERVICE COST CENTERS							
. 00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
. 00	Capital Related - Movable	0		C			0	2. 00
00	Equi pment						0	2 00
. 00 . 00	Plant Operation & Maintenance Transportation	0	0	C	1	0 0	0	3. 00 4. 00
. 00	Administrative and General	200, 236	0	C		0 0	200, 236	
	HHA REIMBURSABLE SERVICES							
. 00 . 00	Skilled Nursing Care Physical Therapy	516, 777 193, 190	0	C	1	0 0	516, 777 193, 190	6. 00 7. 00
. 00	Occupational Therapy	36, 591	0	C	· ·		36, 591	8.00
00	Speech Pathology	12, 756	0	C		0 0	12, 756	
O. CO	Medical Social Services	304	0	C	1	0 0	304	
	Home Health Aide	159, 385	0	C	1	0 0	159, 385	
2. 00 3. 00	Supplies (see instructions) Drugs	14, 161 0	0	C	1	0 0	14, 161 0	12. 00 13. 00
4. 00	DME	Ö	o	C		o o	0	
	HHA NONREIMBURSABLE SERVICES							
	Home Dialysis Aide Services	0	0	C	•	0 0	0	15.00
6. 00 7. 00	Respiratory Therapy Private Duty Nursing	0	0	C	1	0 0	0	16. 00 17. 00
	Clinic		0	C	1		0	18. 00
	Health Promotion Activities	Ö	Ö	C	1	0 0	0	19. 00
	Day Care Program	0	0	C		0 0	0	20. 00
	Home Delivered Meals Program	0	0	C	1	0 0	0	21.00
2. 00 3. 00	Homemaker Service All Others (specify)	39, 414	0	C	1	0 0	39, 414	22. 00 23. 00
	Total (sum of lines 1-23)	1, 172, 814	o	C	1		1, 172, 814	
		Admi ni strati ve	Total (cols.		1			
		& General	4A + 5)					
	GENERAL SERVICE COST CENTERS	5. 00	6. 00					
. 00	Capital Related - Bldg. &							1. 00
	Fixtures							
. 00	Capital Related - Movable Equipment							2. 00
. 00	Plant Operation & Maintenance							3. 00
. 00	Transportation							4. 00
. 00	Administrative and General	200, 236						5. 00
. 00	HHA REIMBURSABLE SERVICES	106, 395	623, 172					6. 00
. 00	Skilled Nursing Care Physical Therapy	39, 774	232, 964					7.00
. 00	Occupational Therapy	7, 533	44, 124					8. 00
. 00	Speech Pathology	2, 626	15, 382					9. 00
0. 00 1. 00	Medical Social Services	63	367					10.00
1. 00 2. 00	Home Health Aide Supplies (see instructions)	32, 815 2, 915	192, 200 17, 076					11. 00 12. 00
3. 00	Drugs	2, 713	0					13. 00
	DME	0	0					14. 00
F 00	HHA NONREI MBURSABLE SERVI CES							15 00
	Home Dialysis Aide Services Respiratory Therapy	0	0					15. 00 16. 00
	Private Duty Nursing	0	0					17. 00
	Clinic	Ö	Ö					18. 00
9. 00	Health Promotion Activities	0	0					19. 00
	Day Care Program Home Delivered Meals Program	0	0					20. 00
1.00								21.00

22. 00 23. 00

24. 00

18.00 Clinic
19.00 Health Promotion Activities
20.00 Day Care Program
21.00 Home Delivered Meals Program
22.00 Homemaker Service
23.00 All Others (specify)
24.00 Total (sum of lines 1-23)

8, 115 0

47, 529 0

1, 172, 814

	Financial Systems		WABASH COUNT				u of Form CMS-2	2552-10
COST A	ALLOCATION - HHA STATISTICAL BAS	SIS		Provi der	CCN: 151310	Peri od: From 01/01/2014	Worksheet H-1	
				HHA CCN:	157061	To 12/31/2014		pared: 4 am
						Home Health	PPS	
						Agency I		
		Capital Rel	ated Costs					
		BI dgs &	Movabl e	PI ant	Transportatio	on Reconciliation	Admi ni strati ve	
		Fixtures	Equi pment	Operation &	(MI LEAGE)		& General	
		(SQUARE FEET)	(DOLLAR VALUE)	Maintenance (SQUARE FEET)			(ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A. 00	5. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	0.00	1.00	0711 00	0.00	
1.00	Capital Related - Bldg. &	0				0		1.00
	Fixtures							
2.00	Capital Related - Movable		0			0		2. 00
	Equi pment							
3. 00	Plant Operation & Maintenance	0	0	0	1	0		3. 00
4.00	Transportation (see	0	0	0	1	0		4. 00
5. 00	instructions)	0	0	0		0 -200, 236	070 570	5. 00
5.00	Administrative and General HHA REIMBURSABLE SERVICES	0	0		1	0 -200, 236	972, 578	5.00
6. 00	Skilled Nursing Care	0	0	0	I	0 0	516, 777	6.00
7. 00	Physical Therapy	0	0	l o		0 0	193, 190	
8. 00	Occupational Therapy	0	0			0 0	36, 591	8.00
9. 00	Speech Pathology	0	0	l o	,	0 0	12, 756	
10.00	Medical Social Services	0	0	l o	)	0 0	304	•
11.00	Home Health Aide	0	0	0	)	0 0	159, 385	11. 00
12.00	Supplies (see instructions)	0	0	0	)	0 0	14, 161	12. 00
13.00	Drugs	0	0	0	)	0	0	13. 00
14. 00	DME	0	0	0		0 0	0	14. 00
	HHA NONREIMBURSABLE SERVICES							
15. 00	Home Dialysis Aide Services	0	0	0	1	0 0	0	15. 00
16. 00	Respiratory Therapy	0	0	0	1	0 0	0	16. 00
17. 00	Private Duty Nursing	0	0	0	1	0	0	17. 00
18. 00	Clinic	0	0	0	1	0	0	18. 00
19. 00	Health Promotion Activities	0	0	0	1	0	0	19. 00
20.00	Day Care Program	0	0	0	1	0	0	20.00
21. 00	Home Delivered Meals Program	0	0	0	1	0	0 44.4	21.00
22. 00	Homemaker Service	0	0		1	0	39, 414	•
23. 00	All Others (specify)		0		1	0 200 224	072 570	23. 00
24. 00 25. 00	Total (sum of lines 1-23)		0			0 -200, 236		
25.00	Cost To Be Allocated (per		0		Ί	U	200, 236	25.00

0. 000000

0.000000

0.000000

0.000000

0. 205882 26. 00

Worksheet H-1, Part I)
26.00 Unit Cost Multiplier

Worksheet H-2 Part I Date/Time Prepared: 5/27/2015 8:04 am Provider CCN: 151310 Peri od: From 01/01/2014 To 12/31/2014 HHA CCN: 157061 Home Health PPS

						Agency I	113	
			CAPI TAL REL	ATED COSTS				
	Cost Center Description	HHA Trial	NEW BLDG &	NEW MVBLE	EMPLOYEE	Subtotal	OTHER	
	cost center bescription	Balance (1)	FLXT	EQUI P	BENEFITS	Subtotal	ADMI NI STRATI VE	
					DEPARTMENT		AND GENERAL	
		0	1. 00	2. 00	4. 00	4A	5. 01	
1.00	Administrative and General	(22, 172	5, 988 0	0		27, 690		1.00
2. 00 3. 00	Skilled Nursing Care Physical Therapy	623, 172 232, 964	0	0	0	623, 172 232, 964		2. 00 3. 00
4. 00	Occupational Therapy	44, 124	0	0	0	l		4. 00
5. 00	Speech Pathology	15, 382	0	0	Ö			5. 00
6.00	Medical Social Services	367	0	0	0			6. 00
7.00	Home Health Aide	192, 200	0	0	0			7. 00
8.00	Supplies (see instructions)	17, 076	0	0		,		8. 00
9.00	Drugs	0	0	0	1	_	0	9.00
10. 00 11. 00	DME Home Dialysis Aide Services	0	0	0	1	_	0	10. 00 11. 00
12. 00	Respiratory Therapy	0	0	0	1	_	0	12.00
13. 00	Private Duty Nursing	0	0	0	Ō	0	O	13. 00
14.00	Clinic	0	0	0	0	0	0	14. 00
15. 00	Health Promotion Activities	0	0	0	0	0	0	15. 00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17. 00 18. 00	Home Delivered Meals Program Homemaker Service	0 47, 529	0	0	0	47, 529	7, 216	17. 00 18. 00
19. 00	All Others (specify)	47, 529	0	0	0	47, 329	7,210	19. 00
20. 00	Total (sum of lines 1-19) (2)	1, 172, 814	5, 988	0	21, 702	1, 200, 504		20. 00
21. 00	Unit Cost Multiplier: column					0. 000000		21. 00
	26, line 1 divided by the sum							
	of column 26, line 20 minus column 26, line 1, rounded to							
	6 decimal places.							
	Cost Center Description	BUSI NESS	MAINTENANCE &	OPERATI ON OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		OFFI CE	REPAI RS	PLANT	LINEN SERVICE			
1.00	Administrative and General	5. 02 62, 466	6. 00 20, 993	7. 00 19, 806	8.00	9. 00 19, 269	10. 00 15, 850	1. 00
2.00	Skilled Nursing Care	02, 400	20, 443	19, 800			15, 850	2.00
3. 00	Physical Therapy	Ö	0	0	1	_	Ö	3. 00
4.00	Occupational Therapy	0	0	0	0	0	0	4. 00
5.00	Speech Pathology	0	0	0	0	_	0	5. 00
6.00	Medical Social Services	0	0	0	0	_	0	6. 00
7. 00 8. 00	Home Health Aide Supplies (see instructions)	0	0	0	0		0	7. 00 8. 00
9.00	Drugs	0	0	0	0	_	0	9. 00
10. 00	DME	o o	0	0	Ö		o o	10.00
11. 00	Home Dialysis Aide Services	0	0	0	0	0	0	11. 00
12.00	Respiratory Therapy	0	0	0	0	0	0	12. 00
13. 00	Private Duty Nursing	0	0	0	0	_	0	13.00
14.00	Clinic Health Promotion Activities	0	0	0	0	_	0	14.00
15. 00 16. 00	Day Care Program	0	0	0	0	_	0	15. 00 16. 00
17. 00	Home Delivered Meals Program	0	0	0	0	_	0	17. 00
18. 00	Homemaker Service	0	0	0	0	0	O	18. 00
19. 00	All Others (specify)	0	0	0	0	_	0	19. 00
20. 00	Total (sum of lines 1-19) (2)	62, 466	20, 993	19, 806	0	19, 269	15, 850	
21. 00	Unit Cost Multiplier: column 26, line 1 divided by the sum							21. 00
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.							

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

Health Financial Systems WAALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS Worksheet H-2 Part I Date/Time Prepared: 5/27/2015 8:04 am Provider CCN: 151310 Peri od: From 01/01/2014 To 12/31/2014 HHA CCN: 157061

						Home Health Agency I	PPS	<u> </u>
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	Subtotal	
		11. 00	13.00	14.00	15.00	16.00	24.00	
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 17. 00 18. 00 20. 00 21. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Heal th Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0			24. 00 170, 278 717, 782 268, 333 50, 823 17, 717 423 221, 380 19, 668 0 0 0 0 0 0 0 0 54, 745 0 1, 521, 149	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 17. 00 18. 00 19. 00
	of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							
	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs			
		25. 00	26. 00	27. 00	28. 00			
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic	0 0 0 0 0 0 0 0 0 0	717, 782 268, 333 50, 823 17, 717 423	90, 477 33, 824 6, 406 2, 233 53 27, 905 2, 479 0 0 0	19, 950 476			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 17. 00 18. 00	Health Promotion Activities Day Care Program	000000000000000000000000000000000000000	0 0 0 54, 745 0	0 0 0 6, 901 0	61, 646 C 1, 521, 149			15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00

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

BASIS Home Health PPS

						Home Health	PPS	
		CAPITAL REL	ATED COSTS			Agency I		
		OALLIAE KEE	ATED COSTS					
	Cost Center Description	NEW BLDG &	NEW MVBLE	EMPLOYEE	Reconciliation	OTHER	BUSI NESS	
	·	FLXT	EQUI P	BENEFITS		ADMI NI STRATI VE	OFFICE	
		(SQUARE	(DOLLAR	DEPARTMENT		AND GENERAL	(ACCUM. COST)	
		FEET)	VALUE)	(GROSS		(ACCUM. COST)		
		1.00	0.00	SALARI ES)	FA 04	F 04	F 00	
1. 00	Administrative and General	1.00	2.00	4.00	5A. 01	5. 01	5. 02 600, 497	1. 00
2.00	Skilled Nursing Care	1, 910	0	713, 969		,	000, 497	2. 00
3.00	Physical Therapy	0	0		1	,	0	3. 00
4.00	Occupational Therapy		0				0	4. 00
5. 00	Speech Pathology		0			, . – .	0	5. 00
6.00	Medical Social Services	l ő	0		ol o		Ö	6. 00
7. 00	Home Health Aide	l o	0				0	7. 00
8. 00	Supplies (see instructions)	0	0	Ċ	ol o		0	8. 00
9.00	Drugs	0	0	C	0		0	9. 00
10.00	DME	0	0	C	0	0	0	10.00
11. 00	Home Dialysis Aide Services	0	0	C	0	0	0	11.00
12.00	Respiratory Therapy	0	0	C	0	0	0	12.00
13. 00	Private Duty Nursing	0	0	C	0	0	0	13.00
14. 00	Clinic	0	0	C	0	0	0	14.00
15. 00	Health Promotion Activities	0	0	C	0	0	0	15. 00
16. 00	Day Care Program	0	0	C	0	0	0	16. 00
17. 00	Home Delivered Meals Program	0	0	(	0	0	0	17. 00
18.00	Homemaker Service	0	0		0	47, 529	0	18.00
19. 00 20. 00	All Others (specify)	1 010	0	712 046		1 200 504	600, 497	19. 00 20. 00
20.00	Total (sum of lines 1-19) Total cost to be allocated	1, 910 5, 988	0	713, 969 21, 702		1, 200, 504 182, 261	62, 466	21. 00
22. 00	Unit cost multiplier	3. 135079	0. 000000	0. 030396	•	0. 151820	0. 104024	22. 00
22.00	Cost Center Description	MAI NTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	22.00
	5651 CoCo. 26561 Pt. 6	REPAI RS	PLANT	LINEN SERVICE		(MEALS	(HOURS)	
		(SQUARE	(SQUARE	(POUNDS OF	FEET)	SERVED)	, ,	
		FEET)	FEET)	LAUNDRY)				
	1	6. 00	7. 00	8. 00	9. 00	10.00	11. 00	
1.00	Administrative and General	1, 910	1, 910	C	1 ., , , ,		0	1. 00
2.00	Skilled Nursing Care	0	0	C	1	0	0	2.00
3.00	Physical Therapy	0	0		0	0	0	3. 00
4. 00 5. 00	Occupational Therapy	0	0			_	0	4. 00 5. 00
6.00	Speech Pathology Medical Social Services		0			_	0	6. 00
7. 00	Home Heal th Aide		0			9	0	7. 00
8. 00	Supplies (see instructions)		0		1	_	0	8. 00
9. 00	Drugs	0	0	Ċ		0	0	9. 00
10. 00	DME	0	0	Ċ	ol o	0	0	10.00
11. 00	Home Dialysis Aide Services	0	0	C	ol o	0	0	11.00
12.00	Respiratory Therapy	0	0	C	0	0	0	12.00
13.00	Private Duty Nursing	0	0	C	0	0	0	13.00
14.00	Clinic	0	0	C	0	0	0	14.00
15. 00	Health Promotion Activities	0	0	C	0	0	0	15.00
16. 00	Day Care Program	0	0	C	0	0	0	16. 00
17. 00	Home Delivered Meals Program	0	0	C	0	0	0	17. 00
18.00	Homemaker Service	0	0	9	0	0	0	18.00
19.00	All Others (specify)	1 010	1 010		1 010	0	0	19.00
20. 00 21. 00	Total (sum of lines 1-19) Total cost to be allocated	1, 910 20, 993	1, 910 19, 806		1, 910 19, 269		0	20. 00 21. 00
	Unit cost nultiplier	10. 991099	10. 369634	0. 000000			0. 000000	
22.00	Tour cost mar tryiter	10. 771099	10. 307034	0.000000	/I 10. 000402	27.370090	0.000000	22.00

Health Financial Systems	WABASH COUNTY HOSPITA	AL	u of Form CMS-2552-10	
ALLOCATION OF GENERAL SERVICE COSTS TO BASIS		ovi der CCN: 151310 A CCN: 157061	Peri od: From 01/01/2014 To 12/31/2014	Worksheet H-2 Part II Date/Time Prepared: 5/27/2015 8:04 am

							Home Health	PPS	
							Agency I		_
	Cost Center Description	NURSI NG	CENTRAL		IARMACY	MEDI CAL			
		ADMI NI STRATI ON	SERVICES &		COSTED	RECORDS &			
		(0) 0507	SUPPLY	RE	QUIS.)	LI BRARY			
		(DI RECT	(COSTED			(GROSS REV)			
		NRSI NG HRS)	REQUIS.)		15.00	1/ 00	_		-
1 00		13. 00	14. 00		15. 00	16. 00			1 00
1.00	Administrative and General	0	0		0		0		1.00
2.00	Skilled Nursing Care	0	0		O		0		2. 00
3.00	Physi cal Therapy	0	0		0		0		3. 00
4.00	Occupational Therapy	0	0		0		0		4. 00
5.00	Speech Pathology	0	0		0		0		5. 00
6.00	Medical Social Services	0	0		0		0		6. 00
7. 00	Home Health Aide	0	0		0		0		7. 00
8. 00	Supplies (see instructions)	0	0		0		0		8. 00
9.00	Drugs	0	0		0		0		9. 00
10.00	DME	0	0		0		0		10.00
11.00	Home Dialysis Aide Services	0	0		0		0		11. 00
12.00	Respiratory Therapy	0	0		0		0		12. 00
13.00	Private Duty Nursing	0	0		0		0		13. 00
14.00	Clinic	0	0		0		0		14. 00
15.00	Health Promotion Activities	0	0		0		0		15. 00
16.00	Day Care Program	0	0		0		0		16. 00
17.00	Home Delivered Meals Program	0	0		0		0		17. 00
18. 00	Homemaker Service	0	0		0		0		18. 00
19.00	All Others (specify)	0	o		0		o		19. 00
20.00	Total (sum of lines 1-19)	0	0		0		O		20.00
21.00	Total cost to be allocated	0	ol		0		o		21. 00
22. 00	Unit cost multiplier	0. 000000	0. 000000		0.000000	0. 00000	o		22. 00

	n Financial Systems TIONMENT OF PATIENT SERVICE COST	rs .	WABASH COUNT		CCN: 151310	Peri od:	u of Form CMS-2 Worksheet H-3	
711 7 010	TOTAL OF TATLET SERVICE SSS			HHA CCN:		From 01/01/2014 To 12/31/2014	Part I Date/Time Prep 5/27/2015 8:04	pared:
				Ti tl	e XVIII	Home Health Agency I	PPS	
	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Ancillary Costs (from	Total HHA Costs (cols. + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col.	
		0	1.00	Part II)	2.00	4.00	4)	
	PART I - COMPUTATION OF LESSER	OF AGGREGATE F	1.00 PROGRAM COST, A	2.00 GGREGATE OF TH	3.00 HE PROGRAM LIN	4.00 MITATION COST, OF	5. 00	
	BENEFICIARY COST LIMITATION  Cost Per Visit Computation							1
1. 00	Skilled Nursing Care	2. 00			808, 25			1.00
2.00	Physical Therapy	3.00		0			161. 93	
3. 00 4. 00	Occupati onal Therapy Speech Pathology	4. 00 5. 00	57, 229 19, 950	0				
5. 00	Medical Social Services	6. 00			47		79. 33	
6. 00	Home Health Aide	7. 00	249, 285		249, 28	5, 624	44. 33	6.00
7. 00	Total (sum of lines 1-6)		1, 437, 356	0	.,,			7. 00
					Program Visit	rs art B		-
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject of Deductibles Coinsurance	to Subject to & Deductibles		
	,	0	1.00	2.00	3. 00	4. 00	5. 00	
8. 00	Limitation Cost Computation Skilled Nursing Care	1	15999	0	78	01		8.00
9. 00	Physical Therapy		15999	0	1, 10			9.00
10. 00	Occupational Therapy		15999	0	23			10.00
11. 00			15999	0	)	32		11.00
12.00	Medical Social Services Home Health Aide		15999 15999	0		0 97		12.00
13. 00 14. 00	l .		13999	0				14.00
11100	Cost Center Description	From Wkst. H-2	Facility Costs	Shared	Total HHA	Total Charges	Ratio (col. 3	1 11 00
		Part I, col. 28, line	(from Wkst. H-2, Part I)	Ancillary Costs (from Part II)	Costs (cols. + 2)	1 (from HHA Record)	÷ col. 4)	
	F-	0	1.00	2.00	3.00	4. 00	5. 00	
15. 00	Supplies and Drugs Cost Comput Cost of Medical Supplies	ations 8.00	22, 147	0	22, 14	17 214	103. 490654	15.00
16. 00		9. 00		O	1	0 1, 932	0. 000000	
			Program Visits		Cost of Services			
	Cost Center Description	Part A	Par Not Subject to		Part A	Part B Not Subject to	Subject to	
	cost center bescription	I di t A	Deductibles &	Deductibles &		Deductibles &	Deductibles &	
			Coi nsurance	Coi nsurance		Coi nsurance	Coi nsurance	
	DADT I COMPUTATION OF LECCED	6. 00	7. 00	8.00	9.00	10.00	11. 00	
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION Cost Per Visit Computation	OI AGGREGATE F	ROGRAW CUST, A	OUREURIE UF IH	IL PRUGRAW LIN	TITATION COST, OF		
1. 00	Cost Per Visit Computation Skilled Nursing Care	0	781			0 238, 838		1.00
2. 00	Physical Therapy	Ö	1, 102			0 178, 447		2. 00
3. 00	Occupational Therapy	0	235			0 32, 174		3.00
4.00	Speech Pathology	0	82 0			0 19, 022		4.00
5. 00 6. 00	Medical Social Services Home Health Aide		97			0 4, 300		5. 00 6. 00
7. 00	Total (sum of lines 1-6)	0	2, 297			0 472, 781		7. 00
	Cost Center Description	/ 00	7.00	0.00	0.00	10.00	11 00	
	Limitation Cost Computation	6. 00	7. 00	8. 00	9. 00	10.00	11. 00	
	El III tati dii cost collibutati dii							8.00
8. 00	Skilled Nursing Care							
9. 00	Skilled Nursing Care Physical Therapy							9.00
9. 00 10. 00	Skilled Nursing Care Physical Therapy Occupational Therapy							10.00
9. 00 10. 00 11. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology							10. 00 11. 00
9. 00 10. 00	Skilled Nursing Care Physical Therapy Occupational Therapy							10. 00 11. 00 12. 00 13. 00

	Financial Systems		WABASH COUNT	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORT	TONMENT OF PATIENT SERVICE COST	S		HHA CCN:	CCN: 151310 157061		5/27/2015 8:0	pared:
					e XVIII	Home Health Agency I	PPS	
		Prog	ram Covered Cha	arges	Cost of Services			
	Cost Center Description	Part A	Not Subject to	t B Subject to Deductibles & Coinsurance	Part A	Part B Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6. 00	7. 00	8. 00	9. 00	10.00	11. 00	
	Supplies and Drugs Cost Computa		1	1				
	Cost of Medical Supplies Cost of Drugs	0	0 1, 932			0	0	15. 00 16. 00
	Cost Center Description	Total Program Cost (sum of cols. 9-10) 12.00						_
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION		PROGRAM COST, A	AGGREGATE OF TH	HE PROGRAM LI	MITATION COST, OF	2	
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	238, 838						1.00
2.00	Physical Therapy	178, 447						2. 00
3.00	Occupational Therapy	32, 174						3. 00
4. 00 5. 00	Speech Pathology Medical Social Services	19, 022 0						4. 00 5. 00
6.00	Home Health Aide	1						6.00
7. 00	Total (sum of lines 1-6)	4, 300 472, 781						7.00
7.00	Cost Center Description	472, 701						7.00
	oost deliter beschiptron	12. 00						1
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
9.00	Physi cal Therapy							9. 00
10.00	Occupational Therapy							10. 00
11. 00	Speech Pathology							11. 00
12. 00	Medical Social Services							12. 00
13.00	Home Heal th Aide							13.00
14. 00	Total (sum of lines 8-13)							14. 00

Heal th	Financial Systems	WABASH COUNTY HOSPITAL					In Lieu of Form CMS-2552		
APP0R	FIONMENT OF PATIENT SERVICE COST	S			Provi der		Peri od:	Worksheet H-3	
					HHA CCN:	157061	From 01/01/2014 To 12/31/2014		
					Ti tl	e XVIII	Home Health	PPS	
							Agency I		
	Cost Center Description	From Wkst. C,	Cost to Charge	To	tal HHA	HHA Shared	Transfer to		
		Part I, col.	Rati o	Char	ge (from	Ancillary	Part I as		
		9, line		pr	ovi der	Costs (col.	1 Indicated		
				re	ecords)	x col. 2)			
		0	1. 00		2.00	3. 00	4. 00		
	PART II - APPORTIONMENT OF COST	T OF HHA SERVIC	ES FURNI SHED B	Y SHA	ARED HOSPI	TAL DEPARTMEN	ITS		
1.00	Physi cal Therapy	66. 00	0. 750205		0		0 col. 2, line 2	. 00	1.00
2.00	Occupational Therapy								2.00
3.00	Speech Pathology								3.00
4.00	Cost of Medical Supplies	71. 00	0. 596313		0		0 col. 2, line 1	5. 00	4.00
5.00	Cost of Drugs	73. 00	0. 210982		0		0 col. 2, line 1	6. 00	5. 00

				Worksheet H-4	r
	HHA CCN:	157061	From 01/01/2014 To 12/31/2014		
	Ti tl	e XVIII	Home Health Agency I	PPS	
		Part A	Not Subject to Deductibles & Coinsurance		
		1. 00	2. 00	3. 00	
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTON	MARY CHARGE	S			
Reasonable Cost of Part A & Part B Services				1	
Reasonable cost of services (see instructions) Total charges			0 0 305, 769		
Customary Charges			0 303, 704	0	<u> </u>
Amount actually collected from patients liable for payment for on a charge basis (from your records)	servi ces		0 0	0	) :
Amount that would have been realized from patients liable for for services on a charge basis had such payment been made in a with 42 CFR §413.13(b)			0 0	0	) 4
Ratio of line 3 to line 4 (not to exceed 1.000000)		0. 0000			
Total customary charges (see instructions)  Excess of total customary charges over total reasonable cost (	complete		0 305, 769 0 305, 769		
only if line 6 exceeds line 1)  Excess of reasonable cost over customary charges (complete only 1 exceeds line 6)	yifline		0 0	0	
Primary payer amounts			0 0	0	
			Part A	Part B	
			Servi ces 1.00	Servi ces 2.00	+
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			1.00	2.00	
Total reasonable cost (see instructions)			0	0	1
OO Total PPS Reimbursement - Full Episodes without Outliers			0		
Total PPS Reimbursement - Full Episodes with Outliers			0	3, 064	
00  Total PPS Reimbursement - LUPA Episodes 00  Total PPS Reimbursement - PEP Episodes			0	8, 488	
00   Total PPS Reimbursement - PEP Episodes 00   Total PPS Outlier Reimbursement - Full Episodes with Outliers			0	4, 091 4, 386	
00   Total PPS Outlier Reimbursement - PEP Episodes			0	4, 300	
O Total Other Payments			0	ő	
DME Payments			0	0	) 1
Oxygen Payments			0	0	) 1
Prosthetic and Orthotic Payments			0	_	
Part B deductibles billed to Medicare patients (exclude coinsu	rance)			0	
OO Subtotal (sum of lines 10 thru 20 minus line 21)			0		
00   Excess reasonable cost (from line 8) 00   Subtotal (line 22 minus line 23)			0	0 387, 435	
00   Subtotal (line 22 minus line 23) 00   Coinsurance billed to program patients (from your records)			0	0	
00 Net cost (line 24 minus line 25)			0		
Reimbursable bad debts (from your records)				337, 133	2
00 Reimbursable bad debts for dual eligible beneficiaries (see in:	structions)				2
Total costs - current cost reporting period (line 26 plus line			0	387, 435	
OO OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	_	1 .
Pioneer ACO demonstration payment adjustment (see instructions	)		0	0	
OU Subtotal (see instructions)			0		
On Sequestration adjustment (see instructions)			0	7, 749	
On Interim payments (see instructions)			0	379, 686	
00  Tentative settlement (for contractor use only) 00  Balance due provider/program (line 31 minus lines 31.01, 32, a	nd 33)		0	0	
DO Protested amounts (nonallowable cost report items) in accordan	,	Pub 15_2		0	

In Lieu of Form CMS-2552-10

 
 Heal th
 Financial
 Systems
 WABASH
 COUNTY
 HOSPITAL

 ANALYSIS
 OF
 PAYMENTS
 TO
 PROVI DER-BASED
 HHAS
 FOR
 SERVI CES
 RENDERED
 TO
 Provi of the provided Provider CCN: 151310 PROGRAM BENEFICIARIES HHA CCN:

				Home Health Agency I	PPS	
		I npati en	t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,			) )	379, 686 0	1. 00 2. 00
3.00	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) Program to Provider					3. 00
3. 01	11 ogram to 11 ovrder		(		0	3. 01
3. 02					l ol	3. 02
3. 03			(		0	3. 03
3.04			(		0	3. 04
3.05			(	)	0	3.05
	Provider to Program			-		
3.50				O O	0	3. 50
3. 51					0	3. 51
3.52					0	3. 52
3. 53 3. 54					0 0	3. 53 3. 54
3. 54 3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines					3. 54 3. 99
3. 99	3. 50-3. 98)		\		١	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		(	D	379, 686	4. 00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
	Program to Provider					
5. 01				O O	0	5. 01
5. 02					0	5. 02
5. 03	Dravi dan ta Dragnam				0	5. 03
5. 50	Provider to Program		,		0	5. 50
5. 51						5. 51
5. 52					l ol	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		(	D	0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER			D	0	6. 01
6. 02	SETTLEMENT TO PROGRAM				0	6. 02
7. 00	Total Medicare program liability (see instructions)			0	379, 686	7. 00
		,	)	Contractor Number	NPR Date (Mo/Day/Yr)	
8. 00	Name of Contractor		)	1. 00	2.00	8. 00
0.00	Intallic of Collet actor	I		T	ı l	0.00

			Hospi ce (		0 12/31/2014	Date/Time Pre	
					Hospi ce I	5/27/2015 8:0	4 alli
		Salaries (from	Employee	Transportati on		Other	
			Benefits (from		Services (from	Other	
		mkst. k i)	Wkst. K-2)	(300 11131.)	Wkst. K-3)		
		1.00	2.00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS				'		
1.00	Capital Related Costs-Bldg and Fixt.			0		0	1. 00
2.00	Capital Related Costs-Movable Equip.			0		0	2. 00
3.00	Plant Operation and Maintenance	C	0	0	o	0	3. 00
4.00	Transportation - Staff	C	0	0	0	0	4. 00
5.00	Volunteer Service Coordination	C	0	0	o	0	5. 00
6.00	Administrative and General	365, 105	157, 398	26, 345	0	0	6. 00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	C	0			0	7. 00
8.00	Inpatient - Respite Care	C	0	0	0	0	8. 00
	VISITING SERVICES						
9.00	Physi ci an Servi ces	C	0	· -		25, 126	9. 00
10.00	Nursing Care	C	0	0	0	0	10. 00
11. 00	Nursing Care-Continuous Home Care	C	0	0	0	0	11. 00
12.00	Physi cal Therapy	C	0	0	0	0	
13. 00	Occupational Therapy	C	0	0	0	0	13. 00
14. 00	Speech/ Language Pathology	C	0	0	0	0	14. 00
15. 00	Medical Social Services	C	0	0	0	0	15. 00
16. 00	Spiritual Counseling	C	0	0	0	0	16. 00
17. 00	Di etary Counseling	C	0	0	0	0	17. 00
18. 00	Counseling - Other	C	0	0	0	0	18. 00
19. 00	Home Health Aide and Homemaker	C	0	0	١	0	19. 00
20. 00	HH Aide & Homemaker - Cont. Home Care	C	0	0		0	20. 00
21. 00	Other	C	0	0	0	0	21. 00
	OTHER HOSPICE SERVICE COSTS	1		1		74 440	
	Drugs, Biological and Infusion Therapy	C	-			71, 118	1
	Anal gesi cs		0	0	0	0	23. 00
	Sedatives / Hypnotics				0	0	24. 00
25. 00	Other - Specify		0		0	0	25. 00
26. 00	Durable Medical Equipment/Oxygen				0	53, 594	1
27. 00	Pati ent Transportation			0	-	0	27. 00
28. 00	I maging Services			0	-	0	28. 00
29. 00	Labs and Diagnostics			0	0	4 001	29. 00
	Medical Supplies				0	4, 081	1
31. 00	Outpatient Services (including E/R Dept.)				0	0	
32. 00	Radi ati on Therapy				0	0	32.00
33. 00 34. 00	Chemotherapy Other			0	-	0	
34.00	HOSPI CE NONREI MBURSABLE SERVI CE		ıl U	ıl U	l d	U	34.00
35. 00	Bereavement Program Costs		) 0	0	ol	0	35. 00
36. 00	Volunteer Program Costs					0	36.00
37. 00	Fundrai si ng					0	37.00
38. 00	Other Program Costs					0	
	Total (sum of lines 1 thru 38)	365, 105	157, 398	26, 345		153, 919	1
37.00	Trotal (Sum of Fried Fried 10)	1 303, 103	137,370	1 20, 343	ı Y	100, 717	1 37.00

WABASH COUNTY HOSPITAL			In Lieu of Form CMS-2552-1			
		Provi der	CCN: 151310		Worksheet K	
		Hospi ce C	CCN: 151545	To 12/31/2014		
				Hospi ce I		
Total (cols.	Recl a	ssi fi cati	Subtotal (col	. Adjustments	Total (col. 8	
1-5)		on	6 ± col. 7)		± col. 9)	
	Total (cols.	Total (cols. Recla	Provi der Hospi ce ( Total (cols. Reclassi fi cati	Provi der CCN: 151310 Hospi ce CCN: 151545  Total (cols. Reclassificati Subtotal (cols.)	Provi der CCN: 151310 Peri od: From 01/01/2014 To 12/31/2014  Hospi ce CCN: 151545 To 12/31/2014  Hospi ce I  Total (col s. Recl assi fi cati   Subtotal (col .   Adj ustments	Provider CCN: 151310

						5/27/2015 8:0	<u>4 am</u>
					Hospi ce I		
		Total (cols.	Recl assi fi cati	Subtotal (col	. Adjustments	Total (col. 8	
		1-5)	on	$6 \pm col. 7$	,	± col. 9)	
		6.00	7.00	8.00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS				•		
1.00	Capital Related Costs-Bldg and Fixt.	0	C	)	0 0	0	1.00
2.00	Capital Related Costs-Movable Equip.	0			0	0	2.00
3. 00	Plant Operation and Maintenance	0		,	0	0	3. 00
4. 00	Transportation - Staff	0		,	0	0	4. 00
5. 00	Volunteer Service Coordination	0			0	0	5. 00
6. 00	Administrative and General	548, 848		548, 84	-	1	6.00
0.00	I NPATI ENT CARE SERVI CE	340, 040		3+0,0+	5  0	340, 040	0.00
7.00	Inpatient - General Care	0	С	l .	0 0	0	7. 00
8. 00	Inpatient - Respite Care	0	1	l .		l .	8.00
0.00	VI SI TI NG SERVI CES			1	5	0	0.00
9. 00	Physician Services	25, 126		25, 12	6 0	25, 126	9. 00
10. 00	Nursing Care	25, 120		,		,	10.00
11. 00	Nursing Care-Continuous Home Care	0				0	11.00
12. 00	Physical Therapy	0		•			12.00
	Occupational Therapy	0				0	•
13.00		0					13.00
14. 00 15. 00	Speech/ Language Pathology Medical Social Services	0		1	0	0	14. 00 15. 00
		0			٥		
16.00	Spiritual Counseling	0		1	0	0	16.00
17. 00	Di etary Counsel i ng	0			0	0	17. 00
18.00	Counseling - Other	0			0	0	18.00
19. 00	Home Health Aide and Homemaker	0			0	0	19. 00
20. 00	HH Aide & Homemaker - Cont. Home Care	0	C	1	0	1	20.00
21. 00	Other	0	C	1	0	0	21. 00
	OTHER HOSPICE SERVICE COSTS						
22. 00	Drugs, Biological and Infusion Therapy	71, 118	C	1		,	
23. 00	Anal gesi cs	0		1	0	0	23. 00
24. 00	Sedatives / Hypnotics	0		1	0	0	24. 00
25. 00	Other - Specify	0			0	0	25. 00
26. 00	Durable Medical Equipment/Oxygen	53, 594		53, 59	4 0	53, 594	26. 00
27. 00	Patient Transportation	0		1	0	0	27. 00
28. 00	I maging Services	0		1	0	0	28. 00
29. 00	Labs and Diagnostics	0	C		0	0	29. 00
30.00	Medical Supplies	4, 081	C	4, 08		4, 081	30. 00
31. 00	Outpatient Services (including E/R Dept.)	0	C		0	0	31. 00
32. 00	Radiation Therapy	0	C		0	0	32. 00
33. 00	Chemotherapy	0	C	l .	0	0	33. 00
34.00	Other	0	C		0	0	34. 00
	HOSPICE NONREIMBURSABLE SERVICE						
35. 00	Bereavement Program Costs	0	C	1	0	l	35. 00
36. 00	Volunteer Program Costs	0	C		0	1	36. 00
37.00	Fundrai si ng	0	[ C	1	0 (C	0	37. 00
38. 00	Other Program Costs	0	C		0 (C	0	38. 00
39.00	Total (sum of lines 1 thru 38)	702, 767	[ c	702, 76	7 0	702, 767	39. 00

Health Financial Systems
HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES WABASH COUNTY HOSPITAL In Lieu of Form CMS-2552-10

			Hospi ce (	CN: 151545	10 12/31/2014	5/27/2015 8:0	
					Hospi ce I	3/2//2013 0.0	7 <del>-1 alli</del>
		Admi ni strator	Di rector	Soci al	Supervi sors	Nurses	
				Servi ces			
	I	1.00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS	T T		Τ			
1.00	Capital Related Costs-Bldg and Fixt.						1. 00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0		0	0	
4.00	Transportation - Staff	0	0		0	0	
5.00	Volunteer Service Coordination	0	0		0	0	
6. 00	Administrative and General	0	0		0 0	0	6. 00
7.00	I NPATI ENT CARE SERVI CE						7 00
7.00	Inpatient - General Care	0	0		0		1
8.00	Inpatient - Respite Care	0	0		0 0	0	8. 00
0.00	VI SI TI NG SERVI CES						0.00
9.00	Physi ci an Servi ces	0	0		0	0	
10.00	Nursing Care	0	0		0	0	
11.00	Nursing Care-Continuous Home Care	0	0		0	0	
12.00	Physical Therapy	0	0		0	0	
13.00	Occupational Therapy	0	0		0	0	
14. 00	Speech/ Language Pathology	0	0		0	0	
15.00	Medical Social Services	0	0		0	0	
16.00	Spiritual Counseling	0	0		0	0	
17. 00	Di etary Counsel i ng	0	0		0	0	
18.00	Counseling - Other	0	0		0	0	
19. 00	Home Health Aide and Homemaker	0	0		0	0	
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		0	0	
21. 00	Other	0	0		0 0	0	21. 00
22.00	OTHER HOSPICE SERVICE COSTS	T		I			22. 00
22. 00	Drugs, Biological and Infusion Therapy						23. 00
23. 00 24. 00	Anal gesics Sedatives / Hypnotics						24. 00
25. 00	7.						25. 00
26. 00	Other - Specify Durable Medical Equipment/Oxygen						26. 00
27. 00	Patient Transportation		0		0	O	
28. 00	Imaging Services		0		0 0	0	1
29. 00	Labs and Diagnostics		0		0 0	0	
30.00	Medical Supplies		0		0	0	
31. 00	Outpatient Services (including E/R Dept.)		0		0 0	0	
32. 00	Radi ati on Therapy		0		0 0	0	
32.00	Chemotherapy	0	0		0 0	0	1
34. 00	Other	0	0		0	0	
34.00	HOSPI CE NONREI MBURSABLE SERVI CE	<u> </u>	0		J <sub>1</sub> 0		34.00
35. 00		0	0		0 0	0	35. 00
36. 00	Volunteer Program Costs		0		0 0	0	
37. 00	Fundrai si ng		0		0 0	0	
38. 00	Other Program Costs		0		0 0	0	
	Total (sum of lines 1 thru 38)		0		0 0		
37.00	1.000. (00 01 111100 1 1111 0 00)	١	O	'	0		1 37. 00

	Financial Systems	WABASH COUNT				u of Form CMS-2552-10
HOSPI C	E COMPENSATION ANALYSIS SALARIES AND WAGES		Provi der	CCN: 151310	Peri od: From 01/01/2014	Worksheet K-1
			Hospi ce	CCN: 151545	To 12/31/2014	Date/Time Prepared: 5/27/2015 8:04 am
					Hospi ce I	6, 2, 7, 2010 0, 0, 1 d.ii
		Total Therapi sts	Ai des	All-Other	Total (1)	
		6.00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS					
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2. 00
3.00	Plant Operation and Maintenance		(	O	0 0	3. 00
4.00	Transportation - Staff		(	0	0 0	4. 00
5.00	Volunteer Service Coordination		(	0	0 0	5. 00
6.00	Administrative and General		(	365, 1	05 365, 105	6. 00
7 00	I NPATI ENT CARE SERVI CE				0	7.00
7. 00 8. 00	Inpatient - General Care			) )	0 0	
8.00	Inpatient - Respite Care VISITING SERVICES			٧	U U	8.00
9. 00	Physi ci an Servi ces				0 0	9. 00
	Nursing Care				0	10.00
	Nursing Care-Continuous Home Care				0 0	11. 00
	Physical Therapy	0		Ď	0 0	12. 00
	Occupational Therapy	0			0 0	13. 00
	Speech/ Language Pathology	0			0 0	14. 00
	Medical Social Services		(		0 0	15. 00
16.00	Spiritual Counseling		(	o	0 0	16. 00
17.00	Di etary Counseling		(	o	0 0	17. 00
18.00	Counseling - Other		(	o	0 0	18. 00
19.00	Home Health Aide and Homemaker		(	0	0 0	19. 00
20.00	HH Aide & Homemaker - Cont. Home Care		(	0	0 0	20. 00
21. 00			(	)	0 0	21. 00
	OTHER HOSPICE SERVICE COSTS					
	Drugs, Biological and Infusion Therapy					22. 00
23. 00	Anal gesi cs					23. 00

24. 00 25. 00

26.00

27.00

28.00

29. 00

30.00

31.00

32.00

33.00

34.00

35.00

36.00

37.00

38.00

39. 00

0 0 0

0

365, 105

0 0 0

0

0 0 0

365, 105

Sedatives / Hypnotics Other - Specify

I maging Services Labs and Diagnostics

27.00 Patient Transportation

Medical Supplies

Radiation Therapy

 ${\tt Chemotherapy}$ 

0ther

37.00 Fundrai si ng

Durable Medical Equipment/Oxygen

HOSPICE NONREIMBURSABLE SERVICE

 $\hbox{\tt Bereavement Program Costs}$ 

Volunteer Program Costs

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

Outpatient Services (including E/R Dept.)

24.00

25.00

26.00

28.00

29.00

30.00

32. 00 33. 00

34.00

35.00

36.00

 
 Heal th Financial
 Systems
 WABASH COUNTY HOSPITAL

 HOSPICE
 COMPENSATION ANALYSIS EMPLOYEE BENEFITS (PAYROLL RELATED)
 Provi
 Provider CCN: 151310 | Period: From 01/01/2014 | Date/Time Prepared: 5/27/2015 8:04 am

				7011	12, 01, 2011	5/27/2015 8:0	4 am
					Hospi ce I		
		Admi ni strator	Director	Soci al Servi ces	Supervi sors	Nurses	
		1.00	2. 00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance		O	,	0 0	0	
4. 00	Transportation - Staff		0		0 0	0	
5. 00	Volunteer Service Coordination		Ö		0 0	0	
6. 00	Administrative and General		0	1	0 0	0	
0.00	I NPATI ENT CARE SERVI CE	<u> </u>		1	<u> </u>	<u> </u>	0.00
7.00	Inpatient - General Care	O	C	ı	0 0	0	7. 00
8.00	Inpatient - Respite Care	o	0		0 0		1
0.00	VI SI TI NG SERVI CES	<u> </u>		1	<u> </u>		0.00
9. 00	Physi ci an Servi ces	O	0		0 0	0	9.00
10. 00	Nursing Care		Ö	1		0	
11. 00	Nursing Care-Continuous Home Care		0		0 0	0	
12. 00	Physical Therapy		0			0	1
13. 00	Occupational Therapy		0		0 0	0	
14. 00	Speech/ Language Pathology		0			0	1
15. 00	Medical Social Services		0		0 0	0	
16. 00	Spiritual Counseling		0		0 0	0	1
17. 00	Di etary Counsel i ng		0		0 0	0	
18. 00	Counseling - Other		0		0 0	0	1
19. 00	Home Health Aide and Homemaker		0		0 0	0	1
20. 00	HH Aide & Homemaker - Cont. Home Care		0		0 0	0	
21. 00	Other		0	1	0 0	0	
	OTHER HOSPICE SERVICE COSTS	-1	-			_	1
22. 00	Drugs, Biological and Infusion Therapy						22. 00
23. 00	Anal gesi cs						23. 00
24. 00	Sedatives / Hypnotics						24. 00
25. 00	Other - Specify						25. 00
26. 00	Durable Medical Equipment/Oxygen						26. 00
27. 00	Pati ent Transportation	ol	0	,	0 0	0	27. 00
28. 00	I maging Services	ol	0	,	0 0	0	28. 00
29. 00	Labs and Diagnostics	ol	0	,	0 0	0	29. 00
30.00	Medical Supplies	ol	0	,	0 0	0	30.00
31. 00	Outpatient Services (including E/R Dept.)	ol	0	,	0 0	0	31.00
32. 00	Radi ati on Therapy	o	0		0 0	0	32. 00
33. 00	Chemotherapy	ol	0		o o	0	
34. 00	Other		0	1	0 0	0	
	HOSPI CE NONREI MBURSABLE SERVI CE	-1	-			_	1
35.00	Bereavement Program Costs	O	0		0 0	0	35. 00
36. 00	Volunteer Program Costs	ol	0	l .	0 0	0	
37. 00	Fundrai si ng		0	,	0 0	0	
38. 00	Other Program Costs	o	O		0 0	0	
	Total (sum of lines 1 thru 38)	0	O		0 0		
				•	•	•	

Health Financial Systems		WABASH COUNT	Y HOSPITAL	u of Form CMS-	2552-10		
HOSPICE COMPENSATION ANA	PAYROLL RELATED)	Provi der		Period: From 01/01/2014	Worksheet K-2	2	
			Hospi ce (	CCN: 151545	To 12/31/2014	Date/Time Pre 5/27/2015 8:0	
					Hospi ce I		
		Total	Ai des	All-Other	Total (1)		
		Therapi sts					
		6. 00	7. 00	8. 00	9. 00		
GENERAL SERVICE CO	ST CENTERS						
1.00 Capital Related Co	sts-Bldg and Fixt.						1.00
2.00 Capital Related Co	sts-Movable Equip.						2.00
0 00   D1		1	1	.I			1 2 22

		Total	Ai des	All-Other	Total (1)		
		Therapists 6.00	7. 00	8. 00	9. 00	+	
	GENERAL SERVICE COST CENTERS	0.00	7.00	8.00	7.00		
1. 00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3. 00	Plant Operation and Maintenance		0		0		3. 00
4. 00	Transportation - Staff		0		0		4. 00
5.00	Volunteer Service Coordination		0	0	0		5. 00
6. 00	Administrative and General		0	· ·	157, 398		6. 00
6.00			0	157, 398	157, 398		0.00
7 00	I NPATI ENT CARE SERVI CE		0		0		7 00
7.00	Inpatient - General Care		0		0	1	7. 00
8. 00	Inpatient - Respite Care		0	0	0	1	8. 00
	VI SI TI NG SERVI CES						4
9.00	Physi ci an Servi ces		0	· ·	0		9. 00
10.00	Nursing Care		0	-	0	1	10.00
	Nursing Care-Continuous Home Care	_	0	0	0		11. 00
	Physical Therapy	0	0	0	0		12. 00
	Occupational Therapy	0	0	0	0		13. 00
	Speech/ Language Pathology	0	0	0	0		14. 00
	Medical Social Services		0	1	0		15. 00
	Spiritual Counseling		0	1	0	4	16. 00
	Dietary Counseling		0	0	0		17. 00
18. 00	Counseling - Other		0	0	0		18. 00
19. 00	Home Health Aide and Homemaker		0	0	0	4	19. 00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0	4	20. 00
21.00	Other		0	0	0	,	21. 00
	OTHER HOSPICE SERVICE COSTS						
22. 00	Drugs, Biological and Infusion Therapy						22. 00
23.00	Anal gesi cs						23. 00
24.00	Sedatives / Hypnotics						24. 00
25. 00	Other - Specify						25. 00
26.00	Durable Medical Equipment/Oxygen						26. 00
27. 00	Patient Transportation		0	0	0	,	27. 00
28. 00	I maging Services		0	0	0	,	28. 00
29. 00	Labs and Diagnostics		0	0	0	,	29. 00
30.00	Medical Supplies		0	o	0	,	30.00
31. 00	Outpatient Services (including E/R Dept.)		0	0	0	,	31.00
32. 00	Radi ati on Therapy		0	0	0	,	32.00
33. 00	Chemotherapy		0	-	0	,	33. 00
34. 00	Other		0		0	1	34. 00
34.00	HOSPI CE NONREI MBURSABLE SERVI CE			<u> </u>			34.00
35 00	Bereavement Program Costs		0	0	0		35. 00
36. 00	Volunteer Program Costs		0	-	0	,	36. 00
37. 00	Fundrai si ng		0		0	.]	37. 00
38. 00	Other Program Costs		0		0	.]	38. 00
	Total (sum of lines 1 thru 38)	0	0	-	157, 398	J	39. 00
37.00	Total (Sum Of Titles I till a 30)	ı Y	U	107, 390	107, 390	I	J 37. UU

 SPITAL
 In Lieu of Form CMS-2552-10

 Provider CCN: 151310
 Period: From 01/01/2014
 Worksheet K-4 Part I

 Hospice CCN: 151545
 To 12/31/2014
 Date/Time Prepared: Part I

			nospi ce c	CN. 151545	10 12/31/2014	5/27/2015 8: 0	
					Hospi ce I	3, 2, 2, 2, 2, 2	
			CAPITAL RE	LATED COST			
		NET EXPENSES	BUI LDI NGS &	MOVABLE	PLANT	TRANSPORTATION	
		FOR COST	FI XTURES	EQUI PMENT	OPERATION &		
		ALLOCATI ON			MAI NT.		
		0	1.00	2. 00	3. 00	4. 00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1.00
2.00	Capital Related Costs-Movable Equip.	0	_		0		2. 00
3.00	Plant Operation and Maintenance	0	0		0		3. 00
4. 00	Transportation - Staff	0	0		0	0	4. 00
5. 00	Volunteer Service Coordination	o o	0				5.00
6. 00	Administrative and General	548, 848	0				6. 00
0.00	I NPATI ENT CARE SERVI CE	0 10, 0 10			<u> </u>		0.00
7. 00	Inpatient - General Care	O	0		0 0	0	7.00
8. 00	Inpatient - Respite Care		0				8.00
0.00	VI SI TI NG SERVI CES	<u> </u>		l	0		0.00
9. 00	Physi ci an Servi ces	25, 126	0		0 0	0	9. 00
10. 00	Nursing Care	20, 120	0				10.00
11. 00	Nursing Care-Continuous Home Care		0		0		11.00
12. 00	Physical Therapy		0			1	12.00
13. 00	Occupational Therapy		0				13.00
14. 00			0			_	14. 00
15. 00	Speech/ Language Pathology		0				15.00
16. 00	Medical Social Services	0	0				16.00
	Spiritual Counseling		0			0	17. 00
17. 00	Di etary Counsel i ng	0	0			1	
18.00	Counseling - Other		0		-	0	18.00
19. 00	Home Health Aide and Homemaker	0	0		0 0	_	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		0 0	_	20.00
21. 00	Other	Ŭ	0		0 0	0	21. 00
22.00	OTHER HOSPICE SERVICE COSTS	71 110		I		0	22.00
22. 00	Drugs, Biological and Infusion Therapy	71, 118	0		0 0		22. 00
23. 00	Anal gesi cs	0	0		0 0		23. 00
24. 00	Sedatives / Hypnotics	0	0		0 0	0	24. 00
25. 00	Other - Specify	50 504	0		0 0	_	25. 00
26.00	Durable Medical Equipment/Oxygen	53, 594	0		0 0	1	26.00
27. 00	Pati ent Transportation	0	0		0 0		27. 00
28. 00	I maging Services	0	0		0 0	_	28. 00
29. 00	Labs and Diagnostics	0	0		0	0	29. 00
30.00	Medical Supplies	4, 081	0		0 0		30.00
31.00	Outpatient Services (including E/R Dept.)	0	0		0 0	0	31.00
32. 00	Radi ati on Therapy	0	0		0 0	_	32. 00
33. 00	Chemotherapy	0	0		0 0		33. 00
34. 00	Other	] 0	0		0 0	0	34. 00
	HOSPICE NONREIMBURSABLE SERVICE					1	
	Bereavement Program Costs	0	0		0 0		35. 00
36.00	Volunteer Program Costs	0	0		0		36. 00
37. 00	Fundrai si ng	0	0		0 0	0	37. 00
38. 00	Other Program Costs	0	0		0 0		38. 00
39. 00	Total (sum of lines 1 thru 38)	702, 767	0	l	0 0	0	39. 00

Health Financial Systems	WABASH COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION - HOSPICE GENERAL SERVICE COST	Provi der CCN: 151310	Period: Worksheet K-4 From 01/01/2014 Part I

151545 To 12/31/2014 Date/Time Prepared: Hospi ce CCN: 5/27/2015 8:04 am Hospi ce I VOLUNTEER SUBTOTAL ADMINISTRATIVE TOTAL (col. 5A SERVI CES (cols. 0 - 5)& GENERAL ± col. 6) COORDI NATOR 5A 6.00 7. 00 5.00 GENERAL SERVICE COST CENTERS Capital Related Costs-Bldg and Fixt. 1.00 2.00 Capital Related Costs-Movable Equip. 2.00 3.00 Plant Operation and Maintenance 3.00 4.00 Transportation - Staff 4.00 5.00 Volunteer Service Coordination 5.00 Administrative and General 0 548, 848 548, 848 6.00 6.00 INPATIENT CARE SERVICE Inpatient - General Care Inpatient - Respite Care 7.00 0 0 7.00 8.00 0 0 8.00 0 VISITING SERVICES 9.00 Physician Services 0 25, 126 89, 595 114, 721 9.00 10.00 Nursing Care 00000000000 10.00 Nursing Care-Continuous Home Care 0 11.00 0 0 11.00 0 12.00 Physical Therapy 0 0 12.00 13.00 Occupational Therapy 13.00 0 0 0 0 0 14.00 Speech/ Language Pathology 14.00 Medical Social Services 0 0 15.00 15.00 16.00 Spiritual Counseling 0 16.00 Dietary Counseling 0 0 17.00 17.00 0 0 0 Counseling - Other 0 18.00 18.00 0 0 19.00 Home Health Aide and Homemaker 19.00 0 20.00 HH Aide & Homemaker - Cont. Home Care 0 0 20.00 0 21.00 0ther 0 0 21.00 OTHER HOSPICE SERVICE COSTS 0 22.00 Drugs, Biological and Infusion Therapy 71, 118 253, 594 324, 712 22.00 23.00 Anal gesi cs 0 23.00 24.00 Sedatives / Hypnotics 0 0 0 0 0 0 0 0 0 0 ol 24.00 25.00 Other - Specify 25.00 26.00 Durable Medical Equipment/Oxygen 53, 594 191, 107 244, 701 26.00 27.00 Patient Transportation 0 0 27.00 28 00 Imaging Services 0 0 28.00 Labs and Diagnostics 29.00 0 29.00 30.00 Medical Supplies 4, 081 14, 552 18, 633 30.00 31.00 Outpatient Services (including E/R Dept.) C 0 31.00 32 00 Radiation Therapy 0 0 32.00 Ω 0 33.00 33.00 Chemotherapy C 0 34.00 34.00 HOSPICE NONREIMBURSABLE SERVICE 35.00 Bereavement Program Costs 0 0 0 0 0 0 35.00 0 0 36.00 Volunteer Program Costs C 0 36.00 37.00 Fundrai si ng 0 0 37.00

0

702, 767

0

702, 767

38.00

39.00

Other Program Costs

39.00 Total (sum of lines 1 thru 38)

38.00

						5/27/2015 8:0	4 am
					Hospi ce I		
		CAPITAL RE	LATED COST				
		BUILDINGS &	MOVABLE	PLANT	TRANSPORTATI ON	VOLUNTEER	
		FIXTURES (SQ.	EQUIPMENT (\$	OPERATION &	(MI LEAGE)	SERVI CES	
		FT.)	VALUE)	MAINT. (SQ.		COORDI NATOR	
		,	ŕ	FT. )		(HOURS)	
		1.00	2. 00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS				•		
1.00	Capital Related Costs-Bldg and Fixt.	0					1.00
2.00	Capital Related Costs-Movable Equip.	0	0				2. 00
3.00	Plant Operation and Maintenance	0	0				3. 00
4. 00	Transportation - Staff	0	0		0		4. 00
5. 00	Volunteer Service Coordination	o o	Ö		0		5. 00
6. 00	Administrative and General	0	0		o o		
0.00	I NPATI ENT CARE SERVI CE				<u> </u>	0	0.00
7. 00	Inpatient - General Care	0	0		0 0	0	7.00
8. 00	Inpatient - Respite Care	0					8.00
8.00	VI SI TI NG SERVI CES				J 0	0	0.00
9. 00		0	0		0 0	0	9. 00
	Physician Services	0	0			-	1
10.00	Nursing Care	0	_			-	10.00
11. 00	Nursing Care-Continuous Home Care	0	0		0	_	11.00
12.00	Physi cal Therapy	0	0		0	-	12.00
13. 00	Occupational Therapy	0	0		0	-	13. 00
14. 00	Speech/ Language Pathology	0	0	1	0	0	14. 00
15. 00	Medical Social Services	0	0		0		15. 00
16. 00	Spiritual Counseling	0	0		0	0	16. 00
17. 00	Di etary Counseling	0	0		0	-	17. 00
18. 00	Counseling - Other	0	0		0	0	18. 00
19. 00	Home Health Aide and Homemaker	0	0	•	0	0	19. 00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		0		20. 00
21. 00	Other	0	0	(	0	0	21. 00
	OTHER HOSPICE SERVICE COSTS						
22. 00	Drugs, Biological and Infusion Therapy	0	0		0	0	22. 00
23.00	Anal gesi cs	0	0		0	0	23. 00
24.00	Sedatives / Hypnotics	0	0		0	0	24. 00
25.00	Other - Specify	0	0		0	0	25. 00
26.00	Durable Medical Equipment/Oxygen	0	0		0	0	26. 00
27.00	Pati ent Transportation	0	0		0	0	27. 00
28.00	I maging Services	0	0		0	0	28. 00
29. 00	Labs and Diagnostics	0	0		0	0	29. 00
30.00	Medical Supplies	0	0		0	0	30.00
31. 00	Outpatient Services (including E/R Dept.)	0	0		0	0	31.00
32. 00	Radi ati on Therapy	0	0	•	0		32. 00
33. 00	Chemotherapy	0	0		o o		33. 00
34. 00	Other	0	0		0	-	34.00
34.00	HOSPI CE NONREI MBURSABLE SERVI CE	0	0	1	<u> </u>	0	34.00
35. 00	Bereavement Program Costs	0	0		0 0	0	35. 00
36. 00	Volunteer Program Costs		0	•			36.00
37.00	,		0			0	37.00
38.00	Fundraising Other Program Costs		0	1		0	38.00
39. 00			0	]		0	38.00
	Cost to be Allocated (per Wkst. K-4, Part I)	0 000000	0 000000	0 00000	0 000000	_	
40.00	Unit Cost Multiplier	0. 000000	0. 000000	0. 00000	0. 000000	0. 000000	4U. UU

Health Financial Systems WABASH COUNTY HOSPITAL In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151310
Hospice CCN: 151545

Period: From 01/01/2014
To 12/31/2014
Date/Time Prepared: 5/27/2015 8:04 am

						5/27/2015 8:	04 am
					Hospi ce I		
		RECONCI LI ATI ON	ADMI NI STRATI VE				
			& GENERAL				
			(ACC. COST)				
		6A	6. 00				
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0					1. 00
2.00	Capital Related Costs-Movable Equip.	0					2. 00
3.00	Plant Operation and Maintenance	0					3.00
4.00	Transportation - Staff	0					4. 00
5.00	Volunteer Service Coordination						5. 00
6.00	Administrative and General	-548, 848	153, 919	,			6. 00
	I NPATI ENT CARE SERVI CE	<u> </u>	·	'			
7.00	Inpatient - General Care	0	0	)			7.00
8.00	Inpatient - Respite Care	0	0				8. 00
	VISITING SERVICES			·			
9.00	Physi ci an Servi ces	0	25, 126				9.00
	Nursing Care	0	0	1			10.00
11. 00	Nursing Care-Continuous Home Care	0	0	,			11. 00
	Physical Therapy	0	0	1			12.00
	Occupational Therapy	0	0				13. 00
	Speech/ Language Pathology	0	0				14. 00
	Medical Social Services	0	0				15. 00
	Spiritual Counseling	0	0				16. 00
	Dietary Counseling	0	0				17. 00
	Counseling - Other	0	0				18. 00
	Home Health Aide and Homemaker	0	0				19. 00
20. 00	HH Aide & Homemaker - Cont. Home Care	0	Ö	1			20.00
21. 00	Other	0	0				21.00
21.00	OTHER HOSPICE SERVICE COSTS			1			21.00
22 00	Drugs, Biological and Infusion Therapy	0	71, 118				22. 00
	Anal gesi cs	0	71,110	1			23. 00
	Sedatives / Hypnotics	0	0	1			24. 00
	Other - Specify	0	0				25. 00
	Durable Medical Equipment/Oxygen	0	53, 594	1			26. 00
	Patient Transportation	0	33, 374				27. 00
	Imaging Services	0	0				28. 00
	Labs and Diagnostics	0	0				29. 00
30.00	Medical Supplies	0	4, 081				30.00
	Outpatient Services (including E/R Dept.)	0	4,081	1			31.00
32.00	Radi ati on Therapy	0	0				32.00
33. 00	Chemotherapy	0	0	1			33.00
34. 00	Other	0	0	1			34.00
34.00	HOSPICE NONREIMBURSABLE SERVICE	0	U	1			34.00
25 00		1 0		1			25 00
35. 00	Bereavement Program Costs	0	0	1			35. 00 36. 00
36. 00 37. 00	Volunteer Program Costs	0					36.00
	Fundrai si ng	0					
38. 00	Other Program Costs	0	E40 040				38. 00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)		548, 848	1			39.00
40.00	Unit Cost Multiplier	1	3. 565824	1			40.00

Health Financial Systems WABASH ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Cost Center Description
Cost Center Description   Hospice Trial Balance (1)   NEW BLDG & FIXT   EQUIP   BENEFITS   DEPARTMENT
Balance (1)
Balance (1)
1.00
1.00   Administrative and General   0   1.00   2.00   4.00   4A
1.00       Administrative and General       0       0       11,098       11,098       1.00         2.00       Inpatient - General Care       0       0       0       0       0       0       0       2.00         3.00       Inpatient - Respite Care       0       0       0       0       0       0       0       3.00         4.00       Physician Services       114,721       0       0       0       0       114,721       4.00         5.00       Nursing Care       0
2.00       Inpatient - General Care       0       0       0       0       0       2.00         3.00       Inpatient - Respite Care       0       0       0       0       0       3.00         4.00       Physician Services       114,721       0       0       0       114,721       4.00         5.00       Nursing Care       0 <t< td=""></t<>
3.00       Inpatient - Respite Care       0       0       0       0       0       3.00         4.00       Physician Services       114,721       0       0       0       114,721       4.00         5.00       Nursing Care       0       0       0       0       0       0       0       5.00         7.00       Physical Therapy       0
4. 00       Physician Services       114, 721       0       0       0       114, 721       4. 00         5. 00       Nursing Care       0       0       0       0       0       0       0       5. 00         6. 00       Nursing Care-Continuous Home Care       0
5. 00         Nursi ng Care         0         0         0         0         0         0         5. 00           6. 00         Nursi ng Care-Conti nuous Home Care         0         0         0         0         0         0         6. 00           7. 00         Physi cal Therapy         0         0         0         0         0         0         7. 00           8. 00         Occupati onal Therapy         0
6.00       Nursing Care-Continuous Home Care       0       0       0       0       0       6.00         7.00       Physical Therapy       0       0       0       0       0       7.00         8.00       Occupational Therapy       0       0       0       0       0       0       8.00         9.00       Speech/ Language Pathology       0
7. 00       Physical Therapy       0       0       0       0       0       7. 00         8. 00       Occupational Therapy       0       0       0       0       0       8. 00         9. 00       Speech/ Language Pathology       0       0       0       0       0       0       9. 00         10. 00       Medical Social Services       0       0       0       0       0       0       0       0       0       10. 00         11. 00       Spiritual Counseling       0       0       0       0       0       0       0       11. 00         12. 00       Dietary Counseling       0       0       0       0       0       0       0       0       0       12. 00         13. 00       Counseling - Other       0       0       0       0       0       0       0       13. 00         14. 00       Home Health Aide and Homemaker       0       0       0       0       0       0       14. 00         15. 00       HH Aide & Homemaker - Cont. Home Care       0       0       0       0       0       0       0       0       16. 00         17. 00       Drugs, Biological and Infu
8.00       Occupational Therapy       0       0       0       0       0       8.00         9.00       Speech/ Language Pathology       0       0       0       0       0       9.00         10.00       Medical Social Services       0       0       0       0       0       0       0       10.00         11.00       Spiritual Counseling       0       0       0       0       0       0       11.00         12.00       Dietary Counseling       0       0       0       0       0       0       0       0       0       0       12.00         13.00       Counseling - Other       0       0       0       0       0       0       0       0       0       0       13.00         14.00       Home Heal th Aide and Homemaker       0       0       0       0       0       0       0       14.00         15.00       HH Aide & Homemaker - Cont. Home Care       0       0       0       0       0       0       0       0       0       16.00         17.00       Drugs, Biological and Infusion Therapy       324,712       0       0       0       0       0       0       0
9. 00       Speech/ Language Pathology       0       0       0       0       9.00         10. 00       Medical Social Services       0       0       0       0       0       10.00         11. 00       Spiritual Counseling       0       0       0       0       0       0       11.00         12. 00       Dietary Counseling       0       0       0       0       0       0       12.00         13. 00       Counseling - Other       0       0       0       0       0       0       13.00         14. 00       Home Heal th Aide and Homemaker       0       0       0       0       0       14.00         15. 00       HH Aide & Homemaker - Cont. Home Care       0       0       0       0       0       0       15.00         16. 00       Other       0       0       0       0       0       0       0       0       16.00         17. 00       Drugs, Biological and Infusion Therapy       324,712       0       0       0       324,712       17.00         18. 00       Anal gesics       0       0       0       0       0       0       18.00
10.00       Medical Social Services       0       0       0       0       10.00         11.00       Spiritual Counseling       0       0       0       0       0       11.00         12.00       Dietary Counseling       0       0       0       0       0       0       12.00         13.00       Counseling - Other       0       0       0       0       0       0       13.00         14.00       Home Heal th Aide and Homemaker       0       0       0       0       0       14.00         15.00       HH Aide & Homemaker - Cont. Home Care       0       0       0       0       0       0       16.00         16.00       Other       0       0       0       0       0       16.00         17.00       Drugs, Biological and Infusion Therapy       324,712       0       0       0       324,712       17.00         18.00       Anal gesics       0       0       0       0       0       18.00
11. 00     Spiritual Counseling     0     0     0     0     0     11. 00       12. 00     Di etary Counseling     0     0     0     0     0     0     12. 00       13. 00     Counseling - Other     0     0     0     0     0     0     13. 00       14. 00     Home Heal th Aide and Homemaker     0     0     0     0     0     14. 00       15. 00     HH Aide & Homemaker - Cont. Home Care     0     0     0     0     0     15. 00       16. 00     Other     0     0     0     0     0     0     16. 00       17. 00     Drugs, Biological and Infusion Therapy     324, 712     0     0     0     324, 712     17. 00       18. 00     Anal gesics     0     0     0     0     0     18. 00
12. 00     Di etary Counseling     0     0     0     0     0     12. 00       13. 00     Counseling - Other     0     0     0     0     0     13. 00       14. 00     Home Heal th Aide and Homemaker     0     0     0     0     0     14. 00       15. 00     HH Aide & Homemaker - Cont. Home Care     0     0     0     0     0     15. 00       16. 00     Other     0     0     0     0     0     0     15. 00       17. 00     Drugs, Biological and Infusion Therapy     324, 712     0     0     0     324, 712     17. 00       18. 00     Anal gesics     0     0     0     0     0     18. 00
13.00     Counseling - Other     0     0     0     0     13.00       14.00     Home Health Aide and Homemaker     0     0     0     0     0     14.00       15.00     HH Aide & Homemaker - Cont. Home Care     0     0     0     0     0     0     15.00       16.00     Other     0     0     0     0     0     0     16.00       17.00     Drugs, Biological and Infusion Therapy     324,712     0     0     0     324,712     17.00       18.00     Anal gesics     0     0     0     0     0     18.00
14.00     Home Heal th Ai de and Homemaker     0     0     0     0     14.00       15.00     HH Ai de & Homemaker - Cont. Home Care     0     0     0     0     0     15.00       16.00     Other     0     0     0     0     0     16.00       17.00     Drugs, Biological and Infusion Therapy     324,712     0     0     0     324,712     17.00       18.00     Anal gesics     0     0     0     0     0     18.00
15.00     HH Ai de & Homemaker - Cont. Home Care     0     0     0     0     0     15.00       16.00     Other     0     0     0     0     0     16.00       17.00     Drugs, Biological and Infusion Therapy     324,712     0     0     0     324,712     17.00       18.00     Anal gesics     0     0     0     0     18.00
16. 00     Other     0     0     0     0     16. 00       17. 00     Drugs, Biological and Infusion Therapy     324, 712     0     0     0     324, 712     17. 00       18. 00     Anal gesics     0     0     0     0     0     18. 00
17. 00     Drugs, Biological and Infusion Therapy     324,712     0     0     0     324,712     17. 00       18. 00     Anal gesics     0     0     0     0     18. 00
18.00   Anal gesi cs   0   0   0   18.00
10.00   Code+ives / Hymnetics
19.00   Sedatives / Hypnotics   0   0   0   19.00
20. 00 Other - Specify 0 0 0 0 0 20. 00
21. 00   Durable Medical Equipment/Oxygen   244, 701   0   0   244, 701   21. 00
22.00   Patient Transportation   0   0   0   22.00
23. 00   I maging Services   0 0 0 0 0 23. 00
24. 00   Labs and Diagnostics   0   0   0   24. 00
25. 00   Medical Supplies   18, 633   0   0   0   18, 633   25. 00
26.00   Outpatient Services (including E/R Dept.)   0   0   0   26.00
27.00   Radiation Therapy   0   0   0   27.00
28.00   Chemotherapy   0   0   0   0   28.00
29. 00 Other 0 0 0 0 0 29. 00
30.00 Bereavement Program Costs 0 0 0 0 0 30.00
31.00   Volunteer Program Costs   0   0   0   31.00
32. 00   Fundrai si ng   0   0   0   32. 00
33.00 Other Program Costs 0 0 0 0 0 33.00
34. 00   Total (sum of lines 1 thru 33) (2)   702, 767   0   0   11, 098   713, 865   34. 00
35.00   Unit Cost Multiplier (see instructions)   0.000000   35.00

Health Financial Systems WABASH ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

						5/27/2015 8: 0	4 am
					Hospi ce I		
	Cost Center Description	OTHER	BUSI NESS	MAINTENANCE &	OPERATION OF	LAUNDRY &	
		ADMI NI STRATI VE	OFFI CE	REPAI RS	PLANT	LINEN SERVICE	
		AND GENERAL					
		5. 01	5. 02	6. 00	7. 00	8. 00	
1.00	Administrative and General	1, 685	39, 566	0	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physi ci an Servi ces	17, 417	0	0	0	0	4.00
5.00	Nursi ng Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physi cal Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11. 00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Di etary Counsel i ng	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15. 00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17. 00	Drugs, Biological and Infusion Therapy	49, 297	0	0	0	0	17.00
18.00	Anal gesi cs	0	0	0	0	0	18.00
19. 00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	37, 151	0	0	0	0	21.00
22. 00	Patient Transportation	0	0	0	0	0	22.00
23.00	I maging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	2, 829	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radi ati on Therapy	0	0	0	0	0	27.00
28. 00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundrai si ng	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	108, 379	39, 566	0	0	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00
		•					

Health Financial Systems WABASH ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

						5/27/2015 8: 0	4 am
					Hospi ce I		
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	
					ADMI NI STRATI ON	SERVICES &	
						SUPPLY	
		9. 00	10. 00	11. 00	13. 00	14. 00	
1.00	Administrative and General	0	0		0	0	1. 00
2.00	Inpatient - General Care	0	0		0	0	2. 00
3.00	Inpatient - Respite Care	0	0		0	0	3. 00
4.00	Physi ci an Servi ces	0	0		0	0	4. 00
5.00	Nursi ng Care	0	0		0 0	0	5. 00
6.00	Nursing Care-Continuous Home Care	0	0		0 0	0	6. 00
7.00	Physi cal Therapy	0	0		0 0	0	7. 00
8.00	Occupational Therapy	0	0		0 0	0	8. 00
9.00	Speech/ Language Pathology	0	0		0 0	0	9. 00
10.00	Medical Social Services	0	0		0 0	0	10.00
11.00	Spiritual Counseling	0	0		0 0	0	11. 00
12.00	Di etary Counsel i ng	0	0		0 0	0	12.00
13.00	Counseling - Other	0	0		0 0	0	13.00
14.00	Home Health Aide and Homemaker	0	0		0 0	0	14. 00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0		0 0	0	15. 00
16.00	Other	0	0		0 0	0	16. 00
17. 00	Drugs, Biological and Infusion Therapy	0	0		0	0	17. 00
18.00	Anal gesi cs	0	0		0 0	0	18. 00
19. 00	Sedatives / Hypnotics	0	0		0	0	19. 00
20.00	Other - Specify	0	0		0	0	20. 00
21. 00	Durable Medical Equipment/Oxygen	0	0		0	0	21. 00
22. 00	Patient Transportation	0	0		0	0	22. 00
23. 00	I maging Services	0	0		0	0	23. 00
24.00	Labs and Diagnostics	0	0		0	0	24. 00
25. 00	Medical Supplies	0	0		0	0	25. 00
26. 00	Outpatient Services (including E/R Dept.)	0	0		0	0	26. 00
27. 00	Radiation Therapy	0	0		0	0	27. 00
28. 00	Chemotherapy	0	0		0 0	0	28. 00
29. 00	Other	0	0		0	0	29. 00
30.00	Bereavement Program Costs	0	0		0 0	0	30. 00
31.00	Volunteer Program Costs	0	0		0 0	0	31. 00
32.00	Fundrai si ng	0	0		0	0	32. 00
33.00	Other Program Costs	0	0		0	0	33. 00
34.00	Total (sum of lines 1 thru 33) (2)	0	0		0	0	34. 00
35. 00	Unit Cost Multiplier (see instructions)						35. 00

| In Lieu of Form CMS-2552-10 | Provider CCN: 151310 | Period: | Worksheet K-5 | From 01/01/2014 | Part | To 12/31/2014 | Date/Time Prepared: | 5/27/2015 8: 04 am Health Financial Systems WABASH ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

						5/27/2015 8: 0	4 am
					Hospi ce I		
	Cost Center Description	PHARMACY	MEDI CAL	Subtotal	Intern &	Subtotal	
			RECORDS &	(col s. 4A-23)	Residents Cost	(cols. 24 ±	
			LI BRARY		& Post	25)	
					Stepdown		
					Adjustments		
		15. 00	16. 00	24.00	25.00	26. 00	
1.00	Administrative and General	0	0	52, 349			1. 00
2.00	Inpatient - General Care	0	0	0	0	0	2. 00
3.00	Inpatient - Respite Care	0	0	0	0	0	3. 00
4.00	Physi ci an Servi ces	0	0	132, 138	0	132, 138	4. 00
5.00	Nursi ng Care	0	0	0	0	0	5. 00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physi cal Therapy	0	0	0	0	0	7. 00
8.00	Occupational Therapy	0	0	0	0	0	8. 00
9.00	Speech/ Language Pathology	0	0	0	0	0	9. 00
10.00	Medical Social Services	0	0	0	0	0	10.00
11. 00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Di etary Counsel i ng	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15. 00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17. 00	Drugs, Biological and Infusion Therapy	0	0	374, 009	0	374, 009	17.00
18. 00	Anal gesi cs	0	0	0	0	0	18. 00
19. 00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21. 00	Durable Medical Equipment/Oxygen	0	0	281, 852	0	281, 852	
22. 00	Pati ent Transportation	0	0	0	0	0	22. 00
23.00	I maging Services	0	0	0	0	0	23. 00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	21, 462	0	21, 462	25. 00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27. 00	Radiation Therapy	0	0	0	0	0	27. 00
28. 00	Chemotherapy	0	0	0	0	0	28. 00
29. 00	Other	0	0	0	0	0	29. 00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31. 00
32. 00	Fundrai si ng	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	861, 810	0	861, 810	
35. 00	Unit Cost Multiplier (see instructions)						35. 00

Health Financial Systems WABASH ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS WABASH COUNTY HOSPITAL In Lieu of Form CMS-2552-10

Provi der CCN: 151310 | Peri od: From 01/01/2014 | Worksheet K-5 | Part I | Date/Time Prepared: 5/27/2015 8:04 am

				Hospi ce I	
	Cost Center Description	Allocated	Total Hospice		
		Hospi ce A&G	Costs (cols.		
		(See Part II)	26 ± 27)		
		27. 00	28. 00		
1.00	Administrative and General				1.00
2.00	Inpatient - General Care	0	0		2. 00
3.00	Inpatient - Respite Care	0	0		3.00
4.00	Physi ci an Servi ces	8, 545	140, 683		4.00
5.00	Nursi ng Care	0	0		5. 00
6.00	Nursing Care-Continuous Home Care	0	0		6. 00
7.00	Physi cal Therapy	0	0		7. 00
8.00	Occupational Therapy	0	0		8. 00
9.00	Speech/ Language Pathology	0	0		9. 00
10.00	Medical Social Services	0	0		10.00
11. 00	Spiritual Counseling	0	0		11. 00
12.00	Di etary Counsel i ng	0	0		12. 00
13.00	Counseling - Other	0	0		13. 00
14.00	Home Health Aide and Homemaker	0	0		14. 00
15. 00	HH Aide & Homemaker - Cont. Home Care	0	0		15. 00
16. 00	Other	0	0		16. 00
17. 00	Drugs, Biological and Infusion Therapy	24, 188	398, 197		17. 00
		0	0		18. 00
	Sedatives / Hypnotics	0	0		19. 00
20.00	Other - Specify	0	0		20.00
21. 00	Durable Medical Equipment/Oxygen	18, 228	300, 080		21.00
22. 00	Patient Transportation	0	0		22. 00
	I maging Services	0	0		23. 00
24.00	Labs and Diagnostics	0	0		24. 00
25.00		1, 388	22, 850		25. 00
26. 00	Outpatient Services (including E/R Dept.)	0	0		26. 00
27. 00	Radiation Therapy	0	0		27. 00
28. 00	Chemotherapy	0	0		28. 00
29. 00	Other	0	0		29. 00
30.00	Bereavement Program Costs	0	0		30.00
31.00	Volunteer Program Costs	0	0		31. 00
32.00	Fundrai si ng	0	0		32. 00
33.00	Other Program Costs	0	0		33.00
34.00	Total (sum of lines 1 thru 33) (2)		861, 810		34.00
35. 00	Unit Cost Multiplier (see instructions)	0. 064671			35. 00

STATISTICAL BASIS

						5/2//2015 8:04	<u>4 am</u>
					Hospi ce I		
		CAPITAL RELA	TED COSTS				
	Cost Center Description	NEW BLDG &	NEW MVBLE	EMPLOYEE	Reconciliation	OTHER	
	·	FLXT	EQUI P	BENEFITS		ADMI NI STRATI VE	
		(SQUARE	(DOLLAR	DEPARTMENT		AND GENERAL	
		FEET)	VALUE)	(GROSS		(ACCUM. COST)	
		<b>'</b>	,	SALARI ES)		,	
		1.00	2. 00	4.00	5A. 01	5. 01	
1.00	Administrative and General	0	0	184, 093	3 0	11, 098	1. 00
2.00	Inpatient - General Care	o	0	(	o	0	2.00
3.00	Inpatient - Respite Care	l ol	0		ol o	0	3.00
4.00	Physi ci an Servi ces	l ol	0	(	ol o	114, 721	4.00
5.00	Nursing Care	l ol	0	(	ol o	0	5.00
6.00	Nursing Care-Continuous Home Care	o	0		0	0	6. 00
7.00	Physical Therapy	o	0		0	0	7. 00
8.00	Occupational Therapy	0	0		0	Ö	8. 00
9. 00	Speech/ Language Pathology	أم	0		0	0	9. 00
10. 00	Medical Social Services	o	0			Ö	10. 00
11. 00	Spiritual Counseling		0			Ö	11. 00
12. 00	Di etary Counsel i ng	o o	0			0	12. 00
13. 00	Counseling - Other	0	0				13. 00
14. 00	Home Health Aide and Homemaker	o o	0			0	14. 00
15. 00	HH Ai de & Homemaker - Cont. Home Care	o o	0		·		15. 00
16. 00	Other		0		1	٥	16. 00
17. 00	Drugs, Biological and Infusion Therapy		0			324, 712	17. 00
18. 00	Anal gesi cs	0	0			0	18. 00
19. 00	Sedatives / Hypnotics	0	0		1	0	19. 00
20. 00	Other - Specify		0				20. 00
21. 00	Durable Medical Equipment/Oxygen	0	0			244, 701	21. 00
22. 00	Pati ent Transportati on	0	0			244, 701	22. 00
23. 00		0	0			0	23. 00
24. 00	I maging Services	0	0		0	0	24. 00
	Labs and Diagnostics	0	0			-	24. 00 25. 00
25. 00	Medical Supplies	0	0			18, 633	
26. 00	Outpatient Services (including E/R Dept.)	0	0			0	26. 00
27. 00	Radi ati on Therapy	0	0		0	0	27. 00
28. 00	Chemotherapy	0	0	(	0	0	28. 00
29. 00	Other	0	0	(	0	0	29. 00
30. 00	Bereavement Program Costs	0	0	(	0	0	30. 00
31. 00	Volunteer Program Costs	0	0	)	0	0	31.00
32. 00	Fundrai si ng	0	0	(	0 ا	0	32.00
33. 00	Other Program Costs	0	0	(	0	0	33. 00
34. 00	Total (sum of lines 1 thru 33) (2)	0	0	184, 093		713, 865	34.00
35. 00	Total cost to be allocated	0	0	11, 098		108, 379	35. 00
36. 00	Unit Cost Multiplier (see instructions)	0. 000000	0. 000000	0. 060285	5	0. 151820	36. 00

PITAL In Lieu of Form CMS-2552-10

Provider CCN: 151310 | Period: From 01/01/2014 | Part II | Date/Time Prepared: 5/27/2015 8:04 am STATISTICAL BASIS

			·			5/27/2015 8: 0	4 am
					Hospi ce I		
	Cost Center Description	BUSI NESS	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		OFFI CE	REPAI RS	PLANT	LINEN SERVICE	(SQUARE	
		(ACCUM. COST)	(SQUARE	(SQUARE	(POUNDS OF	FEET)	
			FEET)	FEET)	LAUNDRY)		
		5. 02	6. 00	7. 00	8. 00	9. 00	
1.00	Administrative and General	818, 995	0		0 0	0	1. 00
2.00	Inpatient - General Care	0	0		0 0	0	2. 00
3.00	Inpatient - Respite Care	0	0		0 0	0	3. 00
4.00	Physician Services	0	0		0 0	0	4. 00
5.00	Nursi ng Care	0	0		0 0	0	5. 00
6.00	Nursing Care-Continuous Home Care	0	0		0 0	0	6. 00
7.00	Physical Therapy	0	0		0 0	0	7. 00
8.00	Occupational Therapy	0	0		0 0	0	8. 00
9.00	Speech/ Language Pathology	0	0		0 0	0	9. 00
10.00	Medical Social Services	0	0		0 0	0	10. 00
11.00	Spiritual Counseling	0	0		0 0	0	11. 00
12.00	Di etary Counseling	0	l o		0 0	l ol	12. 00
13. 00	Counseling - Other	0	0		0 0	o	13. 00
14. 00	Home Health Aide and Homemaker	0	0		0 0	0	14. 00
15. 00	HH Aide & Homemaker - Cont. Home Care	0	0		0 0	0	15. 00
16. 00	Other	0	0		0 0	l ol	16. 00
17. 00	Drugs, Biological and Infusion Therapy	0	0		0 0	l ol	17. 00
18. 00	Anal gesi cs	0	0		0 0	o o	18. 00
19. 00	Sedatives / Hypnotics	0	0		0 0	0	19. 00
20. 00	Other - Specify	0	0		0 0	l ol	20.00
21. 00	Durable Medical Equipment/Oxygen	0	0		0 0	o o	21. 00
22. 00	Patient Transportation	0	0		0 0	l o	22. 00
23. 00	Imaging Services	0	1		0 0	l o	23. 00
24. 00	Labs and Diagnostics		١		0 0	0	24. 00
25. 00	Medical Supplies				0 0	ا	25. 00
26. 00	Outpatient Services (including E/R Dept.)				0 0	ا	26. 00
27. 00	Radi ati on Therapy				0 0	0	27. 00
28. 00	Chemotherapy				0 0	0	28. 00
29. 00	Other				0		29. 00
30. 00	Bereavement Program Costs	0			0		30.00
31. 00	Volunteer Program Costs	0			0	0	31. 00
32. 00	Fundrai si ng				0	0	32.00
32.00	Other Program Costs				0	1	32.00
		818, 995			0	0	
34. 00	Total (sum of lines 1 thru 33) (2)				0	0	34. 00 35. 00
35. 00	Total cost to be allocated	39, 566		0.0000	0 000000		
36.00	Unit Cost Multiplier (see instructions)	0. 048310	0. 000000	0.00000	0. 000000	0.000000	36.00

						5/27/2015 8:0	)4 am
					Hospi ce I		
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
	·	(MEALS	(HOURS)	ADMI NI STRATI ON	SERVICES &	(COSTED	
		SERVED)			SUPPLY	REQUIS.)	
		ŕ		(DI RECT	(COSTED	,	
				NRSING HRS)	REQUIS.)		
		10.00	11. 00	13.00	14. 00	15. 00	
1.00	Administrative and General	0	C	0	0	0	1. 00
2.00	Inpatient - General Care	o	C	0	0	0	2.00
3.00	Inpatient - Respite Care	O	C	o	0	0	3.00
4.00	Physician Services	o	C	o	0	0	4.00
5.00	Nursing Care	o	C	o	0	0	5.00
6.00	Nursing Care-Continuous Home Care	o	C	o	0	0	6.00
7.00	Physical Therapy	o	C	ol	0	l 0	7. 00
8.00	Occupational Therapy	O	C	o	0	0	1
9.00	Speech/ Language Pathology	O	C	o	0	0	1
10.00	Medical Social Services	0	C	0	0	0	10.00
11. 00	Spiritual Counseling	0	Ċ	0	0	Ö	
12. 00	Di etary Counsel i ng	0	Ċ	0	0	0	1
13. 00	Counseling - Other	0	Č		0	l o	1
14. 00	Home Health Aide and Homemaker	0	Č		0	l o	
15. 00	HH Aide & Homemaker - Cont. Home Care	0	Ċ		0	0	
16. 00	Other	0	Č		0	0	
17. 00	Drugs, Biological and Infusion Therapy	0	Č		0	l o	
18. 00	Anal gesi cs	0	Č		0	Ö	1
19. 00	Sedatives / Hypnotics	0	C		0	0	1
20. 00	Other - Specify	0	Ċ	0	0	Ö	1
21. 00	Durable Medical Equipment/Oxygen	0	Ċ	0	0	Ö	
22. 00	Patient Transportation	0	Ċ	0	0	0	1
23. 00	Imaging Services	0	Ċ	0	0	0	
24. 00	Labs and Diagnostics	0	Ċ	0	0	Ö	1
25. 00	Medical Supplies	o	C	o	0	0	25. 00
26.00	Outpatient Services (including E/R Dept.)	0	C	0	0	0	26. 00
27. 00	Radiation Therapy	0	Ċ	0	0	Ö	1
28. 00	Chemotherapy	O	C	o	0	0	1
29. 00	Other	O	C	o	0	0	1
30.00	Bereavement Program Costs	0	C	0	0	0	30.00
31. 00	Volunteer Program Costs	O	C	o	0	0	31.00
32. 00	Fundrai si ng	O	C	o	0	0	32.00
33. 00	Other Program Costs	0	Ċ	ol	0	l o	
34. 00	Total (sum of lines 1 thru 33) (2)	0	Ċ		0	l o	
35. 00	Total cost to be allocated		Č		0	l o	1
	Unit Cost Multiplier (see instructions)	0. 000000	0. 000000	0. 000000	0. 000000	-	
						,	1

Health Financial Systems		WABASH COUNTY HOS	SPI TAL	In Lie	u of Form CMS-2552-10
ALLOCATION OF GENERAL SERVICE STATISTICAL BASIS	COSTS TO HOSPICE COST	CENTERS	Provi der CCI Hospi ce CCN:	From 01/01/2014	Worksheet K-5 Part II Date/Time Prepared: 5/27/2015 8:04 am

				5/27/2015 8: 0	04 am
			Hospi ce I		
	Cost Center Description	MEDI CAL RECORDS & LI BRARY (GROSS REV) 16.00			
1 00	Administrative and Constal		1		1 00
1.00	Administrative and General	0			1. 00 2. 00
2.00	Inpatient - General Care				
3.00	Inpatient - Respite Care				3. 00
4.00	Physician Services				4.00
5.00	Nursing Care				5. 00
6.00	Nursing Care-Continuous Home Care	0			6. 00
7. 00 8. 00	Physical Therapy				7. 00 8. 00
	Occupational Therapy				
9. 00 10. 00	Speech/ Language Pathology Medical Social Services				9. 00 10. 00
11. 00	Spiritual Counseling	0			11.00
12. 00	Dietary Counseling				12.00
13. 00	Counseling - Other				13. 00
14. 00	Home Health Aide and Homemaker				14.00
15. 00	HH Aide & Homemaker - Cont. Home Care				15. 00
16. 00	Other				16. 00
17. 00	Drugs, Biological and Infusion Therapy				17. 00
18. 00	Anal gesi cs				18. 00
19. 00	Sedatives / Hypnotics				19.00
20. 00	Other - Specify				20.00
21. 00	Durable Medical Equipment/Oxygen				21.00
22. 00	Patient Transportation	0			22.00
23. 00	Imaging Services				23. 00
24. 00	Labs and Diagnostics				24. 00
25. 00	Medical Supplies				25. 00
26. 00	Outpatient Services (including E/R Dept.)	0			26.00
27. 00	Radi ati on Therapy	0			27. 00
28. 00	Chemotherapy	0			28. 00
29. 00	Other	0			29. 00
30. 00	Bereavement Program Costs	0			30.00
31. 00	Volunteer Program Costs	0			31. 00
32. 00	Fundrai si ng	0			32.00
33. 00	Other Program Costs				33.00
34. 00	Total (sum of lines 1 thru 33) (2)				34.00
35. 00	Total cost to be allocated				35. 00
	Unit Cost Multiplier (see instructions)	0. 000000			36. 00
	(222)				

Health Financial Systems		WABASH COUNTY HOSPITAL			In Lieu of Form CMS-2552-10			
COMPUTATION OF TOTAL HOSPICE SHARED COSTS			Provi der CCN: 1513					
			Hospi ce (	CCN: 151545	From 01/01/2014 To 12/31/2014			
					Hospi ce I			
	Cost Center Description	1	Wkst. C, Part			Hospi ce Shared		
			I, col. 11	Ratio	Charges	Ancillary		
			line			Costs (cols. 1		
					Records)	x 2)		
			0	1. 00	2. 00	3. 00		
	ANCILLARY SERVICE COST CENTERS							
1.00	PHYSI CAL THERAPY		66. 00	l .	05	0	1. 00	
2.00	OCCUPATI ONAL THERAPY		67. 00	l .			2. 00	
3.00	SPEECH PATHOLOGY		68. 00				3. 00	
4.00	DRUGS CHARGED TO PATIENTS		73. 00	0. 21098	32 0	0	4. 00	
5.00	DURABLE MEDICAL EQUIP-RENTED		96.00				5. 00	
6.00	LABORATORY		60.00	0. 2210°	19 0	0	6. 00	
6. 01	BLOOD LABORATORY		60. 01				6. 01	
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		71. 00	0. 5963	13 0	0	7. 00	
8.00	OTHER OUTPATIENT SERVICE COST CENTER		93.00				8. 00	
9.00	RADI OLOGY-THERAPEUTI C		55.00				9. 00	
10.00	OTHER ANCILLARY SERVICE COST CENTERS		76.00				10.00	
11.00	Totals (sum of lines 1-10)					0	11. 00	

Health Financial Systems WABASH COUNTY HOSPITAL					In Lie	Lieu of Form CMS-2552-10		
CALCULATION OF HOSPICE PER DIEM COST			Provi der CCN: 151310		Peri od: Worksheet K-			
			Hospi ce C	CCN: 151545	From 01/01/2014 To 12/31/2014		pared: 4 am	
					Hospi ce I			
		Ti t	le XVIII	Title XIX	Other	Total		
			1.00	2. 00	3. 00	4. 00		
1. 00 To	otal cost (see instructions)					861, 810	1.00	
2. 00 To	otal Unduplicated Days (Worksheet S-9, column 6, line 5)					7, 351	2. 00	
3. 00 Av	verage cost per diem (line 1 divided by line 2)					117. 24	3. 00	
4. 00 Up	pduplicated Medicare Days (Worksheet S-9, column 1, line )		7, 351				4. 00	
5. 00 A	ggregate Medicare cost (line 3 time line 4)		861, 831			1	5. 00	
6. 00 Ui	nduplicated Medicaid Days (Worksheet S-9, column 2, line				0		6. 00	
7. 00 A	ggregate Medicaid cost (line 3 time line 60)	İ			0	ı	7. 00	
8. 00 U	pduplicated SNF Days (Worksheet S-9, column 3, line 5)		0				8. 00	
9.00 A	ggregate SNF cost (line 3 time line 8)		0				9. 00	
10. 00 Ur	nduplicated NF Days (Worksheet S-9, column 4, line 5)				0		10.00	
11. 00 A	ggregate NF cost (line 3 times line 10)				0		11.00	
12. 00 0	ther Unduplicated days (Worksheet S-9, column 5, line 5)				0		12.00	
13. 00 A	ggregate cost for other days (line 3 times line 12)				0	ı .	13. 00	