This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 05-31-2019 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0086 Worksheet S Peri od: From 01/01/2016 Parts I-III AND SETTLEMENT SUMMARY 12/31/2016 Date/Time Prepared: 3/12/2018 9:21 am PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically filed cost report Date: 3/12/2018 9:21 am use only Manually submitted cost report ] If this is an amended report enter the number of times the provider resubmitted this cost report ] Medicare Utilization. Enter "F" for full or "L" for low. [5] Cost Report Status 
[6] Date Received: 
[7] As Submitted 
[7] Contractor No. 
[8] [N] Initial Report for this Provider CCN 
[9] [N] Final Report for this Provider CCN 
[10] NPR Date: 
[11] Contractor's Vendor Code: 
[12] [0] If line 5, column 1 is 4: Enter 
[13] Number of times reopened = 0-9. Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

## 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 CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by DEARBORN COUNTY HOSPITAL (15-0086) for the cost reporting period beginning 01/01/2016 and ending 12/31/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Si gned)	
	Officer or Administrator of Provider(s)
	• •
Title	
ntre	!
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	134, 290	111, 295	0	45, 152	1. 00
2.00	Subprovi der - IPF	0	0	0		0	2. 00
3.00	Subprovi der - I RF	0	0	0		0	3. 00
5.00	Swing bed - SNF	0	0	0		0	5. 00
6.00	Swing bed - NF	0				0	6. 00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9. 00
200.00	Total	0	134, 290	111, 295	0	45, 152	200. 00

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

	In-State	In-State	Out-of	Out-of	Medi cai d	Other	
	Medi cai d	Medi cai d	State	State	HMO days	Medi cai d	
	pai d days	eligible	Medi cai d	Medi cai d		days	
		unpai d	pai d days	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	33	2, 334	0	870	137	0	24. 00
in-state Medicaid paid days in column 1, in-state							
Medicaid eligible unpaid days in column 2,							
out-of-state Medicaid paid days in column 3,							
out-of-state Medicaid eligible unpaid days in column							
4, Medicaid HMO paid and eligible but unpaid days in							
column 5, and other Medicaid days in column 6.							
25.00 If this provider is an IRF, enter the in-state	0	l o	0	l о	l о		25. 00
Medicaid paid days in column 1, the in-state							
Medicaid eligible unpaid days in column 2,							
out-of-state Medicaid days in column 3, out-of-state							
Medicaid eligible unpaid days in column 4, Medicaid							
HMO paid and eligible but unpaid days in column 5.							
	1	ı	1	ı	ı	1	<u> </u>

HOSPITAL AND H	al Systems HOSPITAL HEALTH CARE COMPI	LEX IDENTIFICATION DA	TA	Provi der CC	N: 15-0086	Peri od: From 01/01/2016 To 12/31/2016		pared:
			Y/N	IME	Direct GME	IME	Direct GME	O alli
			1. 00	2. 00	3. 00	4.00	5. 00	
surgery current 61.05 Enter t	he number of unweighted p allopathic and/or osteop cost reporting period (s he difference between the general surgery FTEs and	athic FTEs in the ee instructions). baseline primary		0.00				61. 05
primary 61.04 m 61.06 Enter to used fo	care and/or general surginus line 61.03). (see in the amount of ACA §5503 awar cap relief and/or FTEs general surgery. (see in	ery FTE counts (line structions) ard that is being that are nonprimary		0.00	0.	00		61. 06
·		·	Pro	ogram Name	Program Cod	e Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
				1. 00	2. 00	3.00	4. 00	
speci al for eac col umn program unwei gh	FTEs in line 61.05, specity, if any, and the numbe h new program. (see instrough 1, the program name. Ente code. Enter in column 3, ted count. Enter in colume eighted count.	r of FTE residents uctions) Enter in r in column 2, the the IME FTE				0.00	0.00	61. 10
of the program residen instruc Enter i 3, the	FTEs in line 61.05, speci specialty, if any, and t ts for each expanded prog tions) Enter in column 1, n column 2, the program c IME FTE unweighted count. ect GME FTE unweighted co	he number of FTE ram. (see the program name. ode. Enter in column Enter in column 4,				0. 00	0. 00	61. 20
							1.00	
62.00 Enter t	visions Affecting the Hea he number of FTE resident spital received HRSA PCRE	s that your hospital	trai nec			riod for which	0.00	62.00
62.01 Énter t during	he number of FTE resident in this cost reporting pe	s that rotated from a riod of HRSA THC prog	ı Teachi ıram. (s	see instruction		o your hospital	0.00	62. 01
63.00 Has you	g Hospitals that Claim Re r facility trained reside	nts in nonprovider se	ttings	during this co			N	63. 00
Y" for	yes or "N" for no in col	umn I. IT yes, comple	ete line	es 64 through 6	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col. 2))	
					1. 00	2.00	3.00	
	5504 of the ACA Base Yea that begins on or after J				inis base yea	ırıs your cost r	reporting	
64.00 Enter i in the residen setting residen	n column 1, if line 63 is base year period, the num t FTEs attributable to ros. Enter in column 2 the t FTEs that trained in youmn 1 divided by (column	yes, or your facilit ber of unweighted nor tations occurring in number of unweighted ur hospital. Enter ir	y trair i-primar all nor I non-pr i columr	ned residents ry care nprovider rimary care n 3 the ratio	0.	0. 00	0. 000000	64.00
		Program Name	Pro	ogram Code	Unwei ghted FTEs Nonprovi der Si te	FTEs in	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00		2. 00	3. 00	4. 00	5. 00	1

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0086 Peri od: Worksheet S-2 From 01/01/2016 Part I Date/Time Prepared: 12/31/2016 3/12/2018 9:20 am Program Code Unwei ghted Unwei ghted Program Name Ratio (col. (col. 3 + col FTEs FTEs in 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 is yes, or your facility 0. 00 0. 00 0.000000 65.00 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) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col 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 Enter in column 1 the number of unweighted non-primary care resident 0.00 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 Unwei ghted Ratio (col. 3/ Program Code Unwei ahted FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 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 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most O 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, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF N 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most 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, indicate which program year began during this cost reporting period. (see instructions)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CO	CN: 15-0086	Peri od: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Pre		
			10 12/31/2010	3/12/2018 9: 2		
				1.00		
Long Term Care Hospital PPS				1.00		
80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes 81.00 Is this a LTCH co-located within another hospital for part c "Y" for yes and "N" for no.			ng period? Enter	N N	80. 00 81. 00	
TEFRA Providers  85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i)  86.00 Did this facility establish a new Other subprovider (exclude [A12.40(f)(1)(i)]) [Temporary No. 100 and [N]] for the property of the				N	85. 00 86. 00	
\$413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.  87.00 Is this hospital a "subclause (II)" LTCH classified under se for yes or "N" for no.	ection 1886(d)	(1) (B) (i v) (I	)? Enter "Y"	N	87. 00	
lion yes on in torino.			V	XI X		
			1. 00	2.00		
Title V and XIX Services	al comilecco Fr	+ "V" for	N	Υ	00.00	
90.00 Does this facility have title V and/or XIX inpatient hospital yes or "N" for no in the applicable column.	ar services? Er	iter i ror	N	Y	90.00	
91.00 Is this hospital reimbursed for title V and/or XIX through t			N	N	91.00	
full or in part? Enter "Y" for yes or "N" for no in the appl 92.00 Are title XIX NF patients occupying title XVIII SNF beds (du				N	92. 00	
instructions) Enter "Y" for yes or "N" for no in the applica	able column.	, ,				
93.00 Does this facility operate an ICF/IID facility for purposes "Y" for yes or "N" for no in the applicable column.	of title V and	XIX? Enter	N	N	93. 00	
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes,	and "N" for no	o in the	N	N	94. 00	
applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the app	olicable column	1	0.00	0.00	95.00	
96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes			N	N	96. 00	
applicable column.	aliooblo oolum		0.00	0. 00	97. 00	
98.00 Does title V or XIX follow Medicare (title XVIII) for the instepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" f	7.00   If line 96 is "Y", enter the reduction percentage in the applicable column.  8.00   Does title V or XIX follow Medicare (title XVIII) for the interns and residents post   Y					
column 1 for title V, and in column 2 for title XIX.  98.01 Does title V or XIX follow Medicare (title XVIII) for the re C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for ti				Y	98. 01	
98.02 Does title V or XIX follow Medicare (title XVIII) for the cabed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes o			Y	Y	98. 02	
for title V, and in column 2 for title XIX.  98.03 Does title V or XIX follow Medicare (title XVIII) for a crit reimbursed 101% of inpatient services cost? Enter "Y" for years.				N	98. 03	
for title V, and in column 2 for title XIX.  98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no ir			N	N	98. 04	
in column 2 for title XIX.  98.05 Does title V or XIX follow Medicare (title XVIII) and add bawkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 2.				Y	98. 05	
column 2 for title XIX.  98.06 Does title V or XIX follow Medicare (title XVIII) when cost  Pts. I through IV? Enter "Y" for yes or "N" for no in column	reimbursed fon n 1 for title \	Wkst. D, /, and in	Y	Y	98. 06	
column 2 for title XIX.  Rural Providers					-	
105.00 Does this hospital qualify as a CAH?			N		105. 00	
106.00 If this facility qualifies as a CAH, has it elected the all- for outpatient services? (see instructions)	-inclusive meth	nod of payme	nt N		106. 00	
107.00 If this facility qualifies as a CAH, is it eligible for cost training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col.	n 1. (see insti	ructions) If			107. 00	
reimbursed. If yes complete Wkst. D-2, Pt. II.  108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sched	dul e? See 42	2 N		108. 00	
	Physi cal	Occupation		Respi ratory		
109.00  f this hospital qualifies as a CAH or a cost provider, are	1. 00 N	2.00 N	3. 00 N	4. 00 N	109. 00	
therapy services provided by outside supplier? Enter "Y"	ίΛ	IN IN	IN	IN IN	109.00	

110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no.

1.00

N

110. 00

IOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCM	J: 15-0086	Peri od:	Worksheet	MS-2552- S-2
FIGURE CONTROL TIENETT SAINE SOME EEX TRENTITION DATA		From 01/01/20 To 12/31/20	016 Part I	Prepared
		1. 00	2.00	
11.00 If this facility qualifies as a CAH, did it participate in the Frontier Cor Health Integration Project (FCHIP) demonstration for this cost reporting po "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, er integration prong of the FCHIP demo in which this CAH is participating in a Enter all that apply: "A" for Ambulance services; "B" for additional beds; for tele-health services.	eriod? Enter nter the column 2.	N	2.33	111.
			1.00 2.00 3.	00
Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 3 either "93" percent for short term hospital or "98" percent for long term psychiatric, rehabilitation and long term hospitals providers) based on the Pub. 15-1, chapter 22, §2208.1.	s "E", enter n care (incl e definition	in column udes		0 115.
16.00 s this facility classified as a referral center? Enter "Y" for yes or "N" 17.00 s this facility legally-required to carry malpractice insurance? Enter "Y' no.	' for yes or		N Y	116. 117.
18.00 Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if claim-made. Enter 2 if the policy is occurrence.	f the policy	is	1	118.
jordim made. Enter E vi the periody to obtain these	Premi ums	Losses	Insuranc	e
	1. 00	2.00	3.00	
18.01 List amounts of malpractice premiums and paid losses:	274, 7	55	0	0 118.
		1. 00	2.00	
Are malpractice premiums and paid losses reported in a cost center other the Administrative and General? If yes, submit supporting schedule listing cost and amounts contained therein.  19.00 DO NOT USE THIS LINE  20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless proving \$3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for the second contents.	st centers sion in ACA for yes or e Outpatient		N	118.    119.    120.
Hold Harmless provision in ACA §3121 and applicable amendments? (see instruenter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implantable devices	•	Y		121.
patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as defined in §1903(v Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included.				122.
Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" 1	for no. If	N		125.
yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare certified kidney transplant center, enter the certifiin column 1 and termination date, if applicable, in column 2.				126.
17.00  f this is a Medicare certified heart transplant center, enter the certific   in column 1 and termination date, if applicable, in column 2.	cation date			127.
(8.00) If this is a Medicare certified liver transplant center, enter the certification in column 1 and termination date, if applicable, in column 2.				128.
19.00 If this is a Medicare certified lung transplant center, enter the certification column 1 and termination date, if applicable, in column 2.		n		129.
30.00  f this is a Medicare certified pancreas transplant center, enter the certi   date in column 1 and termination date, if applicable, in column 2.   31.00  f this is a Medicare certified intestinal transplant center, enter the cer				130. 131.
date in column 1 and termination date, if applicable, in column 2.				132.
in column 1 and termination date, if applicable, in column 2. 3.00 f this is a Medicare certified other transplant center, enter the certific	cation date			133.
in column 1 and termination date, if applicable, in column 2. 44.00 If this is an organ procurement organization (0P0), enter the 0P0 number in and termination date, if applicable, in column 2.	n column 1			134.
All Providers 40.00 Are there any related organization or home office costs as defined in CMS F	Pub 15-1	N		140.
chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home of				140.

Health Financial Systems DEARBORN COUNTY HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0086 Peri od: Worksheet S-2 From 01/01/2016 Part I 12/31/2016 Date/Time Prepared: To 3/12/2018 9:20 am 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: PO Box: 142.00 143.00 Ci ty: State: Zip Code: 143. 00 1.00 144.00 Are provider based physicians' costs included in Worksheet A? γ 144. 00 1. 00 2.00 145.00 of costs for renal services are claimed on Wkst. A, line 74, are the costs for 145.00 inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 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, chapter 40, \$4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 147. 00 Ν 148 00 N 149.00Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no Ν 149.00 Part A Part B Title V Title XIX 1.00 2.00 3.00 4.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal Ν N 155.00 N 156.00 Subprovider - IPF Ν Ν Ν Ν 156.00 157.00 Subprovi der - IRF 157 00 N Ν Ν N 158. 00 SUBPROVI DER 158. 00 159.00 SNF Ν Ν Ν Ν 159. 00 160.00 HOME HEALTH AGENCY 160. 00 Ν Ν Ν Ν 161.00 CMHC Ν Ν N 161. 00 1.00 Multicampus 165.00 s this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Enter "Y" for yes or "N" for no. 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 0.00 166.00 campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 1.00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act

fied the three matron recentled egy (in t) thechte to the the thincir can receive y and recentled	7101		
167.00 s this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.		Υ	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	(	168. 00
reasonable cost incurred for the HIT assets (see instructions)			
168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a	hardshi p		168. 01
exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (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	9. 9	9169.00
transition factor. (see instructions)			
	Begi nni ng	Endi ng	
	1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting	01/01/2016	12/31/2016	170. 00
period respectively (mm/dd/yyyy)			
	1. 00	2.00	
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in	N	(	171. 00
section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter			
"Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section			
1876 Medicare days in column 2. (see instructions)			

	Financial Systems DEARBORN COUN AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-0086	Peri od: From 01/01/2016 To 12/31/2016	3/12/2018 9: 3	2 epared:
				Y/N 1. 00	Date 2.00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	for all NO re	esponses. Ente			
	Provider Organization and Operation					٠
. 00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in c	beginning of	the cost	N		1.00
	reporting period: IT yes, enter the date of the change IT c	orumin 2. (see	Y/N	Date	V/I	
			1.00	2. 00	3. 00	
00	Has the provider terminated participation in the Medicare P yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	J	N			2.00
. 00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of directors through ownership, control, or family and othe relationships? (see instructions)	offices, drug ler or its of the board	N			3.00
			Y/N	Type	Date	
	Financial Data and Danasta		1.00	2. 00	3. 00	-
. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues diffe	or Compiled, ilable in	Y	A		4.00
	those on the filed financial statements? If yes, submit rec	onciliation.				
				Y/N 1. 00	Legal Oper.	
	Approved Educational Activities			1.00	2. 00	
00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	If yes, is th	ne provider is	S N		6. 0
. 00 . 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.		d during the	N N		7. 00 8. 00
00	Are costs claimed for Interns and Residents in an approved		cal education	N		9. 00
0. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.		the current	N		10. 0
1. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N	V /NI	11. 0
					Y/N 1. 00	
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection pperiod? If yes, submit copy.			ost reporting	Y N	12. 00 13. 00
	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement				N	14.00
5.00	Did total beds available change from the prior cost reporti		yes, see inst t A	ructions. Par	+ R	15. 0
		Y/N	Date	Y/N	Date	
		1. 00	2.00	3. 00	4. 00	
. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	Y	03/27/2017	Y	03/27/2017	16. 0
7. 00	date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for	N		N		17. 0
	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)					
8. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18. 00
9. 00	cost report/IT yes, see Instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	N		N		19. 0

Heal th	Financial Systems DEARBORN COU	NTY HOSPITAL		In Lie	u of Form CM	S-2552-10	
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider 0	CN: 15-0086	Peri od: From 01/01/2016 To 12/31/2016		repared:	
		Descr	iption	Y/N	Y/N		
	I		0	1.00	3. 00		
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00	
	· · · · · · · · · · · · · · · · · · ·	Y/N	Date	Y/N	Date		
		1.00	2. 00	3. 00	4. 00		
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00	
					1. 00		
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCI	EPT CHILDRENS I	HOSPI TALS)				
	Capital Related Cost						
22. 00	Have assets been relifed for Medicare purposes? If yes, se				N	22. 00	
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to apprais	sals made dur	ing the cost	N	23. 00	
24. 00	Were new leases and/or amendments to existing leases enter	ed into during	this cost re	eporting period?	Y	24. 00	
25. 00	If yes, see instructions Have there been new capitalized leases entered into during	the cost repo	rting period?	Plf yes, see	N	25. 00	
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during t	he cost report	ng period? I	f yes, see	N	26. 00	
27. 00	instructions. Has the provider's capitalization policy changed during the	e cost reporti:	ng period? If	fyes, submit	N	27. 00	
	copy. Interest Expense	<u> </u>					
28. 00	Were new loans, mortgage agreements or letters of credit el period? If yes, see instructions.	ntered into du	ring the cost	reporting	Y	28. 00	
29. 00	Did the provider have a funded depreciation account and/or		ebt Service F	Reserve Fund)	N	29. 00	
30. 00	treated as a funded depreciation account? If yes, see inst Has existing debt been replaced prior to its scheduled mate		debt? If yes	s, see	N	30. 00	
31. 00	<pre>instructions. Has debt been recalled before scheduled maturity without is instructions.</pre>	ssuance of new	debt? If yes	s, see	N	31. 00	
	Purchased Services						
32. 00	Have changes or new agreements occurred in patient care se		ed through co	ontractual	Y	32. 00	
33. 00	arrangements with suppliers of services? If yes, see instructions. If line 32 is yes, were the requirements of Sec. 2135.2 approximately see instructions.		ng to competi	tive bidding? If		33. 00	
	Provi der-Based Physi ci ans						
34. 00	Are services furnished at the provider facility under an a If yes, see instructions.	rrangement witl	n provider-ba	ased physicians?	Y	34. 00	
35. 00	If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see in		nts with the	provi der-based	N	35. 00	
	, , , , , , , , , , , , , , , , , , ,			Y/N	Date		
	U 066: 0t-			1. 00	2. 00		
36. 00	Home Office Costs 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 p	repared by the	home office?			37. 00	
38. 00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of			-		38. 00	
39. 00	ļ			5,		39. 00	
40. 00	see instructions. If line 36 is yes, did the provider render services to the	home office?	If yes, see			40. 00	
	i nstructi ons.						
	1.00 2.						
	Cost Report Preparer Contact Information						
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	KYLE		SMI TH		41. 00	
42. 00	respectively. Enter the employer/company name of the cost report	BLUE & CO., LI	_C			42. 00	
43. 00	preparer. Enter the telephone number and email address of the cost	317-713-7957		KCSMI TH@BLUEAN	DCO. COM	43. 00	
	report preparer in columns 1 and 2, respectively.						

Health Financial Systems DEARBORN	COUNTY HOSPITAL	In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CCN: 15-0086	Peri od: From 01/01/2016 To 12/31/2016		pared:
	2.00			
	3. 00			
Cost Report Preparer Contact Information				
41.00 Enter the first name, last name and the title/position	SENIOR MANAGER			41. 00
held by the cost report preparer in columns 1, 2, and 3	1			
respecti vel y.				
42.00 Enter the employer/company name of the cost report				42.00
preparer.				
43.00 Enter the telephone number and email address of the cos	t			43.00
report preparer in columns 1 and 2, respectively.				

| Period: | Worksheet S-3 | From 01/01/2016 | Part | To 12/31/2016 | Date/Time Prepared: Health Financial Systems DEARBOR HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-0086

				T	o 12/31/2016	Date/Time Prep 3/12/2018 9:20	
						I/P Days / 0/P	J dill
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
	·	Line Number		Avai I abl e			
		1. 00	2.00	3.00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	80	29, 280	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2. 00
3.00	HMO IPF Subprovider						3. 00
4.00	HMO IRF Subprovider						4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6. 00
7.00	Total Adults and Peds. (exclude observation		80	29, 280	0.00	0	7. 00
	beds) (see instructions)	04.00					
8.00	INTENSIVE CARE UNIT	31. 00	8	2, 928	0.00	0	8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)	40.00					12.00
13.00	NURSERY	43. 00	0.0	22 200	0.00	0	13.00
14. 00	Total (see instructions)		88	32, 208	0.00	0	14.00
15.00	CAH visits					0	15. 00
16.00	SUBPROVIDER - I PF						16. 00 17. 00
17. 00 18. 00	SUBPROVI DER - I RF SUBPROVI DER						17. 00
19.00							18.00
20.00	SKILLED NURSING FACILITY NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY	101. 00				0	22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )	101.00					23. 00
24. 00	HOSPICE	116, 00	C	0			24. 00
24. 10	HOSPICE (non-distinct part)	30. 00		0			24. 10
25. 00	CMHC - CMHC	30.00					25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
27. 00	Total (sum of lines 14-26)	07.00	88			Ŭ	27. 00
28. 00	Observation Bed Days			Ί		0	28. 00
29. 00	Ambulance Trips						29. 00
30.00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days - IRF						31. 00
32. 00	Labor & delivery days (see instructions)		C	0			32. 00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						-
33.00	LTCH non-covered days						33.00
33. 01	LTCH site neutral days and discharges						33. 01

| Period: | Worksheet S-3 | From 01/01/2016 | Part | To 12/31/2016 | Date/Time Prepared: Health Financial Systems DEARBOR HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-0086

				T	o 12/31/2016	Date/Time Pre 3/12/2018 9:2	
		I/P Days	/ O/P Visits	/ Trips	Full Time E		
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7. 00	8. 00	9. 00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	5, 776	33	11, 791			1. 00
	8 exclude Swing Bed, Observation Bed and			•			
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)	4 000					
2.00	HMO and other (see instructions)	1, 309	3, 287				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0	0			4. 00 5. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			6.00
6. 00 7. 00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation	5, 776	33	11, 791			7.00
7.00	beds) (see instructions)	5, 776	33	11, 791			7.00
8. 00	INTENSIVE CARE UNIT	1, 163	0	2, 068			8. 00
9. 00	CORONARY CARE UNIT	1, 103	o o	2,000			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	700			13. 00
14. 00	Total (see instructions)	6, 939	33	14, 559		571. 23	
15. 00	CAH visits	0	0	0			15. 00
16. 00	SUBPROVIDER - IPF	-	1				16.00
17. 00	SUBPROVIDER - IRF						17. 00
18.00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY	4, 722	520	8, 133	0. 00	14. 66	22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE	4, 774	114	5, 459	0.00	4. 02	24. 00
24. 10	HOSPICE (non-distinct part)	0	0	0			24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0. 00	0. 00	
27. 00	Total (sum of lines 14-26)				0. 00	589. 91	
28. 00	Observation Bed Days		0	1, 482			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	54	102			32.00
32. 01	Total ancillary labor & delivery room			0			32. 01
22.00	outpatient days (see instructions)						22.00
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	υĮ					33. 01

Health Financial Systems DEARBOOM
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-0086

				-	To 12/31/2016	Date/Time Pre 3/12/2018 9:20	
		Full Time Equivalents	<u>'</u>	Di sc	harges		
	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 2. 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)		C	) 1, 730 31		4, 159	1. 00 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	C	) 1, 73(	7	4, 159	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	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC	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	FEDERALLY QUALIFIED HEALTH CENTER 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	0. 00 0. 00					26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01
33. 00 33. 01	outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges			1			33. 00 33. 01

| Peri od: | Worksheet S-3 | From 01/01/2016 | Part II | To 12/31/2016 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0086

					To	12/31/2016	Date/Time Pre 3/12/2018 9:2	
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst.	Adjusted Salaries (col.2 ± col.	Paid Hours Related to Salaries in	Average Hourly Wage (col. 4 ÷ col. 5)	
		1. 00	2.00	A-6) 3.00	3) 4. 00	<u>col</u> . 4 5. 00	6. 00	
	PART II - WAGE DATA	1.00	2.00	3.00	4.00	3.00	0.00	
1. 00	SALARIES Total salaries (see	200. 00	34, 914, 762	0	34, 914, 762	1, 390, 678. 00	25. 11	1.00
2. 00	instructions) Non-physician anesthetist Part	200.00	34, 714, 702		., ,	0.00		
3. 00	A Non-physician anesthetist Part		0	0	0	0. 00	0. 00	3. 00
4. 00	B Physician-Part A -		0	0	0	0.00	0. 00	4. 00
4. 01 5. 00	Administrative Physicians - Part A - Teaching Physician and Non		0	1	1	0. 00 0. 00		1
6. 00	Physician-Part B Non-physician-Part B for		0	_		0.00		
7.00	hospital-based RHC and FQHC services	04.00						
7. 00 7. 01	Interns & residents (in an approved program) Contracted interns and	21. 00	0	0		0.00		
7.01	residents (in an approved programs)		O		0	0.00	0.00	7.01
8. 00	Home office and/or related organization personnel		0	0	0	0.00		
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	0 1, 866, 474	0 16, 146	0 1, 882, 620	0. 00 69, 950. 00	l .	1
11. 00	instructions) OTHER WAGES & RELATED COSTS Contract Labor: Direct Patient		549, 479	0	549, 479	9, 641. 00	56. 99	11. 00
12. 00	Care Contract Labor: Top Level		0			0. 00		12. 00
	management and other management and administrative							
13. 00	services Contract Labor: Physician-Part A - Administrative		415, 612	0	415, 612	2, 156. 00	192. 77	13. 00
14. 00	Home office and/or related orgainzation salaries and wage-related costs		0	0	0	0.00	0. 00	14. 00
14. 01 14. 02	Home office salaries Related organization salaries		0	0	1	0. 00 0. 00		14. 01 14. 02
15. 00	Home office: Physician Part A - Administrative		0	_		0.00		15. 00
16. 00	Home office and Contract Physicians Part A - Teaching WAGE-RELATED COSTS		0	0	0	0. 00	0.00	16. 00
17. 00	Wage-related costs (core) (see instructions)		10, 104, 013	0	10, 104, 013			17. 00
	Wage-related costs (other) (see instructions)		0	_				18. 00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		508, 222 0	0				19. 00 20. 00
21. 00	Non-physician anesthetist Part B		0	0	0			21. 00
22. 00	Physician Part A - Administrative		0	0	0			22. 00
22. 01	Physician Part A - Teaching Physician Part B		0	0	0			22. 01 23. 00
23.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25. 00	Interns & residents (in an approved program)		0	0	Ö			25. 00
25. 50	Home office wage-related (core)		0	_				25. 50
25. 51	Related organization wage-related (core)		O	0	0			25. 51
25. 52	Home office: Physician Part A - Administrative -		0	0	0			25. 52
25. 53	wage-related (core) Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25. 53
	OVERHEAD COSTS - DIRECT SALARIE			T			T	
26. 00 27. 00	Employee Benefits Department Administrative & General	4. 00 5. 00			· ·			26. 00 27. 00

| Peri od: | Worksheet S-3 | From 01/01/2016 | Part II | To 12/31/2016 | Date/Time Prepared:

					''	0 12/31/2010	3/12/2018 9: 20	
		Wkst. A Line	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col. 5)	
				A-6)	3)	col. 4		
		1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
28. 00	Administrative & General under		199, 344	0	199, 344	2, 834. 00	70. 34	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00		0	0	0. 00		29. 00
30. 00	Operation of Plant	7. 00				,		30. 00
31. 00	Laundry & Linen Service	8. 00	· ·		175, 518	,		
32. 00	Housekeepi ng	9. 00	748, 226	0	748, 226	,		
33. 00	Housekeeping under contract		0	0	0	0. 00	0. 00	33.00
	(see instructions)							
34. 00	Di etary	10. 00	1, 166, 165	-895, 148	271, 017	,		34.00
35. 00	Dietary under contract (see		0	0	0	0. 00	0. 00	35.00
	instructions)							
36. 00	Cafeteri a	11. 00		895, 148	895, 148			36. 00
37. 00	Maintenance of Personnel	12. 00		0	0	0. 00		37. 00
38. 00	Nursing Administration	13. 00	· ·		938, 270	,		38. 00
39. 00	Central Services and Supply	14. 00	312, 239	0	312, 239		15. 87	39. 00
40.00	Pharmacy	15. 00	1, 644, 389	0	1, 644, 389	44, 535. 00	36. 92	40.00
41.00	Medical Records & Medical	16. 00	814, 822	0	814, 822	38, 865. 00	20. 97	41.00
	Records Library							
42. 00		17. 00	· ·	0	344, 504			42.00
43. 00	Other General Service	18. 00	0	0	0	0. 00	0.00	43. 00

| Peri od: | Worksheet S-3 | From 01/01/2016 | Part III | To 12/31/2016 | Date/Time Prepared: Provider CCN: 15-0086

					'	0 12/31/2010	3/12/2018 9: 20	
		Worksheet A	Amount	Reclassi fi cati	Adjusted	Paid Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
			·	(from	(col.2 ± col.	Salaries in	col . 5)	
				Worksheet A-6)	3)	col. 4		
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		35, 114, 106	0	35, 114, 106	1, 393, 512. 00	25. 20	1.00
	instructions)							
2.00	Excluded area salaries (see		1, 866, 474	16, 146	1, 882, 620	69, 950. 00	26. 91	2.00
	instructions)							
3.00	Subtotal salaries (line 1		33, 247, 632	-16, 146	33, 231, 486	1, 323, 562. 00	25. 11	3.00
	minus line 2)							
4.00	Subtotal other wages & related		965, 091	0	965, 091	11, 797. 00	81. 81	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		10, 104, 013	0	10, 104, 013	0.00	30. 40	5. 00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		44, 316, 736	-16, 146	44, 300, 590	1, 335, 359. 00	33. 18	6. 00
7.00	Total overhead cost (see		12, 511, 389	-16, 146	12, 495, 243	530, 812. 00	23. 54	7.00
	instructions)							

Health Financial Systems	DEARBORN COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0086	Period: Worksheet S-3
		From 01/01/2016   Part IV

	To 12/31/2016	Date/Time Prep 3/12/2018 9:20	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	1, 255, 116	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8. 00	Health Insurance (Purchased or Self Funded)	5, 616, 130	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	0	8. 02
8. 03	Heal th Insurance (Purchased)	0	8. 03
9. 00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	190, 513	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	58, 576	
12. 00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13. 00	Disability Insurance (If employee is owner or beneficiary)	111, 820	13.00
	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15. 00		178, 693	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	2, 016, 819	17. 00
18. 00	Medicare Taxes - Employers Portion Only	480, 868	18. 00
19. 00	Unemployment Insurance	5, 165	19. 00
20.00	State or Federal Unemployment Taxes	0	20. 00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21. 00
22. 00	Day Care Cost and Allowances	0	22. 00
	Tuition Reimbursement	190, 314	
24. 00	Total Wage Related cost (Sum of lines 1 -23)	10, 104, 014	
	Part B - Other than Core Related Cost		
25. 00	EE RECOGNITION	64, 931	25. 00

Health Financial Systems	DEARBORN COUNTY HOSPITAL	In Lie	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0086	Peri od: From 01/01/2016 To 12/31/2016	Worksheet S-3 Part V Date/Time Prepared: 3/12/2018 9:20 am

			3/12/2018 9: 2	o am
	Cost Center Description	Contract Labor	Benefit Cost	
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospi tal	0	0	2.00
3.00	Subprovi der - I PF			3.00
4.00	Subprovi der - I RF			4. 00
5.00	Subprovi der - (Other)	0	0	5. 00
6.00	Swing Beds - SNF	0	0	6. 00
7.00	Swing Beds - NF	0	0	7. 00
8.00	Hospi tal -Based SNF			8. 00
9.00	Hospi tal -Based NF			9. 00
10.00	Hospi tal -Based OLTC			10.00
11.00	Hospi tal -Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospi tal -Based Hospi ce	0	0	13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospi tal -Based-CMHC			16.00
17. 00	Renal Dialysis			17.00
18. 00	Other	0	0	18. 00

Heal th	Financial Systems	DEARBORN COUNTY	HOSPI TAL		In Li∈	eu of Form CMS-2	2552-10
HOME H	IEALTH AGENCY STATISTICAL DATA		Provider Component	CN: 15-0086 CCN: 15-7055	Peri od: From 01/01/2016 To 12/31/2016	Date/Time Pre	pared:
					Home Health Agency I	3/12/2018 9: 2 PPS	<u>u aiii </u>
						00	
0.00	County			-			0.00
			Title XVIII	Title XIX	Other	Total	
	HOME HEALTH ACENOV CTATICTION DATA	1.00	2. 00	3. 00	4. 00	5. 00	
1. 00	HOME HEALTH AGENCY STATISTICAL DATA Home Health Aide Hours	l ol	0	1	0 0	0	1.00
2. 00	Unduplicated Census Count (see instructions)	0.00	286. 00				
				Number of Em	ployees (Full Ti	me Equivalent)	
		Enter the number your normal w		Staff	Contract	Total	
	LIQUE LIEALTH ACENOY NUMBER OF ENDLOYEES	0		1.00	2. 00	3.00	
3 00	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES  Administrator and Assistant Administrator(s)		40, 00	0. (	0.00	0.00	2 00
3. 00 4. 00 5. 00 6. 00 7. 00	Administrator and Assistant Administrator(s) Director(s) and Assistant Director(s) Other Administrative Personnel Direct Nursing Service Nursing Supervisor		40.00	0. ( 3. ( 8. ( 0. (	0. 00 09 0. 00 02 0. 00 0. 00	0. 00 3. 09 8. 02 0. 00	4. 00 5. 00 6. 00 7. 00
8. 00 9. 00 10. 00	Physical Therapy Service Physical Therapy Supervisor Occupational Therapy Service			2. 0. 0.	0. 00 0. 00 0. 00	0. 00 0. 87	9. 00 10. 00
11. 00 12. 00 13. 00	Occupational Therapy Supervisor Speech Pathology Service Speech Pathology Supervisor			0. ( 0. (	0. 00 00 0. 00	0. 10 0. 00	12. 00 13. 00
14. 00 15. 00	Medical Social Service Medical Social Service Supervisor			0. (			
16. 00	Home Health Aide			1.			1
17. 00	Home Health Aide Supervisor			0. (			
18. 00	OTHER			0.	14 0.00	0. 14	18. 00
19. 00	HOME HEALTH AGENCY CBSA CODES  Enter in column 1 the number of CBSAs where you provided services during the cost				5		19. 00
20. 00	reporting period. List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			17140			20. 00
20. 01	contains the first code).			50031			20. 01
20. 02				50034			20. 02
20. 03				50035			20. 03
20. 04				99915			20. 04
			sodes th Outliers	LUPA Episode	es PEP Only	Total (cols.	
		Outliers	tii outii ei s	LUFA LPI SOUE	Epi sodes	1-4)	
		1.00	2.00	3.00	4. 00	5.00	
	PPS ACTIVITY DATA				4-1		
21. 00	Skilled Nursing Visits	2, 116	270	1	45 32		1
22. 00 23. 00	Skilled Nursing Visit Charges Physical Therapy Visits	424, 681 979	54, 189 33		02 6, 422 16 18		
24. 00	Physical Therapy Visit Charges	213, 863	7, 268				1
25.00	Occupational Therapy Visits	366	28		12 2	408	25. 00
26.00	Occupational Therapy Visit Charges	79, 951	6, 167			89, 202	
27. 00	Speech Pathology Visit Charges	50	21 4 625		2 3	76	1
28. 00 29. 00	Speech Pathology Visit Charges Medical Social Service Visits	11, 143	4, 625 2		41 661 0 2	16, 870 9	28. 00 29. 00
30.00	Medical Social Service Visit Charges	1, 499	600		0 600		
31. 00	Home Health Aide Visits	526	93		1 0	620	31.00
32. 00 33. 00	Home Health Aide Visit Charges Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	113, 997 4, 042	21, 842 447		34 0 76 57	136, 073 4, 722	
34. 00 35. 00	Other Charges Total Charges (sum of lines 22, 24, 26, 28,	0 845, 134	0 94, 691		0 44 12, 089	1	34. 00 35. 00
36. 00	30, 32, and 34) Total Number of Episodes (standard/non outlier)	309			54 7	380	36. 00
37. 00 38. 00	Total Number of Outlier Episodes Total Non-Routine Medical Supply Charges	18, 847	11 4, 861	•	78 300		37. 00 38. 00

Heal th	Financial Systems		DEARBORN COUN	ITY HOSPITAL		In Lie	eu of Form CMS-2	2552-10
	AL-BASED HOSPICE IDENTIFICATION	DATA		Provi der C	CN: 15-0086	Peri od:	Worksheet S-9	
				Hooni oo CCI	N: 15-1531	From 01/01/2016 To 12/31/2016		GH IV
				Hospi ce cci	N: 15-1531	To 12/31/2016	3/12/2018 9: 2	
						Hospi ce I	0, 12, 2010 ,12	<u> </u>
		Unduplicated				<u>'</u>		
		Days		_				
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
				Skilled	Nursing		col s. 1, 2 &	
				Nursing Facility	Facility		5)	
		1. 00	2.00	3.00	4. 00	5. 00	6. 00	
	PART I - ENROLLMENT DAYS FOR CO					3.00	0.00	
1. 00	Hospice Continuous Home Care	TOT THE OTT THE	2.11 050 5201 1111	l DEFORE GOTO	1, 2010			1.00
2.00	Hospice Routine Home Care							2. 00
3.00	Hospice Inpatient Respite Care							3. 00
4.00	Hospice General Inpatient Care							4. 00
5.00	Total Hospice Days							5. 00
	Part II - CENSUS DATA FOR COST	REPORTING PERI	ODS BEGINNING	BEFORE OCTOBER	1, 2015			
6. 00	Number of patients receiving							6. 00
7. 00	hospice care Total number of unduplicated							7. 00
7.00	Continuous Care hours billable							7.00
	to Medicare							
8.00	Average Length of Stay (line 5							8. 00
	/ line 6)							
9. 00	Unduplicated census count							9. 00
NOTE:	Parts I and II, columns 1 and 2	also include	the days report	ted in columns	3 and 4.			
				Title XVIII	Title XIX	Other	Total (sum of	
							col s. 1	
							through 3)	
				1.00	2.00	3. 00	4. 00	
10.00	PART III - ENROLLMENT DAYS FOR	COST REPORTING	PERIODS BEGIN	INING ON OR AFT	ER OCTOBER 1,			40.00
10. 00 11. 00				4, 548	1	0 04 567	0	10. 00 11. 00
12. 00	Hospice Inpatient Respite Care			4, 340	''	0 0	5,219	1
	Hospice General Inpatient Care			226		10 4		13. 00
	Total Hospice Days			4, 774		14 571		14. 00
50	PART IV - CONTRACTED STATISTICA	AL DATA FOR COS	ST REPORTING PE					1 55
15.00				0		0 0		15. 00
16.00	Hospice General Inpatient Care			0		0 0		16. 00

T IDSUL	Financial Systems DEARBORN COUNTY HOS TAL UNCOMPENSATED AND INDIGENT CARE DATA Pr	ovider CCN: 15-0086	Peri od:	u of Form CMS-2 Worksheet S-10	
10321 1	AL UNCOMPENSATED AND INDIGENT CARE DATA	OVI dei CCN. 15-0060	From 01/01/2016	WOLKSHEET 3-10	U
			To 12/31/2016	Date/Time Prep 3/12/2018 9:20	pared 0 am
				1. 00	
	Uncompensated and indigent care cost computation				
. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divid	ded by line 202 colur	mn 8)	0. 351055	1. C
	Medicaid (see instructions for each line)			0 775 447	١.,
2. 00 3. 00	Net revenue from Medicaid		2, 775, 447 Y	2. C	
. 00	Did you receive DSH or supplemental payments from Medicaid?  If line 3 is yes, does line 2 include all DSH and/or supplemental	rai d?	Ϋ́Υ	4.0	
. 00	If line 4 is no, then enter DSH and/or supplemental payments from		sar a .	. 0	1
. 00	Medi cai d charges			15, 429, 535	
. 00	Medicaid cost (line 1 times line 6)			5, 416, 615	
. 00	Difference between net revenue and costs for Medicaid program (li	ne 7 minus sum of li	nes 2 and 5; if	2, 641, 168	8.0
	<pre>&lt; zero then enter zero) Children's Health Insurance Program (CHIP) (see instructions for</pre>	each line)			
9. 00	Net revenue from stand-allone CHIP	eden Triie)		0	9.0
0. 00	Stand-alone CHIP charges			0	1
1. 00	Stand-alone CHIP cost (line 1 times line 10)			0	
2. 00	· ·	ne 11 minus line 9;	if < zero then	0	12.0
	enter zero) Other state or local government indigent care program (see instru	ictions for each line	2)		
3. 00	Net revenue from state or local indigent care program (Not include the care program in			0	13.0
4. 00	Charges for patients covered under state or local indigent care p			0	1
	10)				
5. 00	State or local indigent care program cost (line 1 times line 14)			0	
6. 00	Difference between net revenue and costs for state or local indiging; if < zero then enter zero)	gent care program (li	ne 15 minus line	0	16. 0
	Grants, donations and total unreimbursed cost for Medicaid, CHIP	and state/local indi	gent care program	ıs (see	
	instructions for each line)				
7. 00				0	
18. 00 19. 00	Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i		ma (aum af Linaa	0 2, 641, 168	
19.00	8, 12 and 16)	nurgent care program	iis (Suiii 01 1111es	2,041,100	19.0
		Uni nsured	I I nsured	Total (col. 1	
		pati ents		+ col . 2)	
	Uncompensated Care (see instructions for each line)	1.00	2. 00	3. 00	
0. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil	i ty 1, 683, 8	875 0	1, 683, 875	20 (
.0. 00	(see instructions)		3.0	1,000,070	20.0
1. 00	Cost of patients approved for charity care and uninsured discount	ts (see 591,	133 0	591, 133	21.0
	instructions)				00.0
22. 00	Payments received from patients for amounts previously written of charity care	TT as	0 0	0	22.0
23. 00		591,	133 0	591, 133	23.0
				1. 00	
4. 00	Does the amount on line 20 column 2, include charges for patient		n of stay limit	N	24.0
5. 00	imposed on patients covered by Medicaid or other indigent care pr If line 24 is yes, enter the charges for patient days beyond the stay limit		am's length of	0	25.0
6. 00	Total bad debt expense for the entire hospital complex (see instr	ructions)		6, 040, 000	26.0
27. 00	Medicare reimbursable bad debts for the entire hospital complex (	-		329, 184	
7. 01	Medicare allowable bad debts for the entire hospital complex (see	•		506, 438	1
	Non-Medicare bad debt expense (line 26 minus line 27.01)			5, 533, 562	1
					1 20 0
28. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt exper	nse (see instructions	5)	2, 119, 839	•
29. 00 30. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt exper Cost of uncompensated care (line 23 column 3 plus line 29) Total unreimbursed and uncompensated care cost (line 19 plus line	•	5)	2, 119, 839 2, 710, 972 5, 352, 140	30.0

Heal th	Financial Systems	DEARBORN COUNTY	Y HOSPITAL		In Lie	u of Form CMS-	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provi der Co	CN: 15-0086	Peri od:	Worksheet A	
					From 01/01/2016 To 12/31/2016	Date/Time Pre	nared:
					10 12/31/2010	3/12/2018 9: 2	
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Reclassi fi ed	
	'			+ col . 2)	ons (See A-6)		
					, ,	(col. 3 +-	
						col. 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						1
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		3, 552, 531				1
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		2, 142, 158			1	
3.00	00300 OTHER CAPITAL RELATED COSTS	404 574	10 250 202		0		
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	431, 571	10, 259, 283			10, 690, 854 285, 821	
5. 01 5. 02	01160   COMMUNI CATI ONS   00550   DATA   PROCESSI NG	129, 243 1, 019, 829	156, 578 1, 509, 908			2, 529, 737	
5. 02	00560 PURCHASING RECEIVING AND STORES	248, 511	1, 309, 906				1
5. 04	00570 ADMITTING	647, 634	84, 576				1
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	758, 634	509, 530			1	1
5. 06	00591 OTHER ADMINISTRATIVE AND GENERAL	1, 929, 075	5, 148, 216			1	1
7. 00	00700 OPERATION OF PLANT	1, 003, 415	2, 212, 247			1	1
8.00	00800 LAUNDRY & LINEN SERVICE	175, 518	134, 457			1	1
9.00	00900 HOUSEKEEPI NG	748, 226	316, 978				1
10.00	01000 DI ETARY	1, 166, 165	690, 391	1, 856, 55	6 -1, 425, 092	431, 464	10.00
11. 00	01100 CAFETERI A	0	0		1, 425, 092	1, 425, 092	11. 00
13.00	01300 NURSING ADMINISTRATION	938, 270	42, 521	980, 79	1 0	980, 791	13. 00
14. 00	01400 CENTRAL SERVICE & SUPPLY	312, 239	662, 017	·			
15. 00	01500 PHARMACY	1, 644, 389	173, 458		· ·		•
16. 00	01600 MEDICAL RECORDS & LIBRARY	814, 822	155, 906				•
17. 00	01700 SOCI AL SERVI CE	344, 504	11, 756	356, 26	0 0	356, 260	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	6, 582, 404	847, 117				1
31.00	03100 INTENSIVE CARE UNIT	1, 380, 382	175, 364				
43. 00	04300 NURSERY	0	0		566, 988	566, 988	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS    O5000   OPERATING ROOM	1, 814, 125	2, 034, 527	3, 848, 65	2 -1, 531, 510	2, 317, 142	50.00
51.00	05100 RECOVERY ROOM	688, 607	2, 034, 327				1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	000,007	27, 747		315, 084		
53. 00	05300 ANESTHESI OLOGY	0	1, 234, 119				
54. 00	05400 RADI OLOGY-DI AGNOSTI C	2, 489, 149	940, 231				
54. 01	05401 ULTRASOUND	230, 302	53, 159				1
55.00	05500 RADI OLOGY-THERAPEUTI C	439, 364	344, 423				
57.00	05700 CT SCAN	O	195, 854	195, 85	4 -67, 382	128, 472	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	301, 128	301, 12	-9, 764	291, 364	58. 00
59. 00	05900   CARDI AC   CATHETERI ZATI ON	0	0		0 0	0	59. 00
60.00	06000 LABORATORY	2, 317, 903	3, 194, 058	5, 511, 96	1 -4, 529	5, 507, 432	
60. 01	06001 BLOOD LABORATORY	0	0		0	0	60. 01
65. 00	06500 RESPI RATORY THERAPY	766, 841	117, 385				
65. 01	03950 SLEEP CLINIC	0	195, 220				
66.00	06600 PHYSI CAL THERAPY	1, 260, 472	105, 289			1	
	06700 OCCUPATI ONAL THERAPY	265, 371	9, 645				
	06800 SPEECH PATHOLOGY	219, 228	3, 040				
	06900   ELECTROCARDI OLOGY   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	566, 495 0	881, 250 0		-667 2, 603, 542		
	07200 IMPL. DEV. CHARGED TO PATIENT	o	2, 777, 138	l .			
73. 00		2	3, 450, 498			l e	
73.00	OUTPATIENT SERVICE COST CENTERS	2	3, 430, 470	3, 430, 30	5  0	3, 430, 300	73.00
91. 00	09100 EMERGENCY	1, 715, 598	339, 425	2, 055, 02	3 -7, 504	2, 047, 519	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,110,010	,	_, _, _,	1, 22.	_, _,,	92. 00
	OTHER REIMBURSABLE COST CENTERS	<u>'</u>		•	<b>'</b>		
101.00	10100 HOME HEALTH AGENCY	953, 245	134, 126	1, 087, 37	1 -12, 810	1, 074, 561	101. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE		0		0 0	0	113. 00
116.00	11600 HOSPI CE	314, 923	279, 281	•	-64, 846	529, 358	116. 00
118.00		34, 316, 456	45, 505, 968	79, 822, 42	4 -38, 038	79, 784, 386	118. 00
	NONREI MBURSABLE COST CENTERS			T.		Г	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	65, 151	0				190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0 0	178, 147				
	19201 PHYSI CI AN CLI NI C	86, 658	39, 838				
	19202 LI FELI NE	0	3, 080				192. 02
	19203 CREDIT UNION 19204 BREAST MRI STUDY	0	0		0		192. 03 192. 04
	19205 HOSPI TALI ST	Ŋ	1, 255, 105	1, 255, 10	5	1, 255, 105	
	07950 COMMUNITY MENTAL HEALTH	0	1,200,100	1, 200, 10	0		194. 00
	07951 MARKETING	123, 415	155, 554	278, 96	9 ^	278, 969	
	07953 OCCUPATIONAL HEALTH	323, 082	38, 803				•
	07952 PATHS EDUCATION	0	47, 345				194. 02
200.00		34, 914, 762	47, 223, 840				
	, , , , , , , , , , , , , , , , , , , ,	, .–1			•	, , , , , , , , , , , , , , , , , , , ,	

	Financial Systems	DEARBORN COUN		CN 15 000/		u of Form CMS-	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider C	CN: 15-0086	Peri od: From 01/01/2016	Worksheet A	
					To 12/31/2016	Date/Time Pre 3/12/2018 9:2	pared: 20 am
	Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation				
		6. 00	7. 00				
1. 00	GENERAL SERVICE COST CENTERS O0100 NEW CAP REL COSTS-BLDG & FIXT	-167, 475	3, 456, 613	,			1.00
2. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP	-1, 650		1			2.00
3. 00	00300 OTHER CAPITAL RELATED COSTS	0	0	1			3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-15, 246		3			4. 00
5. 01	01160 COMMUNI CATI ONS	-9, 426					5. 01
5. 02 5. 03	00550 DATA PROCESSING 00560 PURCHASING RECEIVING AND STORES	0		•			5. 02 5. 03
5. 04	00570 ADMITTING	0	732, 210	1			5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	-5, 491	1, 262, 673	1			5. 05
5.06	00591 OTHER ADMINISTRATIVE AND GENERAL	-4, 099, 702		1			5. 06
7.00	00700 OPERATION OF PLANT	-118, 393		1			7. 00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	0	309, 975 1, 100, 820	1			8. 00 9. 00
10. 00	01000 DI ETARY	-1, 981	429, 483	1			10.00
11. 00	01100 CAFETERI A	-414, 767	1, 010, 325	1			11. 00
13.00	01300 NURSING ADMINISTRATION	0	980, 791				13. 00
14.00	01400 CENTRAL SERVI CE & SUPPLY	0	476, 572	1			14. 00
15. 00 16. 00	O1500   PHARMACY   O1600   MEDI CAL RECORDS & LI BRARY	0 -14, 977	1, 798, 344 953, 216	1			15. 00 16. 00
17. 00	01700 SOCIAL SERVICE	-14, 9//	l	1			17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS		3331=33	1			1
30. 00	03000 ADULTS & PEDI ATRI CS	-364, 477	6, 151, 902	1			30. 00
31. 00	03100   INTENSIVE CARE UNIT	0		1			31.00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	566, 988	3			43. 00
50. 00	05000 OPERATING ROOM	-62, 250	2, 254, 892	2			50.00
51.00	05100 RECOVERY ROOM	0	708, 177	1			51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	315, 084	1			52. 00
53. 00 54. 00	05300   ANESTHESI OLOGY   05400   RADI OLOGY-DI AGNOSTI C	-1, 171, 379 -139, 231	23, 126 3, 265, 280				53. 00 54. 00
54. 00	05401 ULTRASOUND	-139, 231	266, 921				54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	Ö	608, 538	1			55. 00
57. 00	05700 CT SCAN	-4, 186					57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	291, 364				58. 00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	-100, 664	5, 406, 768	1			59. 00 60. 00
60. 00	06001 BLOOD LABORATORY	-100,004	5, 400, 700				60. 00
65. 00	06500 RESPI RATORY THERAPY	-12, 523	796, 472				65. 00
65. 01	03950 SLEEP CLINIC	0	195, 162	1			65. 01
66.00	06600 PHYSI CAL THERAPY	0	1, 360, 986	1			66.00
67. 00 68. 00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	0	271, 311 222, 268				67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	-271, 658	l	1			69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2, 603, 542	2			71. 00
	07200 I MPL. DEV. CHARGED TO PATIENT	0		1			72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	-846, 792	2, 603, 708	<u> </u>			73. 00
91. 00	09100 EMERGENCY	-106, 190	1, 941, 329				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	-					92. 00
404 00	OTHER REIMBURSABLE COST CENTERS		4 074 5/4	T			104 00
101.00	10100 HOME HEALTH AGENCY  SPECIAL PURPOSE COST CENTERS	0	1, 074, 561				101. 00
113.00	11300 I NTEREST EXPENSE	0	0				113. 00
	11600 H0SPI CE	-5, 134		1			116. 00
118.00	<u> </u>	-7, 933, 592	71, 850, 794				118. 00
100.00	NONREI MBURSABLE COST CENTERS		/F 1F1	1			190. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN   19200 PHYSICIANS' PRIVATE OFFICES	0	1	1			190.00
	19201 PHYSI CI AN CLI NI C	0		1			192. 01
	19202 LI FELI NE	0	3, 080				192. 02
	19203 CREDIT UNION	0	0				192. 03
	19204 BREAST MRI STUDY	0	1 255 425	<u> </u>			192. 04
	19205 HOSPI TALI ST   07950 COMMUNI TY MENTAL HEALTH	0	1, 255, 105				192. 05 194. 00
	07951 MARKETI NG	0	278, 969				194. 00
194. 02	07953 OCCUPATI ONAL HEALTH	0	360, 832	2			194. 02
	07952 PATHS EDUCATION	0	,	1			194. 03
200.00	TOTAL (SUM OF LINES 118 through 199)	-7, 933, 592	74, 205, 010	ין			200. 00

Peri od: Worksheet A-6 From 01/01/2016 To 12/31/2016 Date/Time Prepared:

					3/12/2018 9:20 am
		Increases			
	Cost Center	Li ne #	Sal ary	0ther	
	2. 00	3. 00	4.00	5. 00	
	A - CAFETERIA				
1.00	CAFETERI A	<u>11.</u> 00	895, 148	<u>529, 9</u> 44	1.00
	0		895, 148	529, 944	
	B - NURSERY				
1.00	NURSERY	43.00	469, 458	97, 530	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52. 00	<u>260, 8</u> 85	5 <u>4, 1</u> 99	2.00
	0		730, 343	151, 729	
	C - UTILIZATION REVIEW COST				
1.00	OTHER ADMINISTRATIVE AND	5. 06	0	2, 535	1. 00
	GENERAL				
	0		0	2, 535	
	D - SECURITY GUARD				
1.00	PHYSICIANS' PRIVATE OFFICES	192. 00	<u> </u>	30, 023	1.00
	0		16, 146	30, 023	
	E - MED SUPPLY RECLASS				
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	2, 603, 542	1.00
	PATI ENTS				
2.00		0.00	0	0	2. 00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	O	0	5.00
6.00		0.00	О	0	6.00
7.00		0.00	0	0	7.00
8. 00		0.00	o	0	8.00
9. 00		0.00	o	0	9. 00
10.00		0.00	o	O	10.00
11. 00		0.00	0	O	11. 00
12. 00		0.00	o	O	12. 00
13. 00		0.00	o	Ö	13. 00
14. 00		0.00	o	Ö	14. 00
15. 00		0.00	o	Ö	15. 00
16. 00		0.00	O	ő	16.00
17. 00		0.00	Ö	ő	17. 00
18. 00		0.00	O	ő	18. 00
19. 00		0.00	O	ő	19. 00
20. 00		0.00	O	ő	20. 00
21. 00		0.00	0	o	21. 00
22. 00		0.00	0	o	22. 00
23. 00	1	0.00	o	0	23. 00
24. 00	1	0.00	ol Ol	0	24. 00
25. 00		0.00	0	0	25. 00
			0		
26. 00		0.00	0	0	26.00
27. 00				0	27. 00
	U DOD HOUSEKEED NO		0	2, 603, 542	
1 00	F - POB HOUSEKEEPING	0.00	ما	25 (02	4 00
1.00	HOUSEKEEPI NG	9.00	0	35, 683	1.00
2. 00			•	0	2. 00
	U		0	35, 683	
	G - I NSURANCE				
1.00	OTHER CAPITAL RELATED COSTS	3. 00	0	124, 474	1.00
2.00	PHYSICIANS' PRIVATE OFFICES	1 <u>92.</u> 00		1 <u>0, 9</u> 42	2. 00
	0		0	135, 416	
500 00	Grand Total: Increases		1, 641, 637	3, 488, 872	500.00

Provider CCN: 15-0086 Peri od: Worksheet A-6 From 01/01/2016 To 12/31/2016 Date/Time Prepared:

					1	18 9:20 am
		Decreases				
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.	
	6. 00	7. 00	8. 00	9. 00	10.00	
	A - CAFETERIA					
1.00	DI ETARY	1000	<u>895, 1</u> 48	529, 944	<u> </u>	1. 00
	0		895, 148	529, 944		
	B - NURSERY					
1.00	ADULTS & PEDIATRICS	30.00	730, 343	151, 729	0	1. 00
2.00		0.00	0	0	0	2. 00
			730, 343	151, 729		1
	C - UTILIZATION REVIEW COST					
1.00	MEDICAL RECORDS & LIBRARY	16. 00	0	2, 535	0	1. 00
				2, 535	i	1
	D - SECURITY GUARD	•			•	
1.00	OPERATION OF PLANT	7.00	16, 146	30, 023	0	1.00
			16, 146	30, 023		
	E - MED SUPPLY RECLASS		· · · · · · · · · · · · · · · · · · ·		'	
1.00	PURCHASING RECEIVING AND	5. 03	0	3, 324	0	1. 00
	STORES			•		
2.00	OTHER ADMINISTRATIVE AND	5. 06	О	1	0	2. 00
	GENERAL			•		
3.00	OPERATION OF PLANT	7. 00	О	46	o	3. 00
4.00	HOUSEKEEPI NG	9.00	o	67	o	4.00
5.00	CENTRAL SERVICE & SUPPLY	14.00	0	497, 684		5. 00
6.00	PHARMACY	15. 00	Ö	19, 503		6. 00
7. 00	ADULTS & PEDIATRICS	30.00	0	31, 070		7. 00
8. 00	INTENSIVE CARE UNIT	31. 00	0	1, 101		8. 00
9. 00	OPERATING ROOM	50.00	o	1, 531, 510		9. 00
10.00	RECOVERY ROOM	51.00	Ö	10, 377		10.00
11. 00	ANESTHESI OLOGY	53.00	0	39, 614		11.00
12. 00	RADI OLOGY-DI AGNOSTI C	54.00	o	24, 869	1	12. 00
13. 00	ULTRASOUND	54. 01	o	16, 540	1	13. 00
	1	<b>I</b>	-			1
14. 00	RADI OLOGY-THERAPEUTI C	55. 00	0	175, 249		14. 00
15.00	CT SCAN	57. 00	٩	67, 382	1	15. 00
16. 00	MAGNETIC RESONANCE IMAGING (MRI)	58. 00	0	9, 764		16. 00
17. 00	LABORATORY	60. 00	0	4, 529		17. 00
18. 00	RESPI RATORY THERAPY	65. 00	0	75, 231		18. 00
19. 00	SLEEP CLINIC	65. 01	0	58		19. 00
20.00	PHYSI CAL THERAPY	66. 00	0	4, 775		20. 00
21.00	OCCUPATI ONAL THERAPY	67.00	0	3, 705		21. 00
22.00	ELECTROCARDI OLOGY	69. 00	0	667		22. 00
23.00	EMERGENCY	91.00	0	7, 504		23. 00
24.00	HOME HEALTH AGENCY	101.00	0	12, 810		24. 00
25.00	HOSPI CE	116.00	0	64, 846	0	25. 00
26.00	PHYSICIAN CLINIC	192. 01	0	263	0	26. 00
27.00	OCCUPATI ONAL HEALTH	194. 02	0	1, 053	0	27. 00
	0			2, 603, 542		
	F - POB HOUSEKEEPING					
1.00	OPERATION OF PLANT	7. 00	0	17, 926	0	1. 00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	17, 757	0	2. 00
	0 — — — — —			35, 683		
	G - I NSURANCE	<u> </u>	<u>'</u>		<u>'</u>	
1.00	OTHER ADMINISTRATIVE AND	5. 06	0	135, 416	0	1. 00
	GENERAL					
2 00		0.00	ol	0	ol	2. 00
2.00						
∠. ∪∪		+		135, 416		

Beginning Balances   1.00   2.00   3.00   4.00   5.00						o 12/31/2016	Date/Time Pre	
Beginning Balances   Purchases   Donation   Total   Disposals and Retirements   1.00   2.00   3.00   4.00   5.00					Acqui și ți onș		3/12/2018 9: 20	0 alli
PART   - ANALYSIS OF CHANGES   N CAPITAL ASSET BALANCES   1.00   2.00   3.00   4.00   5.00			Begi nni ng	Purchases		Total	Disposals and	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00   Land   T5, 208   0   0   0   0   0   0   0   0   0			1.00	2. 00	3. 00	4. 00	5. 00	
2.00   Land Improvements	•	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	Γ BALANCES					
3.00 Buildings and Fixtures 4.00 Buildings and Fixtures 5.00 Fixed Equipment 6.00 Movable Equipment 49,992,457 7.00 HIT designated Assets 7.00 Beconciling Items 7.00 Total (line 8 minus line 9)  PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES Fixed Equipment 1.00 Buildings and Fixtures 1.00 Buildings and Fixtures 1.00 Buildings and Fixtures 1.00 Buildings and Fixtures 1.00 Building Improvements 1.00 Building Improvements 1.00 Building Improvement 1.00 Buildi	1.00	Land	75, 208	0	0	0	0	1. 00
4.00   Building Improvements   0   0   0   0   0   0   0   0   0	2.00	Land Improvements	1, 519, 621	0	0	0	0	2. 00
5.00         Fixed Equipment         0         0         0         0         5.00           6.00         Movable Equipment         49,992,457         3,314,638         0         3,314,638         2,572,495         6.00           7.00         HIT designated Assets         0         0         0         0         0         7.00           8.00         Subtotal (sum of lines 1-7)         114,590,246         7,322,536         0         7,322,536         2,572,495         8.00           9.00         Reconciling Items         0         0         0         0         0         0         9.00           10.00         Total (line 8 minus line 9)         114,590,246         7,322,536         0         7,322,536         2,572,495         10.00           Ending Balance         Fully Depreciated Assets         Fully Depreciated Assets         8.00         7.00         7.322,536         0         7,322,536         2,572,495         10.00           1.00         Land         The ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES         Fully Depreciated Assets         0         0         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00<	3.00		63, 002, 960	4, 007, 898	0	4, 007, 898	0	3. 00
6. 00   Movable Equipment	4.00	Building Improvements	0	0	0	0	0	4. 00
7. 00 HIT designated Assets 0 0 0 0 0 0 7. 00 8. 00 Subtotal (sum of lines 1-7) 114,590,246 7,322,536 0 7,322,536 2,572,495 8. 00 9. 00 0 0 0 0 0 0 9. 00 9.	5.00	Fixed Equipment	0	0	0	0	0	5. 00
8.00 Subtotal (sum of lines 1-7)	6.00	Movable Equipment	49, 992, 457	3, 314, 638	0	3, 314, 638	2, 572, 495	6. 00
9.00 Reconciling I tems 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	7.00	HIT designated Assets	0	0	0	0	0	7. 00
10.00   Total (line 8 minus line 9)   114,590,246   7,322,536   0   7,322,536   2,572,495   10.00	8.00	Subtotal (sum of lines 1-7)	114, 590, 246	7, 322, 536	0	7, 322, 536	2, 572, 495	8. 00
Ending Balance	9.00	Reconciling Items	0	0	0	0	0	9. 00
Depreciated Assets	10.00	Total (line 8 minus line 9)	114, 590, 246	7, 322, 536	0	7, 322, 536	2, 572, 495	10. 00
Assets   6.00   7.00			Endi ng Bal ance	Fully				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES				Depreci ated				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES   1.00   Land   75,208   0   1.00   2.00   Land Improvements   1,519,621   0   2.00   3.00   Buildings and Fixtures   67,010,858   0   0   0   4.00   4.00   5.00   Fixed Equipment   0   0   0   5.00   6.00   Movable Equipment   50,734,600   0   0   6.00   Movable Equipment   50,734,600   0   0   0   6.00   Movable Equipment   50,734,600   0   0   0   6.00   8.00   Subtotal (sum of lines 1-7)   119,340,287   0   0   0   8.00   9.00   Reconciling I tems   0   0   0   0   9.00   0   0   0   0   0   0   0   0   0								
1.00     Land     75, 208     0       2.00     Land Improvements     1,519,621     0       3.00     Buildings and Fixtures     67,010,858     0       4.00     Building Improvements     0     0       5.00     Fixed Equipment     0     0       6.00     Movable Equipment     50,734,600     0       7.00     HIT designated Assets     0     0       8.00     Subtotal (sum of lines 1-7)     119,340,287     0       9.00     Reconciling Items     0     0				7. 00				
2.00     Land Improvements     1,519,621     0       3.00     Buildings and Fixtures     67,010,858     0       4.00     Building Improvements     0     0       5.00     Fixed Equipment     0     0       6.00     Movable Equipment     50,734,600     0       7.00     HIT designated Assets     0     0       8.00     Subtotal (sum of lines 1-7)     119,340,287     0       9.00     Reconciling Items     0     0								
3.00 Buildings and Fixtures 67,010,858 0 3.00 4.00 Building Improvements 0 0 0 4.00 5.00 Fixed Equipment 0 0 0 5.00 6.00 Movable Equipment 50,734,600 0 6.00 HIT designated Assets 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 119,340,287 0 8.00 9.00 Reconciling Items 0 0 9.00	1.00	Land	75, 208	0				1. 00
4.00 Building Improvements 0 0 0 5.00 Fixed Equipment 0 0 0 5.00 Movable Equipment 5.00 6.00 HIT designated Assets 0 0 0 7.00 Subtotal (sum of lines 1-7) 119,340,287 0 9.00 Reconciling I tems 0 0 9.00	2.00	Land Improvements	1, 519, 621	0				2. 00
5.00     Fi xed Equi pment     0     0       6.00     Movable Equi pment     50,734,600     0       7.00     HIT desi gnated Assets     0     0       8.00     Subtotal (sum of lines 1-7)     119,340,287     0       9.00     Reconciling I tems     0     0			67, 010, 858	0				3. 00
6.00 Movable Equipment 50,734,600 0 6.00 7.00 HIT designated Assets 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 119,340,287 0 8.00 9.00 Reconciling I tems 0 0 9.00	4.00	Building Improvements	0	0				4. 00
7.00 HIT designated Assets 0 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 119,340,287 0 8.00 9.00 Reconciling I tems 0 0 9.00	5.00	Fixed Equipment	0	0				5. 00
8.00   Subtotal (sum of lines 1-7)   119,340,287   0   8.00   9.00   Reconciling I tems   0   0   9.00	6.00	Movable Equipment	50, 734, 600	0				6. 00
9.00 Reconciling I tems 0 0 9.00	7.00	HIT designated Assets	0	0				7. 00
	8.00		119, 340, 287	0				8. 00
10.00   Total (line 8 minus line 9)   119,340,287   0   10.00	9.00	Reconciling Items	0	0				9. 00
	10. 00	Total (line 8 minus line 9)	119, 340, 287	0				10.00

		DEADDODN COUNTY HOODITAL						
	Financial Systems	DEARBORN COUN			In Lieu of Form CMS-			
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider CO		Peri od:	Worksheet A-7		
					From 01/01/2016 To 12/31/2016		nared:	
				'	12/31/2010	3/12/2018 9: 20		
	·		SL	JMMARY OF CAPI	ΓAL			
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see		
					instructions)	instructions)		
		9. 00	10. 00	11. 00	12. 00	13. 00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORL	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			l	
1.00	NEW CAP REL COSTS-BLDG & FLXT	2, 976, 573	0	539, 675	0	0	1. 00	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1, 791, 890	350, 268	C	0	0	2. 00	
3.00	Total (sum of lines 1-2)	4, 768, 463	350, 268	539, 675	0	0	3. 00	
		SUMMARY 0	F CAPITAL					
	Cost Center Description	0ther	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							
4 00	NEW OAD DEL COCTO DIDO A FLVT	0,000	0 550 504	I .		,	1 4 00	

36, 283

36, 283

3, 552, 531 2, 142, 158 5, 694, 689 1. 00 2. 00 3. 00

1. 00 2. 00 NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-MVBLE EQUIP

3.00 Total (sum of lines 1-2)

Heal th	n Financial Systems	DEARBORN COUN	ITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Peri od: From 01/01/2016	Worksheet A-7 Part III	
						Date/Time Pre	
		2011		T1 00		3/12/2018 9: 20	o am
		COM	COMPUTATION OF RATIOS ALLOCATION OF OTHER				
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio	instructions)		
				(col. 1 - col			
				2)			
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C				_		
1.00	NEW CAP REL COSTS-BLDG & FIXT	68, 605, 687		68, 605, 68			1. 00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	50, 734, 600					2. 00
3.00	Total (sum of lines 1-2)	119, 340, 287		119, 340, 28			3. 00
		ALLOCA	TION OF OTHER (	CAPI TAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
	•		Capi tal -Relate		'		
			d Costs	through 7)			
		6.00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	NEW CAP REL COSTS-BLDG & FLXT	0	0	71, 55	7 2, 826, 807	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	52, 91	7 1, 790, 240	350, 268	2.00
3.00	Total (sum of lines 1-2)	0	0	124, 47	4, 617, 047	350, 268	3. 00
			Sl	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
					Capi tal -Rel ate		
			,		d Costs (see	through 14)	
					instructions)	g. · · · /	
		11. 00	12.00	13.00	14.00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI						
1.00	NEW CAP REL COSTS-BLDG & FLXT	521, 966	71, 557		0 36, 283	3, 456, 613	1. 00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0			0 0	2, 193, 425	2. 00
3.00	Total (sum of lines 1-2)	521, 966	1	1	0 36, 283		3. 00
				•			

| Period: | Worksheet A-8 | From 01/01/2016 | To 12/31/2016 | Date/Time Prepared: Health Financial Systems
ADJUSTMENTS TO EXPENSES DEARBORN COUNTY HOSPITAL Provider CCN: 15-0086

				To	12/31/2016	Date/Time Prep	
				Expense Classification on	Worksheet A	3/12/2018 9: 20	J am
				To/From Which the Amount is	to 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 0	1. 00
1.00	REL COSTS-BLDG & FIXT (chapter		U	FIXT	1.00	o o	1.00
2. 00	2) Investment income - NEW CAP		0	NEW CAP REL COSTS-MVBLE	2. 00	0	2. 00
2.00	REL COSTS-MVBLE EQUIP (chapter		0	EQUI P	2.00		2.00
3. 00	2) Investment income - other		0		0. 00	0	3. 00
	(chapter 2)		· ·				
4. 00	Trade, quantity, and time discounts (chapter 8)	В	-10, 105	OTHER ADMINISTRATIVE AND GENERAL	5. 06	0	4. 00
5.00	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
	suppliers (chapter 8)						
7. 00	Telephone services (pay stations excluded) (chapter	A	-9, 426	COMMUNI CATI ONS	5. 01	0	7. 00
	21)		4 (50	NEW 045 BEI 000TO 18/51 E			
8. 00	Television and radio service (chapter 21)	A	-1, 650	NEW CAP REL COSTS-MVBLE EQUIP	2. 00	9	8. 00
9.00	Parking Lot (chapter 21)	4.0.0	0 015 401		0. 00	0	9. 00
10. 00	Provider-based physician adjustment	A-8-2	-2, 215, 421			U	10. 00
11. 00	Sale of scrap, waste, etc.		0		0. 00	О	11. 00
12. 00	(chapter 23) Related organization	A-8-1	0			0	12. 00
13. 00	transactions (chapter 10) Laundry and linen service		0		0. 00	0	13. 00
14. 00	Cafeteria-employees and guests		-414, 767	CAFETERI A	11. 00	ō	14. 00
15. 00	Rental of quarters to employee and others	:	0		0. 00	0	15. 00
16. 00	Sale of medical and surgical		0		0. 00	0	16. 00
	supplies to other than patients						
17. 00	Sale of drugs to other than	В	-846, 792	DRUGS CHARGED TO PATIENTS	73. 00	0	17. 00
18. 00	patients Sale of medical records and	В	-14, 977	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	abstracts Nursing and allied health		0		0. 00	0	19. 00
17.00	education (tuition, fees,		0		0.00	J	17.00
20. 00	books, etc.) Vending machines		0		0. 00	0	20. 00
21. 00	Income from imposition of		0		0. 00	0	21. 00
	interest, finance or penalty charges (chapter 21)						
22. 00	Interest expense on Medicare		0		0. 00	О	22. 00
	overpayments and borrowings to repay Medicare overpayments						
23. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
	limitation (chapter 14)						
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
	limitation (chapter 14)						
25. 00	Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
27, 00	(chapter 21)		0	NEW CAD DEL COSTS DIDO 0	1 00		24 00
26. 00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT			NEW CAP REL COSTS-BLDG & FLXT	1. 00	0	26. 00
27. 00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			NEW CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
28. 00	Non-physician Anesthetist			*** Cost Center Deleted ***	19. 00		28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	0. 00 67. 00	0	29. 00 30. 00
	therapy costs in excess of		0		57.30		50
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
	instructions)	Λοο			68. 00		31. 00
31. 00	Adjustment for speech pathology costs in excess of	A-8-3	U	SPEECH PATHOLOGY	68.00		31.00
	limitation (chapter 14)	1			l		

				11	0 12/31/2010	3/12/2018 9: 2	
				Expense Classification on	Worksheet A		
				To/From Which the Amount is			
					•		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4. 00	5. 00	
32. 00	CAH HIT Adjustment for		0		0.00	0	32. 00
	Depreciation and Interest						
33.00	REV - FITNESS CENTER	В	-15, 246	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 00
34.00	AMBULANCE BILLING OFFSET	В	-875	CASHI ERI NG/ACCOUNTS	5. 05	0	34.00
				RECEI VABLE			
35.00	HEALTH SERV/WIC MANAGMNT FEE	В	-4, 409	OTHER ADMINISTRATIVE AND	5. 06	0	35. 00
				GENERAL			
36.00	RENT - LUDLOW HILL CLINIC	В	-10, 486	OTHER ADMINISTRATIVE AND	5. 06	0	36. 00
				GENERAL			
37.00	SISIC BILLING SERVICE	В	-4, 616	CASHI ERI NG/ACCOUNTS	5. 05	0	37. 00
				RECEI VABLE			
38. 00	REV - COMMUNITY EDUCATION	В	-13, 396	ADULTS & PEDIATRICS	30.00	0	38. 00
	PROGRAM		•				
39. 00	MI SCELLANEOUS I NCOME	В	-3. 741	RADI OLOGY-DI AGNOSTI C	54.00	0	39. 00
40.00	DIET - NUTRITION COUNSELING	В		DI ETARY	10. 00	0	40.00
40. 01	ADVERTI SI NG	A		OTHER ADMINISTRATIVE AND	5. 06		
10.01	/ STERRITOR NO	,,	0,,0,0	GENERAL	0.00	Ĭ	10.0.
41.00	AHA & IHA DUES	A	-6 512	OTHER ADMINISTRATIVE AND	5. 06	0	41. 00
00	7 4 77 5020	,,	0,012	GENERAL	0.00	Ĭ	55
42. 00	MISC. OFFSET	A	-33 231	OTHER ADMINISTRATIVE AND	5. 06	0	42. 00
12.00	WI 50. 0115E1	,,	00, 201	GENERAL	0.00		12.00
43.00	ADVERTISING STAFF	A	-11 240	OTHER ADMINISTRATIVE AND	5. 06	0	43. 00
10.00	/ STERRITORNO GIVILI	,,	, 2.0	GENERAL	0.00	Ĭ	10.00
44. 00	NON ALLOWABLE REPAIRS	A	-49 725	OPERATION OF PLANT	7. 00	0	44. 00
45. 00	PHYSICIAN RECRUITMENT & HSC	A		OTHER ADMINISTRATIVE AND	5. 06		45. 00
10.00	LOSS	,,	000, 210	GENERAL	0.00	Ĭ	10.00
45. 01	MENTAL HEALTH UTILITIES	A	-68 668	OPERATION OF PLANT	7. 00	0	45. 01
45. 02	NON-ALLOWABLE DEPRECIATION	A		NEW CAP REL COSTS-BLDG &	1. 00		45. 02
40.02	NON ALLOWABLE BEI REGIATION	A	147, 700	FIXT	1.00	<b>'</b>	45.02
45. 03	NON ALLOWABLE INTEREST	A	_17 709	NEW CAP REL COSTS-BLDG &	1. 00	11	45. 03
45. 65	NON ALLOWABLE TWIEREST	A	17, 707	FLXT	1.00		45.05
45. 04	MISC. NONALLOWABLE	A	_5 13 <i>4</i>	HOSPI CE	116. 00	0	45. 04
45. 05	HAF OFFSET	A		OTHER ADMINISTRATIVE AND	5. 06		
45.05	IIAI UII SEI	^		GENERAL	5.00	l "	45.05
45. 06	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	45. 06
40.00	(3)		U		0.00	l	45.00
50. 00	TOTAL (sum of lines 1 thru 49)		-7, 933, 592				50. 00
30.00	(Transfer to Worksheet A,		-1,733,392				30.00
	column 6, line 200.)						
(1) D-	scription - all chapter referen			ONC D L 45 4			

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

<sup>(2)</sup> 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.

| Period: | Worksheet A-8-2 | From 01/01/2016 | To 12/31/2016 | Date/Time Prepared: Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-0086

					1	To 12/31/2016	Date/Time Pre 3/12/2018 9:2	epared: 20 am
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
				·	·		Hours	
	1. 00	2. 00	3.00	4. 00	5. 00	6. 00	7. 00	
1.00		ADULTS & PEDIATRICS	351, 081	351, 081	0	0	0	
2.00		OPERATING ROOM	62, 250			0	0	
3.00		ANESTHESI OLOGY	1, 171, 379			0	0	
4.00		RADI OLOGY-DI AGNOSTI C	135, 490			0	0	
5.00		CT SCAN	4, 186	· ·		0	0	0.00
6.00		LABORATORY	175, 000		175, 000	260, 300	594	
7.00		RESPI RATORY THERAPY	12, 523			0	0	7. 00
8.00		ELECTROCARDI OLOGY	271, 658			0	0	0.00
9.00		EMERGENCY	240, 612		240, 612	179, 000	1, 562	1
10. 00	0. 00		0	ı	0	0	0	10.00
200.00			2, 424, 179					200.00
	Wkst. A Line #		Unadjusted RCE		Cost of		Physician Cost	
		l denti fi er	Limit	Unadjusted RCE			of Mal practice	
				Limit	Conti nui ng Educati on	Share of col.	Insurance	
	1. 00	2.00	8.00	9. 00	12. 00	13. 00	14.00	
1. 00		ADULTS & PEDIATRICS	0.00		12.00	13.00	14.00	1. 00
2. 00		OPERATING ROOM	0		0	0	0	1
3.00		ANESTHESI OLOGY	0	0	0	0	0	1
4. 00		RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	1
5. 00		CT SCAN	l o	Ö	0	Ö	Ö	
6.00		LABORATORY	74, 336	3, 717	0	0	0	1
7.00	65. 00	RESPI RATORY THERAPY	0		0	0	0	1
8.00	69. 00	ELECTROCARDI OLOGY	0	0	0	0	0	8. 00
9.00	91.00	EMERGENCY	134, 422	6, 721	0	0	0	9. 00
10.00	0.00		0	0	0	0	0	10.00
200.00			208, 758	10, 438		0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		l denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	4.00		14	1/ 00	17.00	10.00		
1.00	1.00	2.00	15. 00	16. 00	17. 00	18.00		4 00
1.00		ADULTS & PEDIATRICS	0	· ·	0	351, 081		1.00
2.00		OPERATING ROOM	0	0	0	62, 250		2.00
3.00		ANESTHESI OLOGY	0	0	0	1, 171, 379		3.00
4.00		RADI OLOGY-DI AGNOSTI C CT SCAN	0	0	0	135, 490		4. 00 5. 00
5. 00 6. 00		CT SCAN LABORATORY	0	74, 336	_	4, 186 100, 664		6.00
6. 00 7. 00		RESPI RATORY THERAPY		/4, 336 0	100, 664	12, 523		7. 00
7. 00 8. 00		ELECTROCARDI OLOGY				271, 658		8.00
9. 00		ELECTROCARDI OLOGY EMERGENCY		134, 422	106, 190	106, 190		9.00
9. 00 10. 00	0.00	LIVILINGLIVG		134, 422	100, 190	100, 190		10.00
200.00	0.00			208, 758	206, 854	2, 215, 421		200.00
200.00	ı l		1 0	1 200,730	200, 034	2,210,421	I	1 200.00

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2016 Part I Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0086

				o 12/31/2016	Date/Time Pre	
		CAPI TAL REL	ATED COSTS		3/12/2018 9: 2	o am
Cost Center Description	Net Expenses	NEW BLDG &	NEW MVBLE	EMPLOYEE	COMMUNI CATI ONS	
cost center bescription	for Cost	FIXT	EQUI P	BENEFITS	COMMONICATIONS	
	Allocation			DEPARTMENT		
	(from Wkst A col. 7)					
	0	1.00	2. 00	4. 00	5. 01	
GENERAL SERVICE COST CENTERS						
1. 00 O0100 NEW CAP REL COSTS-BLDG & FLXT	3, 456, 613	3, 456, 613	2 102 425			1.00
2.00   00200   NEW CAP REL COSTS-MVBLE EQUIP 4.00   00400   EMPLOYEE BENEFITS DEPARTMENT	2, 193, 425 10, 675, 608	20, 363	2, 193, 425 13, 150			2. 00 4. 00
5. 01 01160 COMMUNI CATI ONS	276, 395	3, 513	2, 269		322, 315	5. 01
5. 02 00550 DATA PROCESSING	2, 529, 737	33, 665	21, 739		l	5. 02
5.03   00560   PURCHASING RECEIVING AND STORES 5.04   00570   ADMITTING	346, 420 732, 210	73, 860 39, 929	47, 695 25, 784		l	5. 03 5. 04
5. 05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	1, 262, 673	7, 836	5, 060		l	5. 05
5. 06 00591 OTHER ADMINISTRATIVE AND GENERAL	2, 844, 707	121, 647	78, 554		1	5. 06
7.00   00700   OPERATION OF PLANT 8.00   00800   LAUNDRY & LINEN SERVICE	3, 033, 128 309, 975	1, 127, 841 18, 398	728, 311 11, 881		17, 310 597	7. 00 8. 00
9. 00   00900   HOUSEKEEPI NG	1, 100, 820	13, 614	8, 791		ł	9. 00
10. 00 01000 DI ETARY	429, 483	46, 227	29, 852		1, 492	10. 00
11. 00   01100   CAFETERI A 13. 00   01300   NURSI NG   ADMI NI STRATI ON	1, 010, 325 980, 791	32, 787 6, 934	21, 172		l	11. 00 13. 00
14. 00   01400 CENTRAL SERVICE & SUPPLY	476, 572	81, 915	4, 478 52, 897		1	14.00
15. 00 01500 PHARMACY	1, 798, 344	20, 525	13, 254			15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	953, 216	55, 554	35, 874		1	16.00
17. 00 01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	356, 260	6, 738	4, 351	106, 990	2, 984	17. 00
30. 00   03000   ADULTS & PEDI ATRI CS	6, 151, 902	722, 429	466, 513	1, 817, 409	44, 468	30.00
31. 00 03100 INTENSIVE CARE UNIT	1, 554, 645	85, 521	55, 225			31.00
43. 00   04300   NURSERY   ANCI LLARY SERVI CE COST CENTERS	566, 988	4, 623	2, 985	145, 795	0	43. 00
50. 00 05000 OPERATI NG ROOM	2, 254, 892	298, 004	192, 438	563, 396	13, 728	50. 00
51.00 05100 RECOVERY ROOM	708, 177	13, 441	8, 679		3, 880	51.00
52. 00   05200   DELIVERY ROOM & LABOR ROOM 53. 00   05300   ANESTHESI OLOGY	315, 084	5, 825	3, 761 119		0 2, 089	52. 00 53. 00
53. 00   05300   ANESTHESI OLOGY 54. 00   05400   RADI OLOGY - DI AGNOSTI C	23, 126 3, 265, 280	185 133, 262	86, 055			54.00
54. 01   05401   ULTRASOUND	266, 921	7, 165	4, 627	1	597	54. 01
55. 00   05500   RADI OLOGY-THERAPEUTI C	608, 538	13, 348	8, 620			55.00
57.00   05700   CT SCAN 58.00   05800   MAGNETIC RESONANCE IMAGING (MRI)	124, 286 291, 364	9, 280	5, 993	1	0	57. 00 58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	(		0	59. 00
60. 00 06000 LABORATORY	5, 406, 768	77, 662	50, 151	719, 850	l	60.00
60. 01   06001   BLOOD   LABORATORY 65. 00   06500   RESPI RATORY   THERAPY	796, 472	0 13, 452	8, 687	0 '	0 2, 388	60. 01 65. 00
65. 01   03950   SLEEP CLINIC	195, 162	0	0,007	1	5, 372	65. 01
66. 00 06600 PHYSI CAL THERAPY	1, 360, 986	87, 416	56, 449	1	0	66. 00
67. 00   06700   0CCUPATI ONAL THERAPY 68. 00   06800   SPEECH PATHOLOGY	271, 311 222, 268	9, 176 4, 900	5, 92 <i>6</i> 3, 164		3, 283 597	67. 00 68. 00
69. 00   06900   ELECTROCARDI OLOGY	1, 175, 420	37, 687	24, 336	1	10, 445	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 603, 542	0	(	0	0	71. 00
72.00   07200   IMPL. DEV. CHARGED TO PATIENT 73.00   07300   DRUGS CHARGED TO PATIENTS	2, 777, 138	0	(	0	0	72. 00 73. 00
OUTPATIENT SERVICE COST CENTERS	2, 603, 708	U		,	0	/3.00
91. 00 09100 EMERGENCY	1, 941, 329	111, 916	72, 271	532, 798	10, 445	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92. 00
101.00 10100 HOME HEALTH AGENCY	1, 074, 561	35, 653	23, 023	296, 041	1, 791	101. 00
SPECIAL PURPOSE COST CENTERS			., .		,	
113. 00 11300   NTEREST EXPENSE	504.004	2 ( 4 2	0.054	07.000		113.00
116.00 11600 HOSPICE 118.00  SUBTOTALS (SUM OF LINES 1 through 117)	524, 224 71, 850, 794	3, 640 3, 385, 931				116. 00 118. 00
NONREI MBURSABLE COST CENTERS	71,000,771	0,000,701	2, 100, 100	10,010,270	201,717	1110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	65, 151	28, 199		,	l e	190. 00
192. 00 19200  PHYSI CLANS' PRI VATE OFFI CES 192. 01 19201  PHYSI CLAN CLINI C	217, 501 126, 233	0 19, 647				192. 00 192. 01
192. 02 19202 LI FELI NE	3, 080	17, 047		0		192. 01
192. 03 19203 CREDIT UNION	0	12, 088	C	0		192. 03
192. 04 19204 BREAST MRI STUDY	1 255 105	0	(	0	l e	192. 04 192. 05
192. 05 19205  HOSPI TALI ST 194. 00 07950  COMMUNI TY MENTAL HEALTH	1, 255, 105 0	0	(	) O	l e	192. 05
194. 01 07951 MARKETI NG	278, 969	10, 748	6, 940		895	194. 01
194. 02 07953 OCCUPATI ONAL HEALTH	360, 832	0		100, 337		194. 02
194.03 07952 PATHS EDUCATION 200.00  Cross Foot Adjustments	47, 345	U	(	,		194. 03 200. 00
201.00 Negative Cost Centers		0	(	0	0	201. 00

Health Financial Systems	DEARBORN COUN	TY HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 01/01/2016 To 12/31/2016	Worksheet B Part I Date/Time Pre 3/12/2018 9:20	
		CAPI TAL REL	LATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	NEW BLDG & FIXT	NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	COMMUNI CATI ONS	
	0	1. 00	2. 00	4. 00	5. 01	
202.00 TOTAL (sum lines 118 through 201)	74, 205, 010	3, 456, 613	2, 193, 42	5 10, 709, 121	322, 315	202.00

					0 12/31/2016	Date/lime Pre   3/12/2018 9:2	
	Cost Center Description	DATA PROCESSI NG	PURCHASI NG RECEI VI NG AND STORES	ADMI TTI NG	CASHI ERI NG/ACC OUNTS RECEI VABLE	Subtotal	o am
		5. 02	5. 03	5. 04	5. 05	5A. 05	
	GENERAL SERVICE COST CENTERS				, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
1. 00 2. 00 4. 00 5. 01	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 01160 COMMUNICATIONS						1. 00 2. 00 4. 00 5. 01
5. 02 5. 03 5. 04 5. 05 5. 06	OO550   DATA PROCESSING   OO560   PURCHASING RECEIVING AND STORES   OO570   ADMITTING   OO580   CASHIERING/ACCOUNTS RECEIVABLE   OO591   OTHER ADMINISTRATIVE AND GENERAL	2, 918, 573 34, 953 96, 121 151, 463 157, 288	583, 389 2, 535 972			3, 820, 548	5. 02 5. 03 5. 04 5. 05 5. 06
7. 00 8. 00 9. 00 10. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY	40, 778 0 14, 564 93, 208	9, 352 5, 982 8, 903		o o	5, 263, 327 401, 342 1, 384, 434 691, 479	7. 00 8. 00 9. 00 10. 00
11. 00 13. 00 14. 00 15. 00 16. 00	O1100   CAFETERI A   O1300   NURSI NG ADMI NI STRATI ON   O1400   CENTRAL SERVI CE & SUPPLY   O1500   PHARMACY   O1600   MEDI CAL RECORDS & LI BRARY	0 49, 517 61, 168 90, 295 157, 288		(		1, 346, 759 1, 339, 401 810, 967 2, 448, 598 1, 480, 575	13. 00 14. 00 15. 00
17. 00	01700 SOCI AL SERVI CE INPATIENT ROUTINE SERVI CE COST CENTERS	26, 215		(	- 1	503, 944	
30. 00	03000 ADULTS & PEDIATRICS	518, 469	18, 279	819, 342	126, 103	10, 684, 914	30.00
31.00	03100 INTENSIVE CARE UNIT	78, 644	2, 322	117, 292	27, 246	2, 354, 661	31.00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	0	94, 174	4, 834	819, 399	43.00
50.00	05000 OPERATING ROOM	183, 503	110, 917	(	247, 776	3, 864, 654	50. 00
51. 00 52. 00	O5100   RECOVERY ROOM   O5200   DELIVERY ROOM & LABOR ROOM	0	1, 654			980, 746 417, 969	1
53. 00	05300 ANESTHESI OLOGY	0	2, 754			44, 492	
54.00	05400 RADI OLOGY-DI AGNOSTI C	139, 812	23, 243	C	,	4, 598, 263	
54. 01 55. 00	05401   ULTRASOUND   05500   RADI OLOGY-THERAPEUTI C	0 29, 127	1, 248 15, 110	1		381, 156 865, 337	
57. 00	05700 CT SCAN	0	8, 572			296, 082	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	3, 041	(		339, 681	
59. 00 60. 00	05900   CARDI AC CATHETERI ZATI ON   06000   LABORATORY	198, 067	103, 312	(	315, 565	0 6, 882, 716	60.00
60. 01 65. 00	06001 BL00D LABORATORY  06500 RESPIRATORY THERAPY	0 104, 859	0 3, 552	(	-	0 1, 215, 762	60. 01 65. 00
65. 01	03950 SLEEP CLINIC	0	155	(		206, 126	
66. 00 67. 00	O6600  PHYSI CAL THERAPY   O6700  OCCUPATI ONAL THERAPY	64, 080 0	2, 414 293		,	2, 016, 386 378, 628	
68. 00	06800 SPEECH PATHOLOGY	0	102	Č	I I	304, 898	
69. 00	06900 ELECTROCARDI OLOGY	0	1, 979	i		1, 486, 278	
71. 00 72. 00	07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   07200   MPL. DEV. CHARGED TO PATIENT	0	180, 503			2, 646, 140 2, 962, 375	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0				2, 704, 861	
91. 00 92. 00	OUTPATIENT SERVICE COST CENTERS  09100 EMERGENCY  09200 OBSERVATION BEDS (NON-DISTINCT PART)	99, 033	4, 134	72, 273	118, 483	2, 962, 682 0	1
101.00	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	116, 510	2, 417	(	11, 920	1, 561, 916	101. 00
	SPECIAL PURPOSE COST CENTERS   11300   INTEREST EXPENSE   11600   HOSPICE   SUBTOTALS (SUM OF LINES 1 through 117)	0 2, 504, 962			8, 481 1, 678, 313	641, 192 71, 108, 688	
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0			114, 478	
192. 00 192. 01	19200 PHYSICIANS' PRIVATE OFFICES 19201 PHYSICIAN CLINIC	372, 832 26, 215	798 486	(	0 0	645, 983 202, 478	192. 00 192. 01
192. 03	19202 LI FELI NE 19203 CREDIT UNI ON	0	0	·	o o	15, 072	192. 02 192. 03
192. 05	19204 BREAST MRI STUDY 19205 HOSPI TALI ST	11, 651	135			1, 266, 891	
	07950 COMMUNITY MENTAL HEALTH  07951 MARKETING	0 2, 913	0 205			0 338, 998	194. 00 194. 01
194. 02	07953 OCCUPATI ONAL HEALTH	2, 713	603		215	461, 987	194. 02
	07952 PATHS EDUCATION	0	10				194. 03
200. 00 201. 00	1 1	0	0		ol		200. 00 201. 00
202.00	1 1 0	2, 918, 573	583, 389	1, 103, 081	1, 678, 528	74, 205, 010	

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2016 Part I
To 12/31/2016 Date/Time Prepared:
3/12/2018 9:20 am

				'	0 12/31/2010	3/12/2018 9: 2	
	Cost Center Description	OTHER ADMI NI STRATI VE	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
		AND GENERAL 5.06	7. 00	8. 00	9. 00	10. 00	
	GENERAL SERVICE COST CENTERS				,		
1. 00 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04	O0100 NEW CAP REL COSTS-BLDG & FIXT O0200 NEW CAP REL COSTS-MYBLE EQUIP O0400 EMPLOYEE BENEFITS DEPARTMENT O1160 COMMUNI CATIONS O0550 DATA PROCESSING O0560 PURCHASING RECEIVING AND STORES O0570 ADMITTING						1. 00 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04
5. 05 5. 06 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00	00580 CASHI ERING/ACCOUNTS RECEIVABLE 00591 OTHER ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICE & SUPPLY	3, 820, 548 285, 699 21, 785 75, 148 37, 534 73, 103 72, 704 44, 020	5, 549, 026 50, 343 37, 251 126, 490 89, 713 18, 974 224, 140	473, 470 62, 195 4, 140 13, 859 0 665	1, 559, 028 36, 108 25, 610 5, 416 63, 983	895, 751 0 0 0	5. 05 5. 06 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00
15.00	01500 PHARMACY	132, 912	56, 162			0	15.00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	80, 367 27, 355	152, 009 18, 436			0	16. 00 17. 00
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	27, 333	10, 430	0	3, 203	0	17.00
30. 00	03000 ADULTS & PEDIATRICS	579, 998	1, 976, 757	148, 903	564, 288	716, 177	30.00
31.00	03100 INTENSIVE CARE UNIT	127, 813	234, 007	32, 079	66, 800	59, 207	31.00
43.00	04300 NURSERY	44, 478	12, 649	0	3, 611	0	43. 00
FO 00	ANCI LLARY SERVI CE COST CENTERS	200 777	015 410	21 042	222 771		 
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	209, 777 53, 236	815, 418 36, 777		232, 771 10, 498	0 2, 287	50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	22, 688	15, 938			2, 287	52.00
53. 00	05300 ANESTHESI OLOGY	2, 415	506		144	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	249, 598	364, 639	30, 202	104, 090	0	54.00
54. 01	05401 ULTRASOUND	20, 690	19, 606	5, 879	5, 597	0	54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	46, 971	36, 524		10, 426	0	55. 00
57. 00	05700 CT SCAN	16, 072	0	0	0	0	57. 00
58. 00 59. 00	05800   MAGNETI C RESONANCE I MAGING (MRI)   05900   CARDI AC CATHETERI ZATI ON	18, 438	25, 393	0	7, 249	0	58. 00 59. 00
60.00	06000 LABORATORY	373, 601	212, 503	4, 956	60, 662	0	60.00
60. 01	06001 BLOOD LABORATORY	0	212, 303	0	00,002	0	60. 01
65. 00	06500 RESPI RATORY THERAPY	65, 993	36, 809	7, 147	10, 507	0	65. 00
65. 01	03950 SLEEP CLINIC	11, 189	0	0	0	0	65. 01
66. 00	06600 PHYSI CAL THERAPY	109, 451	239, 193			0	66. 00
67. 00	06700 OCCUPATIONAL THERAPY	20, 552	25, 108			0	67.00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	16, 550	13, 408	0 2, 087	3, 827	0	68. 00 69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	80, 677 143, 635	103, 121 0		29, 437	0	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	160, 801	0			0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	146, 823	0	0	0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS			,			
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	160, 817	306, 233	81, 136	87, 418	12, 180	91. 00 92. 00
101.00	10100 HOME HEALTH AGENCY	84, 782	97, 555	0	27, 848	0	101. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE			_		_	113. 00
	11600 HOSPI CE	34, 805	9, 961	0	2, 844		116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)   NONREIMBURSABLE COST CENTERS	3, 652, 477	5, 355, 623	463, 888	1, 503, 819	789, 851	]118. 00 
100 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	6, 214	77, 159	0	22, 026	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	35, 065	77, 139	1, 449			192. 00
	19201 PHYSI CI AN CLI NI C	10, 991	53, 758		15, 346		192. 01
	19202 LI FELI NE	167	0	0	o		192. 02
	19203 CREDIT UNION	818	33, 077	0	9, 442		192. 03
	19204 BREAST MRI STUDY	0	0	0	0		192. 04
	19205 HOSPI TALI ST	68, 768	0	0 122	0	0 105, 900	192.05
	07950 COMMUNITY MENTAL HEALTH 07951 MARKETING	18, 401	29, 409	8, 133 0	8, 395		194. 00
	07953 OCCUPATI ONAL HEALTH	25, 077	27, 707	l ő	0, 373		194. 02
	07952 PATHS EDUCATION	2, 570	0	0	o		194. 03
200.00	1 1	]					200. 00
201.00		0	0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	3, 820, 548	5, 549, 026	473, 470	1, 559, 028	895, 751	J202. 00

Provider CCN: 15-0086

				10	0 12/31/2016	Date/lime Pre   3/12/2018 9:2	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
			ADMI NI STRATI ON	SERVI CE & SUPPLY		RECORDS & LI BRARY	
	1	11. 00	13. 00	14. 00	15. 00	16. 00	
1 00	GENERAL SERVICE COST CENTERS						1 00
1. 00 2. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	01160 COMMUNI CATI ONS						5. 01
5. 02	00550 DATA PROCESSING						5. 02
5. 03	00560 PURCHASING RECEIVING AND STORES						5. 03
5.04	00570 ADMI TTI NG						5. 04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
5.06	00591 OTHER ADMINISTRATIVE AND GENERAL						5. 06
7.00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	1 540 044					10. 00 11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	1, 549, 044 37, 581	1, 474, 076				13.00
14. 00	01400 CENTRAL SERVICE & SUPPLY	31, 751	59, 847	1, 235, 373			14. 00
15. 00	01500 PHARMACY	74, 156	0,047	1, 233, 373	2, 727, 860		15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	62, 270	Ö	0	0	1, 818, 614	1
17. 00	01700 SOCIAL SERVICE	20, 587	O	0	o	0	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	381, 818	719, 687	0	0	119, 461	30. 00
31. 00	03100 INTENSIVE CARE UNIT	78, 241	147, 476	0		29, 978	1
43. 00	04300 NURSERY	27, 267	51, 395	0	0	5, 318	43. 00
	ANCILLARY SERVICE COST CENTERS	100 150	100 550		al	074 070	
50.00	05000 OPERATING ROOM	102, 159	192, 558	0	0	271, 979	50.00
51. 00 52. 00	05100 RECOVERY ROOM	36, 436	68, 677	0	0	34, 175	1
53. 00	05200   DELI VERY ROOM & LABOR ROOM   05300   ANESTHESI OLOGY	15, 153 0	28, 562	0	0	13, 197 17, 845	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	154, 169	0	0	0	171, 584	1
54. 01	05401 ULTRASOUND	10, 393	0	0	Ö	31, 990	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	20, 468	Ö	0	ol	56, 736	1
57. 00	05700 CT SCAN	0	O	0	o	179, 590	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	o	0	o	32, 458	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	o	0	59. 00
60.00	06000 LABORATORY	174, 820	0	0	0	347, 114	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
65. 00	06500 RESPI RATORY THERAPY	41, 613	0	0	0	52, 256	
65. 01	03950 SLEEP CLINIC	0	0	0	0	5, 982	65. 01
66.00	06600 PHYSI CAL THERAPY	70, 974	0	0	0	58, 961	1
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	11, 660 8, 841	0	0	U O	6, 849	1
69. 00	06900 ELECTROCARDI OLOGY	37, 812	0	0	0	6, 362 59, 357	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1, 235, 373	0	46, 869	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	0	ő	0	Ö	6, 214	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	2, 727, 860	111, 294	
	OUTPATIENT SERVICE COST CENTERS	•					1
91.00	09100 EMERGENCY	109, 223	205, 874	0	0	130, 363	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	13, 115	101. 00
112 00	SPECIAL PURPOSE COST CENTERS						112 00
	11300   I NTEREST EXPENSE   11600   HOSPI CE	0	0	0		0 221	113. 00 116. 00
118.00		1, 507, 392	1, 474, 076	1, 235, 373	2, 727, 860	1, 818, 378	
110.00	NONREI MBURSABLE COST CENTERS	1, 507, 372	1,474,070	1, 233, 373	2, 727, 860	1,010,370	1110.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	10, 119	0	0	ol	0	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	873	ő	0	o		192. 00
	1 19201 PHYSI CI AN CLI NI C	10, 856	0	0	o		192. 01
192. 02	19202 LI FELI NE	0	o	0	o	0	192. 02
192.03	3 19203 CREDIT UNION	0	0	0	o	0	192. 03
	19204 BREAST MRI STUDY	0	0	0	0		192. 04
	5 19205 HOSPI TALI ST	0	0	0	0		192. 05
	07950 COMMUNITY MENTAL HEALTH	_ 0	0	0	0		194. 00
	1 07951 MARKETI NG	7, 165	0	0	0		194. 01
	207953 OCCUPATI ONAL HEALTH	12, 639		0	0		194. 02
200. 00	BO7952 PATHS EDUCATION Cross Foot Adjustments		ا	U	٥	0	194. 03 200. 00
200.00		0	n	n	Λ	n	200.00
201.00		1 540 044	1 474 074	1 225 272	2 727 040		
202.00	TOTAL (sum lines 118 through 201)	1, 549, 044	1, 474, 076	1, 235, 373	2, 727, 860	1, 818, 614	1202.00

	nancial Systems	DEARBORN COUNT		ON 15 000/ D		u of Form CMS-2552-1
COST ALLC	OCATION - GENERAL SERVICE COSTS		Provider C		eriod: rom 01/01/2016 0 12/31/2016	Worksheet B   Part I   Date/Time Prepared:
	Cost Contor Description	SOCIAL SERVICE	Subtotal	Intern &	Total	3/12/2018 9: 20 am
	Cost Center Description	SUCIAL SERVICE	Subtotal	Residents Cost	iotai	
				& Post		
				Stepdown		
		17. 00	24. 00	Adjustments 25.00	26. 00	
GEI	NERAL SERVICE COST CENTERS	17.00	21.00	20.00	20.00	
1	100 NEW CAP REL COSTS-BLDG & FIXT					1. 0
	200 NEW CAP REL COSTS-MVBLE EQUIP					2.0
	400 EMPLOYEE BENEFITS DEPARTMENT 160 COMMUNICATIONS					4. 0 5. 0
	550 DATA PROCESSING					5. 0
1	560 PURCHASING RECEIVING AND STORES					5. 0
	570 ADMI TTI NG					5. 0
	580 CASHIERING/ACCOUNTS RECEIVABLE 591 OTHER ADMINISTRATIVE AND GENERAL					5. 0 5. 0
1	700 OPERATION OF PLANT					7.0
	800 LAUNDRY & LINEN SERVICE					8. 0
	900 HOUSEKEEPI NG					9. 0
1	000 DI ETARY					10.0
	100 CAFETERIA 300 NURSING ADMINISTRATION					11. 0
	400 CENTRAL SERVICE & SUPPLY					14. 0
15. 00 01	500 PHARMACY					15. 0
1	600 MEDICAL RECORDS & LIBRARY	575 505				16. 0
	700 SOCIAL SERVICE PATIENT ROUTINE SERVICE COST CENTERS	575, 585				17. 0
	000 ADULTS & PEDIATRICS	530, 080	16, 422, 083	B O	16, 422, 083	30.0
1	100 INTENSIVE CARE UNIT	21, 060	3, 151, 322		3, 151, 322	31. 0
	300 NURSERY	0	964, 117	7 0	964, 117	43. 0
	CILLARY SERVICE COST CENTERS OOO OPERATING ROOM	15, 043	5, 735, 402	2 0	5, 735, 402	50. 0
1	100 RECOVERY ROOM	15, 043	1, 248, 373	1	1, 248, 373	51. 0
1	200 DELIVERY ROOM & LABOR ROOM	O	518, 057	1	518, 057	52. 0
	300 ANESTHESI OLOGY	0	65, 402	1	65, 402	53. 0
	400  RADI OLOGY-DI AGNOSTI C 401  ULTRASOUND	0	5, 672, 545 475, 311	1	5, 672, 545	54. 0 54. 0
1	500 RADI OLOGY-THERAPEUTI C	0	1, 040, 421	1	475, 311 1, 040, 421	55. 0
1	700 CT SCAN	O	491, 744	1	491, 744	57. 0
	800 MAGNETIC RESONANCE IMAGING (MRI)	0	423, 219		423, 219	58. 0
	900 CARDI AC CATHETERI ZATI ON	0	8, 056, 372	7	0 057 373	59. 0
	000 LAB0RATORY 001 BL00D LAB0RATORY	0	8, 056, 372		8, 056, 372 0	60. 0
1	500 RESPI RATORY THERAPY	O	1, 430, 087	1	1, 430, 087	65. 0
1	950 SLEEP CLINIC	0	223, 297		223, 297	65. 0
	600 PHYSI CAL THERAPY	0	2, 572, 458	1	2, 572, 458	66. 0
	700 OCCUPATIONAL THERAPY 800 SPEECH PATHOLOGY	0	450, 848 353, 886	1	450, 848 353, 886	67. 0 68. 0
1	900 ELECTROCARDI OLOGY	o	1, 798, 769	-	1, 798, 769	69. 0
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4, 072, 017		4, 072, 017	71. 0
	200 I MPL. DEV. CHARGED TO PATIENT	0	3, 129, 390	1	3, 129, 390	72.0
	300 DRUGS CHARGED TO PATIENTS TPATIENT SERVICE COST CENTERS	0	5, 690, 838	3 0	5, 690, 838	73. 0
	100 EMERGENCY	9, 402	4, 065, 328	B 0	4, 065, 328	91. 0
	200 OBSERVATION BEDS (NON-DISTINCT PART)			0		92. 0
	HER REIMBURSABLE COST CENTERS	1	1 705 01/	·I	4 705 04/	101.0
	100 HOME HEALTH AGENCY ECLAL PURPOSE COST CENTERS	0	1, 785, 216	0	1, 785, 216	101. 0
	300 I NTEREST EXPENSE					113. 0
	600 HOSPI CE	0	698, 133		698, 133	116. 0
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	575, 585	70, 534, 635	5 0	70, 534, 635	118. 0
	NREIMBURSABLE COST CENTERS OOO GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	229, 996	o	229, 996	190. 0
	200 PHYSI CLANS' PRI VATE OFFI CES	0	683, 370	1	683, 370	190. 0
	201 PHYSI CI AN CLI NI C	O	293, 429	1	293, 429	192. 0
	202 LI FELI NE	0	3, 247		3, 247	192. 0
	203 CREDIT UNION 204 BREAST MRI STUDY	0	58, 409		58, 409	192. 0 192. 0
	205 HOSPI TALI ST	0	1, 335, 659		1, 335, 659	192. 0
	950 COMMUNITY MENTAL HEALTH	O	114, 033		114, 033	194. 0
1	951 MARKETI NG	0	402, 368	1	402, 368	194. 0
1	953 OCCUPATIONAL HEALTH	0	499, 939	1	499, 939	194. 0
194. 03 07 200. 00	952 PATHS EDUCATION Cross Foot Adjustments		49, 925 C	5 O	49, 925 0	194. 0 200. 0
201.00	Negative Cost Centers	o	C		ol	201. 0
202. 00	TOTAL (sum lines 118 through 201)	575, 585	74, 205, 010	1	74, 205, 010	202. 0

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2016 Part II
To 12/31/2016 Date/Time Prepared:
3/12/2018 9:20 am Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0086

						) 12/31/2010	3/12/2018 9: 2	
PIXE   Support   PIXE   Support   PIXE   Support   Support   PIXE   Support   Suppor				CAPI TAL REI	_ATED_COSTS			
PIXE   POPERTINENT   PIXE   PIXE   POPERTINENT   POPERTI		Coot Conton Decemintion	Dimontly	NEW DLDC 0	NEW MYDLE	Cubtatal	EMDL OVEE	
Capital   Sealand Costs   1,00   2,00   2A   4,00		Cost Center Description				Subtotai		
PRIME SPENIOR CORT CIPITIES   0   2.00   2A   4.00   1.00   2.00   2A   4.00   4				1171	LGOIT			
SEREPAL SERVICE COST CENTERS								
1.00   0.000   NEW CAPT REL COSTS -BUILD & FIXT   1.00			0	1.00	2. 00	2A	4. 00	
2.00	4 00		1			T		1 4 00
0.000   DEMILY OF BEKET TS DEPARTWENT   0   20, 363   13, 100   33, 513   33, 131   4, 00   10   10   10   10   10   10   10								
0.1100  COMMUNICATIONS			0	20. 363	13 150	33 513	33 513	•
0.0000   DOBATA PRICEISSING   0   33, 666   21, 739   55, 404   991   5.02			_	·				
0.0570  ADMITTING		00550 DATA PROCESSING	0					
5.05   0.0580   0.0	5.03	00560 PURCHASING RECEIVING AND STORES	0	73, 860	47, 695	121, 555	242	5. 03
5.06   OSPO] GHTER ADMINISTRATIVE AND GENERAL   0   121, 647   78, 554   200, 201   1,875   5,00   7,00   20700   OPERATION OF PLEMT   0   1,177, 841   1,788   130, 279   171   8,00   7,00   00000   OPERATION OF PLEMT   0   18,398   11,881   30, 279   171   8,00   10,000   OPERATION OF PLEMT   0   46,227   29,535   76,079   171   8,00   10,000   DETARY   0   46,227   29,535   76,079   203   10,000   DETARY   0   46,227   29,535   76,079   203   10,000   DETARY   0   46,227   29,535   76,079   203   10,000   10,000   DETARY   0   46,227   29,535   76,079   203   10,000   14,000   CENTRAL SERVICE & SUPPLY   0   81,915   52,897   134,812   303   14,000   14,000   CENTRAL SERVICE & SUPPLY   0   81,915   52,897   134,812   303   14,000   10,000   DETARY   0   0   0,000   DETARY   0   0   0,000   DETARY   0   0   0,000   DETARY   0   0   0   0   0   0   0   0   0			0	39, 929		65, 713		•
0.000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.00000000		I I	-					•
8.00   00800   LANDRY & LINEN SERVICE   0   18, 398   11,881   30,277   171   8.00   10.00   001000   DIETARY   0   46,227   29, 982   76, 079   233   10.00   10.100   10.0			-					•
9.00   09900   MOSEKEEPI NS		1 1	-					•
10.00   1000   10   12   12   17   17   18   18   19   19   19   19   19   19			-					
11-00   0100  CAPETERIA   0   32,787   21,172   53,959   870   11,00   1300  MISSIN AMINISTRATION   0   6,934   4,478   11,412   303   14,00   14,00   CHITRAL SERVICE & SUPPLY   0   31,915   52,897   134,812   303   14,00   15,00   1500  MISSIN AMINISTRATION   0   20,525   33,934   91,428   792   10,00   10,00   MISSIN AMINISTRATION   0   35,554   35,934   91,428   792   10,00   10,00   MISSIN AMINISTRATION   0   35,554   35,934   91,428   792   10,00   10,00   MISSIN AMINISTRATION   0   10,00   MISSI		I I			· ·			•
14.00   01400   CENTRAL SERVICE & SUPPLY   0   81,915   52,897   134,812   303   14.00   16.00   10500   PREMARCY   0   20,555   13,556   33,874   91,428   792   16.00   17			0					•
15.00   01500   PHARMACY   0   20,525   13,254   33,779   1,596   15,00   17,00   01700   SOCIAL SERVICE   05.00   15,554   30,877   1,198   15,00   17,00	13.00	01300 NURSING ADMINISTRATION	o	6, 934	4, 478	11, 412	912	13. 00
16.00   01600   MEDICAL RECORDS & LIBRARY   0   5.5, 564   3.3, 874   91, 428   792   16.00   17.00   1700   0700   0800   0401   13 Per BENT ROUTINE SERVICE COST CENTERS			- 1					
17.00   01700   SOCIAL SERVICE   0   6.738   4.351   11.099   335   17.00		+ +	-		· ·			1
INPART   ENT ROUTINE SERVICE COST CENTERS   0   722,429   466,513   1,188,942   5,684   30,00   30,00   0,300   ADULTS & PEDIDITRIC S   0   722,429   466,513   1,188,942   5,684   30,00   31,00   30,00   AUSTO, APEDIDITRIC S   0   4,623   2,985   7,608   456   43,00		1 1	1					1
30.00	17.00		J U	6, 738	4, 351	11, 089	335	17.00
31.00   0.3100   INTENSI VE CARE UNIT   0   85, 521   55, 226   140, 746   1, 342   31.00	30 00		0	722 429	466 513	1 188 942	5 684	30.00
ANCILLARY SERVICE COST CENTERS			1	·				
50.00   050000   0FEATI NG ROOM   0   298.004   192, 438   490, 442   1,763   50.00   51.00   510.00   ECOUPERY ROOM   0   0   51.00   52.00   05200   DELIVERY ROOM   0   51.00   52.00   05200   DELIVERY ROOM   0   51.00   53.00   05300   ARSTHESI OLOCY   0   185   119   304   0   53.00   53.00   ARSTHESI OLOCY   0   185   119   304   0   53.00   53.00   ARSTHESI OLOCY   0   185   119   304   0   53.00   53.00   ARSTHESI OLOCY   0   185   119   304   0   53.00   53.00   ARSTHESI OLOCY   0   185   119   304   0   53.00   53.00   ARSTHESI OLOCY   0   185   119   304   0   53.00   53.00   ARSTHESI OLOCY   0   185   119   304   0   53.00   54.00   54.00   54.00   54.00   54.00   54.00   54.00   54.00   54.00   54.00   54.00   54.00   54.00   54.00   54.00   54.00   54.00   54.00   54.00   55.00   55.00   65.00   ARSTHESI OLOCY   11,792   224   54.00   55.00   65.00   65.00   ARSTHESI OLOCY   11,792   224   54.00   65.00   65.00   65.00   ARSTHESI OLOCY   11,792   24.00   44.00   65.00   65.00   65.00   ARSTHESI OLOCY   15.00   65.00   65.00   65.00   ARSTHESI OLOCY   0   0   0   0   0   0   0   0   0	43.00		0					43. 00
15.1 0.0   05.100   RECOVERY ROOM   ALADOR ROOM   0   13, 44.1   8, 67.9   22, 12.0   66.9   51.0   05.2 0.0   05.200   DELI LYEPE ROOM   & LABOR ROOM   0   5, 82.5   5, 82.5   11.9   30.4   0   53.0   05.3 0.0   05.300   ARISTHESI OLOCY   0   18.5   11.9   30.4   0   53.0   05.4 0.0   05.400   RADIOLOGY POLI AGNOSTIC   0   133, 26.2   86.055   21.9   31.7   2, 41.9   54.00   54.00   05.400   RADIOLOGY PIREAPEUTIC   0   13, 34.8   86.055   21.9   81.7   2, 41.9   54.00   57.00   05.00   0   0   0   0   0   0   0   0   0								
S2 00   05200   DELIVERY ROOM & LABOR ROOM   0   5,825   3,761   9,886   254   52,00   53.00   05300   OS400   RADIOLOGY   0   0   185   119   304   0   53,00   54.00   05400   RADIOLOGY-DIAGNOSTIC   0   133,262   86,055   219,317   2,419   54,00   55.00   05500   RADIOLOGY-HERAPPUTIC   0   13,348   8,620   21,968   427   55,00   57.00   05700   OTSOAN   0   0   0   0   0   0   0   58.00   05500   RADIOLOGY-HERAPPUTIC   0   13,348   8,620   21,968   427   55,00   59.00   05500   CT SCAN   0   0   0   0   0   0   0   0   59.00   05500   CT SCAN   0   0   0   0   0   0   0   0   59.00   05500   CARDIAC CATHETERIZATION   0   9,280   5,993   15,273   0   58,00   60.00   05600   CARDIAC CATHETERIZATION   0   77,662   50,151   127,813   2,253   60,00   60.00   06000   LABORATORY   0   77,662   50,151   127,813   2,253   60,00   60.00   06000   BLODD LABORATORY   0   70,60   0   0   0   0   0   0   65.00   05500   SEEP RATORY THERAPY   0   87,416   56,449   143,865   1,225   66,00   66.00   06600   PHYSICAL THERAPY   0   87,416   56,449   143,865   1,225   66,00   67.00   06700   OCCUPATIONAL THERAPY   0   87,416   56,449   143,865   1,225   66,00   68.00   06800   SEEP L PATHOLOGY   0   4,900   3,164   8,064   213   68,00   69.00   06900   LECTROCARDIOLOGY   0   4,900   3,164   8,064   213   68,00   69.00   06900   DELECTROCARDIOLOGY   0   37,687   24,336   62,023   551   69,00   69.00   06900   DELECTROCARDIOLOGY   0   37,687   24,336   62,023   551   69,00   69.00   06900   DELECTROCARDIOLOGY   0   3,565   23,023   58,676   927   101.00   60.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   0   77.00   60.00   07100   MEDICAL SUPPLIES COST CENTERS   61.00   07100   0   0   0   0   0   0   0   0   61.00   07100   MEDICAL SUPPLIES COST CENTERS   61.00   07100   07100   07100   07100   0   0   0   0   0   0   0   61.00   07100   07100   07100   07100			-					•
S3.00   OS300   ANSTHESI OLOGY   0   185   119   304   0   53.0   0   54.00   OS400   RADIO RADIO LAPOSTIC   0   0   7, 165   4, 677   11, 792   224   54.01   55.00   OS500   RADIO LAPOSTIC   0   0   7, 165   4, 677   11, 792   224   54.01   55.00   OS500   RADIO LOCY-THERAPEUTI C   0   13, 348   6,200   21, 966   427   55.00   OS500   RADIO LOCY-THERAPEUTI C   0   0   0   0   0   0   0   0   0		1 1						•
54.00   0.05400   RADIO LOGY - DI ACNOSTIC   0   133, 262   86, 055   219, 317   2, 419   54. 00     54.01   0.5401   ULTRASOUND   0   0   13, 348   8,620   21, 968   427   55. 00     55.00   0.05500   RADIO LOGY-THERAPEUTIC   0   13, 348   8,620   21, 968   427   55. 00     57.00   0.570   0.0500   CT SCAM   0   0   0   0   0   0   0     57.00   0.570   0.0500   CT SCAM   0   0   0   0   0   0   0   0     59.00   0.05800   MAGNETI C RESONANCE I IMAGING (MRI )   0   9, 280   5, 993   15, 272   0   58. 00     59.00   0.05900   CARDIA C CATHETERI ZATI ON   0   0   0   0   0   0   0   0   0     60.01   0.06000   LABORATORY   0   0   77, 662   50, 151   127, 813   2, 253   60. 00     60.01   0.06000   LABORATORY   0   0   0   0   0   0   0   0   0								
54. 0  05401   ULTRASQUIND		I I	_			•		
55.00   05500   RADIOLOGY-THERAPEUTIC   0   13, 348   8, 620   21, 968   427   55.00   057.00   057.00   057.00   057.00   057.00   057.00   057.00   057.00   057.00   057.00   057.00   057.00   057.00   057.00   059.			1					•
S8. 00   OSBOO MAGNETI C RESONANCE I MAGING (MRI )   0   9,280   5,993   15,273   0   58,00			_					
99.00   05900   CARDIAC CATHETER ZATION   0   0   0   0   0   0   0   0   0	57.00	05700 CT SCAN	0	0	0	0	0	57. 00
60.00   06000   LABORATORY   0   077, 662   50,151   127,813   2,253   60,00			-	9, 280	5, 993	15, 273		
60.01			-	0	0	0		•
65. 00   06500   RESPIRATORY THERAPY   0   13,452   8,687   22,139   745   65,00   65. 01   03950   SLEEP CLINIC   0   0   0   0   0   0   0   65. 01   03950   SLEEP CLINIC   0   0   0   0   0   0   66. 00   06600   PHYSICAL THERAPY   0   87,416   56,449   143,865   1,225   66.01   67. 00   06700   0CCUPATI ONAL THERAPY   0   9,176   5,926   15,102   258   67.00   68. 00   06800   SPECED   PATHOLOGY   0   4,900   3,164   8,064   213   68.00   69. 00   06900   ELECTROCARDI OLOGY   0   37,687   24,336   62,023   551   69.00   71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   74. 00   07400   07400   07400   75. 00   07400   07400   07400   07400   76. 00   07400   07400   07400   07400   77. 00   07400   07400   07400   07400   78. 00   07400   07400   07400   07400   79. 00   07400   07400   07400   07400   79. 00   07400   07400   07400   07400   79. 00   07400   07400   07400   07400   79. 00   07400   07400   07400   07400   79. 00   07400   07400   07400   07400   79. 00   07400   07400   07400   07400   79. 00   07400   07400   07400   07400   79. 00   07400   07400   07400   07400   79. 00   07400   07400   07400   07400   79. 00   07400   07400   07400   07400   79. 00   07400   07400   07400   07400   79. 00   07400   07400   07400   07400   79. 00   07400   07400   07400   07400   79. 00   07400   07400   07400   07400   79. 00   07400   07400   07400   07400   79. 00   07400   07400   07400   07400   79. 00   07400   07400   07400   07400   79. 00   07400   07400   07400   07400   79. 00   07400   07400   07400   79. 00   07400   07400   07400   07400   79. 00   07400   07400   07400   79. 00   07400   07400   07400   79. 00   07400   07400   07400   79. 00   07400   07400   07400   79. 00   07400   07400   07400   79. 00   07400   07400   07400   79. 00   07400		1 1	-	77, 662	50, 151	127, 813		•
65. 01 03950 SLEEP CLINIC 0 0 0 0 0 0 0 0 0 65. 01 66. 00 06600 PHYSICAL THERAPY 0 87, 416 56, 449 143, 865 1, 225 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0 9, 176 5, 926 15, 102 258 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 4, 900 3, 164 8, 064 213 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 37, 687 24, 336 62, 023 551 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 72. 00 073.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 72. 00 071. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			-	12 452	0 607	22 120		
66.00   06600   PHYSI CAL THERAPY   0   87, 416   56, 449   143, 865   1, 225   66, 00   67. 00   06700   0CCUPATI ONAL THERAPY   0   9, 176   5, 926   15, 102   258   67, 00   68.00   06800   SPEECH PATHOLOGY   0   4, 900   3, 164   8, 064   213   68, 069   69. 00   06900   ELECTROCARDI OLOGY   0   37, 687   24, 336   62, 023   551   69, 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   0   0   0   72. 00   07200   MPL DEV. CHARGED TO PATI ENTS   0   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATI ENT   0   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATI ENT   0   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATI ENT   0   0   0   0   0   74. 00   07100   MEDICARTI ON BEDS   MON-DISTINCT PART)   0   0   75. 00   0700   MERGENCY   0   111, 916   72, 271   184, 187   1, 668   91. 00   75. 00   0700   MERGENCY   0   35, 653   23, 023   58, 676   927   75. 00   0700   MERGENCY   0   35, 653   23, 023   58, 676   927   75. 00   0700   MERGENCY   0   35, 653   23, 023   58, 676   927   75. 00   0700   MERGENCY   0   35, 653   23, 023   58, 676   927   75. 00   0700   MERGENCY   0   35, 653   23, 023   58, 676   927   75. 00   0700   MERGENCY   0   35, 653   23, 023   58, 676   927   75. 00   0700   MERGENCY   0   35, 653   23, 023   58, 676   927   75. 00   0700   MERGENCY   0   35, 653   23, 023   58, 676   927   75. 00   0700   MERGENCY   0   35, 653   23, 023   58, 676   927   75. 00   0700   MERGENCY   0   3, 640   2, 351   5, 991   306   116, 001   75. 00   0700   MERGENCY   0   3, 640   2, 351   5, 991   306   116, 001   75. 00   0700   MERGENCY   0   3, 640   2, 351   5, 991   306   116, 001   75. 00   0700   MERGENCY   0   0   0   0   0   0   0   75. 00   0700   MERGENCY   0   0   0   0   0   0   75. 00   0700   MERGENCY   0   0   0   0   0   75. 00   0700   0700   0700   0700   0700   0700   0700   0700   0700   75. 00   0700   0700   0700   0700   0700   0700   0700   0700   75. 00   0700   0700   0700   0700   0700   0700   0700   0700   75. 00   070		I I	-	13, 432		22, 137		•
67.00   06700   OCCUPATI ONAL THERAPY   0   9,176   5,926   15,102   258   67.00   68.00   06800   SPEECH PATHOLOGY   0   4,900   3,164   8,064   213   68.00   69.00   06900   ELECTROCARDI OLLOGY   0   37,687   24,336   62,023   551   69.00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   0   72.00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   73.00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   73.00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   73.00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   73.00   07900   EMERCENCY   0   0700   0   0   0   74.00   07000   EMERCENCY   0   0700   0   0   0   75.00   07000   EMERCENCY   0   0   0   0   0   75.00   07000   EMERCENCY   0   0   0   0   0   75.00   07000   DRUGS CHARGED TO PATIENTS   0   0   0   0   76.00   07000   EMERCENCY   0   0   0   0   0   77.00   07000   EMERCENCY   0   0   0   0   0   78.00   07000   EMERCENCY   0   0   0   0   0   79.00   07000   DRUGS COST CENTERS   0   0   0   0   79.00   07000   DRUGS COST CENTERS   0   0   0   0   79.00   07000   DRUGS COST CENTERS   0   0   0   0   79.00   07000   DRUGS COST CENTERS   0   0   0   0   79.00   07000   DRUGS COST CENTERS   0   0   0   0   79.00   07000   DRUGS COST CENTERS   0   0   0   0   79.00   07000   DRUGS COST CENTERS   0   0   0   0   79.00   07000   DRUGS COST CENTERS   0   0   0   0   79.00   07000   DRUGS COST CENTERS   0   0   0   0   79.00   07000   DRUGS COST CENTERS   0   0   0   0   79.00   07000   DRUGS COST CENTERS   0   0   0   0   79.00   07000   DRUGS COST CENTERS   0   0   0   0   79.00   07000   DRUGS COST CENTERS   0   0   0   0   79.00   07000   DRUGS COST CENTERS   0   0   0   0   79.00   07000   DRUGS COST CENTERS   0   0   0   0   79.00   07000   DRUGS COST CENTERS   0   0   0   0   79.00   07000   DRUGS COST CENTERS   0   0   0   0   79.00   07000   DRUGS COST CENTERS   0   0   0   0   79.00   07000   DRUGS COST CENTERS   0   0   0   0   79.00   DRUGS COST CENTERS   0   0		I I	-	87, 416	56, 449	143, 865		
69.00   06900   ELECTROCARDIOLOGY   0   37,687   24,336   62,023   551   69,00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   0   72.00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   73.00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   73.00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   73.00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   73.00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   73.00   07400   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   73.00   07400   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   73.00   07400   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   74.00   09100   EMERGENCY   0   111,916   72,271   184,187   1,668   91.00   75.00   09200   085ERVATION BEDS (NON-DISTINCT PART)   0   0   35,653   23,023   58,676   927   75.00   07400   DRUGS COST CENTERS   0   0   35,653   23,023   58,676   927   75.00   113.00   INTEREST EXPENSE   113.00   11600   HOSPICE   0   3,640   2,351   5,991   306   116.00   75.00   11600   HOSPICE   0   3,640   2,351   5,991   306   116.00   75.00   07400   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   3,385,931   2,186,485   5,572,416   32,916   118.00   75.00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   0   192.00   75.00   192.01   19201   PHYSI CI AN CLI NI C   0   19,647   0   19,647   84   192.01   75.01   192.01   19201   PHYSI CI AN CLI NI C   0   19,647   0   19,647   84   192.01   75.02   192.03   192.04   19204   BREAST MRI STUDY   0   0   0   0   0   0   192.05   75.04   192.05   19205   HOSPI TALI STUDY   0   0   0   0   0   0   194.00   75.04   192.05   19205   HOSPI TALI STUDY   0   0   0   0   0   0   0   194.00   75.04   192.05   19205   HOSPI TALI STUDY   0   0   0   0   0   0   0   194.00   75.04   192.05   19205   HOSPI TALI STUDY   0   0   0   0   0   0   0   0   0	67. 00		o			15, 102		67. 00
77. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 72. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 72. 00 73. 00 07300 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 72. 00 73. 00 07300 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 73. 00 00 00 0 0 0 0 0 73. 00 00 00 0 0 0 0 0 73. 00 00 00 0 0 0 0 0 0 73. 00 00 00 0 0 0 0 0 0 0 0 0 73. 00 00 00 00 0 0 0 0 0 0 0 0 0 0 0 0 0	68. 00		O	4, 900	3, 164	8, 064	213	68. 00
72. 00   07200   IMPL   DEV. CHARGED TO PATIENT   0   0   0   0   0   0   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   0   0UTPATIENT SERVICE COST CENTERS  91. 00   09100   EMERGENCY   0   111, 916   72, 271   184, 187   1, 668   91. 00   00			1					
07300   DRUGS CHARGED TO PATIENTS			-		1	0		
91.00   O9100  EMERGENCY   0   1111, 916   72, 271   184, 187   1, 668   91.00   92.00   09200  DBSERVATI ON BEDS (NON-DISTINCT PART)   0   35, 653   23, 023   58, 676   92.7   101.00   00140ME HEALTH AGENCY   0   35, 653   23, 023   58, 676   92.7   101.00   00140ME HEALTH AGENCY   0   3, 640   2, 351   5, 991   306   116.00   118.00   INTEREST EXPENSE   113.00   INTEREST EXPENSE   118.00   NONREI MBURSABLE COST CENTERS   119.00   0   28, 199   0   28, 199   63   190.00   192.00   19200   PHYSI CI ANS CLI NIC C   0   19, 647   0   19, 647   84   192.01   192.01   19201   PHYSI CI AN CLI NI C   0   19, 647   0   19, 647   84   192.01				-	-	O O		
91. 00   09100   EMERGENCY   0   09100   EMERGENCY   0   09200   0BSERVATI ON BEDS (NON-DISTINCT PART)   0   0   1111, 916   72, 271   184, 187   0   92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART)   92. 00   010100   HOME HEALTH AGENCY   0   35, 653   23, 023   58, 676   927   101. 00   010100   HOME HEALTH AGENCY   0   35, 653   23, 023   58, 676   927   101. 00   01100   HOME HEALTH AGENCY   0   3, 640   2, 351   5, 991   306   116. 00   116. 00   10100   HOME HEALTH AGENCY   0   3, 385, 931   2, 186, 485   5, 572, 416   32, 916   118. 00	73.00		l o	0	l 0	U <sub>I</sub>	0	73.00
92. 00 OP200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REI MBURSABLE COST CENTERS  101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS  113. 00 11300 INTEREST EXPENSE 116. 00 11600 HOSPI CE SUBTOTALS (SUM OF LINES 1 through 117) O 3, 385, 931 2, 186, 485 5, 572, 416 32, 916 118. 00 NONREI MBURSABLE COST CENTERS  190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN O 0 28, 199 0 28, 199 63 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES O 0 0 0 0 0 19, 647 0 19, 647 84 192. 01 192. 01 19201 PHYSI CI ANS' PRI VATE OFFI CES O 0 0 0 0 0 0 0 192. 02 192. 02 19202 LI FELI NE O 0 0 0 0 0 0 0 192. 02 192. 03 19203 CREDIT UNI ON O 12, 088 0 12, 088 0 192. 03 192. 04 19204 BREAST MRI STUDY O 0 0 0 0 0 0 0 0 192. 04 194. 01 07951 MARKETING O 0 10, 748 6, 940 17, 688 120 194. 01 194. 02 07953 OCCUMUNIT TY MENTAL HEALTH O 0 0 0 0 0 0 0 194. 02 194. 03 07952 PATHS EDUCATION O Negative Cost Centers O 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	91. 00		l ol	111, 916	72, 271	184, 187	1, 668	91.00
101. 00   10100   HOME   HEALTH   AGENCY   SPECI   AL PURPOSE COST CENTERS   SUBTOTALS (SUM OF LINES 1 through 117)   O   3, 3640   2, 351   5, 991   306   116. 00   118. 00   SUBTOTALS (SUM OF LINES 1 through 117)   O   3, 385, 931   2, 186, 485   5, 572, 416   32, 916   118. 00   NONREI   MBURSABLE COST CENTERS   SPECIAL   AL PURPOSE COST CENTERS   SPECIAL   A				,	ŕ	0	,	
113. 00   11300   NTEREST EXPENSE								
113.00	101. 0		0	35, 653	23, 023	58, 676	927	101. 00
116.00   11600   HOSPI CE   SUBTOTALS (SUM OF LINES 1 through 117)   0   3, 3640   2, 351   5, 991   306   116.00	440.0		1			T		1440 00
118.00   SUBTOTALS (SUM OF LINES 1 through 117)   0   3,385,931   2,186,485   5,572,416   32,916   118.00   NONREI MBURSABLE COST CENTERS   190.00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   28,199   0   28,199   63   190.00   192.00   19200				2 640	2 251	5 001	206	
NONREI MBURSABLE COST CENTERS   190.00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   28, 199   0   28, 199   63   190.00   192.00   19200   19200   19210   19			1					
190. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   28, 199   0   0   1900   19200   19200   19200   19200   19200   19200   19201   19201   19201   19201   19201   19201   19201   19201   19201   19201   19201   19202   19202   19202   19202   19202   19202   19202   19202   19202   19203   1	110.0		<u> </u>	3, 303, 731	2, 100, 403	3, 372, 410	32, 710	1110.00
192. 01 19201 PHYSI CI AN CLINI C 0 19. 647 0 19. 647 84 192. 01 192. 02 19202 LI FELI NE 0 0 0 0 0 0 192. 02 19202 LI FELI NE 0 0 0 0 0 0 192. 02 192. 03 19203 CREDI T UNI ON 0 12, 088 0 12, 088 0 192. 03 192. 04 19204 BREAST MRI STUDY 0 0 0 0 0 0 0 192. 04 192. 05 19205 HOSPI TALI ST 0 0 0 0 0 0 0 192. 05 194. 00 07950 COMMUNI TY MENTAL HEALTH 0 0 0 0 0 0 194. 00 194. 00 194. 01 194. 01 194. 02 194. 02 194. 03 194. 02 194. 03 194. 0	190.0		0	28, 199	0	28, 199	63	190. 00
192. 02 19202 LI FELI NE 0 0 0 0 0 0 192. 02 192. 03 19203 CREDI T UNI ON 0 12, 088 0 12, 088 0 192. 03 192. 04 19204 BREAST MRI STUDY 0 0 0 0 0 0 192. 04 192. 05 19205 HOSPI TALI ST 0 0 0 0 0 0 0 192. 05 194. 00 07950 COMMUNI TY MENTAL HEALTH 0 0 0 0 0 0 194. 00 194. 00 194. 01 194. 02 07953 OCCUPATI ONAL HEALTH 0 0 0 0 0 0 194. 01 194. 01 194. 02 07953 OCCUPATI ONAL HEALTH 0 0 0 0 0 0 0 194. 03 194. 03 197952 PATHS EDUCATI ON 0 0 0 0 0 194. 03 200. 00 Cross Foot Adjustments 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0	0	0	16	192. 00
192. 03 19203 CREDIT UNION 0 12, 088 0 12, 088 0 192. 03 192. 04 19204 BREAST MRI STUDY 0 0 0 0 0 0 192. 04 192. 05 19205 HOSPI TALIST 0 0 0 0 0 0 192. 05 194. 00 07950 COMMUNI TY MENTAL HEALTH 0 0 0 0 0 0 194. 00 194. 00 194. 01 07951 MARKETI NG 0 10, 748 6, 940 17, 688 120 194. 01 194. 02 07953 OCCUPATI ONAL HEALTH 0 0 0 0 0 0 314 194. 02 194. 03 07952 PATHS EDUCATI ON 0 0 0 0 0 194. 03 200. 00 Cross Foot Adjustments 0 Negati ve Cost Centers 0 0 0 0 0 0 0 0 201. 00			0	19, 647	0	19, 647		
192. 04 19204 BREAST MRI STUDY  192. 05 19205 HOSPI TALI ST  0 0 0 0 0 0 0 192. 05 194. 00 195. 05 194. 00 195. 05 194. 00 195. 05 194. 00 195. 05 195			0	0	0	0		
192. 05   19205   HOSPI TALI ST			0	12, 088	0	12, 088		
194. 00 07950 COMMUNITY MENTAL HEALTH 0 0 0 10,748 6,940 17,688 120 194. 01 194. 02 07953 OCCUPATIONAL HEALTH 0 0 0 0 0 0 314 194. 02 194. 03 07952 PATHS EDUCATION 0 0 0 0 0 194. 03 200. 00 Cross Foot Adjustments 0 Negative Cost Centers 0 0 0 0 0 0 0 0 201. 00			0	0	0	O O		
194. 01 07951 MARKETING 0 10,748 6,940 17,688 120 194. 01 194. 02 07953 OCCUPATIONAL HEALTH 0 0 0 0 0 314 194. 02 194. 03 07952 PATHS EDUCATION 0 0 0 0 194. 03 200. 00 Cross Foot Adjustments 0 Negative Cost Centers 0 0 0 0 0 0 201. 00		I I		0	0	0		
194. 02 07953 OCCUPATIONAL HEALTH 0 0 0 0 0 314 194. 02 194. 03 07952 PATHS EDUCATION 0 0 0 0 194. 03 200. 00 Cross Foot Adjustments 0 Negative Cost Centers 0 0 0 0 0 201. 00				10. 748	6. 940	17. 688		
194. 03 07952 PATHS EDUCATION 0 0 0 194. 03 200. 00 201. 00 Negative Cost Centers 0 0 0 0 201. 00				0	0	0		
201.00   Negative Cost Centers   0   0   0   201.00			0	0	0	0		
		1 1				O		
202.00			[ _ [	0	0	0		
	202. 0	ગુ   IUTAL (sum lines 118 through 201)	0	3, 456, 613	2, 193, 425	5, 650, 038	33, 513	J2U2. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0086

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2016 Part II
To 12/31/2016 Date/Time Prepared:
3/12/2018 9:20 am

					) 12/31/2016	3/12/2018 9: 2	
	Cost Center Description	COMMUNI CATIONS	DATA	PURCHASI NG	ADMI TTI NG	CASHI ERI NG/ACC	
			PROCESSI NG	RECEIVING AND		OUNTS	
		5.04	F 00	STORES	F 04	RECEI VABLE	
	CENEDAL CEDVICE COST CENTEDS	5. 01	5. 02	5. 03	5. 04	5. 05	
1. 00	GENERAL SERVICE COST CENTERS OO100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			•			4. 00
5. 01	01160 COMMUNI CATI ONS	5, 908					5. 01
5. 02	00550 DATA PROCESSING	306	56, 701				5. 02
5. 03	00560 PURCHASING RECEIVING AND STORES	60	679	122, 536			5. 03
5. 04	00570 ADMI TTI NG	98	1, 867		68, 840		5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	274	2, 943	1	0	17, 054	5. 05
5.06	00591 OTHER ADMINISTRATIVE AND GENERAL	170	3, 056	1	0	0	5. 06
7.00	00700 OPERATION OF PLANT	317	792	1, 964	0	0	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	11	0	1, 257	0	0	8. 00
9.00	00900 HOUSEKEEPI NG	98	283		0	0	9. 00
10.00	01000 DI ETARY	27	1, 811	1, 481	0	0	10. 00
11. 00	01100 CAFETERI A	82	0	0	0	0	11. 00
13. 00	01300 NURSING ADMINISTRATION	98	962	1	0	0	13. 00
14. 00	01400 CENTRAL SERVI CE & SUPPLY	77	1, 188	1	0	0	14. 00
15. 00	01500 PHARMACY	186	1, 754	1	0	0	15. 00
16.00	01600 MEDI CAL RECORDS & LI BRARY	438	3, 056	1	0	0	16. 00
17. 00	01700 SOCI AL SERVI CE	55	509	85	0	0	17. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	015	10.072	2 020	F1 122	1 270	20.00
30.00	03000 ADULTS & PEDIATRICS	815	10, 073		51, 133	1, 278	30.00
31.00	03100 I NTENSI VE CARE UNI T 04300 NURSERY	93	1, 528 0		7, 320 5, 977	276	31.00
43. 00	ANCI LLARY SERVI CE COST CENTERS	U U		ıj U	5, 877	49	43. 00
50. 00	05000 OPERATING ROOM	252	3, 565	23, 298	0	2, 511	50. 00
51. 00	05100 RECOVERY ROOM	71	3, 303		0	315	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	124	52. 00
53. 00	05300 ANESTHESI OLOGY	38	0	578	0	164	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	394	2, 716		0	1, 582	54. 00
54. 01	05401 ULTRASOUND	11	_, 0	262	0	295	54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	44	566	1	0	525	55. 00
57. 00	05700 CT SCAN	0	0	1, 801	0	1, 654	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	o	0	639	0	304	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
60.00	06000 LABORATORY	208	3, 848	21, 700	0	3, 240	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
65.00	06500 RESPI RATORY THERAPY	44	2, 037	746	0	489	65. 00
65. 01	03950 SLEEP CLINIC	98	0	33	0	55	65. 01
66. 00	06600 PHYSI CAL THERAPY	0	1, 245	507	0	543	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	60	0	62	0	63	67. 00
68. 00	06800 SPEECH PATHOLOGY	11	0	21	0	59	68. 00
69. 00	06900 ELECTROCARDI OLOGY	191	0	416	0	613	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	432	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	0	37, 911	0	48	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	1, 025	73. 00
01 00	OUTPATIENT SERVICE COST CENTERS O9100 EMERGENCY	191	1 024	040	4 E10	1 201	01 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	191	1, 924	868	4, 510	1, 201	91. 00 92. 00
92.00	OTHER REIMBURSABLE COST CENTERS						92.00
101 00	10100 HOME HEALTH AGENCY	33	2, 264	508	0	121	101. 00
101.00	SPECIAL PURPOSE COST CENTERS	33	2, 204	300	<u> </u>	121	101.00
113 00	11300   I NTEREST EXPENSE						113. 00
	11600 H0SPI CE	0	0	986	0	86	116. 00
118.00	1 1	4, 851	48, 666		68, 840	17, 052	
	NONREI MBURSABLE COST CENTERS	.,	,	1227 555	55/ 5.5	,	
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	16	0	0	0	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	915	7, 243	168	0	0	192. 00
192. 01	19201 PHYSICIAN CLINIC	55	509	102	0	0	192. 01
192. 02	19202 LI FELI NE	0	0	0	0	0	192. 02
192.03	19203 CREDIT UNION	55	0	0	0	0	192. 03
192. 04	19204 BREAST MRI STUDY	0	0	0	0		192. 04
	19205 HOSPI TALI ST	0	226	1	0		192. 05
	07950 COMMUNITY MENTAL HEALTH	0	0		0		194. 00
	07951 MARKETI NG	16	57	1	0		194. 01
	07953 OCCUPATI ONAL HEALTH	0	0	127	0		194. 02
	07952 PATHS EDUCATION	0	0	2	0	0	194. 03
200.00	1 1						200. 00
201.00		0	0	0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	5, 908	56, 701	122, 536	68, 840	17, 054	J2U2. UU

| Period: | Worksheet B | From 01/01/2016 | Part II | To | 12/31/2016 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0086

					o 12/31/2016		
	Cost Center Description	OTHER ADMI NI STRATI VE	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	3/12/2018 9: 2 DI ETARY	o am
		AND GENERAL 5.06	7. 00	8.00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS	3.00	7.00	0.00	7. 00	10.00	
1. 00 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 5. 05	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 01160 COMMUNICATIONS 00550 DATA PROCESSING 00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING 00580 CASHIERING/ACCOUNTS RECEIVABLE						1. 00 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 5. 05
5.06	00591 OTHER ADMINISTRATIVE AND GENERAL	207, 404					5. 06
7. 00 8. 00	00700 OPERATION OF PLANT	15, 511	1, 875, 696				7. 00
9. 00	O0800   LAUNDRY & LINEN SERVICE   O0900   HOUSEKEEPING	1, 183 4, 080	17, 017 12, 592				8. 00 9. 00
10. 00	01000 DI ETARY	2, 038	42, 757			126, 018	10. 00
11.00	01100 CAFETERI A	3, 969	30, 325			0	11.00
13. 00 14. 00	01300   NURSI NG ADMI NI STRATI ON   01400   CENTRAL SERVI CE & SUPPLY	3, 947 2, 390	6, 413 75, 765			0	13. 00 14. 00
15. 00	01500 PHARMACY	7, 216	18, 984			0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	4, 363	51, 383		,	0	16. 00
17. 00	01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	1, 485	6, 232	C	164	0	17. 00
30. 00	03000 ADULTS & PEDIATRICS	31, 470	668, 187	15, 701	17, 593	100, 754	30. 00
31. 00	03100 INTENSIVE CARE UNIT	6, 939	79, 100			8, 330	31. 00
43. 00	04300 NURSERY	2, 415	4, 276	C	113	0	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS    O5000   OPERATING ROOM	11, 389	275, 630	3, 273	7, 258	0	50. 00
51. 00	05100 RECOVERY ROOM	2, 890	12, 431	2, 693		322	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1, 232	5, 387	C		0	52. 00
53. 00 54. 00	05300  ANESTHESI OLOGY   05400  RADI OLOGY-DI AGNOSTI C	131 13, 551	171 123, 256	0 3, 184	-	0	53. 00 54. 00
54. 01	05401 ULTRASOUND	1, 123	6, 627	620		0	54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	2, 550	12, 346	1		0	55. 00
57. 00 58. 00	05700 CT SCAN	873	0 503	0		0	57. 00 58. 00
59. 00	05800   MAGNETIC RESONANCE I MAGING (MRI)   05900   CARDIAC CATHETERIZATION	1, 001	8, 583 0			0	59.00
60.00	06000 LABORATORY	20, 283	71, 831	523	1, 891	0	60.00
60. 01	06001 BLOOD LABORATORY	0	12 442	0		0	60. 01
65. 00 65. 01	06500   RESPI RATORY   THERAPY   03950   SLEEP   CLI NI C	3, 583 607	12, 442 0	753 0		0	65. 00 65. 01
66. 00	06600 PHYSI CAL THERAPY	5, 942	80, 853	971	2, 129	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	1, 116	8, 487			0	67. 00
68. 00 69. 00	06800   SPEECH   PATHOLOGY   06900   ELECTROCARDI OLOGY	899 4, 380	4, 532 34, 857			0	68. 00 69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	7, 798	0 34, 037	1		0	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	8, 730	0			0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	7, 971	0	C	0	0	73. 00
91. 00	09100 EMERGENCY	8, 731	103, 514	8, 554	2, 726	1, 714	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
101 00	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	4, 603	32, 976	С	868	0	101. 00
101.00	SPECIAL PURPOSE COST CENTERS	4, 003	32, 470		000		101.00
	11300   NTEREST EXPENSE						113. 00
116. 00 118. 00	11600 HOSPI CE	1, 890	3, 367				116. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)   NONREIMBURSABLE COST CENTERS	198, 279	1, 810, 321	48, 908	46, 890	111, 120	118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	337	26, 081	C	687	0	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	1, 904	0	153			192. 00
	19201   PHYSI CI AN CLI NI C   19202   LI FELI NE	597 9	18, 172	0			192. 01 192. 02
	19203 CREDIT UNION	44	11, 181		-		192. 02
	19204 BREAST MRI STUDY	o	0	C	-		192. 04
	19205 HOSPITALIST  07950 COMMUNITY MENTAL HEALTH	3, 734	0	0 857	0	0 14, 898	192. 05
	07950 COMMONTTY MENTAL HEALTH	999	9, 941	007	262		194. 00
194. 02	07953 OCCUPATI ONAL HEALTH	1, 361	0	C	0	0	194. 02
	07952 PATHS EDUCATION	140	0	C	0	0	194. 03
200. 00 201. 00		0	0	l o	0	0	200. 00 201. 00
202.00		207, 404	1, 875, 696	49, 918	48, 612	126, 018	202. 00

Provider CCN: 15-0086

				10	12/31/2016	Date/lime Pre   3/12/2018 9:2	
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICE &	PHARMACY	MEDI CAL RECORDS &	O dill
				SUPPLY		LI BRARY	
	GENERAL SERVICE COST CENTERS	11.00	13. 00	14. 00	15. 00	16. 00	
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	01160 COMMUNI CATI ONS						5. 01
5. 02	00550 DATA PROCESSING						5. 02
5. 03 5. 04	00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING						5. 03 5. 04
5. 05	00570 ADMITTING 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
5. 06	00591 OTHER ADMINISTRATIVE AND GENERAL						5. 06
7. 00	00700 OPERATION OF PLANT						7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY	01 4/5					10.00
11. 00 13. 00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	91, 465 2, 219	26, 325				11. 00 13. 00
	01400 CENTRAL SERVICE & SUPPLY	1, 875	1, 069	227, 372			14. 00
	01500 PHARMACY	4, 379	0	0	69, 520		15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	3, 677	0	0	o	156, 850	16. 00
17. 00	01700 SOCIAL SERVICE	1, 216	0	0	0	0	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	I 00 544	40.050		ما	10.007	
30.00	03000 ADULTS & PEDIATRICS	22, 544	12, 852	0	0	10, 297	1
31. 00 43. 00	03100 I NTENSI VE CARE UNI T 04300 NURSERY	4, 620 1, 610		0 0	0	2, 584 458	1
43.00	ANCI LLARY SERVI CE COST CENTERS	1,010	710	U	<u> </u>	430	43.00
50. 00	05000 OPERATING ROOM	6, 032	3, 439	0	0	23, 443	50.00
51. 00	05100 RECOVERY ROOM	2, 151	1, 226	0	0	2, 946	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	895	510	0	0	1, 137	52. 00
53. 00	05300 ANESTHESI OLOGY	0	0	0	0	1, 538	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	9, 103	0	0	0	14, 789	1
54. 01 55. 00	05401 ULTRASOUND 05500  RADI OLOGY-THERAPEUTI C	614 1, 209	0	0	0	2, 757 4, 890	1
57. 00	05700 CT SCAN	1, 207	0	0	o	15, 479	1
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	Ō	Ō	2, 798	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	o	0	59. 00
60.00	06000 LABORATORY	10, 322	0	0	0	30, 019	1
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	1
65. 00 65. 01	06500 RESPI RATORY THERAPY 03950 SLEEP CLINIC	2, 457	0	0	0	4, 504 516	1
66. 00	06600 PHYSI CAL THERAPY	4, 191	0	0	0	5, 082	1
67. 00	06700 OCCUPATI ONAL THERAPY	688	0	0	o	590	1
68. 00	06800 SPEECH PATHOLOGY	522	0	0	o	548	1
69. 00	06900 ELECTROCARDI OLOGY	2, 233	0	0	0	5, 116	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	227, 372	0	4, 040	1
72. 00	07200 MPL. DEV. CHARGED TO PATIENT	0	0	0	(0.520	536	1
73. 00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	0	0	69, 520	9, 593	73. 00
	09100 EMERGENCY	6, 449	3, 677	0	ol	11, 236	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0,117	0,077	J	Ğ	11, 200	92.00
	OTHER REIMBURSABLE COST CENTERS						]
	10100 HOME HEALTH AGENCY	0	0	0	0	1, 130	101. 00
	SPECIAL PURPOSE COST CENTERS	T					
	11300   I NTEREST EXPENSE 11600   HOSPI CE			0		004	113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0 89, 006	26, 325	227, 372	69, 520	156, 830	116.00
110.00	NONREI MBURSABLE COST CENTERS	07,000	20, 323	221, 312	07, 520	150, 650	1118.00
190. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	597	0	0	O	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	52	0	0	o		192. 00
	19201 PHYSICIAN CLINIC	641	0	0	0		192. 01
	19202 LI FELI NE	0	0	0	0		192. 02
	19203 CREDIT UNION	0	0	0	0		192. 03
	19204 BREAST MRI STUDY 19205 HOSPITALIST	0	0	0	0		192. 04 192. 05
	07950 COMMUNITY MENTAL HEALTH	0	0	0	0		194. 00
	07951 MARKETI NG	423	ő	Ö	ől		194. 01
194. 02	07953 OCCUPATI ONAL HEALTH	746	0	0	o		194. 02
	07952 PATHS EDUCATION	0	0	0	0	0	194. 03
200.00	Cross Foot Adjustments					_	200. 00
201. 00 202. 00	Negative Cost Centers TOTAL (sum lines 118 through 201)	91, 465	0 26, 325	0 227, 372	69, 520	0 156, 850	201.00
202.00	TOTAL (Sum TITIES TTO EMOUGH 201)	71, 405	20, 323	221, 312	07, 320	130, 030	1202.00

From 01/01/2016 Part II Date/Time Prepared: 12/31/2016 3/12/2018 9:20 am Cost Center Description SOCIAL SERVICE Total Subtotal Intern & Residents Cost & Post Stepdown Adjustments 17.00 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 01160 COMMUNI CATI ONS 5.01 5.01 00550 DATA PROCESSING 5.02 5.02 5.03 00560 PURCHASING RECEIVING AND STORES 5.03 5.04 00570 ADMITTING 5.04 5.05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.05 00591 OTHER ADMINISTRATIVE AND GENERAL 5 06 5 06 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICE & SUPPLY 14 00 14 00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 01700 SOCIAL SERVICE 17.00 17.00 21, 170 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 19, 496 2, 160, 658 0 2, 160, 658 30.00 03100 INTENSIVE CARE UNIT 0 262, 240 31.00 775 262, 240 31.00 43.00 04300 NURSERY 23, 780 0 23, 780 43.00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 553 852, 848 0 852, 848 50.00 05100 RECOVERY ROOM 0 51.00 0 48, 508 48.508 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 19, 267 0 52.00 19, 267 52.00 2, 929 0 05300 ANESTHESI OLOGY 53.00 2.929 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 00000000000 398, 439 0 398, 439 54.00 05401 ULTRASOUND 0 24, 500 54.01 24, 500 54.01 55.00 05500 RADI OLOGY-THERAPEUTI C 48, 441 0 48, 441 55.00 0 57 00 05700 CT SCAN 19, 807 19, 807 57 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 28, 824 28, 824 58.00 05900 CARDIAC CATHETERIZATION 0 59.00 59.00 0 06000 LABORATORY 60.00 293, 931 293, 931 60.00 06001 BLOOD LABORATORY 60.01 60.01 65.00 06500 RESPIRATORY THERAPY 50, 267 0 50, 267 65.00 03950 SLEEP CLINIC 65.01 1, 309 1.309 65.01 06600 PHYSI CAL THERAPY 246, 553 0 66.00 246, 553 66.00 26, 742 67.00 06700 OCCUPATIONAL THERAPY 0 0 0 0 26, 742 67.00 68.00 06800 SPEECH PATHOLOGY 14, 988 0 14, 988 68.00 06900 ELECTROCARDI OLOGY 0 111, 518 69.00 111, 518 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 239, 642 239, 642 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 47, 225 0 47, 225 72.00 07300 DRUGS CHARGED TO PATIENTS 88, 109 0 88, 109 73.00 73.00 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 346 341, 496 0 341, 496 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 102, 106 0 102, 106 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | I NTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 13, 519 0 13 519 116 00 SUBTOTALS (SUM OF LINES 1 through 117) 0 118.00 21, 170 5, 467, 646 5, 467, 646 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 55, 980 0 55, 980 190.00 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 10, 451 10, 451 192 00 192. 01 19201 PHYSICIAN CLINIC 40, 286 40, 286 192. 01 192. 02 19202 LI FELI NE 0000 0 192. 02 192. 03 19203 CREDIT UNION 23, 662 0 23,662 192.03 192. 04 19204 BREAST MRI STUDY 0 192.04 0 192. 05 19205 HOSPI TALI ST 3, 988 3, 988 192.05 194. 00 07950 COMMUNITY MENTAL HEALTH 15, 755 15, 755 194.00 0 194. 01 07951 MARKETI NG 29.549 0 29.549 194. 01 194. 02 07953 OCCUPATIONAL HEALTH 0 2, 570 0 2,570 194. 02 194. 03 07952 PATHS EDUCATION 0 194. 03 142 142 200.00 Cross Foot Adjustments C 0 0 200. 00 0 201.00 Negative Cost Centers 0 0 201. 00 0 202.00 TOTAL (sum lines 118 through 201) 21, 170 5, 650, 038 5, 650, 038 202.00

	FINANCIAI SYSTEMS	DEARBORN COUNT		ON 45 000/ 5		eu of Form CMS	
COST	LLOCATION - STATISTICAL BASIS		Provider CO		Period: From 01/01/2016	Worksheet B-1	
						Date/Time Pre	
		CAPITAL RELA	ATED COSTS			3/12/2018 9:2	U alli
	Cost Center Description	NEW BLDG &	NEW MVBLE	EMPLOYEE	COMMUNI CATI ONS		
		FIXT (SQUARE	EQUI P (SQUARE	BENEFITS DEPARTMENT	(PHONES)	PROCESSING (DP EQUIPMENT)	
		FEET)	FEET)	(GROSS	(PHUNES)	(DP EQUIPMENT)	
		,		SALARI ES)			
	OFNEDAL CEDILLOS COCT OFNEDO	1.00	2. 00	4. 00	5. 01	5. 02	
1. 00	GENERAL SERVICE COST CENTERS OO100 NEW CAP REL COSTS-BLDG & FIXT	299, 097					1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	2,,,0,,	293, 911				2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 762	1, 762	34, 483, 191			4. 00
5. 01	01160 COMMUNI CATI ONS	304	304			l e	5. 01
5. 02	00550 DATA PROCESSING	2, 913	2, 913				5. 02
5. 03 5. 04	00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING	6, 391 3, 455	6, 391 3, 455	248, 511 647, 634		l	5. 03 5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	678	678			l .	5. 05
5.06	00591 OTHER ADMINISTRATIVE AND GENERAL	10, 526	10, 526			54	5. 06
7.00	00700 OPERATION OF PLANT	97, 591	97, 591			l .	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	1, 592	1, 592			0	8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	1, 178 4, 000	1, 178 4, 000			l e	9. 00 10. 00
11. 00	01100 CAFETERI A	2, 837	2, 837			l .	11.00
13.00	01300 NURSING ADMINISTRATION	600	600			17	13. 00
14. 00	01400 CENTRAL SERVI CE & SUPPLY	7, 088	7, 088			l	
15.00	01500 PHARMACY	1, 776	1, 776			l .	15.00
16.00	01600   MEDICAL RECORDS & LIBRARY   01700   SOCIAL SERVICE	4, 807 583	4, 807 583	814, 822 344, 504		l	16. 00 17. 00
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	303	303	344, 30-	. 10	7	17.00
30.00	03000 ADULTS & PEDIATRICS	62, 511	62, 511	5, 852, 061	149	178	30.00
31. 00	03100 INTENSIVE CARE UNIT	7, 400	7, 400			1	31. 00
43. 00	04300 NURSERY	400	400	469, 458	8 0	0	43. 00
50. 00	ANCI LLARY SERVI CE COST CENTERS    05000   OPERATI NG ROOM	25, 786	25, 786	1, 814, 125	46	63	50.00
51. 00	05100 RECOVERY ROOM	1, 163	1, 163			1	ı
52.00	05200 DELIVERY ROOM & LABOR ROOM	504	504	260, 885	0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	16	16		1	0	53.00
54. 00 54. 01	05400 RADI OLOGY-DI AGNOSTI C 05401 ULTRASOUND	11, 531 620	11, 531 620	2, 489, 149 230, 302		48	
55. 00	05500 RADI OLOGY-THERAPEUTI C	1, 155	1, 155				•
57. 00	05700 CT SCAN	0	0	(		l	•
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	803	803	(	_	l .	58. 00
59. 00 60. 00	05900   CARDI AC   CATHETERI ZATI ON   06000   LABORATORY	0 6, 720	0 6, 720	2, 317, 903	0 38		
60. 00	06001 BLOOD LABORATORY	0, 720	0, 720	2,317,900	0	l .	1
65.00	06500 RESPIRATORY THERAPY	1, 164	1, 164	766, 841	8	36	1
65. 01	03950 SLEEP CLINIC	0	0	(	18	l e	65. 01
	06600 PHYSI CAL THERAPY	7, 564	7, 564		1	l	ı
67.00	06700   OCCUPATI ONAL THERAPY   06800   SPEECH PATHOLOGY	794 424	794 424			0	
69. 00	06900 ELECTROCARDI OLOGY	3, 261	3, 261	566, 495		1	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(	0	1	ı
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	(		l	
73. 00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	0		2 0	0	73. 00
91. 00	09100 EMERGENCY	9, 684	9, 684	1, 715, 598	35	34	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,001	.,	., ,			92.00
404.00	OTHER REIMBURSABLE COST CENTERS	0.005		050.045			
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	3, 085	3, 085	953, 245	6	40	101. 00
113.00	11300 I NTEREST EXPENSE						113. 00
	11600 HOSPI CE	315	315	314, 923	0	0	116. 00
118.00		292, 981	292, 981	33, 868, 739	887	860	118. 00
100.00	NONREIMBURSABLE COST CENTERS  19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 440	0	65, 151	3		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	2, 440	0	16, 146		<b>l</b>	192.00
	19201 PHYSI CI AN CLI NI C	1, 700	0	86, 658			192. 01
	19202 LI FELI NE	0	0	(	_	l .	192. 02
	19203 CREDIT UNION	1, 046	0	(	10		192. 03
	19204 BREAST MRI STUDY	0	0	(	0		192. 04 192. 05
	19205   HOSPI TALI ST   07950   COMMUNI TY   MENTAL   HEALTH		0		) 0	<b>l</b>	194. 00
	07951 MARKETI NG	930	930	123, 415	3	<b>l</b>	194. 01
194. 02	07953 OCCUPATI ONAL HEALTH	0	0	323, 082		0	194. 02
	07952 PATHS EDUCATION	0	0		0	0	194. 03
200. 00 201. 00							200. 00 201. 00
201.00	negative cost centers	<u> </u>		I	1	I	1201.00

Health Fina	ncial Systems	DEARBORN COUNT	TY HOSPITAL		In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS			Provi der CC		Period: From 01/01/2016 To 12/31/2016		pared:	
		CAPITAL REL	ATED COSTS					
	Cost Center Description	NEW BLDG & FLXT	NEW MVBLE EQUI P	EMPLOYEE BENEFITS	COMMUNI CATI ONS	DATA PROCESSI NG		
		(SQUARE FEET)	(SQUARE FEET)	DEPARTMENT (GROSS SALARIES)	(PHONES)	(DP EQUIPMENT)		
		1.00	2.00	4. 00	5. 01	5. 02		
202. 00	Cost to be allocated (per Wkst. B, Part I)	3, 456, 613	2, 193, 425	10, 709, 12	1 322, 315	2, 918, 573	202. 00	
203. 00	Unit cost multiplier (Wkst. B, Part I)	11. 556829	7. 462888	0. 31056	1 298. 439815	2, 912. 747505	203. 00	
204. 00	Cost to be allocated (per Wkst. B, Part II)			33, 51	5, 908	56, 701	204. 00	
205. 00	Unit cost multiplier (Wkst. B, Part			0. 00097	5. 470370	56. 587824	205. 00	

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0086 

				To	12/31/2016	Date/Time Pre 3/12/2018 9:2	
	Cost Center Description	PURCHASI NG		CASHI ERI NG/ACC F	Reconciliation		
		RECEIVING AND STORES	(ADMISSIONS)	OUNTS RECEI VABLE		ADMINISTRATIVE AND GENERAL	
		(SUPPLY		(GROSS		(ACCUM.	
		5. 03	5. 04	CHARGES) 5. 05	5A. 06	COST) 5. 06	
	GENERAL SERVICE COST CENTERS	0.00	0.01	0.00	57.11 00	0.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2. 00 4. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 01	01160 COMMUNI CATI ONS						5. 01
5. 02	00550 DATA PROCESSING						5. 02
5.03	00560 PURCHASING RECEIVING AND STORES	8, 975, 863	1				5. 03
5.04	00570 ADMITTING	39, 002		202 510 500			5. 04
5. 05 5. 06	OO580   CASHI ERI NG/ACCOUNTS RECEI VABLE   OO591   OTHER ADMINI STRATI VE AND GENERAL	14, 956 153, 935	1	202, 519, 598	-3, 820, 548	70, 384, 462	5. 05 5. 06
7. 00	00700 OPERATION OF PLANT	143, 887	Ö	0	0, 020, 340	5, 263, 327	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	92, 043	0	0	0	401, 342	8. 00
9. 00	00900 HOUSEKEEPI NG	136, 978	0	0	0	1, 384, 434	
10.00	01000 DI ETARY	108, 463	0	0	0	691, 479	
11. 00 13. 00	O1100   CAFETERI A   O1300   NURSI NG   ADMI NI STRATI ON	0 14, 133	0	0	0	1, 346, 759 1, 339, 401	
14. 00	01400 CENTRAL SERVI CE & SUPPLY	573, 398	1	0	0	810, 967	
15.00	01500 PHARMACY	82, 318		0	0	2, 448, 598	
16. 00	01600 MEDI CAL RECORDS & LI BRARY	26, 399	1	0	0	1, 480, 575	
17. 00	01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	6, 254	0	0	0	503, 944	17. 00
30. 00	03000 ADULTS & PEDIATRICS	281, 240	3, 367	15, 215, 136	0	10, 684, 914	30.00
31. 00	03100   NTENSI VE CARE UNI T	35, 728		3, 287, 408	0		
43.00	04300 NURSERY	0	387	583, 230	0	819, 399	43. 00
	ANCILLARY SERVICE COST CENTERS	1 704 540		00 005 700			
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	1, 706, 542 25, 448	0	29, 895, 709 3, 747, 707	0	3, 864, 654 980, 746	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	25, 446	0	1, 481, 367	0	417, 969	
53. 00	05300 ANESTHESI OLOGY	42, 372	o	1, 956, 915	0	44, 492	
54.00	05400 RADI OLOGY-DI AGNOSTI C	357, 605	1	18, 833, 198	0	4, 598, 263	1
54. 01	05401   ULTRASOUND	19, 208	1	3, 508, 084	0	381, 156	
55. 00 57. 00	05500   RADI OLOGY-THERAPEUTI C   05700   CT   SCAN	232, 485 131, 889	1	6, 244, 834 19, 693, 995	0	865, 337 296, 082	1
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	46, 785	1	3, 620, 019	0	339, 681	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	o	0	0	0	59. 00
60.00	06000 LABORATORY	1, 589, 539	0	38, 069, 769	0	6, 882, 716	1
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
65. 00 65. 01	06500 RESPI RATORY THERAPY 03950 SLEEP CLINIC	54, 657 2, 382	0	5, 815, 745 656, 010	0	1, 215, 762 206, 126	1
66. 00	06600 PHYSI CAL THERAPY	37, 143	o	6, 465, 774	0	2, 016, 386	
67. 00	06700 OCCUPATI ONAL THERAPY	4, 507	0	751, 062	0	378, 628	1
68. 00	06800 SPEECH PATHOLOGY	1, 569		697, 715	0	304, 898	1
69. 00	06900 ELECTROCARDI OLOGY	30, 445		7, 297, 248	0	1, 486, 278	1
71.00	O7100   MEDICAL SUPPLIES CHARGED TO PATIENTS   O7200   IMPL. DEV. CHARGED TO PATIENT	2, 777, 138		5, 139, 739 571, 138	0	2, 646, 140 2, 962, 375	
	07300 DRUGS CHARGED TO PATIENTS	2,777,130		12, 204, 627	0		
	OUTPATIENT SERVICE COST CENTERS						
	09100 EMERGENCY	63, 599	297	14, 295, 773	0	2, 962, 682	
92.00	O9200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   OTHER REIMBURSABLE COST CENTERS						92. 00
101.00	10100 HOME HEALTH AGENCY	37, 188	0	1, 438, 182	0	1, 561, 916	101.00
	SPECIAL PURPOSE COST CENTERS			, ,			
	11300 INTEREST EXPENSE						113. 00
116. 00 118. 00	11600 HOSPI CE	72, 208 8, 941, 443		,	2 020 540	641, 192	
118.00	SUBTOTALS (SUM OF LINES 1 through 117)   NONREIMBURSABLE COST CENTERS	8, 941, 443	4, 533	202, 493, 673	-3, 820, 548	67, 288, 140	] 118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	114, 478	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	12, 285	1	0	0	645, 983	
	19201 PHYSICIAN CLINIC	7, 476	0	0	0	202, 478	
	2 19202 LIFELINE 3 19203 CREDIT UNION	0	0	0	0	3,080	192. 02 192. 03
	19204 BREAST MRI STUDY	0	0	0	0		192. 03
	19205 HOSPI TALI ST	2,074	0	0	0	1, 266, 891	192. 05
	07950 COMMUNITY MENTAL HEALTH	0	0	0	0	l .	194. 00
	07951 MARKETI NG	3, 159		0	0	338, 998	
	07953 OCCUPATIONAL HEALTH 07952 PATHS EDUCATION	9, 272 154		25, 925 0	0	461, 987 47 355	194. 02 194. 03
200.00		154		U	U	47, 335	200. 00
201.00							201. 00
202.00		583, 389	1, 103, 081	1, 678, 528		3, 820, 548	202. 00
	Part I)	<u> </u>					<u> </u>

Health Financial Systems	DEARBORN COUN	TY HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	
				From 01/01/2016 To 12/31/2016		
Cost Center Description	PURCHASI NG	ADMI TTI NG	CASHI ERI NG/AC	C Reconciliation	OTHER	
	RECEIVING AND	(ADMISSIONS)	OUNTS		ADMI NI STRATI VE	
	STORES		RECEI VABLE		AND GENERAL	
	(SUPPLY		(GROSS		(ACCUM.	
	EXPENSE)		CHARGES)		COST)	
	5. 03	5. 04	5. 05	5A. 06	5. 06	
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 064995	243. 344584	0.00828	8	0. 054281	203. 00
204.00 Cost to be allocated (per Wkst. B,	122, 536	68, 840	17, 05	4	207, 404	204. 00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	0. 013652	15. 186411	0.00008	4	0.002947	205. 00
)						

	-inanciai systems	DEARBURN COUN		ou 45 000/ D		u of form CMS	
COST ALI	LOCATION - STATISTICAL BASIS		Provi der C		eriod: com 01/01/2016 o 12/31/2016	Worksheet B-1 Date/Time Pre 3/12/2018 9:2	pared:
	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	
		7. 00	8. 00	9. 00	10. 00	11. 00	
1. 00 0 2. 00 0 4. 00 0 5. 01 0 5. 02 0 5. 03 0	JENERAL SERVICE COST CENTERS  JO100 NEW CAP REL COSTS-BLDG & FIXT  JO200 NEW CAP REL COSTS-MVBLE EQUIP  JO400 EMPLOYEE BENEFITS DEPARTMENT  JO1160 COMMUNICATIONS  JO550 DATA PROCESSING  JO560 PURCHASING RECEIVING AND STORES						1. 00 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04
5. 05 0 5. 06 0 7. 00 0 8. 00 0	00580 CASHIERING/ACCOUNTS RECEIVABLE 00591 OTHER ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	175, 477 1, 592 1, 178	822, 491	1			5. 04 5. 05 5. 06 7. 00 8. 00 9. 00
11. 00 0 13. 00 0	01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICE & SUPPLY	4, 000 2, 837 600	24, 076 0	2, 837 600	48, 171 0 0 0	846, 419 20, 535	13. 00
15. 00 0 16. 00 0	11400 PHARMACY 11600 MEDI CAL RECORDS & LI BRARY 11700 SOCI AL SERVI CE	7, 088 1, 776 4, 807 583	1, 156 0 0 0	1, 776 4, 807	0 0 0	17, 349 40, 520 34, 025 11, 249	15. 00 16. 00
	NPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	62, 511	258, 669	62, 511	38, 514	208, 631	30.00
31. 00 0 43. 00 0	JABOUR ADDETS & FEDITATINGS JA100 INTENSIVE CARE UNIT JA300 NURSERY NCILLARY SERVICE COST CENTERS	7, 400 400	55, 727	7, 400	3, 184	42, 752 14, 899	31. 00
50.00 0	05000 OPERATING ROOM	25, 786	l	1	0	55, 821	1
52. 00 0	75100 RECOVERY ROOM 5200 DELIVERY ROOM & LABOR ROOM	1, 163 504	44, 368 0	504	123 0	19, 909 8, 280	52. 00
1	)5300  ANESTHESI OLOGY )5400  RADI OLOGY-DI AGNOSTI C	16 11, 531	0 52, 465	16 11, 531	0	0 84, 240	
54. 01 0	05401 ULTRASOUND	620	10, 212	620	0	5, 679	54. 01
	DS500 RADI OLOGY-THERAPEUTI C DS700 CT SCAN	1, 155 0	6, 877 0	1	0	11, 184 0	57. 00
59. 00 0	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION 06000 LABORATORY	803 0 6, 720	0 0 8, 610	0	0 0 0	0 0 95, 524	59. 00
60. 01 0 65. 00 0	06001 BLOOD LABORATORY 06500 RESPIRATORY THERAPY	0 1, 164	0	0 1, 164	0	0 22, 738	60. 01 65. 00
	03950  SLEEP CLINIC 06600  PHYSICAL THERAPY	7, 564	0 16, 005	0 7, 564	0	0 38, 781	
	06700  OCCUPATI ONAL THERAPY 06800  SPEECH PATHOLOGY	794 424	1, 536	l l	0	6, 371 4, 831	1
69. 00 0	06900 ELECTROCARDI OLOGY	3, 261	3, 625	3, 261	0	20, 661	69. 00
72. 00 0	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	
	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	73. 00
91. 00 0 92. 00 0	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	9, 684	140, 945	9, 684	655	59, 681	91. 00 92. 00
101.001	THER REIMBURSABLE COST CENTERS 0100 HOME HEALTH AGENCY	3, 085	0	3, 085	0	0	101. 00
	PECIAL PURPOSE COST CENTERS 1300 INTEREST EXPENSE						113. 00
118. 00	1600 HOSPI CE SUBTOTALS (SUM OF LINES 1 through 117) IONREI MBURSABLE COST CENTERS	315 169, 361	805, 846	315 166, 591	0 42, 476	823, 660	116. 00
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 9200 PHYSICIANS' PRIVATE OFFICES	2, 440	0 2, 517	_,	0		190. 00 192. 00
192. 01 1	9201 PHYSICI AN CLINIC 92021 LIFELINE	1, 700	l	1, 700	0	5, 932	192. 01 192. 02
192. 03 1	9203 CREDIT UNION 9204 BREAST MRI STUDY	1, 046	0	1, 046 0	0	0	192. 02 192. 03 192. 04
	9205 HOSPITALIST 07950 COMMUNITY MENTAL HEALTH	0	0 14, 128	0	0 5, 695		192. 05 194. 00
194. 01 0	07951 MARKETI NG	930	0	930	0,075	3, 915	194. 01
194. 03 0	07953 OCCUPATIONAL HEALTH 07952 PATHS EDUCATION	0 0	0 0	0	0		194. 02 194. 03
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers						200. 00 201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	5, 549, 026	473, 470	1, 559, 028	895, 751	1, 549, 044	
203. 00	Unit cost multiplier (Wkst. B, Part I)	31. 622526	0. 575654	9. 027011	18. 595234	1. 830115	203. 00

Heal th Finar	ncial Systems	DEARBORN COUNTY HOSPITAL			In Lieu of Form CMS-2552-10			
COST ALLOCA	TION - STATISTICAL BASIS		Provi der Co		Peri od: From 01/01/2016	Worksheet B-1		
					To 12/31/2016	Date/Time Pre 3/12/2018 9:2		
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A		
		PLANT	LINEN SERVICE	(SQUARE	(MEALS	(MAN HOURS)		
		(SQUARE	(POUNDS OF	FEET)	SERVED)			
		FEET)	LAUNDRY)					
		7. 00	8. 00	9. 00	10.00	11. 00		
204.00	Cost to be allocated (per Wkst. B, Part II)	1, 875, 696	49, 918	48, 61	2 126, 018	91, 465	204. 00	
205. 00	Unit cost multiplier (Wkst. B, Part	10. 689127	0. 060691	0. 28147	2. 616055	0. 108061	205. 00	

OCCT A	Financial Systems	DEARBURN COUNT		45 0007		u or form CMS	
COST A	NLLOCATION - STATISTICAL BASIS		Provi der CCN		Period: From 01/01/2016 To 12/31/2016	Worksheet B-1 Date/Time Pre	
					10 12/31/2010	3/12/2018 9: 2	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY		SOCIAL SERVICE	
		ADMI NI STRATI ON	SERVICE &	(100%)	RECORDS &	(T1115	
		(CDOSS HOUDS)	SUPPLY		LI BRARY	(TIME SPENT)	
		(GROSS HOURS)	(100%)		(ADJUSTED CHARGES)	SPENT)	
		13.00	14.00	15. 00	16.00	17. 00	
	GENERAL SERVICE COST CENTERS		'		1		
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 5. 02	O1160   COMMUNI CATI ONS   O0550   DATA   PROCESSI NG						5. 01 5. 02
5. 02	00560 PURCHASING RECEIVING AND STORES						5. 02
5. 03	00570 ADMITTING						5. 03
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
5. 06	00591 OTHER ADMINISTRATIVE AND GENERAL						5. 06
7. 00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	427, 322					13. 00
14.00	01400 CENTRAL SERVICE & SUPPLY	17, 349	100	4.0			14.00
15.00	01500 PHARMACY	0	0	10			15. 00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	0		0 199, 436, 382 0 0	2 041	16.00
17. 00	O1700   SOCIAL SERVICE     INPATIENT ROUTINE SERVICE COST CENTERS	l d	0		<u>u</u> u	3, 061	17. 00
30. 00	03000 ADULTS & PEDIATRICS	208, 631	O		0 13, 100, 228	2, 819	30.00
31. 00	03100   NTENSI VE CARE UNI T	42, 752	Ö		0 3, 287, 408	112	1
43. 00	04300 NURSERY	14, 899	o		0 583, 230	0	
	ANCILLARY SERVICE COST CENTERS		-1				1
50.00	05000 OPERATI NG ROOM	55, 821	0		0 29, 825, 519	80	50.00
51.00	05100 RECOVERY ROOM	19, 909	0		0 3, 747, 707	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	8, 280	0		0 1, 447, 171	0	
53.00	05300 ANESTHESI OLOGY	0	0		0 1, 956, 915	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 18, 816, 148	0	
54. 01	05401 ULTRASOUND	0	0		0 3, 508, 084	0	
55. 00 57. 00	05500   RADI OLOGY-THERAPEUTI C   05700   CT   SCAN	0	0		0 6, 221, 725 0 19, 693, 995	0	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)		0		0 19, 693, 993	0	
59. 00	05900 CARDI AC CATHETERI ZATI ON		0		0 3, 337, 341	0	
60.00	06000 LABORATORY	0	o		0 38, 069, 769	0	
60. 01	06001 BLOOD LABORATORY	0	o		o o	0	
65.00	06500 RESPI RATORY THERAPY	0	0		0 5, 730, 402	0	65. 00
65. 01	03950 SLEEP CLINIC	0	0		0 656, 010	0	65. 01
66.00	06600 PHYSI CAL THERAPY	0	0		0 6, 465, 774	0	
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0 751, 062	0	
68. 00	06800 SPEECH PATHOLOGY	0	0		0 697, 715	0	
	06900 ELECTROCARDI OLOGY	0	100		0 6, 509, 157	0	
	07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   07200   MPL. DEV. CHARGED TO PATIENT	0	100		0 5, 139, 739 0 681, 487	0	
72.00	07300 DRUGS CHARGED TO PATIENTS		ol ol	10		0	
73.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	<u> </u>	10	0 12, 204, 027		73.00
91. 00	09100 EMERGENCY	59, 681	0		0 14, 295, 773	50	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS		-				
101.00	10100 HOME HEALTH AGENCY	0	0		0 1, 438, 182	0	101. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE						113. 00
	11600 HOSPI CE	0	0		0 1, 023, 289		116. 00
118.00	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	427, 322	100	10	0 199, 410, 457	3, 061	118. 00
100 00	NONREIMBURSABLE COST CENTERS   19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	0		ol ol	0	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES		o				192. 00
	19201 PHYSI CLAN CLINI C		0				192. 01
	19202 LI FELI NE	0	o		ol ol		192. 02
	19203 CREDIT UNION	0	O		o o		192. 03
	19204 BREAST MRI STUDY		ó		ol ol		192. 04
192.05	19205 HOSPI TALI ST	0	О		o  o		192. 05
	07950 COMMUNITY MENTAL HEALTH	0	О		0 0		194. 00
	07951 MARKETI NG	0	o		이		194. 01
	07953 OCCUPATI ONAL HEALTH	0	o		0 25, 925		194. 02
	07952 PATHS EDUCATION		0		이	0	194. 03
200.00	1 1						200.00
004	Negative Cost Centers	1					201. 00
201.00	Cost to be allegated (non Wiset D	1 474 07/	1 225 272	2 727 0/	0 1 010 /14	E7E E0E	
201. 00 202. 00	Cost to be allocated (per Wkst. B, Part I)	1, 474, 076	1, 235, 373	2, 727, 86	0 1, 818, 614	575, 585	202.00

Systems		DEARBORN COUN	TY HOSPITAL		In Lie	eu of Form CMS-2	2552-10
STATISTICAL BASIS			Provi der CO			Worksheet B-1	
						Date/Time Pre	pared: 0 am
Center Description		NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
	А	ADMI NI STRATI ON	SERVICE &	(100%)	RECORDS &		
			SUPPLY		LI BRARY	(TIME	
		(GROSS HOURS)	(100%)		(ADJUSTED	SPENT)	
					CHARGES)		
		13. 00	14.00	15. 00	16. 00	17. 00	
cost multiplier (Wkst. B, Par	-t I)	3. 449567	12, 353. 730000	27, 278. 60000	0. 009119	188. 038223	203. 00
to be allocated (per Wkst. B, II)		26, 325	227, 372	69, 52	156, 850	21, 170	204. 00
cost multiplier (Wkst. B, Par	-t	0. 061605	2, 273. 720000	695. 20000	0. 000786	6. 916041	205. 00
	Center Description  cost multiplier (Wkst. B, Par to be allocated (per Wkst. B, II)	Center Description  cost multiplier (Wkst. B, Part I) to be allocated (per Wkst. B,	Center Description  Center Description  NURSING ADMINISTRATION (GROSS HOURS)  13.00  cost multiplier (Wkst. B, Part I) to be allocated (per Wkst. B,  11)	NURSING   ADMINISTRATION   SERVICE & SUPPLY (GROSS HOURS)   13.00	Provider CCN: 15-0086	Provider CCN: 15-0086   Period: From 01/01/2016 To 12/31/2016	Provider CCN: 15-0086   Period: From 01/01/2016   To 12/31/2018 9: 21   Date/Time Pre 3/12/2018 9: 21

Health Financial Systems	DEARBORN COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0086	Peri od: Worksheet C
		From 01/01/2016   Part I
		To 12/21/2014   Data/Time Dropared.

					To 12/31/2016	Date/Time Pre 3/12/2018 9:2	pared: O am
			Title	XVIII	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1					
	03000 ADULTS & PEDIATRICS	16, 422, 083		16, 422, 08			
31. 00	03100 INTENSIVE CARE UNIT	3, 151, 322		3, 151, 32		3, 151, 322	
43.00	04300 NURSERY	964, 117		964, 11	7 0	964, 117	43. 00
	ANCILLARY SERVICE COST CENTERS	T					4
50. 00	05000 OPERATING ROOM	5, 735, 402		5, 735, 40		5, 735, 402	
51. 00	05100 RECOVERY ROOM	1, 248, 373		1, 248, 37		1, 248, 373	
52.00	05200 DELIVERY ROOM & LABOR ROOM	518, 057		518, 05		518, 057	1
53. 00	05300 ANESTHESI OLOGY	65, 402		65, 40		65, 402	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 672, 545		5, 672, 54		5, 672, 545	1
54. 01	05401 ULTRASOUND	475, 311		475, 31		475, 311	1
	05500 RADI OLOGY-THERAPEUTI C	1, 040, 421		1, 040, 42		1, 040, 421	1
57. 00	05700 CT SCAN	491, 744		491, 74		491, 744	1
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	423, 219		423, 21		423, 219	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0			0	0	
60.00	06000 LABORATORY	8, 056, 372		8, 056, 37		8, 157, 036	
60. 01	06001 BLOOD LABORATORY	0			0 0	0	
65.00	06500 RESPI RATORY THERAPY	1, 430, 087	0	.,,		1, 430, 087	
65. 01	03950 SLEEP CLINIC	223, 297	0	223, 29		223, 297	
66.00	06600 PHYSI CAL THERAPY	2, 572, 458	0	2, 572, 45		2, 572, 458	
67. 00	06700 OCCUPATI ONAL THERAPY	450, 848	0	450, 84		450, 848	
68. 00	06800 SPEECH PATHOLOGY	353, 886	0	353, 88		353, 886	
	06900 ELECTROCARDI OLOGY	1, 798, 769		1, 798, 76		1, 798, 769	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 072, 017		4, 072, 01		4, 072, 017	
	07200 I MPL. DEV. CHARGED TO PATIENT	3, 129, 390		3, 129, 39		3, 129, 390	
73.00	07300 DRUGS CHARGED TO PATIENTS	5, 690, 838		5, 690, 83	8 0	5, 690, 838	73. 00
	OUTPATIENT SERVICE COST CENTERS						
	09100 EMERGENCY	4, 065, 328		4, 065, 32	•		1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 833, 605		1, 833, 60	5	1, 833, 605	92. 00
	OTHER REIMBURSABLE COST CENTERS	<u>,                                      </u>					1
101.00	10100 HOME HEALTH AGENCY	1, 785, 216		1, 785, 21	6	1, 785, 216	101. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE						113. 00
	11600 HOSPI CE	698, 133		698, 13		698, 133	
200.00		72, 368, 240	0	,			
201.00		1, 833, 605		1, 833, 60		1, 833, 605	
202.00	Total (see instructions)	70, 534, 635	0	70, 534, 63	5 206, 854	70, 741, 489	202. 00

Health Financial Systems	DEARBORN COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0086	Period: Worksheet C From 01/01/2016 Part I
		To 12/31/2016 Date/Time Prepared

					Го 12/31/2016	Date/Time Pre 3/12/2018 9:2	pared: O am
			Title	XVIII	Hospi tal	PPS	<u> </u>
			Charges	-			
	Cost Center Description	Inpati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	<b>'</b>		'	+ col. 7)	Rati o	Inpati ent	
						Rati o	
		6.00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	13, 100, 228		13, 100, 22	3		30. 00
31.00	03100 INTENSIVE CARE UNIT	3, 287, 408		3, 287, 40	3		31. 00
43.00	04300 NURSERY	583, 230		583, 230			43.00
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATING ROOM	8, 787, 480	21, 038, 038	29, 825, 51	0. 192298	0.000000	50. 00
51.00	05100 RECOVERY ROOM	569, 389	3, 178, 318	3, 747, 70	0. 333103	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 352, 483	94, 688	1, 447, 17 <sup>-</sup>	0. 357979	0.000000	52. 00
53.00	05300 ANESTHESI OLOGY	582, 916	1, 373, 999	1, 956, 91	0. 033421	0.000000	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 666, 305	16, 149, 843	18, 816, 14	0. 301472	0.000000	54.00
54. 01	05401 ULTRASOUND	466, 386	3, 041, 698	3, 508, 08	0. 135490	0.000000	54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	2, 668, 811	3, 552, 914			0.000000	55. 00
57.00	05700 CT SCAN	4, 541, 190	15, 152, 805	19, 693, 99	0. 024969	0.000000	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	396, 710	3, 162, 631			0.000000	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0. 000000	0.000000	
60.00	06000 LABORATORY	9, 881, 240	28, 188, 529	38, 069, 769		0.000000	
60. 01	06001 BLOOD LABORATORY	0	0		0. 000000	0.000000	
65. 00	06500 RESPIRATORY THERAPY	4, 766, 272	964, 130	5, 730, 40		0.000000	
65. 01	03950 SLEEP CLINIC	2, 439	653, 572			0.000000	
66. 00	06600 PHYSI CAL THERAPY	1, 182, 504	5, 283, 269			0.000000	
67. 00	06700 OCCUPATI ONAL THERAPY	402, 646	348, 416			0. 000000	
68. 00	06800 SPEECH PATHOLOGY	198, 982	498, 733			0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	2, 415, 558	4, 093, 599			0. 000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 262, 372	1, 877, 367			0. 000000	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	123, 359	558, 128			0. 000000	
73. 00	07300 DRUGS CHARGED TO PATIENTS	8, 014, 553	4, 190, 074			0. 000000	
	OUTPATIENT SERVICE COST CENTERS	2, 21., 22.	.,,	,,			1
91 00	09100 EMERGENCY	3, 135, 336	11, 160, 437	14, 295, 77	0. 284373	0. 000000	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	197, 738	1, 313, 971			0. 000000	
72.00	OTHER REIMBURSABLE COST CENTERS	177,700	1,010,771	1,011,70	1.212700	0.00000	72.00
101 00	10100 HOME HEALTH AGENCY	0	1, 438, 182	1, 438, 18			101.00
	SPECIAL PURPOSE COST CENTERS	<u> </u>	17 1007 102	17 1007 101			1.000
113 00	11300 I NTEREST EXPENSE						113. 00
	11600 HOSPI CE	0	1, 023, 289	1, 023, 28	9		116.00
200.00	1	72, 585, 535	128, 336, 630				200. 00
201.00		, 2, 000, 000	.20, 000, 000	200, 722, 10.			201.00
202.00	1	72, 585, 535	128, 336, 630	200, 922, 16	5		202.00
202.00	1.000. (300 11130 400 613)	, 2,000,000	.20, 000, 000	200, 722, 10	1		1202.00

Health Financial Systems	DEARBORN COUNTY HO	OSPI TAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	P	Provider CCN: 15-0086	From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepared:

			10 12/31/2016	Date/II me Prepared:   3/12/2018 9:20 am
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
43. 00 04300 NURSERY				43. 00
ANCILLARY SERVICE COST CENTERS				
50.00   05000   OPERATING ROOM	0. 192298			50. 00
51.00   05100   RECOVERY ROOM	0. 333103			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 357979			52. 00
53. 00   05300   ANESTHESI OLOGY	0. 033421			53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 301472			54. 00
54. 01  05401 ULTRASOUND	0. 135490			54. 01
55. 00   05500   RADI OLOGY-THERAPEUTI C	0. 167224			55. 00
57. 00  05700   CT   SCAN	0. 024969			57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 118904			58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	0. 000000			59. 00
60. 00   06000   LABORATORY	0. 214265			60.00
60. 01   06001   BLOOD LABORATORY	0. 000000			60. 01
65. 00 06500 RESPI RATORY THERAPY	0. 249561			65. 00
65. 01   03950   SLEEP CLINIC	0. 340386			65. 01
66. 00   06600   PHYSI CAL THERAPY	0. 397858			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 600281			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 507207			68. 00
69. 00   06900   ELECTROCARDI OLOGY	0. 276344			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 792261			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	4. 592002			72. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0. 466285			73. 00
OUTPATIENT SERVICE COST CENTERS				
91. 00   09100   EMERGENCY	0. 291801			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 212935			92. 00
OTHER REIMBURSABLE COST CENTERS				
101.00 10100 HOME HEALTH AGENCY				101. 00
SPECIAL PURPOSE COST CENTERS				
113.00 11300 I NTEREST EXPENSE				113. 00
116. 00 11600 HOSPI CE				116. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00   Total (see instructions)				202. 00

Health Financial Systems	DEARBORN COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0086	Peri od: Worksheet C
		From 01/01/2016   Part

				To 12/31/2016		Date/Time Prep 3/12/2018 9: 20	pared: O am
			Ti tl	Title XIX Hospital		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)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1				
	03000 ADULTS & PEDI ATRI CS	16, 422, 083	ł	16, 422, 083		16, 422, 083	
	03100 I NTENSI VE CARE UNI T	3, 151, 322	ł	3, 151, 322		3, 151, 322	1
	04300 NURSERY	964, 117		964, 117	0	964, 117	43. 00
	ANCILLARY SERVICE COST CENTERS		Г		T		
	05000 OPERATING ROOM	5, 735, 402		5, 735, 402		5, 735, 402	50. 00
	05100 RECOVERY ROOM	1, 248, 373		1, 248, 373		1, 248, 373	
	05200 DELIVERY ROOM & LABOR ROOM	518, 057		518, 057		518, 057	52.00
	05300 ANESTHESI OLOGY	65, 402	l e	65, 402		65, 402	
	05400 RADI OLOGY-DI AGNOSTI C	5, 672, 545		5, 672, 545		5, 672, 545	1
	05401 ULTRASOUND	475, 311		475, 311		475, 311	54. 01
	05500 RADI OLOGY-THERAPEUTI C	1, 040, 421		1, 040, 421		1, 040, 421	1
	05700 CT SCAN	491, 744		491, 744		491, 744	
	05800 MAGNETIC RESONANCE I MAGING (MRI)	423, 219		423, 219	이	423, 219	
	05900 CARDI AC CATHETERI ZATI ON	0		(	0	0	
	06000 LABORATORY	8, 056, 372		8, 056, 372	100, 664	8, 157, 036	
	06001 BLOOD LABORATORY	0	_	(	0	0	
	06500 RESPI RATORY THERAPY	1, 430, 087	0	.,,		1, 430, 087	
	03950 SLEEP CLINIC	223, 297				223, 297	65. 01
	06600 PHYSI CAL THERAPY	2, 572, 458		2, 572, 458		2, 572, 458	
	06700 OCCUPATI ONAL THERAPY	450, 848	l .	100,010		450, 848	1
	06800 SPEECH PATHOLOGY	353, 886		353, 886		353, 886	
	06900 ELECTROCARDI OLOGY	1, 798, 769		1, 798, 769		1, 798, 769	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 072, 017		4, 072, 017		4, 072, 017	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENT	3, 129, 390		3, 129, 390		3, 129, 390	1
	07300 DRUGS CHARGED TO PATIENTS	5, 690, 838		5, 690, 838	8 0	5, 690, 838	73. 00
	OUTPATIENT SERVICE COST CENTERS						
	09100 EMERGENCY	4, 065, 328	l e	4, 065, 328	·	.,	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 833, 605		1, 833, 605		1, 833, 605	92. 00
	OTHER REIMBURSABLE COST CENTERS						
	10100 HOME HEALTH AGENCY	1, 785, 216		1, 785, 216		1, 785, 216	101.00
	SPECIAL PURPOSE COST CENTERS		Γ	T			
	11300 INTEREST EXPENSE			,,,,			113. 00
	11600 HOSPI CE	698, 133		698, 133		698, 133	
200.00		72, 368, 240		,,		72, 575, 094	
201.00		1, 833, 605		1, 833, 605		1, 833, 605	
202. 00	Total (see instructions)	70, 534, 635	0	70, 534, 635	206, 854	70, 741, 489	202.00

Health Financial Systems	DEARBORN COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0086	Period: Worksheet C From 01/01/2016 Part I
		To 12/31/2016 Date/Time Prepared

						Γο 12/31/2016	Date/Time Pre 3/12/2018 9:2	pared: O am
				Ti tl	e XIX	Hospi tal	Cost	
				Charges				
		Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
					+ col . 7)	Ratio	Inpatient Ratio	
			6. 00	7. 00	8. 00	9. 00	10.00	
	I NPAT	IENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	7. 00	10.00	
30.00		ADULTS & PEDIATRICS	13, 100, 228		13, 100, 22	3		30. 00
31. 00	03100	INTENSIVE CARE UNIT	3, 287, 408		3, 287, 40			31.00
43.00	04300	NURSERY	583, 230		583, 230			43. 00
		LARY SERVICE COST CENTERS						
50.00		OPERATING ROOM	8, 787, 480	21, 038, 038			0. 000000	
51.00		RECOVERY ROOM	569, 389	3, 178, 318			0.000000	
52.00		DELIVERY ROOM & LABOR ROOM	1, 352, 483	94, 688			0.000000	
53.00		ANESTHESI OLOGY	582, 916	1, 373, 999			0. 000000	
54.00		RADI OLOGY-DI AGNOSTI C	2, 666, 305	16, 149, 843			0. 000000	
54. 01		ULTRASOUND	466, 386	3, 041, 698			0. 000000	1
55.00		RADI OLOGY-THERAPEUTI C	2, 668, 811	3, 552, 914			0. 000000	
57. 00	1	CT SCAN	4, 541, 190	15, 152, 805			0. 000000	1
58. 00		MAGNETIC RESONANCE IMAGING (MRI)	396, 710	3, 162, 631			0. 000000	
59. 00		CARDI AC CATHETERI ZATI ON	0	0		0.000000	0. 000000	
60.00		LABORATORY	9, 881, 240	28, 188, 529			0. 000000	
60. 01		BLOOD LABORATORY	0	0		0.000000	0. 000000	
65. 00		RESPI RATORY THERAPY	4, 766, 272	964, 130			0. 000000	1
65. 01		SLEEP CLINIC	2, 439	653, 572			0.000000	
66.00		PHYSI CAL THERAPY	1, 182, 504	5, 283, 269			0.000000	1
67.00		OCCUPATIONAL THERAPY	402, 646	348, 416			0.000000	
68. 00 69. 00		SPEECH PATHOLOGY ELECTROCARDI OLOGY	198, 982	498, 733			0. 000000 0. 000000	
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 415, 558	4, 093, 599			0. 000000	1
71.00		IMPL. DEV. CHARGED TO PATIENTS	3, 262, 372 123, 359	1, 877, 367 558, 128			0. 000000	
73. 00		DRUGS CHARGED TO PATTENT	8, 014, 553	4, 190, 074			0. 000000	1
73.00		TIENT SERVICE COST CENTERS	0,014,000	4, 190, 074	12, 204, 62	0.400203	0.000000	73.00
91. 00		EMERGENCY	3, 135, 336	11, 160, 437	14, 295, 77	0. 284373	0. 000000	91. 00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)	197, 738	1, 313, 971			0. 000000	1
72.00		REI MBURSABLE COST CENTERS	177,700	1,010,771	1,011,70	1.212700	0.00000	72.00
101.00		HOME HEALTH AGENCY	0	1, 438, 182	1, 438, 18			101.00
		AL PURPOSE COST CENTERS		, ,	, , , , , , , , ,	'		
113.00		INTEREST EXPENSE						113. 00
116.00	11600	HOSPI CE	0	1, 023, 289	1, 023, 28	e		116. 00
200.00	o	Subtotal (see instructions)	72, 585, 535	128, 336, 630	200, 922, 16	5		200. 00
201.00		Less Observation Beds						201. 00
202.00	)	Total (see instructions)	72, 585, 535	128, 336, 630	200, 922, 16	5		202. 00

Health Financial Systems	DEARBORN COUNTY HOSPITAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0086	From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepared: 3/12/2018 9:20 am

			10 12/31/2016	Date/lime Prepared:   3/12/2018 9:20 am
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00   03000   ADULTS & PEDI ATRI CS				30. 00
31.00 03100 INTENSIVE CARE UNIT				31. 00
43. 00 04300 NURSERY				43. 00
ANCILLARY SERVICE COST CENTERS	0.00000			50.00
50. 00 05000 OPERATING ROOM	0. 000000			50.00
51. 00   05100   RECOVERY ROOM	0. 000000			51.00
52. 00   05200   DELI VERY ROOM & LABOR ROOM	0. 000000			52. 00
53. 00   05300   ANESTHESI OLOGY	0. 000000			53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000			54. 00
54. 01   05401   ULTRASOUND	0. 000000			54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000			55. 00
57. 00  05700   CT   SCAN	0. 000000			57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000			58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	0. 000000			59. 00
60. 00   06000   LABORATORY	0. 000000			60. 00
60. 01  06001 BLOOD LABORATORY	0. 000000			60. 01
65. 00 06500 RESPI RATORY THERAPY	0. 000000			65. 00
65. 01  03950   SLEEP CLINIC	0. 000000			65. 01
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66. 00
67.00 06700 OCCUPATIONAL THERAPY	0. 000000			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
69. 00   06900   ELECTROCARDI OLOGY	0. 000000			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000			72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
OUTPATIENT SERVICE COST CENTERS				
91. 00   09100   EMERGENCY	0. 000000			91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92. 00
OTHER REIMBURSABLE COST CENTERS				
101.00 10100 HOME HEALTH AGENCY				101. 00
SPECIAL PURPOSE COST CENTERS				110.00
113. 00 11300   NTEREST EXPENSE				113. 00
116. 00 11600 HOSPI CE				116. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00   Total (see instructions)				202. 00

Health Financial Systems	DEARBORN COUN	TY HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der Co		Peri od:	Worksheet D	
				From 01/01/2016 To 12/31/2016		narod:
				10 12/31/2010	3/12/2018 9: 2	
		Title	XVIII	Hospi tal	PPS	
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			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	2, 160, 658	0	2, 160, 65	8 13, 273	162. 79	30.00
31.00   INTENSIVE CARE UNIT	262, 240		262, 24	0 2, 068	126. 81	31.00
43. 00 NURSERY	23, 780		23, 78	0 700	33. 97	43.00
200.00 Total (lines 30 through 199)	2, 446, 678		2, 446, 67	8 16, 041		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	5, 776	940, 275				30.00
31.00 INTENSIVE CARE UNIT	1, 163	147, 480				31.00
43. 00 NURSERY	0	0				43. 00
200.00 Total (lines 30 through 199)	6, 939	1, 087, 755				200. 00

Health Financial Systems	DEARBORN COUN	ITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der Co		Period: From 01/01/2016 To 12/31/2016	Worksheet D Part II Date/Time Pre 3/12/2018 9:2	
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges		Inpati ent	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	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	1					
50.00   05000   OPERATI NG ROOM	852, 848		•		111, 239	1
51.00   05100   RECOVERY ROOM	48, 508	3, 747, 707	0. 01294	3 254, 140	3, 289	51. 00
52.00   05200   DELIVERY ROOM & LABOR ROOM	19, 267				83	52. 00
53. 00   05300   ANESTHESI OLOGY	2, 929	1, 956, 915			380	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	398, 439	18, 816, 148	0. 02117	5 1, 940, 570	41, 092	54.00
54. 01   05401   ULTRASOUND	24, 500	3, 508, 084	0. 00698	4 183, 856	1, 284	54. 01
55. 00   05500   RADI OLOGY-THERAPEUTI C	48, 441	6, 221, 725	0. 00778	6 1, 301, 282	10, 132	55. 00
57. 00  05700 CT SCAN	19, 807	19, 693, 995	0.00100	6 2, 606, 718	2, 622	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	28, 824	3, 559, 341	0.00809	8 226, 985	1, 838	58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON	0	0	0.00000	0	0	59. 00
60. 00   06000   LABORATORY	293, 931	38, 069, 769	0.00772	1 5, 359, 678	41, 382	60.00
60. 01   06001   BL00D   LABORATORY	0	0	0.00000	0	0	60. 01
65. 00 06500 RESPIRATORY THERAPY	50, 267	5, 730, 402	0. 00877	2 3, 496, 090	30, 668	65.00
65. 01   03950   SLEEP CLINIC	1, 309	656, 011	0.00199	5 0	0	65. 01
66. 00 06600 PHYSI CAL THERAPY	246, 553	6, 465, 773	0. 03813	2 748, 563	28, 544	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	26, 742	751, 062	0. 03560	6 252, 184	8, 979	67. 00
68. 00 06800 SPEECH PATHOLOGY	14, 988	697, 715	0. 02148	2 137, 472	2, 953	68. 00
69. 00 06900 ELECTROCARDI OLOGY	111, 518	6, 509, 157	0.01713	2, 327, 906	39, 882	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	239, 642	5, 139, 739	0. 04662	1, 094, 185	51, 016	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	47, 225	681, 487	0.06929	7, 459	517	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	88, 109	12, 204, 627	0.00721	9 4, 738, 622	34, 208	73. 00
OUTPATIENT SERVICE COST CENTERS	•					
91. 00 09100 EMERGENCY	341, 496	14, 295, 773	0. 02388	8 1, 860, 348	44, 440	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	241, 247	1, 511, 709	0. 15958	6 105, 005	16, 757	92. 00
200.00 Total (lines 50 through 199)	3, 146, 590	181, 489, 828		30, 791, 048	471, 305	200. 00

Health Financial Systems	DEARBORN COUN	ITY HOSPITAL		In Li€	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS			Period: From 01/01/2016 To 12/31/2016		
			e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Allied Health	All Other	Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos	t Amount (see	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 & PEDI ATRI CS	0	(		0	0	30. 00
31.00 03100 INTENSIVE CARE UNIT	0	(		0	0	31.00
43. 00 04300 NURSERY	0			0	0	43.00
200.00 Total (lines 30 through 199)	0		ol	О	0	200. 00
Cost Center Description	Total Patient	Per Diem (col.	Inpatient	Inpati ent		
'	Days	5 ÷ col. 6)	Program Days			
		<b>_</b>		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	13, 273	0.00	5, 77	6 0	,	30.00
31.00 03100 INTENSIVE CARE UNIT	2,068	0.00	1, 16	3 0	,	31.00
43. 00   04300 NURSERY	700	l .	•	ol	J	43.00
200.00   Total (lines 30 through 199)	16, 041		6, 93	9 0		200. 00

Health Financial Systems	DEARBORN COUNTY	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILL/ THROUGH COSTS	ARY SERVICE OTHER PASS		Peri od: From 01/01/2016 To 12/31/2016	Date/Time Pre	
		Title XVIII	Hospi tal	3/12/2018 9: 20 PPS	) am
Cost Center Description	Non Physician Nur Anesthetist	rsing School Allied Healt		Total Cost (sum of cols.	

					3/12/2018 9: 2	0 am
			XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursing School	Allied Health		Total Cost	
	Anesthetist			Medi cal	(sum of cols.	
	Cost			Education Cost	1, 2, 3, and	
					4)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS				1		
50.00   05000   OPERATING ROOM	0	0	0	0	0	50.00
51.00   05100   RECOVERY ROOM	0	0	0	0	0	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53. 00   05300   ANESTHESI OLOGY	0	0	0	0	0	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	54. 00
54. 01   05401   ULTRASOUND	0	0	0	0	0	54. 01
55. 00   05500   RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
57. 00   05700   CT   SCAN	0	0	0	0	0	57. 00
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)	0	0	0	0	0	58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
60. 00   06000   LABORATORY	0	0	0	0	0	60.00
60. 01   06001   BLOOD LABORATORY	0	0	0	0	0	60. 01
65. 00  06500   RESPI RATORY THERAPY	0	0	0	0	0	65. 00
65. 01  03950   SLEEP CLI NI C	0	0	0	0	0	65. 01
66. 00   06600   PHYSI CAL THERAPY	0	0	0	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
68. 00   06800   SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	C	0	0	73. 00
OUTPATIENT SERVICE COST CENTERS						
91. 00  09100 EMERGENCY	0	0	0	0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92. 00
200.00   Total (lines 50 through 199)	0	0	0	0	0	200. 00

Heal th	Financial Systems	DEARBORN COUN	ITY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORT	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF H COSTS			F	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV	pared:
				XVIII	Hospi tal	PPS	
	Cost Center Description	Total		Ratio of Cost		I npati ent	
			(from Wkst. C,		Ratio of Cost	Program	
		Cost (sum of	·	(col. 5 ÷ col.	9	Charges	
		cols. 2, 3 and	8)	7)	(col. 6 ÷ col.		
		4)			7)		
		6. 00	7. 00	8. 00	9. 00	10. 00	
	ANCI LLARY SERVI CE COST CENTERS						
50.00	05000 OPERATING ROOM	0	29, 825, 518			3, 890, 149	
51. 00	05100 RECOVERY ROOM	0	3, 747, 707	•		254, 140	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	1, 447, 171				
53.00	05300 ANESTHESI OLOGY	0	1, 956, 915				
54.00	05400  RADI OLOGY-DI AGNOSTI C	0	18, 816, 148			1, 940, 570	
54. 01	05401 ULTRASOUND	0	3, 508, 084	0. 000000	0.000000	183, 856	54. 01
55.00	05500  RADI OLOGY-THERAPEUTI C	0	6, 221, 725	0.000000	0. 000000	1, 301, 282	55. 00
57.00	05700  CT SCAN	0	19, 693, 995	0.000000	0. 000000	2, 606, 718	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	3, 559, 341	0.000000	0. 000000	226, 985	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0.000000	0.000000	0	59. 00
60.00	06000 LABORATORY	0	38, 069, 769	0.000000	0. 000000	5, 359, 678	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60. 01
65.00	06500 RESPI RATORY THERAPY	0	5, 730, 402	0.000000	0.000000	3, 496, 090	65.00
65. 01	03950 SLEEP CLINIC	0	656, 011	0. 000000	0.000000	0	65. 01
66.00	06600 PHYSI CAL THERAPY	0	6, 465, 773	0.000000	0. 000000	748, 563	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	751, 062	0.000000	0. 000000	252, 184	67. 00
68.00	06800 SPEECH PATHOLOGY	0	697, 715	0.000000	0. 000000	137, 472	68. 00
/ 0 00	O COOR ELECTROCARRILOLOGY	1	/ 500 157	0 000000	0 000000	2 227 007	1 (0 00

0

6, 509, 157

5, 139, 739

12, 204, 627

14, 295, 773 1, 511, 709 181, 489, 828

681, 487

0.000000

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0.000000

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0.000000

0.000000

0.000000

0.000000

69.00

71.00

72.00

73.00

2, 327, 906

1, 094, 185

4, 738, 622

7, 459

1, 860, 348 91. 00

105, 005 92. 00 30, 791, 048 200. 00

73.00 07300 DRUGS CHARGED TO PATIENTS

OUTPATIENT SERVICE COST CENTERS
91. 00 09100 EMERGENCY

71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT

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

Total (lines 50 through 199)

69. 00 06900 ELECTROCARDI OLOGY

200.00

Health Financial Systems	DEARBORN COUNTY	HOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0086		Worksheet D
THROUGH COSTS			From 01/01/2016	Part IV

			To	12/31/2016	Date/Time Pro 3/12/2018 9:3	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Inpati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8		Costs (col. 9			
	x col. 10)		x col. 12)			
	11.00	12.00	13. 00			
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	5, 929, 032				50.00
51. 00   05100   RECOVERY ROOM	0	1, 148, 445	0			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0			52.00
53. 00   05300   ANESTHESI OLOGY	0	213, 768				53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	4, 580, 000				54.00
54. 01   05401   ULTRASOUND	0	571, 579				54. 01
55. 00   05500   RADI OLOGY-THERAPEUTI C	0	1, 616, 466				55. 00
57. 00  05700   CT   SCAN	0	4, 945, 808				57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	862, 615	0			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0			59. 00
60. 00   06000   LABORATORY	0	2, 737, 263	0			60.00
60. 01   06001   BLOOD   LABORATORY	0	0	0			60. 01
65. 00 06500 RESPI RATORY THERAPY	0	436, 741				65. 00
65. 01   03950   SLEEP CLINIC	0	170, 709				65. 01
66. 00 06600 PHYSI CAL THERAPY	0	262, 647				66. 00
67.00 06700 OCCUPATIONAL THERAPY	0	6, 483				67. 00
68. 00   06800   SPEECH PATHOLOGY	0	253				68. 00
69. 00   06900   ELECTROCARDI OLOGY	0	1, 597, 079				69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	74, 825				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	278, 061				72. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0	1, 378, 292	0			73. 00
OUTPATIENT SERVICE COST CENTERS						4
91. 00   09100   EMERGENCY	0	2, 346, 401				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1, 050, 085				92.00
200.00   Total (lines 50 through 199)	0	30, 206, 552	0			200. 00

Health Financial Systems	DEARBORN COUN	ITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der Co	CN: 15-0086	Peri od:	Worksheet D	
				From 01/01/2016		
				To 12/31/2016		
		T: +1 o	xVIII	Hospi tal	3/12/2018 9: 20 PPS	u am
		l little	Charges	поѕрі таі	Costs	
Cost Center Description	Cost to Chargo	PPS Reimbursed		Cost	PPS Services	
cost center bescription		Services (see	Rei mbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Servi ces Not	(366 11131.)	
	Part I, col. 9		Subject To	Subject To		
	lart i, coi. /		Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	0.00	1.00	0.00	
50. 00 05000 OPERATING ROOM	0. 192298	5, 929, 032	4, 68	1 0	1, 140, 141	50.00
51. 00   05100   RECOVERY   ROOM	0. 333103		·	0	382, 550	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 357979			0	0	52. 00
53. 00   05300   ANESTHESI OLOGY	0. 033421			0	7, 144	l
54. 00   05400 RADI OLOGY-DI AGNOSTI C	0. 301472			0	1, 380, 742	54.00
54. 01   05401   ULTRASOUND	0. 135490			0	77, 443	l
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 167224			0	270, 312	55. 00
57. 00   05700   CT   SCAN	0. 024969			0 0	123, 492	
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 118904			0 0	102, 568	58.00
59. 00   05900   CARDI AC   CATHETERI ZATI ON	0. 000000			0 0	0	59.00
60. 00   06000   LABORATORY	0. 211621			0	579, 262	
60. 01   06001   BLOOD LABORATORY	0. 000000			0	0	60. 01
65. 00 06500 RESPIRATORY THERAPY	0. 249561			0	108, 994	
65. 01   03950   SLEEP CLINIC	0. 340386			0	58, 107	65. 01
66. 00 06600 PHYSI CAL THERAPY	0. 397858			0	104, 496	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 600281			0	3, 892	67. 00
68.00 06800 SPEECH PATHOLOGY	0. 507207			0	128	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 276344			0	441, 343	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 792261			0	59, 281	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	4. 592002			0	1, 276, 857	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 466285		2, 22	0 4, 047	642, 677	1
OUTPATIENT SERVICE COST CENTERS		., ., ., .,	_,	., .,	5 12, 511	
91. 00 09100 EMERGENCY	0. 284373	2, 346, 401		0 0	667, 253	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 212935	,	1, 20	0 227		
200.00 Subtotal (see instructions)		30, 206, 552	·			
201.00 Less PBP Clinic Lab. Services-Program		,,	]	0 0		201. 00
Only Charges						
202.00 Net Charges (line 200 - line 201)	1	30, 206, 552	8, 10	1 4, 274	8, 700, 367	202. 00
	•		•	1		•

Health Financial Systems	DEARBORN COUN	NTY HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provider CO	CN: 15-0086	Peri od: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prep 3/12/2018 9:20	pared: 0 am
		Title	XVIII	Hospi tal	PPS	
	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.)				

	cost center bescription	0031	0031	
		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			
	05000 OPERATING ROOM	900	0	50.00
	05100 RECOVERY ROOM	0	0	51. 00
	05200 DELIVERY ROOM & LABOR ROOM	0	0	52. 00
	05300 ANESTHESI OLOGY	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	54. 00
54. 01	05401 ULTRASOUND	0	0	54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	55. 00
57.00	05700 CT SCAN	0	0	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	59. 00
60.00	06000 LABORATORY	0	0	60. 00
60.01	06001 BLOOD LABORATORY	0	0	60. 01
65.00	06500 RESPI RATORY THERAPY	0	0	65. 00
65. 01	03950 SLEEP CLINIC	0	0	65. 01
66.00	06600 PHYSI CAL THERAPY	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 035	1, 887	73. 00
	OUTPATIENT SERVICE COST CENTERS			
91.00	09100 EMERGENCY	0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 456		92. 00
200.00	Subtotal (see instructions)	3, 391	2, 162	200. 00
201.00	Less PBP Clinic Lab. Services-Program	0		201. 00
	Only Charges			1
202.00	Net Charges (line 200 - line 201)	3, 391	2, 162	202. 00

Health Financial Systems	DEARBORN COUNTY HOSP	PITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Pro	ovider CCN: 15-0086	Period: From 01/01/2016	Worksheet D-1
				Date/Time Prepared: 3/12/2018 9:20 am
		Title XVIII	Hospi tal	PPS

		Title XVIII	Hospi tal	3/12/2018 9: 2 PPS	<u> </u>
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
4 00	I NPATI ENT DAYS			40.070	4 00
1. 00 2. 00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-b			13, 273 13, 273	1. 00 2. 00
3. 00	Private room days (excluding swing-bed and observation bed day	<b>3</b> /	vate room days,	0	3. 00
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	od days)		11, 791	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private roo		r 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private rooreporting period (if calendar year, enter 0 on this line)	om days) after December 3	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	0	7. 00
8.00	reporting period Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	n days) after December 3	1 of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swi ng-bed and	5, 776	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct		oom days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private ro	oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, er Swing-bed NF type inpatient days applicable to titles V or XI) through December 31 of the cost reporting period		e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI) after December 31 of the cost reporting period (if calendar ye			0	13. 00
14.00	Medically necessary private room days applicable to the Progra			0	14. 00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	15. 00 16. 00
	SWING BED ADJUSTMENT	oo through Dogombor 21 o	E the cost		17. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	<u> </u>			
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period				18.00
19. 00	Medicald rate for swing-bed NF services applicable to services reporting period	J			19. 00
20. 00	Medical drate for swing-bed NF services applicable to services reporting period		ne cost		20. 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe		ng period (line	16, 422, 083 0	21. 00 22. 00
23. 00	$5 \times 1$ ine 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December	- 31 of the cost reporti	ng period (line	0	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)	, ,		0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost ( PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		16, 422, 083	
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00
30. 00	Semi-private room charges (excluding swing-bed charges)			0	30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 -	· line 28)		0.000000	31.00
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	32. 00 33. 00
34. 00	, , , , , , , , , , , , , , , , , , , ,	nus lina 33)(saa instruc	tions)	0.00	34. 00
35. 00				0.00	35. 00
36. 00			0.00	36. 00	
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	16, 422, 083	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 237. 25	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	•		7, 146, 356	39.00
40. 00 41. 00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39			0 7, 146, 356	40. 00 41. 00
			'		

	Financial Systems	DEARBORN COUNT				u of Form CMS-2	
COMPUT	TATION OF INPATIENT OPERATING COST		Provi der C	CN: 15-0086	Peri od: From 01/01/2016	Worksheet D-1	
					To 12/31/2016	Date/Time Pre 3/12/2018 9: 2	
			_	XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total	Average Per		Program Cost (col. 3 x col.	
		·		col . 2)		4)	
42 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5. 00	42. 00
42.00	Intensive Care Type Inpatient Hospital Units						
43. 00 44. 00	I NTENSI VE CARE UNI T	3, 151, 322	2, 068	1, 523.	1, 163	1, 772, 238	1
45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
46. 00	· ·						46. 00
47.00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						47. 00
	·	-				1. 00	
48. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			nne)		8, 727, 053 17, 645, 647	
47.00	PASS THROUGH COST ADJUSTMENTS	41 till odgir 40) (.	see mstructro	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		17, 043, 047	47.00
50. 00	Pass through costs applicable to Program inp	atient routine s	services (from	n Wkst. D, sur	n of Parts I and	1, 087, 755	50. 00
51. 00		atient ancillar	y services (fr	om Wkst. D, s	sum of Parts II	471, 305	51.00
F0 00	and IV)		,			4 550 0/0	F0 00
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		ated, non-phy	sician anesth	netist, and	1, 559, 060 16, 086, 587	
	medical education costs (line 49 minus line					, ,	
54 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
	Target amount per discharge						55. 00
56. 00 57. 00	,	ing cost and to	cast amount (	ino E4 minus	lino E2)	0 0	56. 00 57. 00
58. 00	Bonus payment (see instructions)	ing cost and tai	get amount (i	THE 56 IIITHUS	111le 53)	0	
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period (	endi ng 1996, ι	ipdated and co	ompounded by the	0.00	59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report, upo	dated by the m	narket basket		0.00	60.00
61. 00	If line 53/54 is less than the lower of line	s 55, 59 or 60 e	enter the less	ser of 50% of		0	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)						
	2.00 Relief payment (see instructions)						
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ctions)			0	63.00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	cost reporti	ng period (See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Decembe	er 31 of the d	ost reporting	a period (See	0	65. 00
	instructions) (title XVIII only)						
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line d	64 plus line 6	o5)(title XVII	I only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 c	of the cost re	eporting period	0	67. 00
68 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after De	ecember 31 of	the cost reno	orting period	0	68. 00
	(line 13 x line 20)			•	or tring portion		
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		ne 70 ÷ line	2)			71. 00 72. 00
73. 00	Medically necessary private room cost applic		(line 14 x li	ne 35)			73. 00
74.00	Total Program general inpatient routine serv	•			>		74.00
75. 00	Capital-related cost allocated to inpatient 26. line 45)	routine service	COSTS (Trom W	ЮГКSNEET В, Н	Part II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li						76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for exces	s costs (from pi					79. 00
80. 00 81. 00	Total Program routine service costs for comp		ost limitation	ı (line 78 mir	nus line 79)		80. 00 81. 00
82.00	· ·						82.00
83.00							83.00
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		ns)				84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum	of lines 83 th					86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					1, 482	87. 00
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			1, 237. 25	88. 00
	Observation bed cost (line 87 x line 88) (se	o instructions)				1, 833, 605	

Health Financial Systems	DEARBORN COUN	TY HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2016 To 12/31/2016	Date/Time Prep 3/12/2018 9: 20	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital-related cost	2, 160, 658	16, 422, 083	0. 13157	1, 833, 605	241, 247	90.00
91.00 Nursing School cost	0	16, 422, 083	0.00000	1, 833, 605	0	91.00
92.00 Allied health cost	0	16, 422, 083	0.00000	1, 833, 605	0	92.00
93.00 All other Medical Education	0	16, 422, 083	0. 00000	1, 833, 605	0	93. 00

Health Financial Systems	DEARBORN COUNTY HOSPITAL	In Lie	u of Form CMS-:	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0086	Peri od: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Pre 3/12/2018 9:2	pared:
	Title XIX	Hospi tal	Cost	

		Title XIX	Hospi tal	3/12/2018 9: 2 Cost	0 am
	Cost Center Description			'	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			13, 273	1.00
2.00	Inpatient days (including private room days, excluding swing-l	<i>y</i> ,		13, 273	2.00
3. 00	Private room days (excluding swing-bed and observation bed day do not complete this line.	ys). If you have only pri	vate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		11, 791	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private roo		31 of the cost	0	5. 00
	reporting period	3 7			
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December 3	31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	m days) through Docombor	21 of the cost	0	7. 00
7.00	reporting period	ii days) tiii ougii beceiibei	31 Of the Cost	U	7.00
8.00	Total swing-bed NF type inpatient days (including private roor	m days) after December 3°	of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)	3 7			
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swi ng-bed and	33	9. 00
10. 00	newborn days)	alv. (i polyudi pa privoto pr	som dava)	0	10 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instructions)		oom days)	U	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, en		,		
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI)	Konly (including private	e room days)	0	12. 00
12.00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI)	/ anly (including private	s maam daya)	0	12 00
13. 00	after December 31 of the cost reporting period (if calendar ye			U	13. 00
14. 00	Medically necessary private room days applicable to the Progra			0	14. 00
15.00	Total nursery days (title V or XIX only)			700	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 service	as through December 21 et	f the cost	0.00	17. 00
17.00	reporting period	es till ough becember 31 of	the cost	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	the cost	0. 00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	ne cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	s)		16, 422, 083	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ng period (line	0	22. 00
	5 x line 17)	•			
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December	- 31 of the cost reportin	na period (line	0	24. 00
21.00	7 x line 19)	or or the cost reporter.	.g po ou (	· ·	2 00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)			0	27 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		16, 422, 083	26. 00 27. 00
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(11110 21 111110 11110 20)		10/ 122/ 000	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00
30. 00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27	: line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 min	aus lino 22)(soo instruct	tions)	0. 00 0. 00	33. 00 34. 00
35. 00	Average per diem private room cost differential (line 34 x line)		11 0113)	0.00	35.00
36. 00	Private room cost differential adjustment (line 3 x line 35)			0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost dit	ferential (line	16, 422, 083	37. 00
	27 minus line 36)		,		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ICTUENTO			
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU		Т	1 227 25	20.00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			1, 237. 25 40, 829	38. 00 39. 00
40. 00	Medically necessary private room cost applicable to the Progra			40, 829	40.00
	Total Program general inpatient routine service cost (line 39	•		40, 829	
			·		

Heal th	Financial Systems DEARBORN COUNTY HOSPITAL In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST Provider CCN: 15-0086 Period: From 01/01/2016	Worksheet D-1	
	To 12/31/2016	Date/Time Prep 3/12/2018 9: 20	
	Title XIX Hospital	Cost	<u> </u>
	Cost Center Description   Total   Total   Average Per   Program Days   Inpatient Cost   Inpatient Days   Diem (col. 1 ÷	Program Cost (col. 3 x col.	
	1.00 2.00 3.00 4.00	4) 5. 00	
42. 00	NURSERY (title V & XIX only) 964, 117 700 1, 377. 31 0		42. 00
43. 00	Intensive Care Type Inpatient Hospital Units  INTENSIVE CARE UNIT 3,151,322 2,068 1,523.85 0	0	43. 00
44. 00	CORONARY CARE UNIT		44. 00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT		45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)		47. 00
	Cost Center Description	1. 00	
48. 00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	194, 902	48. 00
49. 00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions) PASS THROUGH COST ADJUSTMENTS	235, 731	49. 00
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and	0	50. 00
51. 00		0	51. 00
F2 00	and IV) Total Program evaluable seet (our of lines 50 and 51)	0	52. 00
52. 00 53. 00	Total Program excludable cost (sum of lines 50 and 51) Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and	0	52.00
	medical education costs (line 49 minus line 52) TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54. 00
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)	0. 00 0	55. 00 56. 00
57. 00	Difference between adjusted inpatient operating cost and target amount (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 reporting period ending 1996, updated and compounded by the	0 0. 00	58. 00 59. 00
	market basket		
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket  If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by	0. 00 0	60. 00 61. 00
	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target		
62. 00	amount (line 56), otherwise enter zero (see instructions) Relief payment (see instructions)	0	62. 00
63. 00	Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST	0	63. 00
64. 00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See	0	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See	0	65. 00
	instructions)(title XVIII only)		
66. 00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period	0	68. 00
69 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69. 00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70. 00 71. 00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		70. 00 71. 00
72.00	Program routine service cost (line 9 x line 71)		72.00
73. 00 74. 00	Medically necessary private room cost applicable to Program (line 14 x line 35) Total Program general inpatient routine service costs (line 72 + line 73)		73. 00 74. 00
75. 00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ line 2)		76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line 76) Inpatient routine service cost (line 74 minus line 77)		77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for excess costs (from provider records)		79. 00
80. 00 81. 00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) Inpatient routine service cost per diem limitation		80. 00 81. 00
82. 00	Inpatient routine service cost limitation (line 9 x line 81)		82. 00
83. 00 84. 00	Reasonable inpatient routine service costs (see instructions) Program inpatient ancillary services (see instructions)		83. 00 84. 00
85.00	Utilization review - physician compensation (see instructions)		85. 00
86. 00	Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		86. 00
87.00	Total observation bed days (see instructions)	1, 482	87. 00
88. 00 89. 00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) Observation bed cost (line 87 x line 88) (see instructions)	1, 237. 25 1, 833, 605	

Health Financial Systems	DEARBORN COUN	ITY HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2016 To 12/31/2016		pared: O am
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	2, 160, 658	16, 422, 083	0. 13157	1, 833, 605	241, 247	90.00
91.00 Nursing School cost	C	16, 422, 083	0.00000	1, 833, 605	0	91.00
92.00 Allied health cost		16, 422, 083	0.00000	1, 833, 605	0	92.00
93 00 All other Medical Education		16 422 083	0 00000	1 833 605	0	93 00

Health Financial Systems DEARBORN COUNTY INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		ON 15 000/	In Lie	eu of Form CMS-2 Worksheet D-3	
INPATIENT ANGILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0086	From 01/01/2016		
			To 12/31/2016		
	Titl∈	XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2. 00	2) 3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS			4, 314, 507		30. 00
31. 00   03100   NTENSI VE CARE UNI T			1, 774, 451		31. 00
43. 00   04300   NURSERY			, , , , ,		43.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 1922			
51. 00   O5100   RECOVERY ROOM		0. 3331			
52.00 O5200 DELIVERY ROOM & LABOR ROOM		0. 3579			
53. 00   05300   ANESTHESI OLOGY		0. 0334			
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 3014			
54. 01   05401   ULTRASOUND		0. 1354			
55. 00   05500   RADI OLOGY-THERAPEUTI C		0. 1672			
57. 00   05700   CT   SCAN		0. 0249			
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI) 59.00   05900   CARDIAC CATHETERIZATION		0. 1189 0. 0000			58. 00 59. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON 60. 00   06000   LABORATORY		0.0000		0 1, 148, 391	60.00
60. 01   06000  EABORATORY		0. 0000		1, 140, 391	60.00
65. 00   06500   RESPI RATORY   THERAPY		0. 2495		-	
65. 01   03950   SLEEP CLINIC		0. 3403		0,2,100	1
66. 00   06600   PHYSI CAL THERAPY		0. 3978			66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 6002			67. 00
68. 00 06800 SPEECH PATHOLOGY		0. 5072			68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 2763	44 2, 327, 906	643, 303	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 7922	1, 094, 185	866, 880	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		4. 5920	7, 459	34, 252	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 4662	4, 738, 622	2, 209, 548	73. 00
OUTPAȚI ENT SERVI CE COST CENTERS					1
91. 00   09100   EMERGENCY		0. 2918			
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 2129			
Total (sum of lines 50 through 94 and 96 through 98)	(1.1		30, 791, 048	8, 727, 053	
201.00 Less PBP Clinic Laboratory Services-Program only charges	(IIne 61)		0 701 040		201. 00
202.00 Net charges (line 200 minus line 201)		I	30, 791, 048	I	202. 00

Health Financial Systems DEARBORN COUNTY H	OSPI TAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od:	Worksheet D-3	
			From 01/01/2016 To 12/31/2016	Date/Time Prep 3/12/2018 9:20	
	Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00   03000   ADULTS & PEDI ATRI CS			101, 825		30. 00
31.00 03100 INTENSIVE CARE UNIT			8, 100		31. 00
43. 00   04300   NURSERY			18, 214		43. 00
ANCILLARY SERVICE COST CENTERS					
50. 00   05000   OPERATI NG ROOM		0. 19229		7, 310	
51. 00   05100   RECOVERY ROOM		0. 33310		314	51.00
52.00 O5200 DELIVERY ROOM & LABOR ROOM		0. 35797		4, 831	52. 00
53. 00 05300 ANESTHESI OLOGY		0. 03342		1, 293	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 30147		3, 405	54.00
54. 01   05401   ULTRASOUND		0. 13549		5, 411	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 16722		934	55. 00
57. 00   05700   CT   SCAN		0. 02496		3, 118	57. 00
58. 00   05800   MAGNETI C RESONANCE I MAGI NG (MRI)		0. 11890		4, 049	
59. 00   05900   CARDI AC   CATHETERI ZATI ON		0.00000		0	59. 00
60. 00   06000   LABORATORY		0. 21162		12, 681	60.00
60. 01   06001   BLOOD LABORATORY		0. 00000		0	60. 01
65. 00   06500   RESPI RATORY THERAPY		0. 24956		3, 226	65. 00
65. 01   03950   SLEEP CLINIC		0. 34038		0	65. 01
66. 00   06600   PHYSI CAL THERAPY		0. 39785		3, 298	•
67. 00   06700   OCCUPATI ONAL THERAPY		0. 60028		46	67. 00
68. 00 06800 SPEECH PATHOLOGY		0. 50720		39	68. 00
69. 00   06900   ELECTROCARDI OLOGY		0. 27634		20, 186	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 79226		2, 782	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT		4. 59200		118, 694	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 46628	5 0	0	73. 00

0. 284373

1. 212935

91.00

92.00 0

201. 00

3, 285

194, 902 200. 00

11, 551

502, 135

502, 135

OUTPATIENT SERVICE COST CENTERS
91. 00 09100 EMERGENCY

200.00

201.00 202.00

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

Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)
Net charges (line 200 minus line 201)

Health Financial Systems	DEARBORN COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0086	Peri od: Worksheet E From 01/01/2016 Part A To 12/31/2016 Date/Time Prepared: 3/12/2018 9:20 am

PART A _			Title XVIII	Hospi tal	3/12/2018 9: 20 PPS	o am
PART A - IMPATIBIT HOSPITAL SERVICES WIDER IPPS					1 00	
DRG amounts other than outlier payments for discharges occurring on or after Dotober 1 (see   11,959,339   1.02   DRC amounts other than outlier payments for discharges occurring on or after Dotober 1 (see   11,959,339   1.02   1.03   DRC amounts other than outlier payments for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)   1.03   DRC amounts of the payments for discharges occurring on or after		PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1.00	
Instructions   1.02   DRI commonits other than outlier payments for discharges occurring on or after October 1 (see   11,959,339   1.02   1.03   1.05   1.		,				
DRC amounts other than outlier payments for discharges occurring on or after October 1 (see   11,599,339   1.02     Instructions)   DRC for frederial space fire operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see   1.03     DRC for frederial space fire operating payment for Model 4 BPCI for discharges occurring on or after 0   1.04     DRC for frederial space fire operating payment for Model 4 BPCI for discharges occurring on or after 0   1.04     DRC for frederial space fire operating payment for Model 4 BPCI (see instructions)   0.2 (DRC   1.04     DRC for frederial space fire operating payment for Model 4 BPCI (see instructions)   0.2 (DRC   1.04     DRC for frederial space fire operating payment for Model 4 BPCI (see instructions)   0.2 (DRC   1.04     DRC for frederial space fire operating payment for Model 4 BPCI (see instructions)   0.2 (DRC   1.04     DRC for frederial space fire operating payment for Model 4 BPCI (see instructions)   0.2 (DRC   1.04     DRC for frederial space fire operating payment for Model 4 BPCI (see instructions)   0.2 (DRC   1.04     DRC for frederial space fire operating payment for flow payment flow payment flow payment flow payment flow flow payment flow payment flow flow payment flow flow payment flow payment flow flow payment flow flow payment flow flow payment payment flow flow payment	1. 01		g prior to October 1 (s	see	0	1. 01
1.03   1.08	1.02	DRG amounts other than outlier payments for discharges occurring	g on or after October 1	l (see	11, 959, 339	1. 02
1.04   0x16 for Tederal specific operating payment for Model 4 BPCI for discharges occurring on or after   0   1.04	1.03	DRG for federal specific operating payment for Model 4 BPCI for	discharges occurring	orior to October	0	1. 03
2.00   Outlier payments for discharges. (see instructions)	1.04	DRG for federal specific operating payment for Model 4 BPCI for	di scharges occurri ng	on or after	0	1. 04
2.02   2.01   Control of discharges for Model 4 BPCI (see instructions)   0.3.00   Managed Care Simulated Payments   0.3.00   0.0		Outlier payments for discharges. (see instructions)				
Managed Care Simulated Payments			ne)		-	
Bed days available divided by number of days in the cost reporting period (see instructions)   83.95   4.00		, , ,	113)		-	
FTE count for all opathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/19/96, (see instructions)		Bed days available divided by number of days in the cost report	ing period (see instru	ctions)	83. 95	
FIE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)   7.00	5.00	FTE count for allopathic and osteopathic programs for the most	recent cost reporting p	period ending on	0.00	5. 00
7.00         MMA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(v)(8)(2) If the cost report straddles July 1, 2011 then see instructions.         0.00         7.00         0.00         7.00         0.00         8.00         All systemet (increase or decrease) to the FIE count for all opathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50099 (Mugust 1, 2002).         0.00         8.00           8.01         The amount of increase if the hospital was awarded FIE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.         0.00         8.01           8.02         The amount of increase if the hospital was awarded FIE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.         0.00         8.01           9.00         Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see 0.00         0.00         9.00           10.00         FIE count for allopathic and osteopathic programs in the current year from your records         0.00         10.00           10.00         Current year allowable FIE (see instructions)         0.00         1.00           10.00         Current year allowable FIE count for the prior year.         0.00         1.00           10.00         Ticcount for residents in initial years of the program of the	6. 00	FTE count for allopathic and osteopathic programs which meet the	e criteria for an add-o	on to the cap	0. 00	6. 00
ACA \$ 5503 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(i)(i)(B)(2) if the cost report straddles July 1, 2011 then see instructions.	7. 00		der 42 CFR §412.105(f)	(1) (i v) (B) (1)	0. 00	7. 00
Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		ACA § 5503 reduction amount to the IME cap as specified under 4			0. 00	7. 01
The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report stradies July 1, 2011, see instructions.	8. 00	Adjustment (increase or decrease) to the FTE count for allopath affiliated programs in accordance with 42 CFR 413.75(b), 413.79			0. 00	8. 00
8.02   The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	8. 01	The amount of increase if the hospital was awarded FTE cap slot	s under § 5503 of the A	ACA. If the cost	0. 00	8. 01
9.00   Sum of Ilnes 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see   0.00   9.00   10.00   FTE count for all opathic and osteopathic programs.   0.00   10.00   FTE count for residents in dental and podiatric programs.   0.00   11.00   12.00   13.00   10.00   14.00   15.00   10.00   15.00   15.00   15.00   15.00   16.00	8. 02	The amount of increase if the hospital was awarded FTE cap slot	s from a closed teachin	ng hospital	0.00	8. 02
10.00   FTE count for allopathic and osteopathic programs in the current year from your records   0.00   10.	9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines	(8, 8,01 and 8,02) (s	see	0. 00	9. 00
12.00   Current year allowable FTE (see instructions)   0.00   12.00   13.00   10.00		FTE count for allopathic and osteopathic programs in the curren	t year from your record	ds		
13.00   Total allowable FTE count for the prior year.   0.00   13.00   14.00						
14.00		, , , , , , , , , , , , , , , , , , ,				
15. 00   Sum of lines 12 through 14 divided by 3.   0. 00   15. 00   16. 00   16. 00   16. 00   16. 00   16. 00   16. 00   16. 00   17. 00   17. 00   18. 00   18. 00   18. 00   19.		Total allowable FTE count for the penultimate year if that year	ended on or after Sept	tember 30, 1997,		
16. 00       Adj ustment for residents displaced by program or hospital closure       0.00       16. 00         17. 00       Adj ustment for residents displaced by program or hospital closure       0.00       17. 00         18. 00       Adj usted rolling average FTE count       0.00       18. 00         19. 00       Current year resident to bed ratio (line 18 divided by line 4).       0.000000       19. 00         20. 00       Prior year resident to bed ratio (see instructions)       0.000000       20. 00         21. 00       Enter the lesser of lines 19 or 20 (see instructions)       0.000000       21. 00         22. 01       IME payment adj ustment (see instructions)       0.000000       22. 00         1 IME payment adj ustment + Managed Care (see instructions)       0.000000       22. 01         1 Imid rect Medical Education Adj ustment for the Add-on for § 422 of the MMA       0.000000       23. 00         23. 00       (f)(1)(iv)(C).       0.000000       24. 00         25. 00       If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see       0.00       25. 00         26. 00       Resident to bed ratio (divide line 25 by line 4)       0.000000       26. 00         27. 00       IME payments adjustment factor. (see instructions)       0.28. 00         28. 01       IME add-on adjustme	15 00				0.00	15 00
18.00       Adjusted rolling average FTE count       0.00       18.00         19.00       Current year resident to bed ratio (line 18 divided by line 4).       0.000000       19.00         20.00       Prior year resident to bed ratio (see instructions)       0.000000       20.00         21.00       Enter the lesser of lines 19 or 20 (see instructions)       0.000000       21.00         22.00       IME payment adjustment (see instructions)       0.22.00         1 IME payment adjustment - Managed Care (see instructions)       0.22.01         1 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA       0.00         23.00       Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105       0.00       23.00         (f)(1)(iv)(c).       0.1       0.00       24.00       25.00       0.00       24.00       25.00         25.00       IME FTE Resident Count Over Cap (see instructions)       0.00       25.00       0.00       25.00         26.00       Resident to bed ratio (divide line 25 by line 4)       0.000000       26.00         27.00       IME payments adjustment factor. (see instructions)       0.000000       27.00         28.01       IME add-on adjustment amount - Managed Care (see instructions)       0.28.01         29.00       Total IME paym						
19.00       Current year resident to bed ratio (line 18 divided by line 4).       0.000000   19.00         20.00       Prior year resident to bed ratio (see instructions)       0.000000   20.00         21.00       Enter the lesser of lines 19 or 20 (see instructions)       0.000000   21.00         22.00       IME payment adjustment (see instructions)       0.22.00         1 IME payment adjustment - Managed Care (see instructions)       0.00000         23.00       Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA         23.00       (f)(1)(iv)(c).       0.00         24.00       IME FTE Resident Count Over Cap (see instructions)       0.00         25.00       If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)       0.00         26.00       Resident to bed ratio (divide line 25 by line 4)       0.000000         27.00       IME payments adjustment factor. (see instructions)       0.00000         28.01       IME add-on adjustment amount (see instructions)       0.00000         28.01       IME add-on adjustment amount - Managed Care (see instructions)       0.28.01         29.01       Total IME payment (sum of lines 22 and 28)       0.29.00         70 tal IME payment - Managed Care (sum of lines 22.01 and 28.01)       0.00000         Disproportionate Share Adjustment	17.00	Adjustment for residents displaced by program or hospital closu	re		0.00	17. 00
20.00   Prior year resident to bed ratio (see instructions)   0.000000   20.00   21.00   Enter the lesser of lines 19 or 20 (see instructions)   0.000000   21.00   0.000000   21.00   0.000000   21.00   0.000000   21.00   0.000000   22.00   0.000000   21.00   0.000000   22.00   0.000000   22.00   0.0000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.0000000   0.00000000						
21.00   Enter the lesser of lines 19 or 20 (see instructions)   0.000000   21.00     22.00   IME payment adjustment (see instructions)   0   22.00     1ME payment adjustment - Managed Care (see instructions)   0   22.01     1		, ,				
22. 00 IME payment adjustment (see instructions) 0 22. 00 IME payment adjustment - Managed Care (see instructions) 0 22. 01 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA  23. 00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412. 105 0. 00 23. 00 (f) (1) (iv) (C).  24. 00 IME FTE Resident Count Over Cap (see instructions) 0. 00 24. 00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25. 00 instructions)  26. 00 IME payments adjustment factor. (see instructions) 0. 0000000 27. 00 IME payments adjustment factor. (see instructions) 0. 0000000 27. 00 IME payments adjustment amount (see instructions) 0. 000000 27. 00 IME add-on adjustment amount (see instructions) 0. 28. 01 IME add-on adjustment amount - Managed Care (see instructions) 0. 000000 29. 01 Total IME payment (sum of lines 22 and 28) 0. 029. 01 Total IME payment - Managed Care (sum of lines 22. 01 and 28. 01) 0. 029. 00 Total IME payment - Managed Care (sum of lines 22. 01 and 28. 01) 0. 029. 01 Disproportionate Share Adjustment  30. 00 Sum of lines 30 and 31 3. 00 Sum of lines 30 and 31 3. 00 Allowable disproportionate share percentage (see instructions) 10. 71 33. 00						
22. 01    IME payment adjustment - Managed Care (see instructions)   0   1   1   1   1   1   1   1   1   1		,				
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA  23.00   Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105   0.00   23.00						
23. 00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 0.00 23.00 (f) (1) (iv) (c).  24. 00 IME FTE Resident Count Over Cap (see instructions) 0.00 24.00 1f the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 instructions)  26. 00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26.00 1ME payments adjustment factor. (see instructions) 0.000000 27.00 1ME payments adjustment amount (see instructions) 0.000000 27.00 1ME add-on adjustment amount - Managed Care (see instructions) 0.28.01 1ME add-on adjustment amount - Managed Care (see instructions) 0.28.01 29.00 Total IME payment (sum of lines 22 and 28) 0.29.00 1Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 0.29.01 1Disproportionate Share Adjustment  30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 3.04 30.00 31.00 Sum of lines 30 and 31 20.00 Sum of lines 30 and 31 31.00 Allowable disproportionate share percentage (see instructions) 10.71 33.00	22.01		of the MMA		- O	22.01
24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 29.01 Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 31.00 Instructions 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 30.00 Instructions 30.00 Percentage of Medicaid patient days (see instructions)	23. 00	Number of additional allopathic and osteopathic IME FTE residen		FR 412. 105	0.00	23. 00
25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see  0.00 25.00 instructions)  Resident to bed ratio (divide line 25 by line 4)  0.000000 26.00  IME payments adjustment factor. (see instructions)  0.000000 27.00  IME add-on adjustment amount (see instructions)  0.000000 28.01  IME add-on adjustment amount - Managed Care (see instructions)  10 28.01  Total IME payment (sum of lines 22 and 28)  10 29.01  Disproportionate Share Adjustment  20.00  Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  30.00  Sum of lines 30 and 31  20.05  Allowable disproportionate share percentage (see instructions)  10.00  25.00  26.00  26.00  27.00  28.01  27.00  28.01  29.00  29.01  29.01  29.01  29.01  29.01  20.00  20.0	24. 00				0. 00	24. 00
26.00       Resident to bed ratio (divide line 25 by line 4)       0.000000       26.00         27.00       IME payments adjustment factor. (see instructions)       0.000000       27.00         28.00       IME add-on adjustment amount (see instructions)       0       28.00         28.01       IME add-on adjustment amount - Managed Care (see instructions)       0       28.01         29.00       Total IME payment (sum of lines 22 and 28)       0       29.00         29.01       Total IME payment - Managed Care (sum of lines 22.01 and 28.01)       0       29.01         Disproportionate Share Adjustment       29.01         30.00       Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)       3.04       30.00         31.00       Percentage of Medicaid patient days (see instructions)       23.01       31.00         32.00       Sum of lines 30 and 31       26.05       32.00         33.00       Allowable disproportionate share percentage (see instructions)       10.71       33.00		If the amount on line 24 is greater than -0-, then enter the lo	wer of line 23 or line	24 (see		
27.00 IME payments adjustment factor. (see instructions)  28.00 IME add-on adjustment amount (see instructions)  28.01 IME add-on adjustment amount - Managed Care (see instructions)  29.00 Total IME payment (sum of lines 22 and 28)  29.01 Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  30.00 Percentage of Medicaid patient days (see instructions)  30.00 Sum of lines 30 and 31  30.00 Allowable disproportionate share percentage (see instructions)  30.00 Allowable disproportionate share percentage (see instructions)  30.00 IME payment adjustment amount (see instructions)  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  30.00 Sum of lines 30 and 31  30.00 Allowable disproportionate share percentage (see instructions)  30.00 IME add-on adjustment amount (see instructions)  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  30.00 Percentage of Medicaid patient days (see instructions)  30.00 IME add-on adjustment amount (see instructions)  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  30.00 Percentage of Medicaid patient days (see instructions)  30.00 IME add-on adjustment amount (see instructions)  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  30.00 Percentage of Medicaid patient days (see instructions)  30.00 IME add-on adjustment amount (see instructions)  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  30.00 Percentage of Medicaid patient days (see instructions)  30.00 Percentage of Medicaid patient days (see instructions)	26. 00				0.000000	26. 00
28.00 IME add-on adjustment amount (see instructions)  28.01 IME add-on adjustment amount - Managed Care (see instructions)  29.00 Total IME payment (sum of lines 22 and 28)  29.01 Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  30.00 Percentage of Medicaid patient days (see instructions)  30.00 Sum of lines 30 and 31  30.00 Allowable disproportionate share percentage (see instructions)						
29.00 Total IME payment (sum of lines 22 and 28) 0 29.00 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 0 29.01 Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 3.04 31.00 Percentage of Medicaid patient days (see instructions) 23.01 31.00 Sum of lines 30 and 31 26.05 32.00 Allowable disproportionate share percentage (see instructions) 10.71 33.00	28.00	, , , , , , , , , , , , , , , , , , , ,			0	28. 00
29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  31.00 Percentage of Medicaid patient days (see instructions)  32.00 Sum of lines 30 and 31  33.00 Allowable disproportionate share percentage (see instructions)  30.01 29.01  30.02 30.00  30.03 30.00  30.00 30.00	28. 01	IME add-on adjustment amount - Managed Care (see instructions)			0	28. 01
Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  31.00 Percentage of Medicaid patient days (see instructions)  32.00 Sum of lines 30 and 31  33.00 Allowable disproportionate share percentage (see instructions)  30.00 23.00 31.00  31.00 25.00 32.00  32.00 33.00 Allowable disproportionate share percentage (see instructions)	29. 00	Total IME payment ( sum of lines 22 and 28)			0	29. 00
31.00 Percentage of Medicaid patient days (see instructions)  23.01 31.00  32.00 Sum of lines 30 and 31  33.00 Allowable disproportionate share percentage (see instructions)  23.01 31.00  26.05 32.00  10.71 33.00	29. 01				0	29. 01
32.00 Sum of lines 30 and 31 26.05 32.00 33.00 Allowable disproportionate share percentage (see instructions) 10.71 33.00	30.00		ient days (see instruct	tions)	3. 04	30.00
33.00 Allowable disproportionate share percentage (see instructions) 10.71 33.00	31. 00	, , , , , , , , , , , , , , , , , , , ,				
34.00 pulsproportionate share adjustment (see instructions) 320,211 34.00						
	34.00	puisproportionate snare adjustment (see instructions)		l	320, 211	34.00

	Financial Systems DEARBORN COUNT ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0086	Peri od: From 01/01/2016 To 12/31/2016	u of Form CMS-2 Worksheet E Part A Date/Time Pre 3/12/2018 9:20	pared:
	<u> </u>	Title XVIII	Hospi tal	PPS	
			Prior to 10/1		
	Uncompensated Care Adjustment		1. 00	2. 00	
5. 00	Total uncompensated care amount (see instructions)		6 406 145 534	5, 977, 483, 147	35.0
5. 01	Factor 3 (see instructions)		0. 000086163	0. 000089427	
5. 02	1	ter zero on this line) (se		534, 550	1
6. 03 6. 00	Total uncompensated care (sum of columns 1 and 2 on line 35	. 03)	413, 227 547, 963	134, 736	35. 0 36. 0
0. 00	Additional payment for high percentage of ESRD beneficiary of Total Medicare discharges on Worksheet S-3, Part I excluding		gh 46) 0		40.0
. 00	652, 682, 683, 684 and 685 (see instructions) Total ESRD Medicare discharges excluding MS-DRGs 652, 682, instructions)	683, 684 an 685. (see	0		41.0
. 01	Total ESRD Medicare covered and paid discharges excluding M: an 685. (see instructions)	S-DRGs 652, 682, 683, 684	0		41. C
2. 00 3. 00	Divide line 41 by line 40 (if less than 10%, you do not qual Total Medicare ESRD inpatient days excluding MS-DRGs 652, (instructions)	, , , , , , , , , , , , , , , , , , ,	0. 00 0		42. 0 43. 0
. 00	Ratio of average length of stay to one week (line 43 divided days)	d by line 41 divided by 7	0. 000000		44. C
. 00	Average weekly cost for dialysis treatments (see instruction	,	0.00		45. C
. 00	Total additional payment (line 45 times line 44 times line	41. 01)	0		46. 0
. 00	Subtotal (see instructions)	!!!: +-!-	12, 923, 134		47. (
3. 00	Hospital specific payments (to be completed by SCH and MDH, only (see instructions)	small rural nospitals	0		48. 0
	join y. (see Tristractrons)			Amount	
				1.00	
0. 00	Total payment for inpatient operating costs (see instruction			12, 923, 134	1
0.00	Payment for inpatient program capital (from Wkst. L, Pt. I			971, 622	
. 00	Exception payment for inpatient program capital (Wkst. L, P Direct graduate medical education payment (from Wkst. E-4,			0	
3. 00	Nursing and Allied Health Managed Care payment	Title 49 see flistructions).		0	
. 00	Special add-on payments for new technologies			0	
. 01	Islet isolation add-on payment			0	1
. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line	69)		0	1
. 00	Cost of physicians' services in a teaching hospital (see in	tructi ons)		0	56.
. 00	Routine service other pass through costs (from Wkst. D, Pt.	III, column 9, lines 30 t	hrough 35).	0	57.
. 00	Ancillary service other pass through costs from Wkst. D, Pt.	. IV, col. 11 line 200)		0	
0.00	Total (sum of amounts on lines 49 through 58)			13, 894, 756	
. 00	Primary payer payments Total amount payable for program beneficiaries (line 59 min	us Line 60)		3, 640 13, 891, 116	1
. 00	Deductibles billed to program beneficiaries	us Title 60)		1, 506, 316	1
. 00				22, 862	1
. 00	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			271, 365	
	Adjusted reimbursable bad debts (see instructions)			176, 387	
. 00	Allowable bad debts for dual eligible beneficiaries (see in	structions)		181, 946	1
. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			12, 538, 325	1
. 00	Credits received from manufacturers for replaced devices for		,	0	1
. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96)	).(For SCH see instruction	S)	2 004	1
. 00 . 50	OTHER Rural Community Hospital Demonstration Project (§410A Demons	stration) adjustment (see	instructions)	2, 004	1
i. 30 i. 87	Demonstration payment adjustment amount before sequestration	, ,	i nati ucti unaj	0	1
	SCH or MDH volume decrease adjustment (contractor use only)			0	1
	Pioneer ACO demonstration payment adjustment amount (see in:	structions)		0	1
. 88	HSP bonus payment HVBP adjustment amount (see instructions)	•		0	1
). 88 ). 89				0	70.
). 88 ). 89 ). 90	HSP bonus payment HRR adjustment amount (see instructions)				
). 88 ). 89 ). 90 ). 91 ). 92	Bundled Model 1 discount amount (see instructions)			0	
). 88 ). 89 ). 90 ). 91				0 -10, 829 -92, 868	70.

Heal th	Financial Systems	DEARBORN COUNTY H	OSPI TAL		In Lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT	1	Provi der CC		Peri od: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Pre 3/12/2018 9:20	pared:
			Title	XVIII	Hospi tal	PPS	
				FFY	(yyyy)	Amount	
					0	1. 00	
70. 96	the corresponding federal year for the perio	od prior to 10/1)			0	0	70. 96
70. 97	Low volume adjustment for federal fiscal yea the corresponding federal year for the perio				0	0	70. 97
70. 98	Low Volume Payment-3					0	70. 98
70. 99	HAC adjustment amount (see instructions)					0	70. 99
71.00	Amount due provider (line 67 minus lines 68	plus/minus lines 69	& 70)			12, 436, 632	71. 00
71. 01	Sequestration adjustment (see instructions)					248, 733	71. 01
71. 02		er sequestration				0	
72.00	Interim payments					12, 053, 609	
73.00	Tentative settlement (for contractor use onl					0	73. 00
74. 00	Balance due provider/program (line 71 minus 73)	lines 71.01, 71.02,	72, and			134, 290	74. 00
75. 00	Protested amounts (nonallowable cost report CMS Pub. 15-2, chapter 1, §115.2	•	e with			287, 342	75. 00
	TO BE COMPLETED BY CONTRACTOR (lines 90 thro						
90.00	Operating outlier amount from Wkst. E, Pt. A	A, line 2 (see instr	uctions)			0	90.00
91. 00	Capital outlier from Wkst. L, Pt. I, line 2					0	91.00
92.00	1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2					0	92. 00
93. 00	Capital outlier reconciliation adjustment am					0	93. 00
	The rate used to calculate the time value of		tions)			0.00	
	Time value of money for operating expenses (					0	95. 00
96. 00	Time value of money for capital related expe	enses (see instructi	ons)			0	96. 00
					Prior to 10/1		
	LICE D. D. L.A. L				1. 00	2. 00	
	HSP Bonus Payment Amount						
100.00	HSP bonus amount (see instructions)				0	0	100. 00
101 00	HVBP Adjustment for HSP Bonus Payment				0.0000000000	0.0000000000	101 00
	HVBP adjustment factor (see instructions)	t (aaa imatmust:)			0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment HRR Adjustment for HSP Bonus Payment	(See Instructions)			0	0	J 102. 00
102.00	HRR adjustment factor (see instructions)				0.0000	0.0000	102 00
	HRR adjustment factor (see instructions)	(coo inctructions)			0.0000		103.00
104.00	print aujustillerit alliourit for nor borius payllerit	(SEE THISTINGTIONS)			١	U	1104.00

In Lieu of Form CMS-2552-10

Period: Worksheet E
From 01/01/2016 Part A Exhibit 4
To 12/31/2016 Date/Time Prepared: 3/12/2018 9:20 am Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Provider CCN: 15-0086

Department   Dep						10	12/31/2016	3/12/2018 9: 2	
100			W/S E Dort A	Amounts (from					
100   106 amounts other than out   em   1.00   0   0   0   0   0   0   0   0   0									
Department of the Chemoth   1.01			0						
1.00   1.00	1.00		1. 00	0	0	0	0	0	1. 00
1.02   BRG amounts other than outlier   1.02   11,959,339   0   11,959,339   11,9	1. 01	DRG amounts other than outlier payments for discharges	1. 01	0	0	0		0	1. 01
Department for Model 4   BPCI occurring prior to   October 1   O	1. 02	DRG amounts other than outlier payments for discharges	1. 02	11, 959, 339	0		11, 959, 339	11, 959, 339	1. 02
DRG for Federal specific	1.03	operating payment for Model 4 BPCI occurring prior to	1. 03	О	0	0		0	1. 03
2.00	1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after	1. 04	0	0		0	0	1. 04
2.01   Outlier payments for   2.02   O   O   O   O   O   O   O   O   O	2.00	Outlier payments for	2. 00	95, 621	0	0	95, 621	95, 621	2. 00
3.00   Operating outlier   2.01   O   O   O   O   O   O   O   O   O	2. 01	Outlier payments for	2. 02	0	0	0	0	0	2. 01
payments	3. 00	Operating outlier	2. 01	0	0	0	0	0	3. 00
5.00   Amount from Worksheet E, Part   21.00   0.0000000   0.0000000   0.00000000	4. 00	payments		0	0	0	0	0	4. 00
A. I fine 21 (see instructions) 6.00 IME payment adjustment (see instructions) 1.01 IME payment adjustment for 22.01 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	F 00			0.00000	0.00000	0.00000	0.00000		F 00
6.00   IME payment adjustment (see   22.00   0   0   0   0   0   0   0   0   0	5.00		21.00	0.000000	0.000000	0. 000000	0.000000		5. 00
Section   Sect	6. 00	IME payment adjustment (see	22. 00	0	0	0	0	0	6. 00
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA   7.00   1.	6. 01	IME payment adjustment for managed care (see	22. 01	0	0	0	0	0	6. 01
1.00   IME payment adjustment factor   27.00   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.00000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000			istment for the	Add on for Co	a+: an 122 af +	es MMA			
See instructions   See   Section	7. 00						0. 000000		7. 00
8.01   IME payment adjustment add on for managed care (see instructions)   9.00   Total IME payment (sum of lines 6 on all 8)   9.01   Total IME payment (sum of lines 6 on all 8)   9.01   Total IME payment for managed   29.01   0   0   0   0   0   0   0   9.		(see instructions)	28. 00			0	0	0	8. 00
Instructions   Fig. 20	8. 01	IME payment adjustment add on	28. 01	0	0	0	0	0	8. 01
1   1   1   1   1   1   1   2   2   2		instructions)		_				_	
Care (sum of lines 6.01 and 8.01)   Disproportionate Share Adjustment   Sisproportionate Share Adjustment   Sisproportionate Share Adjustment   Sisproportionate Share Percentage (see instructions)   11.00   Disproportionate Share percentage (see instructions)   11.01   Disproportionate Share adjustment (see instructions)   34.00   320,211   0   0   320,211   320,211   11.   11.01   Uncompensated care payments   36.00   547,963   0   413,227   134,736   547,963   11.   Additional payment for high percentage of ESRD beneficiary discharges   12.00   Total ESRD additional payment   46.00   0   0   0   0   0   0   12.   13.00   12.   13.00   13.00   14.   14.00   14.   15.		lines 6 and 8)		0	0	0	0		9. 00
Disproportionate Share Adjustment	9.01	care (sum of lines 6.01 and	29.01	0	U	Ü	0	0	9. 01
Share percentage (see   instructions)			ent						
11.00   Disproportionate share adjustment (see instructions)   34.00   320,211   0   0   320,211   320,211   11.	10. 00		33. 00	0. 1071	0. 1071	0. 1071	0. 1071		10. 00
11. 01   Uncompensated care payments   36. 00   547, 963   0   413, 227   134, 736   547, 963   11.	11. 00	Di sproporti onate share	34. 00	320, 211	0	0	320, 211	320, 211	11. 00
12.00 Total ESRD additional payment (see instructions) 13.00 Subtotal (see instructions) 14.00 Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient operating costs (see instructions) 16.00 Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 17.01 Net organ aquisition cost 17.02 Credits received from  46.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 12.  12, 923, 134 0 0 413, 227 12, 509, 907 12, 923, 134 0 0 413, 227 12, 509, 907 12, 923, 134 15.  16.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	11. 01	Uncompensated care payments				413, 227	134, 736	547, 963	11. 01
13.00 Subtotal (see instructions)	12. 00	Total ESRD additional payment		o beneficiary o		0	0	0	12. 00
14. 00       Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)       48. 00       0       0       0       0       0       0       0       14.         15. 00       Total payment for inpatient operating costs (see instructions)       49. 00       12, 923, 134       0       413, 227       12, 509, 907       12, 923, 134       15.         16. 00       Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)       50. 00       971, 622       0       0       971, 622       971, 622       971, 622       16.         17. 01       Net organ adulisition cost       54. 00       0       0       0       0       0       0       0       0       17.         17. 02       Credits received from       68. 00       0 <td>13. 00</td> <td></td> <td>47. 00</td> <td>12, 923, 134</td> <td>o</td> <td>413, 227</td> <td>12, 509, 907</td> <td>12, 923, 134</td> <td>13. 00</td>	13. 00		47. 00	12, 923, 134	o	413, 227	12, 509, 907	12, 923, 134	13. 00
15.00 Total payment for inpatient operating costs (see instructions)  16.00 Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)  17.00 Special add-on payments for new technologies  17.01 Net organ aquisition cost  17.02 Credits received from 68.00  12,923,134  0 413,227  0 971,622  0 971,622  0 971,622  0 0 0 0 0 0 0 0 17.		Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	48. 00	0	0	0	0	0	14.00
Capital (from Wkst. L, Pt. I, if applicable)		Total payment for inpatient operating costs (see instructions)				·			
new technologies	16. 00	capital (from Wkst. L, Pt. I, if applicable)	50.00	971, 622	0	0	971, 622	971, 622	16. 00
17.02   Credits received from   68.00   0   0   0   17.		new technologies	54. 00	0	0	0	0	0	
devices for applicable MS-DRGs		Credits received from manufacturers for replaced		O	0	0	0	0	17. 01 17. 02

							3/12/2018 9:20	U alli
				Ti tl e	: XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01		
		0	1.00	2.00	3.00	4. 00	5. 00	
18. 00	Capital outlier reconciliation	93.00	0	0		0 0	0	18. 00
	adjustment amount (see							
	instructions)							
19 00	SUBTOTAL			0	413, 22	7 13, 481, 529	13, 894, 756	19 00
171.00	000101112	W/S L, line	(Amounts from		110/22	10/101/02/	10,071,700	17100
		117 5 E, 11116	L)					
		0	1.00	2. 00	3. 00	4. 00	5. 00	
20. 00	Capital DRG other than outlier		956, 422	0		0 956, 422		20, 00
20. 01	Model 4 BPCI Capital DRG other		700, 122	0		0 700, 122	0	1
20.01	than outlier	1.01	O	0			l o	20.01
21. 00	Capital DRG outlier payments	2. 00	15, 200	0		0 15, 200	15, 200	21 00
21. 00	Model 4 BPCI Capital DRG	2. 01	13, 200	0		0 13, 200	13, 200	21.00
21.01	outlier payments	2.01	O	0			l o	21.01
22. 00	Indirect medical education	5. 00	0. 0000	0. 0000	0.000	0. 0000		22. 00
22.00	percentage (see instructions)	3.00	0.0000	0.0000	0.000	0.0000		22.00
23. 00	Indirect medical education	6. 00	0	0		0	0	23. 00
23.00	adjustment (see instructions)	0.00	U	U		0	U	23.00
24. 00	Allowable disproportionate	10.00	0. 0000	0. 0000	0.000	0. 0000		24. 00
24.00		10.00	0.0000	0.0000	0.000	0.0000		24.00
	share percentage (see instructions)							
25 00	1	11. 00		0			0	25 00
25. 00	Di sproporti onate share	11.00	U	U		U U	U	25. 00
27 00	adjustment (see instructions)	12.00	071 (22	0		071 (22	071 (22	24 00
26. 00	Total prospective capital	12. 00	971, 622	U		0 971, 622	971, 622	26.00
	payments (see instructions)	W/C E D-:-+ A	(A					
		W/S E, Part A						
		line	Part A)	2.00	2.00	4.00	F 00	
07.00	I	0	1. 00	2. 00	3.00	4. 00	5. 00	07.00
27. 00	Low volume adjustment factor				0. 00000	0. 000000		27. 00
28. 00	Low volume adjustment	70. 96				0	0	28. 00
	(transfer amount to Wkst. E,							
	Pt. A, line)							
29. 00	Low volume adjustment	70. 97				0	0	29. 00
	(transfer amount to Wkst. E,							
	Pt. A, line)							
100.00	Transfer low volume		Υ					100. 00
	adjustments to Wkst. E, Pt. A.							

HUSPI I	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	ITON EXHIBIT 5		F	From 01/01/2016 To 12/31/2016	Date/Time Pre 3/12/2018 9:2	pared:
				XVIII	Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3. 00	4. 00	
1. 00 1. 01	DRG amounts other than outlier payments DRG amounts other than outlier payments for discharges occurring prior to October 1	1. 00 1. 01	0	(	)	0	1. 00 1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	11, 959, 339		11, 959, 339	11, 959, 339	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1. 03	0	(	)	0	1. 03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after lOctober 1	1. 04	0		0	0	1. 04
2. 00	Outlier payments for discharges (see linstructions)	2. 00	95, 621	(	95, 621	95, 621	2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	(	0	0	2. 01
3. 00 4. 00	Operating outlier reconciliation Managed care simulated payments	2. 01 3. 00	0	(	0 0	0	3. 00 4. 00
5. 00	Amount from Worksheet E, Part A, line 21	21.00	0. 000000	0. 000000	0.000000		5. 00
6. 00	(see instructions)  IME payment adjustment (see instructions)	21.00	0.00000	0.00000			6. 00
6. 01	IME payment adjustment for managed care (see instructions)	22. 01	0	(	0	0	6. 01
	Indirect Medical Education Adjustment for the	Add-on for Se	ection 422 of t	he MMA	_		
7. 00	IME payment adjustment factor (see instructions)	27. 00	0. 000000	0. 000000	0. 000000		7. 00
8.00	IME adjustment (see instructions)	28. 00	0	(	0	0	8. 00
8. 01	IME payment adjustment add on for managed care (see instructions)	28. 01	0	(	0	0	8. 01
9.00	Total IME payment (sum of lines 6 and 8)	29. 00	0	(	0	0	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	0	(	0	0	9. 01
	Disproportionate Share Adjustment					L	
10. 00	Allowable disproportionate share percentage (see instructions)	33. 00	0. 1071	0. 107	0. 1071		10. 00
11. 00	Disproportionate share adjustment (see instructions)	34. 00	320, 211	(	320, 211	320, 211	11. 00
11. 01	Uncompensated care payments	36.00	547, 963	413, 227	134, 736	547, 963	11. 01
12. 00	Additional payment for high percentage of ESF Total ESRD additional payment (see	RD beneficiary 46.00	di scharges 0	(	0	0	12. 00
13. 00	instructions) Subtotal (see instructions)	47. 00	12, 923, 134	413, 227	12, 509, 907	12, 923, 134	13. 00
14. 00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	413, 22.	0	0	1
15. 00	Total payment for inpatient operating costs (see instructions)	49. 00	12, 923, 134	413, 227	12, 509, 907	12, 923, 134	15. 00
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50. 00	971, 622	(	971, 622	971, 622	16. 00
17. 00 17. 01	Special add-on payments for new technologies Net organ acquisition cost	54. 00	0	(	0	0	17. 00 17. 01
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	-1, 722			
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0	(			
19. 00	SUBTOTAL	I	1	411, 505	13, 483, 251	13, 894, 756	19.00

Heal th	Financial Systems	DEARBORN COUN	TY HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider Co	CN: 15-0086	Peri od: From 01/01/2016 To 12/31/2016	Worksheet E Part A Exhibi Date/Time Pre 3/12/2018 9:2	pared:
			Title	: XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from				
			Wkst. L)				
		0	1.00	2.00	3. 00	4. 00	
20. 00	Capital DRG other than outlier	1.00	956, 422		0 956, 422	956, 422	20. 00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0		0 0	0	20. 01
21. 00	Capital DRG outlier payments	2.00	15, 200		0 15, 200	15, 200	21.00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0		ol o	0	21. 01

	Wkst. L, line					
	_	Wkst. L)				
	0	1.00	2. 00	3. 00	4. 00	
20.00 Capital DRG other than outlier	1. 00	956, 422	0	956, 422	956, 422	
20.01   Model 4 BPCI Capital DRG other than outlier	1. 01	0	0	0	0	20. 01
21.00 Capital DRG outlier payments	2.00	15, 200	0	15, 200	15, 200	21. 00
21.01   Model 4 BPCI Capital DRG outlier payments	2. 01	0	0	0	0	21. 01
22.00 Indirect medical education percentage (see	5.00	0.0000	0.0000	0.0000		22. 00
instructions)						
23.00 Indirect medical education adjustment (see	6.00	0	0	0	0	23. 00
instructions)						
24.00 Allowable disproportionate share percentage	10.00	0.0000	0.0000	0. 0000		24. 00
(see instructions)						
25.00 Disproportionate share adjustment (see	11. 00	0	0	0	0	25. 00
instructions)						
26.00 Total prospective capital payments (see	12.00	971, 622	0	971, 622	971, 622	26. 00
i nstructi ons)						
	Wkst. E, Pt.	(Amt. from				
	A, line	Wkst. E, Pt.				
	_	A)				
	0	1.00	2. 00	3. 00	4. 00	
27. 00						27. 00
28.00 Low volume adjustment prior to October 1	70. 96	0	0		0	28. 00
29.00 Low volume adjustment on or after October 1	70. 97	0		0	0	29. 00
30.00 HVBP payment adjustment (see instructions)	70. 93	-10, 829	0	-10, 829	-10, 829	
30.01 HVBP payment adjustment for HSP bonus	70. 90	0	0	0	0	30. 01
payment (see instructions)						
31.00 HRR adjustment (see instructions)	70. 94	-92, 868	0	-92, 868		
31.01 HRR adjustment for HSP bonus payment (see	70. 91	0	0	0	0	31. 01
instructions)						
					(Amt. to Wkst.	
	_				E, Pt. A)	
	0	1.00	2. 00	3. 00	4. 00	00.00
32.00 HAC Reduction Program adjustment (see	70. 99		0	0	0	32. 00
instructions)						100.00
100.00 Transfer HAC Reduction Program adjustment to		N				100. 00
Wkst. E, Pt. A.	Ţ	I				

Health Financial Systems	DEARBORN COUNTY HOSPITAL	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-C	From 01/01/2016 F To 12/31/2016 E	Worksheet E Part B Date/Time Prepared: 3/12/2018 9:20 am

			10 12/31/2010	3/12/2018 9: 2	
		Title XVIII	Hospi tal	PPS	o am
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			5, 553	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	tions)		8, 700, 367	2.00
3.00	OPPS payments			6, 074, 909	3.00
4.00	Outlier payment (see instructions)			5, 974	4.00
4.01	Outlier reconciliation amount (see instructions)				4. 01
5.00	Enter the hospital specific payment to cost ratio (see instruc	ctions)		0.000	5. 00
6.00	Line 2 times line 5			0	6. 00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
8.00	Transitional corridor payment (see instructions)			0	
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. I	IV, col. 13, line 200		0	
10. 00	Organ acqui si ti ons			0	
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			5, 553	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES				1
	Reasonable charges			10.075	
	Ancillary service charges	(0)		12, 375	
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ne 69)		0	
14.00	Total reasonable charges (sum of lines 12 and 13)			12, 375	14.00
15 00	Customary charges	commont for condess on	, oborgo bool o	0	15 00
	Aggregate amount actually collected from patients liable for Amounts that would have been realized from patients liable for			0	
16. 00	· ·		i a chargebasis	0	16. 00
17. 00	had such payment been made in accordance with 42 CFR §413.13(a Ratio of line 15 to line 16 (not to exceed 1.000000)	=)		0. 000000	17. 00
	Total customary charges (see instructions)			12, 375	
	Excess of customary charges over reasonable cost (complete onl	v if line 18 exceeds lin	na 11) (saa	6, 822	1
17.00	instructions)	Ty IT TITLE TO EXCEEDS ITT	16 11) (366	0,022	17.00
20. 00	Excess of reasonable cost over customary charges (complete onl	vifline 11 exceeds lin	ne 18) (see	0	20.00
20.00	instructions)	ye execute	.0 .0) (000		20.00
21. 00	Lesser of cost or charges (line 11 minus line 20) (see instruc	ctions)		5, 553	21.00
	Interns and residents (see instructions)	,		0	l .
	Cost of physicians' services in a teaching hospital (see instr	ructions)		0	1
	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	ŕ		6, 080, 883	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				1
25.00	Deductibles and coinsurance (for CAH, see instructions)			0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for	r CAH, see instructions)		1, 270, 981	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) ;	olus the sum of lines 22	and 23] (see	4, 815, 455	27. 00
	instructions)				
	Direct graduate medical education payments (from Wkst. E-4, li	ne 50)		0	
	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
	Subtotal (sum of lines 27 through 29)			4, 815, 455	
	Primary payer payments			2, 491	
32. 00	Subtotal (line 30 minus line 31)	250)		4, 812, 964	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	ES)			
	Composite rate ESRD (from Wkst. I-5, line 11)			0	
	Allowable bad debts (see instructions)			235, 073	
	Adjusted reimbursable bad debts (see instructions)			152, 797	
	Allowable bad debts for dual eligible beneficiaries (see instructions)	ructions)		196, 974	
	Subtotal (see instructions)			4, 965, 761	ı
	MSP-LCC reconciliation amount from PS&R			63	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	-)		0	
	Pioneer ACO demonstration payment adjustment (see instructions	5)			39. 50 39. 9
	Demonstration payment adjustment amount before sequestration	and daylone (one impersue)	·i ono)	0	
	Partial or full credits received from manufacturers for replace RECOVERY OF ACCELERATED DEPRECIATION	Sed devices (See INSTRUCT	.1 0113)	0	39. 98
	Subtotal (see instructions)				
	Sequestration adjustment (see instructions)			4, 965, 698 99, 314	1
	Demonstration payment adjustment amount after sequestration			99, 314	1
	Interim payments			4, 755, 089	
	Tentative settlement (for contractors use only)			4, 733, 007	l l
43. 00	Balance due provider/program (see instructions)			111, 295	
	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub 15-2 o	chapter 1	0	1
11.00	§115. 2	.55 W til Omo l'ub. 15-2, (	ap coi 1,	I	' *. 5
	TO BE COMPLETED BY CONTRACTOR				1
90.00	Original outlier amount (see instructions)			0	90.00
	Outlier reconciliation adjustment amount (see instructions)			l ő	l
	The rate used to calculate the Time Value of Money			0.00	
	Time Value of Money (see instructions)			0.00	1
	Total (sum of lines 91 and 93)			Ö	1
94. UU	iotai (Sum oi iines yi ana ya)			ı O	<sub>1</sub> 94

| Period: | Worksheet E-1 | From 01/01/2016 | Part | To 12/31/2016 | Date/Time Prepared: 3/12/2018 9:20 am Health Financial Systems DEA ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-0086

-					3/12/2018 9: 20	o am
			XVIII	Hospi tal	PPS	
		Inpatier	it 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		11, 901, 816	,	4, 711, 924	1. 00
2.00	Interim payments payable on individual bills, either		C	)	0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	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. 01	ADJUSTMENTS TO PROVIDER	12/31/2016	29, 045	12/31/2016	107, 084	3. 01
3. 02	ADJUSTIMENTS TO TROVIDER	08/05/2016	38, 700		0	3. 02
3. 02		007 037 2010	30, 700			3. 02
3. 04						3. 04
3. 05		06/01/2017	84, 048		l ő	3. 05
0.00	Provider to Program	00/01/201/	01,010			0.00
3.50	ADJUSTMENTS TO PROGRAM		C	)	0	3. 50
3. 51				)	0	3. 51
3.52			l c	)	0	3. 52
3.53				)	0	3. 53
3.54				06/01/2017	63, 919	3. 54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		151, 793		43, 165	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		12, 053, 609	1	4, 755, 089	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
г оо	TO BE COMPLETED BY CONTRACTOR	1	I			Г 00
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			<b>1</b>	1 0	5. 01
5. 02	TENTATI VE TO TROVIDER				0	5. 02
5. 03			l d		0	5. 03
	Provider to Program	1	-		_	
5.50	TENTATI VE TO PROGRAM		C		0	5. 50
5. 51			l c	)	o	5. 51
5. 52				)	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		[ c	)	0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		134, 290		111, 295	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		0	6. 02
7. 00	Total Medicare program liability (see instructions)		12, 187, 899		4, 866, 384	7. 00
				Contractor	NPR Date	
			<u> </u>	Number	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor		J	1. 00	2.00	8. 00
o. UU	INAILE OF COULT ACTO	I		Į.	1	o. UU

Heal th	Financial Systems DEARBORN COUNT	TY HOSPITAL	In Lie	u of Form CMS-2	2552-10			
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT  Provider CCN: 15-0086 From 01/01/2016 To 12/31/2016 Barrier 3/							
	Title XVIII Hospital							
				1. 00				
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS							
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION							
1.00	Total hospital discharges as defined in AARA §4102 from Wks		e 14	4, 159	1. 00			
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1,	8-12		6, 939	2. 00			
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			1, 309	3. 00			
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1,	8-12		13, 859	4. 00			
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			200, 922, 165	5. 00			
6.00	Total hospital charity care charges from Wkst. S-10, col. 3	line 20		1, 683, 875	6. 00			
7. 00	CAH only - The reasonable cost incurred for the purchase of line 168	certified HIT technology	Wkst. S-2, Pt. I	0	7. 00			
8.00	Calculation of the HIT incentive payment (see instructions)			0	8. 00			
9.00	Sequestration adjustment amount (see instructions)			0	9. 00			
10.00	Calculation of the HIT incentive payment after sequestration	n (see instructions)		0	10.00			
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH							
30.00	Initial/interim HIT payment adjustment (see instructions)			0	30. 00			
31.00	Other Adjustment (specify)			0	31. 00			
22 00	Polance due provider (line 0 (er line 10) minus line 20 and	line 21) (coo inctruction	)	Λ	22 00			

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

0 30.00 0 31.00 0 32.00

Health Financial Systems	DEARBORN COUNTY HOSPITAL	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0086	From 01/01/2016 To 12/31/2016	Worksheet E-3 Part VII Date/Time Prepared: 3/12/2018 9:20 am

			10 12/31/2016	3/12/2018 9: 2	
		Title XIX	Hospi tal	Cost	
		<u> </u>	Inpati ent	Outpati ent	
			1. 00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	VICES FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		235, 731		1.00
2.00	Medical and other services			0	2. 00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		235, 731	0	4.00
5.00	Inpatient primary payer payments		0		5. 00
6.00	Outpatient primary payer payments			0	6. 00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		235, 731	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
8.00	Routine service charges		128, 139		8. 00
9.00	Ancillary service charges		502, 135	0	
10. 00	Organ acquisition charges, net of revenue		0		10.00
11. 00	Incentive from target amount computation		0	_	11.00
12. 00	Total reasonable charges (sum of lines 8 through 11)		630, 274	0	12. 00
	CUSTOMARY CHARGES	<del> </del>			
13. 00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
14. 00	basis	normant for compless on	0	0	14 00
14.00	Amounts that would have been realized from patients liable for a charge basis had such payment been made in accordance with 4		0	Ü	14. 00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	12 CIR 9413. 13(e)	0. 000000	0. 000000	15. 00
16. 00	Total customary charges (see instructions)		630, 274	0.000000	1
17. 00	Excess of customary charges over reasonable cost (complete onl	v if line 16 exceeds	394, 543	0	
17.00	line 4) (see instructions)	y II IIIIe Ie execeds	071,010	· ·	17.00
18. 00	Excess of reasonable cost over customary charges (complete onl	vifline 4 exceeds line	0	0	18.00
	16) (see instructions)	,			
19.00	Interns and Residents (see instructions)		0	0	19. 00
20.00	Cost of physicians' services in a teaching hospital (see instr	ructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 1	6)	235, 731	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provide	ers.		
22. 00	Other than outlier payments		0	0	22. 00
	Outlier payments		0	0	
24.00	Program capital payments		0		24. 00
	Capital exception payments (see instructions)		0		25. 00
	Routine and Ancillary service other pass through costs		0	0	
	Subtotal (sum of lines 22 through 26)		0	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	
29. 00			235, 731	0	29. 00
20.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	20.00
30.00	Excess of reasonable cost (from line 18)		0	0	
31. 00 32. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) Deductibles		235, 731	0	
33. 00			0	0	
	Allowable bad debts (see instructions)		0	0	
35. 00	Utilization review		0	Ü	35.00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	1 33)	235, 731	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	1 33)	233, 731	0	
	Subtotal (line 36 ± line 37)		235, 731	0	
	Direct graduate medical education payments (from Wkst. E-4)	255, 751	O	39.00	
	Total amount payable to the provider (sum of lines 38 and 39)	235, 731	0	1	
41. 00	Interim payments	190, 579	0	1	
42. 00	Balance due provider/program (line 40 minus line 41)	45, 152	0		
43. 00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub 15-2.	0	0	1
	chapter 1, §115.2	•			
					•

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

Provider CCN: 15-0086

Peri od: From 01/01/2016 To 12/31/2016 Date/Ti me Prepared: 3/12/2018 9: 20 am

Speci fi c Endowment Fund General Fund Plant Fund Purpose Fund 1.00 3.00 4.00 2.00 CURRENT ASSETS 1.00 Cash on hand in banks 968, 509 0 0 0 1.00 0 0 2.00 Temporary investments 0 2.00 3.00 Notes receivable 0 0 0 0 0 3.00 27, 666, 957 0 4 00 4 00 Accounts receivable 0 5.00 Other receivable -276 0 0 5.00 -14, 992, 574 6.00 Allowances for uncollectible notes and accounts receivable 6.00 0 7.00 Inventory 1,840,339 0 0 7.00 0 8.00 Prepaid expenses 918, 325 0 8.00 0 9.00 Other current assets 1, 310, 315 0 9.00 10 00 Due from other funds 0 0 0 10 00 Total current assets (sum of lines 1-10) 17, 711, 595 0 0 11.00 0 11 00 FIXED ASSETS 12.00 Land 75, 208 0 0 0 12.00 Land improvements 0 13.00 1, 523, 621 0 0 0 0 0 0 0 0 0 0 0 0 0 13.00 οl Accumulated depreciation 14.00 -1, 235, 183 0 14.00 15.00 Bui I di ngs 55, 672, 044 0 0 15.00 0 16.00 Accumulated depreciation -32, 675, 300 16.00 0 17.00 Leasehold improvements 11, 338, 813 17.00 0 0 18 00 Accumulated depreciation -8, 177, 038 0 18.00 Fi xed equipment 16, 907, 751 19.00 19.00 0 0 20.00 Accumulated depreciation -12, 409, 388 0 20.00 0 21.00 Automobiles and trucks 252, 980 0 21.00 22.00 Accumulated depreciation -182, 023 Ω 22.00 23.00 Major movable equipment 33, 569, 094 0 0 23.00 Accumulated depreciation 0 24.00 -27, 526, 203 0 24.00 4, 775 0 25.00 Mi nor equi pment depreci able Ω 25, 00 26.00 Accumulated depreciation -4, 775 0 0 26.00 27.00 HIT designated Assets 0 0 0 0 27.00 0 28.00 28.00 Accumulated depreciation 0 0 0 29.00 Mi nor equi pment-nondepreci abl e 0 29.00 30.00 Total fixed assets (sum of lines 12-29) 37, 134, 376 0 30.00 OTHER ASSETS 31 00 Investments O 0 n 31 00 0 0 32.00 Deposits on Leases 0 0 32.00 Due from owners/officers 0 0 0 33.00 33.00 0 34.00 Other assets 66, 586, 144 0 0 34.00 0 Total other assets (sum of lines 31-34) 35.00 66, 586, 144 0 35, 00 36.00 Total assets (sum of lines 11, 30, and 35) 121, 432, 115 0 0 0 36.00 CURRENT LIABILITIES 37 00 13, 994, 831 O 0 n 37 00 Accounts payable 0 0 38.00 Salaries, wages, and fees payable 4, 080, 134 0 38.00 0 Payroll taxes payable 400, 396 0 0 39.00 39.00 0 40.00 Notes and Loans payable (short term) 600,000 0 40.00 0 0 Deferred income 41 00 41 00 C 0 42.00 Accelerated payments C 42.00 43.00 Due to other funds 0 0 0 43.00 Other current liabilities 1, 140, 743 0 0 44.00 0 44.00 Total current liabilities (sum of lines 37 thru 44) 0 0 45.00 20, 216, 104 0 45.00 ONG TERM LIABILITIES 46.00 Mortgage payable 0 46.00 0 0 47.00 Notes payable 27, 131, 995 0 47.00 48 00 Unsecured Loans 0 0 0 48 00 Other long term liabilities 2, 148, 810 0 0 49.00 49.00 0 50 00 Total long term liabilities (sum of lines 46 thru 49) 29, 280, 805 0 0 0 50.00 49, 496, 909 Total liabilities (sum of lines 45 and 50) 51.00 0 0 0 51.00 CAPITAL ACCOUNTS 52.00 71, 935, 206 General fund balance 52.00 53.00 Specific purpose fund 0 53.00 Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted 54.00 0 54.00 55.00 0 55.00 56.00 Governing body created - endowment fund balance 0 56.00 Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement, 57.00 0 57.00 58.00 0 58.00 replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 71, 935, 206 0 59.00 60.00 Total liabilities and fund balances (sum of lines 51 and 121, 432, 115 0 0 0 60.00

Provider CCN: 15-0086

| Peri od: | Worksheet G-1 | From 01/01/2016 | To 12/31/2016 | Date/Time Prepared:

					To 12/31/2016	Date/Time Prep 3/12/2018 9: 20	
		General	Fund	Speci al	Purpose Fund	Endowment Fund	Jaiii
		1.00	2. 00	3. 00	4. 00	5. 00	
1.00	Fund balances at beginning of period		73, 535, 037		0		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-1, 599, 831				2. 00
3.00	Total (sum of line 1 and line 2)		71, 935, 206		0		3. 00
4.00	Additions (credit adjustments) (specify)	0			0	0	4. 00
5.00		0			0	0	5. 00
6.00		0			0	0	6. 00
7.00		0			0	0	7. 00
8.00		0			0	0	8. 00
9.00		0			0	0	9. 00
10. 00	Total additions (sum of line 4-9)		0		0		10. 00
11. 00	Subtotal (line 3 plus line 10)		71, 935, 206		0		11. 00
12.00	Deductions (debit adjustments) (specify)	0			0	0	12. 00
13.00		0			0	0	13. 00
14. 00		0			0	0	14. 00
15. 00		0			0	0	15. 00
16. 00		0			0	0	16. 00
17. 00		0			0	0	17. 00
18. 00	Total deductions (sum of lines 12-17)		0		0		18. 00
19. 00	Fund balance at end of period per balance		71, 935, 206		0		19. 00
	sheet (line 11 minus line 18)	E 1 . E 1	DI 1	F 1			
		Endowment Fund	PI ant	Funa			
		6.00	7. 00	8. 00	_		
1. 00	Fund balances at beginning of period	0		0.00	0		1. 00
2. 00	Net income (loss) (from Wkst. G-3, line 29)						2. 00
3. 00	Total (sum of line 1 and line 2)	0			0		3. 00
4. 00	Additions (credit adjustments) (specify)		0				4. 00
5. 00	(		0				5. 00
6. 00			0				6. 00
7. 00			0				7. 00
8. 00			0				8. 00
9. 00			0				9. 00
10.00	Total additions (sum of line 4-9)	o			0		10.00
11. 00	Subtotal (line 3 plus line 10)	o			0		11. 00
12.00	Deductions (debit adjustments) (specify)		o				12. 00
13.00			0				13. 00
14.00			0				14.00
15.00			0				15. 00
16.00			0				16. 00
17. 00			ol				17. 00
18. 00	Total deductions (sum of lines 12-17)	0	1		0		18. 00
19. 00	Fund balance at end of period per balance	0			Ö		19. 00
	sheet (line 11 minus line 18)						
	,		'		•	'	•

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provi der CCN: 15-0086

			То	12/31/2016	Date/Time Prep 3/12/2018 9:20	
	Cost Center Description	Inpatient		Outpati ent	Total	
		1, 00		2, 00	3. 00	
	PART I - PATIENT REVENUES	, , , , , , , , , , , , , , , , , , ,				
	General Inpatient Routine Services					
1.00	Hospi tal	13, 683,	459		13, 683, 459	1. 00
2.00	SUBPROVIDER - I PF	1,,				2. 00
3. 00	SUBPROVI DER - I RF					3. 00
4. 00	SUBPROVI DER					4. 00
5. 00	Swing bed - SNF		0		0	5. 00
6.00	Swing bed - NF		0		0	6. 00
7. 00	SKILLED NURSING FACILITY		Ŭ		ŭ.	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)	13, 683,	459		13, 683, 459	
	Intensive Care Type Inpatient Hospital Services	1.07.0007	.07		10/000/10/	
11. 00	INTENSIVE CARE UNIT	3, 287,	408		3, 287, 408	11. 00
12. 00	CORONARY CARE UNIT	3, 23. ,	.00		0, 20, 1, 100	12. 00
13. 00	BURN INTENSIVE CARE UNIT					13. 00
14. 00	SURGI CAL INTENSI 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 li	nes 3, 287,	408		3, 287, 408	16. 00
	11-15)	, , ,			2, 20.,	
17.00	Total inpatient routine care services (sum of lines 10 and 16)	16, 970,	367		16, 970, 867	17.00
18. 00	Ancillary services	52, 281,		113, 400, 752	165, 682, 347	18. 00
19. 00	Outpatient services	3, 333,		12, 474, 408	15, 807, 482	19. 00
20. 00	RURAL HEALTH CLINIC	, , , , ,	0	ol	0	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER	İ	0	ol	0	21. 00
22. 00	HOME HEALTH AGENCY			1, 438, 182	1, 438, 182	
23.00	AMBULANCE SERVICES					23.00
24.00	CMHC					24.00
25.00	AMBULATORY SURGICAL CENTER (D. P. )					25.00
26.00	HOSPI CE		0	1, 023, 289	1, 023, 289	26.00
27.00	OCCUPATIONAL HEALTH		0	25, 925	25, 925	
27. 01	PROFESSI ONAL FEES	425,	140	1, 146, 367	1, 571, 507	27. 01
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to	Wkst. 73,010,	676	129, 508, 923	202, 519, 599	28. 00
	G-3, line 1)					
	PART II - OPERATING EXPENSES		•			
29.00	Operating expenses (per Wkst. A, column 3, line 200)			82, 138, 602		29.00
30.00	ADD (SPECIFY)		0			30.00
31.00			0			31.00
32.00			0			32.00
33.00			0			33.00
34.00			0			34.00
35.00			0			35.00
36.00	Total additions (sum of lines 30-35)			o		36.00
37.00	DEDUCT (SPECIFY)		0			37.00
38.00			0			38.00
39.00			0			39.00
40.00			0			40.00
41.00			0			41.00
42.00	Total deductions (sum of lines 37-41)			ol		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(	transfer		82, 138, 602		43.00
	to Wkst. G-3, line 4)					

Heal th Financial Systems   DEARBORN COUNTY HOSPITAL   In Lieu of Form CMS-2552-10	Hoal +b	Financial Systems	DEADBOON COUNTY	HOSDITAL	In Lie	u of Form CMS 3	)EE2 10		
Total patient revenues (from Wkst. 6-2, Part I, column 3, line 28)   1.00   1			DEARBORN COUNTY				2332-10		
1.00					From 01/01/2016	Date/Time Prep			
1.00		·							
2.00   Less contractual allowances and discounts on patients' accounts   126, 726, 745   2.00   3.00   Net patient revenues (line 1 minus line 2)   75, 792, 854   3.00   75, 792, 854   3.00   75, 792, 854   3.00   75, 792, 854   3.00   75, 792, 854   3.00   75, 702, 854   3.00   75, 702, 854   3.00   75, 702, 854   3.00   75, 702   75, 702, 854   3.00   75, 702   75, 702, 854   3.00   75, 702   75, 702, 854   3.00   75, 702   75, 702, 854   3.00   75, 702   75, 702, 854   75, 702									
3.00   Net patient revenues (line 1 minus line 2)   75,792,854   3.00     4.00   Less total operating expenses (from Wkst. G-2, Part II, line 43)   62,138,602   4.00     5.00   Net income from service to patients (line 3 minus line 4)   -6,345,748     5.00   THER INCOME									
4.00   Less total operating expenses (from Wkst. G-2, Part II, line 43)   82, 138, 602   4.00   Net income from service to patients (line 3 minus line 4)   5.00   Net income from service to patients (line 3 minus line 4)   5.00   Net income from service to patients (line 3 minus line 4)   5.00   Net income from service to patients (line 3 minus line 4)   5.00   Net income from investments   0   6.00   0.00   Net income from telephone and other miscellaneous communication services   0   8.00   8.00   8.00   Revenue from television and radio service   0   9.00   0.00			patients' account	S					
Net income from service to patients (line 3 minus line 4)									
OTHER INCOME         Contributions, donations, bequests, etc         6.00         Contributions, donations, bequests, etc         6.00         6.00           7.00         Income 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 discounts         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 guests         0         14.00           15.00         Revenue from mals sold to employees and guests         0         14.00           16.00         Revenue from sale of medical and surgical supplies to other than patients         0         15.00           16.00         Revenue from sale of medical records and abstracts         0         17.00           18.00         Revenue from sale of medical records and abstracts         0         18.00           19.00         Tuit ion (fees, sale of textbooks, uniforms, e									
6.00         Contributions, donations, bequests, etc         0         6.00           7.00         Income 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 discounts         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 guests         0         14.00           15.00         Revenue from meals sold to employees and guests         0         14.00           16.00         Revenue from meals sold to employees and guests         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 medical medical records and abstracts         0         17.00           18.00         Revenue from gale of medical records and abstracts         0         18.00           1	5.00			-6, 345, 748	5.00				
7.00       Income 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 discounts       0       10.00         11.00       Rebattes and refunds of expenses       0       11.00         12.00       Parking lot receipts       0       12.00         13.00       Revenue from laundry and linen service       0       13.00         14.00       Revenue from meals sold to employees and guests       0       14.00         15.00       Revenue from sale of medical and surgical supplies to other than patients       0       15.00         16.00       Revenue from sale of medical and surgical supplies to other than patients       0       17.00         18.00       Revenue from sale of medical records and abstracts       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 hospital space       0									
8.00       Revenues from telephone and other miscellaneous communication services       0       8.00         9.00       Revenue from television and radio service       0       9.00         10.00       Purchase discounts       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 guests       0       14.00         15.00       Revenue from medical and surgical supplies to other than patients       0       15.00         16.00       Revenue from sale of medical and surgical supplies to other than patients       0       17.00         18.00       Revenue from sale of medical records and abstracts       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       Reverlue from gifts, flowers, coffee shops, and ca									
9.00       Revenue from television and radio service       0       9.00         10.00       Purchase discounts       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 meal's sold to employees and guests       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       15.00         17.00       Revenue from sale of medical records and abstracts       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       4, 745, 917       24.00         24.00						-			
10.00   Purchase discounts   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 guests   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 medical records and abstracts   0   17.00     19.00   Tuition (fees, sale of textbooks, uniforms, etc.)   0   19.00     10.00   Revenue from sale of medical records and abstracts   0   18.00     19.00   Revenue from gifts, flowers, coffee shops, and canteen   0   20.00     19.00   Rental of vending machines   0   21.00     20.00   Rental of hospital space   0   22.00     23.00   Governmental appropriations   0   23.00     24.00   OTHER REVENUE   4, 745, 917   24.00     25.00   Total other income (sum of lines 6-24)   4, 745, 917   25.00     27.00   OTHER EXPENSES (SPECIFY)   -1, 599, 831   26.00     28.00   Total other expenses (sum of line 27 and subscripts)   0   28.00			ous communication	servi ces		-			
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   12.00     14.00   Revenue from meals sold to employees and guests   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   OTHER REVENUE   4, 745, 917   24.00     25.00   Total other income (sum of lines 6-24)   7.599, 831   26.00     27.00   OTHER EXPENSES (SPECIFY)   0   27.00     28.00   Total other expenses (sum of line 27 and subscripts)   0   28.00									
12.00									
13.00       Revenue from laundry and linen service       0       13.00         14.00       Revenue from meals sold to employees and guests       0       14.00         15.00       Revenue from rental of living quarters       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       OTHER REVENUE       4,745,917       24.00         25.00       Total other income (sum of lines 6-24)       4,745,917       25.00         27.00       OTHER EXPENSES (SPECIFY)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00 <td></td> <td colspan="8"></td>									
14.00 Revenue from meals sold to employees and guests 15.00 Revenue from rental of living quarters 16.00 Revenue from sale of medical and surgical supplies to other than patients 17.00 Revenue from sale of drugs to other than patients 18.00 Revenue from sale of medical records and abstracts 19.00 Tuition (fees, sale of textbooks, uniforms, etc.) 20.00 Revenue from gifts, flowers, coffee shops, and canteen 21.00 Rental of vending machines 22.00 Rental of hospital space 23.00 Governmental appropriations 24.00 OTHER REVENUE 25.00 Total other income (sum of lines 6-24) 25.00 Total (line 5 plus line 25) 27.00 OTHER EXPENSES (SPECIFY) 28.00 Total other expenses (sum of line 27 and subscripts) 20 14.00 15.00 16.00 17.00 16.00 17.						~ I			
15.00 Revenue from rental of living quarters 16.00 Revenue from sale of medical and surgical supplies to other than patients 17.00 Revenue from sale of drugs to other than patients 18.00 Revenue from sale of medical records and abstracts 19.00 Tuition (fees, sale of textbooks, uniforms, etc.) 19.00 Revenue from gifts, flowers, coffee shops, and canteen 19.00 Rental of vending machines 19.00 Rental of hospital space 19.00 Rental of hospital space 20.00 Rental of hospital space 21.00 Governmental appropriations 22.00 Total other income (sum of lines 6-24) 25.00 Total (line 5 plus line 25) 27.00 OTHER EXPENSES (SPECIFY) 28.00 Total other expenses (sum of line 27 and subscripts) 20.10 Total other expenses (sum of line 27 and subscripts)						0			
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       OTHER REVENUE       4,745,917       24.00         25.00       Total other income (sum of lines 6-24)       4,745,917       25.00         27.00       OTHER EXPENSES (SPECIFY)       -1,599,831       26.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00		1 3	sts			0			
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       OTHER REVENUE       4, 745, 917       25. 00         25. 00       Total other income (sum of lines 6-24)       4, 745, 917       25. 00         26. 00       Total (line 5 plus line 25)       -1, 599, 831       26. 00         27. 00       OTHER EXPENSES (SPECIFY)       0       27. 00         28. 00       Total other expenses (sum of line 27 and subscripts)       0       28. 00						- 1			
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       OTHER REVENUE       4,745,917       25.00         25.00       Total other income (sum of lines 6-24)       4,745,917       25.00         26.00       Total (line 5 plus line 25)       -1,599,831       26.00         27.00       OTHER EXPENSES (SPECIFY)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00				an patients					
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       OTHER REVENUE       4,745,917       24.00         25.00       Total other income (sum of lines 6-24)       4,745,917       25.00         26.00       Total (line 5 plus line 25)       -1,599,831       26.00         27.00       OTHER EXPENSES (SPECIFY)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00									
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       OTHER REVENUE       4, 745, 917       24. 00         25. 00       Total other income (sum of lines 6-24)       4, 745, 917       24. 00         26. 00       Total (line 5 plus line 25)       -1, 599, 831       26. 00         27. 00       OTHER EXPENSES (SPECIFY)       0       27. 00         28. 00       Total other expenses (sum of line 27 and subscripts)       0       28. 00									
21.00       Rental of vending machines       0       21.00         22.00       Rental of hospital space       0       22.00         23.00       Governmental appropriations       0       23.00         24.00       OTHER REVENUE       4,745,917       24.00         25.00       Total other income (sum of lines 6-24)       4,745,917       25.00         26.00       Total (line 5 plus line 25)       -1,599,831       26.00         27.00       OTHER EXPENSES (SPECIFY)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00			,			0			
22. 00       Rental of hospital space       0       22. 00         23. 00       Governmental appropriations       0       23. 00         24. 00       OTHER REVENUE       4,745,917       24. 00         25. 00       Total other income (sum of lines 6-24)       4,745,917       25. 00         26. 00       Total (line 5 plus line 25)       -1,599,831       26. 00         27. 00       OTHER EXPENSES (SPECIFY)       0       27. 00         28. 00       Total other expenses (sum of line 27 and subscripts)       0       28. 00			nd canteen			- 1			
23.00       Governmental appropriations       0       23.00         24.00       OTHER REVENUE       4,745,917       24.00         25.00       Total other income (sum of lines 6-24)       4,745,917       25.00         26.00       Total (line 5 plus line 25)       -1,599,831       26.00         27.00       OTHER EXPENSES (SPECIFY)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00						0			
24. 00       OTHER REVENUE       4,745,917       24. 00         25. 00       Total other income (sum of lines 6-24)       4,745,917       25. 00         26. 00       Total (line 5 plus line 25)       -1,599,831       26. 00         27. 00       OTHER EXPENSES (SPECIFY)       0       27. 00         28. 00       Total other expenses (sum of line 27 and subscripts)       0       28. 00	22. 00					0			
25. 00 Total other income (sum of lines 6-24) 26. 00 Total (line 5 plus line 25) 27. 00 OTHER EXPENSES (SPECIFY) 28. 00 Total other expenses (sum of line 27 and subscripts) 4, 745, 917   25. 00 -1, 599, 831   26. 00 0 27. 00 28. 00 0 28. 00	23.00	Governmental appropriations				0	23.00		
26. 00 Total (line 5 plus line 25) 27. 00 OTHER EXPENSES (SPECIFY) 28. 00 Total other expenses (sum of line 27 and subscripts) -1, 599, 831   26. 00   27. 00   27. 00   28. 00						4, 745, 917	24.00		
27.00       OTHER EXPENSES (SPECIFY)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00									
28.00 Total other expenses (sum of line 27 and subscripts) 0 28.00	26. 00	Total (line 5 plus line 25)				-1, 599, 831	26.00		
	27.00	OTHER EXPENSES (SPECIFY)				0	27.00		
29.00   Net income (or loss) for the period (line 26 minus line 28) -1,599,831   29.00			۱						
	29. 00	Net income (or loss) for the period (line 26	minus line 28)			-1, 599, 831	29. 00		

1,074,561

24.00

24.00 Total (sum of lines 1-23)

No.   15 7785   15 7785   17 7785   17 7785   17 7785   17 7785   17 7785   17 7785   17 7785   17 7785   17 7785   18 785   18		Financial Systems		DEARBORN COUNT				Lieu of Form CMS-	
Mort Superiors   Mort	COST A	ALLOCATION - HHA GENERAL SERVICE	E COST					Worksheet H-1   Worksheet H-1   Worksheet H-1	
New Page   Pag					HHA CCN:	15-7055	To 12/31/20		
Capital Related - Movable   Capital Related - Capital Related - Movable   Capital Related - Movable   Capital Related - Movable   Capital Related - Movable   Capital Related - Capital									
Net Expenses   Firstures   Figure   Fraginate   Frag				Capital Rela	ated Costs		Agency I		
For Cost   Firstures   Equipment   Operation & Maintenance   Cost   Co									
All Location   Cyron Wisks: It   Coli. 10)   1.00   2.00   3.00   4.00   44.00									
Col. 10			Allocation	11710	zqui piiioii t			(66.6. 6 1)	
Capital Related - Bidg. A									
Capital Related - Bldg, 8				1.00	2. 00	3. 00	4. 00	4A. 00	
2. 0. Capital Related - Movabile   0   0   0   0   0   0   0   0   0	1 00		1 0	ol		I			1 00
3.0   Pilant Operation & Maintenance   0   0   0   0   0   3.00	1.00								1.00
1.00   Paris Composition   2.00   0   0   0   0   0   0   0   0   0	2.00		0		0				2.00
5,00	3.00		0	0	O		О		3.00
Mark Refuells SERVICES	4.00	1	0	- 1		1	-	-	4.00
\$\$\text{\$0.00}\$\$ \$\text{\$1.1 ct Nursing Care}\$\$   522,498   0   0   0   522,498   6.06\$ \$0.00\$ \$\text{\$0.00}\$   \$\text{\$0.00}\$   \$\text{\$1.33}\$, 994   0   0   0   0   0   56,001   8.06\$ \$0.00\$ \$\text{\$0.00}\$   \$\text{\$0.00}\$   \$\text{\$1.33}\$, 994   0   0   0   0   0   56,001   8.06\$ \$0.00\$ \$\text{\$0.00}\$   \$\text{\$0.00}\$   \$\text{\$1.33}\$, 994   0   0   0   0   0   0   68,008   9.00\$ \$10.00\$ \$\text{\$0.00}\$   \$\t	5.00		306, 684	<u> </u>		1	O	0  306, 684	5.00
Section   Sect	6.00	9				1			
9,00   Speech Pathology   8,868   0   0   0   0   8,868   9,01   11,00   Medical Social Services   41   0   0   0   4,11   10   00   Medical Social Services   41   0   0   0   0   4,11   11,10   10   Medical Social Services   41   0   0   0   0   0   11,10   10   Medical Social Services   0   0   0   0   0   0   13,00   Drugs   0   0   0   0   0   0   13,00   Drugs   0   0   0   0   0   0   0   14,10   DME   Medical Me				- 1		l .	-		1
	9. 00	Speech Pathology		- 1	0		0		9.00
12.00   Supplies (see instructions)   0   0   0   0   0   0   0   12.00	10.00			0		1	-	٠,	
14.00   DME	12.00		40, 383	0	•				1
HA NONEL MURCH SALE SERVICES	13.00		0	-1		1	-		
	14.00		] 0	<u>U</u>		1	O	OJ (	14.00
17.00   Private Duty Nursing	15. 00	Home Dialysis Aide Services	1	- 1		1	-		
18.00   Clinic   0   0   0   0   0   0   18.00			0	0		1			1
Day Care Program   0   0   0   0   0   0   0   0   0	18. 00	, ,	Ö	Ö		1	-	٩	1
1.00   Home Delivered Meals Program   0   0   0   0   0   0   0   0   0	19.00		0	0		1	-		
Administrative and General   306,684   HA REIMBURSABLE SERVICES   16 57   5.00   6.0	21. 00	, ,	0	0		1	-		1
Telemedic line	22.00		0	0	-	1	-	- T	
1,074,561   0	23. 00		0	0		1	-		1
Seneral   4A + 5    5		1		0		1		0 1, 074, 56	1
Seneral Service Cost Centers   1.00   Capital Related - Bidg. & Fixtures   2.00   Capital Related - Movable   Equipment   3.06,684   4.00   Transportation   4.00   Transpor				`					
1.00   Capital Related - Bidg. & Fixtures									
Fixtures Capital Related - Movable Equipment 3.00 Plant Operation & Maintenance Transportation 5.00 Administrative and General 306, 684  HHA REIMBURSABLE SERVICES 6.00 Skilled Nursing Care 208, 682 731, 180 7.00 Physical Therapy 53, 516 187, 510 8.00 Occupational Therapy 22, 402 78, 493 9.00 Occupational Therapy 22, 402 78, 493 9.00 Desch Pathology 3, 542 12, 410 10.00 Medical Social Services 16 57 10.00 Home Health Aide 18, 526 64, 911 12.00 Supplies (see instructions) 0 0 0 12.00 Drugs 0 0 0 12.00 Drugs 0 0 0 14.00 DME 0 0 0 15.00 The NonReimBursable Services 0 0 0 16.00 Respiratory Therapy 0 0 0 17.00 Private Duty Nursing 0 0 0 18.00 Clinic 0 0 0 19.00 Health Promotion Activities 0 0 0 19.00 Day Care Program 0 0 0 19.00 Home Delivered Meals Program 0 0 0 19.00 Home Delivered Meals Program 0 0 0 10.00 Home Delivered Meals Program 0 0 0 0 10.00 Home Delivered Meals Program 0 0 0 0 10.00 Home Delivered Meals Program 0 0 0 0 10.00 Home Delivered Meals Program 0 0 0 0 10.00 Home Delivered Meals Program 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1 00								1 00
Equipment   Plant Operation & Maintenance   3.00   Administrative and General   306,684   5.00   Administrative and General   306,684   Administrative and General   306,682   Administrative and General   306,684   Administrative and General		Fixtures							
Plant Operation & Maintenance   3.00	2.00	1 .							2. 00
Administrative and General   306, 684	3.00								3. 00
HHA REIMBURSABLE SERVICES	4.00	1	306 684						4.00
7. 00	5.00								3.00
8.00 Occupational Therapy	6.00		·						6.00
10. 00   Medical Social Services   16   57   10. 00     11. 00   Home Health Aide   18,526   64,911   11. 00     12. 00   Supplies (see instructions)   0   0   0     13. 00   Drugs   0   0   0     14. 00   DME	8.00								8.00
11.00   Home Health Aide   18,526   64,911   11.00   12.00   13.00   13.00   13.00   14.00   14.00   14.00   14.00   14.00   14.00   15.00   15.00   15.00   16.00	9.00	1							9.00
12.00   Supplies (see instructions)   0   0   0   13.00   13.00   14.00   DME	10.00	1							11.00
14. 00   DME	12.00	Supplies (see instructions)	0	0					12. 00
HHA NONREIMBURSABLE SERVICES   15. 00   Home Dialysis Aide Services   0   0   0   15. 00     16. 00   Respiratory Therapy   0   0   0   16. 00     17. 00   Private Duty Nursing   0   0   0   17. 00     18. 00   Clinic   0   0   18. 00     19. 00   Health Promotion Activities   0   0   19. 00     19. 00   Day Care Program   0   0   0     20. 00   Day Care Program   0   0   0     21. 00   Home Delivered Meals Program   0   0     22. 00   Homemaker Service   0   0   0     23. 00   All Others (specify)   0   0     23. 50   Tel emedicine   0   0   0     24. 00   0   0     25. 00   0   0   0     26. 00   0   0     27. 00   0   0     28. 00   0   0     28. 00   0   0     29. 00   0   0     29. 00   0     20			1						13.00
16.00     Respiratory Therapy     0     0       17.00     Private Duty Nursing     0     0       18.00     Clinic     0     0       19.00     Heal th Promotion Activities     0     0       20.00     Day Care Program     0     0       21.00     Home Delivered Meals Program     0     0       22.00     Homemaker Service     0     0       23.00     All Others (specify)     0     0       23.50     Tel emedicine     0     0	14.00			<u> </u>					14.00
17. 00     Private Duty Nursing     0     0       18. 00     Clinic     0     0       19. 00     Heal th Promotion Activities     0     0       20. 00     Day Care Program     0     0       21. 00     Home Delivered Meals Program     0     0       22. 00     Homemaker Service     0     0       23. 00     All Others (specify)     0     0       23. 50     Tel emedicine     0     0	15. 00 16. 00	3							15.00
19.00     Health Promotion Activities     0     0       20.00     Day Care Program     0     0       21.00     Home Delivered Meals Program     0     0       22.00     Homemaker Service     0     0       23.00     All Others (specify)     0     0       23.50     Tel emedicine     0     0	17. 00								17. 00
20.00     Day Care Program     0     0       21.00     Home Delivered Meals Program     0     0       22.00     Homemaker Service     0     0       23.00     All Others (specify)     0     0       23.50     Tel emedicine     0     0	18.00	II .	0	-					18.00
21.00     Home Delivered Meals Program     0     0       22.00     Homemaker Service     0     0       23.00     All Others (specify)     0     0       23.50     Tel emedicine     0     0	19. 00 20. 00	1		-					20.00
23.00     Al I Others (specify)     0     0       23.50     Tel emedicine     0     0	21. 00	Home Delivered Meals Program	0	0					21. 00
23. 50 Tel emedi ci ne 0 0 23. 50		1	0						22. 00 23. 00
24.00   Total (sum of lines 1-23)   1,074,561   24.00	23. 50	Tel emedi ci ne		0					23. 50
	24. 00	Total (sum of lines 1-23)	1	1, 074, 561					24. 00

	Financial Systems		DEARBORN COUN				u of Form CMS-2	
COST A	LLOCATION - HHA STATISTICAL BAS	IS		Provi der C		Peri od:	Worksheet H-1	
				HHA CCN:		From 01/01/2016 To 12/31/2016	Part II Date/Time Pre	pared:
							3/12/2018 9: 2	
						Home Health	PPS	
		Conital Do	ated Costs			Agency I		
		Саргтаг ке	ated Costs					
		BI dgs &	Movabl e	PI ant	  Transportatic	nReconciliation	Admi ni strati ve	
		Fixtures	Equi pment	Operation &	(MI LEAGE)		& General	
		(SQUARE FEET)	(DOLLAR VALUE)	Mai ntenance			(ACCUM. COST)	
				(SQUARE FEET)				
	DENIEDAL CEDIU DE COCE CENTEDO	1. 00	2. 00	3. 00	4. 00	5A. 00	5. 00	
1. 00	GENERAL SERVICE COST CENTERS  Capital Related - Bldg. &	0			1	0		1. 00
1.00	Fixtures	0				U		1.00
2.00	Capital Related - Movable		0			0		2.00
	Equipment							
3.00	Plant Operation & Maintenance	0	0	0		0		3. 00
4.00	Transportation (see	0	0	0		0		4. 00
	instructions)							
5.00	Administrative and General	0	0	0		0 -306, 684	767, 877	5. 00
6. 00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	0	0	0		0 0	522, 498	6. 00
7. 00	Physical Therapy		0			0 0	522, 498 133, 994	
8. 00	Occupational Therapy		0	0		0 0	56, 091	1
9. 00	Speech Pathology	0	0	0		0 0	8, 868	•
10.00	Medical Social Services	Ö	0	0		o o	41	10.00
11.00	Home Health Aide	O	0	0		0 0	46, 385	1
12.00	Supplies (see instructions)	0	0	0		0 0	0	12. 00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0		0 0	0	14. 00
	HHA NONREI MBURSABLE SERVI CES		T		T			
	Home Dialysis Aide Services	0	0	0	1	0	0	
16.00	Respiratory Therapy	0	0	0		0	0	
17.00	Private Duty Nursing		0	0		0 0	0	
18. 00 19. 00	Health Promotion Activities	0	0	0		0 0	0	
20. 00	Day Care Program	0	0	0		0	0	ı
21.00	Home Delivered Meals Program	0	0	0		0 0	0	1
22.00	Homemaker Service		0	0		0 0	0	ı
23. 00	All Others (specify)	١	0	0		0 0	0	
23. 50	Tel emedi ci ne	0	0	0		0 0	0	23. 50
24. 00	Total (sum of lines 1-23)	l o	0	Ö		0 -306, 684	767, 877	
25. 00	Cost To Be Allocated (per	Ō	0	0		0	306, 684	
	Worksheet H-1, Part I)							
24 00	Unit Cost Multiplier	0. 000000	0. 000000	0. 000000	0.00000	00	0. 399392	26.00

Peri od: Worksheet H-2
From 01/01/2016 Part I
To 12/31/2016 Date/Time Prepared: 3/12/2018 9: 20 am HHA CCN: 15-7055 Home Health PPS

						Agency I		
			CAPI TAL REI	LATED COSTS	<u> </u>			
	Cost Center Description	HHA Trial Balance (1)	NEW BLDG & FIXT	NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	COMMUNI CATI ONS	DATA PROCESSI NG	
		0	1.00	2.00	4. 00	5. 01	5. 02	
1.00 A	Administrative and General	0	35, 653		296, 041	1, 791	116, 510	1. 00
3. 00 F 4. 00 C 5. 00 S 6. 00 M 7. 00 H 8. 00 E 11. 00 H 12. 00 F 13. 00 F 14. 00 C 15. 00 H 16. 00 E 17. 00 H 18. 00 H 19. 00 A 19. 50 T 20. 00 T	Skilled Nursing Care Physical Therapy Decupational Therapy Speech Pathology Medical Social Services Home Health 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 Home Delivered Meals Program Home Manage Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to	731, 180 187, 510 78, 493 12, 410 57 64, 911 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	000000000000000000000000000000000000000	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50
	6 decimal places. Cost Center Description	PURCHASI NG	ADMI TTI NG	CASHI ERI NG/ACC	Subtotal	OTHER	OPERATION OF	
		RECEIVING AND STORES		OUNTS RECEI VABLE		ADMINISTRATIVE AND GENERAL	PLANT	
		5. 03	5. 04	5. 05	5A. 05	5. 06	7. 00	
2. 00 S 3. 00 F 4. 00 C 5. 00 S 6. 00 H 8. 00 S 9. 00 D 11. 00 E 12. 00 F 13. 00 F 14. 00 C 15. 00 H 18. 00 E 17. 00 H 18. 00 E 19. 00 F 19. 00 F 20. 00 T 21. 00 E	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 Health Promotion Activities Day Care Program Home Delivered Meals Program Home Manaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	2, 417 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0	487, 355 731, 180 187, 510 78, 493 12, 410 57 64, 911 0 0 0 0 0 0 0 0 0 0 1, 561, 916 0. 0000000	39, 689 10, 178 4, 261 674 3 3, 523 0 0 0 0 0 0 0 0 0 0 0 0 0 84, 782	97, 555 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00 19. 50

<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.

						Agency I		
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	
		LINEN SERVICE				ADMI NI STRATI ON	SERVICE &	
							SUPPLY	
		8. 00	9. 00	10.00	11. 00	13.00	14. 00	
1. 00	Administrative and General	0	27, 848	0	C		0	1. 00
2.00	Skilled Nursing Care	l ol	. 0	ol	l c	ol	ol	2.00
3. 00	Physical Therapy	ا	0	o		ا	ol	3. 00
4. 00	Occupational Therapy	٥	0	0	Ĭ		Ö	4. 00
		0	0	0			0	5. 00
5.00	Speech Pathology	0	0	-	_	_	-	
6. 00	Medical Social Services	0	0	0	C		0	6. 00
7. 00	Home Health Aide	0	0	0	_		0	7. 00
8.00	Supplies (see instructions)	0	0	0	C	_	0	8. 00
9.00	Drugs	0	0	0	0		0	9. 00
10.00	DME	0	0	0	C	0	0	10. 00
11. 00	Home Dialysis Aide Services	0	0	0	C	0	0	11.00
12.00	Respiratory Therapy	0	0	0	C	0	0	12.00
13.00	Private Duty Nursing	l ol	0	ol		ol	ol	13.00
14.00	Clinic	ol	0	ol		ol	ol	14.00
15. 00	Health Promotion Activities	ا	0	o	_		o	15. 00
16. 00	Day Care Program	0	0	o	_	_	o	16. 00
17. 00	Home Delivered Meals Program	٥	0	0	Ö		Ö	17. 00
	g .	0	0	0		0	o o	18. 00
18.00	Homemaker Service	0	U	U		U	U	
19. 00	All Others (specify)	0	0	0	C	0	0	19. 00
19. 50	Tel emedi ci ne	0	0	O	0	0	0	19. 50
20. 00	Total (sum of lines 1-19) (2)	0	27, 848	0	C	0	0	20. 00
21. 00	Unit Cost Multiplier: column							21. 00
	26, line 1 divided by the sum							
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.							
	Cost Center Description	PHARMACY		SOCIAL SERVICE	Subtotal	Intern &	Subtotal	
			RECORDS &			Residents Cost		
			LI BRARY			& Post		
						Stepdown		
						Adjustments		
		15. 00	16. 00	17. 00	24. 00	Adjustments 25.00	26. 00	
1.00	Administrative and General	15. 00	16. 00 13, 115	0	652, 327	Adjustments 25.00	652, 327	1. 00
2.00	Administrative and General Skilled Nursing Care					Adjustments 25.00	652, 327 770, 869	1. 00 2. 00
	1			0	652, 327	Adjustments 25.00 0	652, 327	
2.00	Skilled Nursing Care			0	652, 327 770, 869	Adjustments 25.00 0 0	652, 327 770, 869	2.00
2. 00 3. 00	Skilled Nursing Care Physical Therapy			0 0 0	652, 327 770, 869 197, 688	Adjustments 25.00 0 0 0 0 0	652, 327 770, 869 197, 688	2. 00 3. 00
2. 00 3. 00 4. 00 5. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology			0 0 0 0	652, 327 770, 869 197, 688 82, 754 13, 084	Adj ustments 25.00 0 0 0 0 0 0	652, 327 770, 869 197, 688 82, 754 13, 084	2. 00 3. 00 4. 00 5. 00
2. 00 3. 00 4. 00 5. 00 6. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services			0 0 0 0	652, 327 770, 869 197, 688 82, 754 13, 084	Adj ustments 25.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	652, 327 770, 869 197, 688 82, 754 13, 084 60	2. 00 3. 00 4. 00 5. 00 6. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide			0 0 0 0 0 0	652, 327 770, 869 197, 688 82, 754 13, 084 60 68, 434	Adj ustments 25.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	652, 327 770, 869 197, 688 82, 754 13, 084 60 68, 434	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions)			0 0 0 0 0 0	652, 327 770, 869 197, 688 82, 754 13, 084 60 68, 434	Adj ustments 25.00 0 0 0 0 0 0 0 0 0 0 0 0	652, 327 770, 869 197, 688 82, 754 13, 084 60 68, 434	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs			0 0 0 0 0 0	652, 327 770, 869 197, 688 82, 754 13, 084 60 68, 434	Adj ustments 25.00 0 0 0 0 0 0 0 0 0 0 0 0	652, 327 770, 869 197, 688 82, 754 13, 084 60 68, 434 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME			0 0 0 0 0 0 0	652, 327 770, 869 197, 688 82, 754 13, 084 60 68, 434	Adj ustments 25.00 0 0 0 0 0 0 0 0 0 0 0 0	652, 327 770, 869 197, 688 82, 754 13, 084 60 68, 434 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services			0 0 0 0 0 0	652, 327 770, 869 197, 688 82, 754 13, 084 60 68, 434	Adj ustments 25.00 0 0 0 0 0 0 0 0 0 0 0 0	652, 327 770, 869 197, 688 82, 754 13, 084 60 68, 434 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	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			0 0 0 0 0 0 0	652, 327 770, 869 197, 688 82, 754 13, 084 60 68, 434	Adj ustments 25.00 0 0 0 0 0 0 0 0 0 0 0 0	652, 327 770, 869 197, 688 82, 754 13, 084 60 68, 434 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 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	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			0 0 0 0 0 0 0	652, 327 770, 869 197, 688 82, 754 13, 084 60 68, 434	Adj ustments 25.00 0 0 0 0 0 0 0 0 0 0 0 0	652, 327 770, 869 197, 688 82, 754 13, 084 60 68, 434 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 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	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	652, 327 770, 869 197, 688 82, 754 13, 084 60 68, 434 0 0 0	Adj ustments 25.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	652, 327 770, 869 197, 688 82, 754 13, 084 60 68, 434 0 0 0 0	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
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	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 Health Promotion Activities			0 0 0 0 0 0 0	652, 327 770, 869 197, 688 82, 754 13, 084 68, 434 0 0 0 0 0	Adj ustments 25.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	652, 327 770, 869 197, 688 82, 754 13, 084 60 68, 434 0 0 0 0 0	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
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	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 Health Promotion Activities Day Care Program			0 0 0 0 0 0 0 0 0	652, 327 770, 869 197, 688 82, 754 13, 084 60 68, 434 0 0 0	Adj ustments 25.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	652, 327 770, 869 197, 688 82, 754 13, 084 60 68, 434 0 0 0 0 0	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
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	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 Health Promotion Activities Day Care Program Home Delivered Meals Program			0 0 0 0 0 0 0 0	652, 327 770, 869 197, 688 82, 754 13, 084 68, 434 0 0 0 0 0	Adj ustments 25.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	652, 327 770, 869 197, 688 82, 754 13, 084 60 68, 434 0 0 0 0 0	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
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	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 Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service			0 0 0 0 0 0 0 0 0	652, 327 770, 869 197, 688 82, 754 13, 084 68, 434 0 0 0 0 0	Adj ustments 25.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	652, 327 770, 869 197, 688 82, 754 13, 084 60 68, 434 0 0 0 0 0	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
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	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 Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify)			0 0 0 0 0 0 0 0 0	652, 327 770, 869 197, 688 82, 754 13, 084 68, 434 0 0 0 0 0	Adj ustments 25.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	652, 327 770, 869 197, 688 82, 754 13, 084 60 68, 434 0 0 0 0 0	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
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	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 Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service			0 0 0 0 0 0 0 0 0	652, 327 770, 869 197, 688 82, 754 13, 084 68, 434 0 0 0 0 0	Adj ustments 25.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	652, 327 770, 869 197, 688 82, 754 13, 084 60 68, 434 0 0 0 0 0	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
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	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 Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify)			0 0 0 0 0 0 0 0 0	652, 327 770, 869 197, 688 82, 754 13, 084 68, 434 0 0 0 0 0	Adj ustments 25.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	652, 327 770, 869 197, 688 82, 754 13, 084 60 68, 434 0 0 0 0 0	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
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	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 Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine		13, 115 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	652, 327 770, 869 197, 688 82, 754 13, 084 68, 434 0 0 0 0 0 0 0 0 0	Adj ustments 25.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	652, 327 770, 869 197, 688 82, 754 13, 084 60 68, 434 0 0 0 0 0 0 0 0	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 19. 50
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. 50 20. 00	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 Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2)		13, 115 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	652, 327 770, 869 197, 688 82, 754 13, 084 68, 434 0 0 0 0 0 0 0 0 0	Adj ustments 25.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	652, 327 770, 869 197, 688 82, 754 13, 084 60 68, 434 0 0 0 0 0 0 0 0	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 19. 50 20. 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 19. 50 20. 00	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 Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column		13, 115 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	652, 327 770, 869 197, 688 82, 754 13, 084 68, 434 0 0 0 0 0 0 0 0 0	Adj ustments 25.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	652, 327 770, 869 197, 688 82, 754 13, 084 60 68, 434 0 0 0 0 0 0 0 0	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 19. 50 20. 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 19. 50 20. 00	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 Health Promotion Activities Day Care Program Home Delivered Meals Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum		13, 115 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	652, 327 770, 869 197, 688 82, 754 13, 084 68, 434 0 0 0 0 0 0 0 0 0	Adj ustments 25.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	652, 327 770, 869 197, 688 82, 754 13, 084 60 68, 434 0 0 0 0 0 0 0 0	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 19. 50 20. 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 19. 50 20. 00	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 Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus		13, 115 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	652, 327 770, 869 197, 688 82, 754 13, 084 68, 434 0 0 0 0 0 0 0 0 0	Adj ustments 25.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	652, 327 770, 869 197, 688 82, 754 13, 084 60 68, 434 0 0 0 0 0 0 0 0	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 19. 50 20. 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 19. 50 20. 00	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 Health Promotion Activities Day Care Program Home Delivered Meals Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to		13, 115 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	652, 327 770, 869 197, 688 82, 754 13, 084 68, 434 0 0 0 0 0 0 0 0 0	Adj ustments 25.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	652, 327 770, 869 197, 688 82, 754 13, 084 60 68, 434 0 0 0 0 0 0 0 0	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 19. 50 20. 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.

				Home Health	PPS	
				Agency I		
	Cost Center Description	Allocated HHA	Total HHA			
		A&G (see Part	Costs			
		11)				
		27. 00	28. 00			
1.00	Administrative and General					1.00
2.00	Skilled Nursing Care	443, 873	1, 214, 742			2. 00
3.00	Physi cal Therapy	113, 830	311, 518			3. 00
4.00	Occupational Therapy	47, 650	130, 404			4. 00
5.00	Speech Pathology	7, 534	20, 618			5. 00
6.00	Medical Social Services	35	95			6. 00
7.00	Home Health Aide	39, 405	107, 839			7. 00
8.00	Supplies (see instructions)	0	0			8. 00
9.00	Drugs	0	0			9. 00
10.00	DME	0	0			10.00
11.00	Home Dialysis Aide Services	0	0			11. 00
12.00	Respiratory Therapy	0	0			12.00
13.00	Private Duty Nursing	0	O			13. 00
14.00	Clinic	0	O			14. 00
15.00	Health Promotion Activities	O	O			15. 00
16.00	Day Care Program	0	O			16. 00
17.00	Home Delivered Meals Program	0	O			17. 00
18.00	Homemaker Service	o	ol			18. 00
19.00	All Others (specify)	0	O			19. 00
19. 50	Tel emedi ci ne	O	O			19. 50
20. 00	Total (sum of lines 1-19) (2)	652, 327	1, 785, 216			20.00
21. 00	Unit Cost Multiplier: column	0. 575808	,			21. 00
	26, line 1 divided by the sum					
	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.

							3/12/2018 9: 20	am
						Home Health	PPS	
		CAPITAL REL	ATED COSTS			Agency I		
		CAFITAL KLL	LATED COSTS					
	Cost Center Description	NEW BLDG &	NEW MVBLE	EMPLOYEE	COMMUNICATIONS	DATA	PURCHASI NG	
	·	FLXT	EQUI P	BENEFITS		PROCESSI NG	RECEIVING AND	
		(SQUARE	(SQUARE	DEPARTMENT	(PHONES)	(DP EQUIPMENT)	STORES	
		FEET)	FEET)	(GROSS			(SUPPLY	
		1.00	2.00	SALARI ES)	F 01	F 00	EXPENSE)	
1.00	Administrative and General	1.00	2. 00 3, 085	4. 00 953, 245	5. 01	5. 02	5. 03 37, 188	1. 00
2.00	Skilled Nursing Care	3,000	3,065	955, 245 0			37, 100	2. 00
3. 00	Physical Therapy			0			0	3. 00
4. 00	Occupational Therapy	l ő	l öl	0		_	Ö	4. 00
5.00	Speech Pathology	0	o	0	0	0	0	5. 00
6.00	Medical Social Services	0	o	0	0	0	0	6.00
7.00	Home Health Aide	0	o	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0		0	8. 00
9. 00	Drugs	0	0	0	0		0	9. 00
10.00	DME	0	0	0	0		0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	_	0	11. 00
12. 00 13. 00	Respiratory Therapy Private Duty Nursing	0	0	0	0		0	12. 00 13. 00
14. 00	Clinic		0	0			0	14. 00
15. 00	Health Promotion Activities			0			0	15. 00
16. 00	Day Care Program	0	l ö	0			Ö	16. 00
17. 00	Home Delivered Meals Program	0	Ö	0	0	0	0	17. 00
18. 00	Homemaker Service	0	o	0	0	0	0	18. 00
19. 00	All Others (specify)	0	o	0	0	0	0	19.00
19. 50	Tel emedi ci ne	0	0	0	0	0	0	19. 50
20. 00	Total (sum of lines 1-19)	3, 085	3, 085	953, 245		40		20. 00
	Total cost to be allocated	25 652	22 0221	296, 041	1, 791	116, 510	2, 417	21 00
21. 00	1	35, 653						21. 00
22. 00	Unit cost multiplier	11. 556888	7. 462885	0. 310561	298. 500000	2, 912. 750000	0. 064994	
	1	11. 556888 ADMI TTI NG	7. 462885 CASHI ERI NG/ACC	0. 310561	298. 500000 OTHER	2, 912. 750000 OPERATION OF	0. 064994 LAUNDRY &	
	Unit cost multiplier	11. 556888	7. 462885	0. 310561	298. 500000	2, 912. 750000 OPERATION OF	0. 064994	
	Unit cost multiplier	11. 556888 ADMI TTI NG	7. 462885 CASHI ERI NG/ACC OUNTS	0. 310561	298. 500000 OTHER ADMI NI STRATI VE	2, 912. 750000 OPERATION OF PLANT	O. 064994 LAUNDRY & LINEN SERVICE	
	Unit cost multiplier	11. 556888 ADMI TTI NG (ADMI SSI ONS)	7. 462885 CASHI ERI NG/ACC OUNTS RECEI VABLE (GROSS CHARGES)	0.310561 Reconciliation	298. 500000 OTHER ADMI NI STRATI VE AND GENERAL (ACCUM. COST)	2, 912. 750000 OPERATION OF PLANT (SQUARE FEET)	O. 064994 LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)	
22. 00	Unit cost multiplier  Cost Center Description	11. 556888 ADMI TTI NG (ADMI SSI ONS)	7. 462885 CASHI ERI NG/ACC OUNTS RECEI VABLE (GROSS CHARGES) 5. 05	0.310561 Reconciliation 5A.06	298. 500000 OTHER ADMI NI STRATI VE AND GENERAL (ACCUM. COST) 5. 06	2, 912. 750000  OPERATION OF PLANT (SQUARE FEET)  7. 00	0. 064994 LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)	22. 00
1.00	Unit cost multiplier Cost Center Description  Administrative and General	11. 556888 ADMI TTI NG (ADMI SSI ONS)	7. 462885 CASHI ERI NG/ACC OUNTS RECEI VABLE (GROSS CHARGES)	0.310561 Reconciliation	298. 500000 OTHER ADMI NI STRATI VE AND GENERAL (ACCUM. COST) 5. 06 487, 355	2, 912. 750000 OPERATION OF PLANT (SQUARE FEET) 7. 00 3, 085	0. 064994 LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)  8. 00	1.00
1. 00 2. 00	Unit cost multiplier Cost Center Description  Administrative and General Skilled Nursing Care	11. 556888 ADMI TTI NG (ADMI SSI ONS)	7. 462885 CASHI ERI NG/ACC OUNTS RECEI VABLE (GROSS CHARGES) 5. 05	0.310561 Reconciliation 5A.06	298. 500000 OTHER ADMI NI STRATI VE AND GENERAL (ACCUM. COST) 5. 06 487, 355 731, 180	2, 912. 750000  OPERATION OF PLANT (SQUARE FEET)  7. 00  3, 085	0. 064994 LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)  8. 00 0	1. 00 2. 00
1. 00 2. 00 3. 00	Administrative and General Skilled Nursing Care Physical Therapy	11. 556888 ADMI TTI NG (ADMI SSI ONS)	7. 462885 CASHI ERI NG/ACC OUNTS RECEI VABLE (GROSS CHARGES) 5. 05	0.310561 Reconciliation 5A.06	298. 500000 OTHER ADMI NI STRATI VE AND GENERAL (ACCUM. COST) 5. 06 487, 355 731, 180 187, 510	2, 912. 750000  OPERATION OF PLANT (SQUARE FEET)  7. 00  3, 085 0 0	0. 064994 LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)  8. 00  0 0	1. 00 2. 00 3. 00
1. 00 2. 00 3. 00 4. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy	11. 556888 ADMI TTI NG (ADMI SSI ONS)	7. 462885 CASHI ERI NG/ACC OUNTS RECEI VABLE (GROSS CHARGES) 5. 05	0.310561 Reconciliation 5A.06	298. 500000 OTHER ADMI NI STRATI VE AND GENERAL (ACCUM. COST) 5. 06 487, 355 731, 180 187, 510 78, 493	2, 912. 750000  OPERATION OF PLANT (SOUARE FEET)  7. 00  3, 085 0 0	0. 064994 LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)  8. 00 0	1. 00 2. 00 3. 00 4. 00
1. 00 2. 00 3. 00 4. 00 5. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	11. 556888 ADMI TTI NG (ADMI SSI ONS)	7. 462885 CASHI ERI NG/ACC OUNTS RECEI VABLE (GROSS CHARGES) 5. 05	0.310561 Reconciliation 5A.06	298. 500000 OTHER ADMI NI STRATI VE AND GENERAL (ACCUM. COST) 5. 06 487, 355 731, 180 187, 510 78, 493 12, 410	2, 912. 750000  OPERATION OF PLANT (SQUARE FEET)  7. 00  3, 085  0  0 0	0. 064994 LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)  8. 00  0 0	1. 00 2. 00 3. 00 4. 00 5. 00
1. 00 2. 00 3. 00 4. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy	11. 556888 ADMI TTI NG (ADMI SSI ONS)	7. 462885 CASHI ERI NG/ACC OUNTS RECEI VABLE (GROSS CHARGES) 5. 05	0.310561 Reconciliation 5A.06	298. 500000 OTHER ADMI NI STRATI VE AND GENERAL (ACCUM. COST) 5. 06 487, 355 731, 180 187, 510 78, 493	2, 912. 750000  OPERATION OF PLANT (SQUARE FEET)  7. 00  3, 085  0  0  0 0	0. 064994 LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)  8. 00  0 0	1. 00 2. 00 3. 00 4. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	11. 556888 ADMI TTI NG (ADMI SSI ONS)	7. 462885 CASHI ERI NG/ACC OUNTS RECEI VABLE (GROSS CHARGES) 5. 05	0.310561 Reconciliation 5A.06	298. 500000 OTHER ADMI NI STRATI VE AND GENERAL (ACCUM. COST) 5. 06 487, 355 731, 180 187, 510 78, 493 12, 410	2, 912. 750000  OPERATION OF PLANT (SQUARE FEET)  7. 00  3, 085  0  0  0  0 0	0. 064994 LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)  8. 00  0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs	11. 556888 ADMI TTI NG (ADMI SSI ONS)	7. 462885 CASHI ERI NG/ACC OUNTS RECEI VABLE (GROSS CHARGES) 5. 05	0.310561 Reconciliation 5A.06	298. 500000 OTHER ADMI NI STRATI VE AND GENERAL (ACCUM. COST) 5. 06 487, 355 731, 180 187, 510 78, 493 12, 410 57 64, 911	2, 912. 750000  OPERATION OF PLANT (SQUARE FEET)  7. 00  3, 085  0  0  0  0  0  0 0	0. 064994 LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)  8. 00  0  0  0  0  0  0  0  0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME	11. 556888 ADMI TTI NG (ADMI SSI ONS)	7. 462885 CASHI ERI NG/ACC OUNTS RECEI VABLE (GROSS CHARGES) 5. 05	0.310561 Reconciliation 5A.06	298. 500000 OTHER ADMI NI STRATI VE AND GENERAL (ACCUM. COST) 5. 06 487, 355 731, 180 187, 510 78, 493 12, 410 57 64, 911	2, 912. 750000  OPERATION OF PLANT (SQUARE FEET)  7. 00  3, 085  0  0  0  0  0  0  0  0  0 0	0. 064994 LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)  8. 00  0  0  0  0  0  0  0  0  0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 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	11. 556888 ADMI TTI NG (ADMI SSI ONS)	7. 462885 CASHI ERI NG/ACC OUNTS RECEI VABLE (GROSS CHARGES) 5. 05	0.310561 Reconciliation 5A.06	298. 500000 OTHER ADMI NI STRATI VE AND GENERAL (ACCUM. COST) 5. 06 487, 355 731, 180 187, 510 78, 493 12, 410 57 64, 911	2, 912. 750000  OPERATION OF PLANT (SQUARE FEET)  7. 00  3, 085  0  0  0  0  0  0  0  0  0  0 0 0 0	0. 064994 LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)  8. 00  0  0  0  0  0  0  0  0  0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 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	11. 556888 ADMI TTI NG (ADMI SSI ONS)	7. 462885 CASHI ERI NG/ACC OUNTS RECEI VABLE (GROSS CHARGES) 5. 05	0.310561 Reconciliation 5A.06	298. 500000 OTHER ADMI NI STRATI VE AND GENERAL (ACCUM. COST) 5. 06 487, 355 731, 180 187, 510 78, 493 12, 410 57 64, 911	2, 912. 750000  OPERATION OF PLANT (SQUARE FEET)  7. 00  3, 085  0  0  0  0  0  0  0  0  0  0 0 0 0	0. 064994 LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)  8. 00  0  0  0  0  0  0  0  0  0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 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	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	11. 556888 ADMI TTI NG (ADMI SSI ONS)	7. 462885 CASHI ERI NG/ACC OUNTS RECEI VABLE (GROSS CHARGES) 5. 05	0.310561 Reconciliation 5A.06	298. 500000 OTHER ADMI NI STRATI VE AND GENERAL (ACCUM. COST) 5. 06 487, 355 731, 180 187, 510 78, 493 12, 410 57 64, 911	2, 912. 750000  OPERATION OF PLANT (SQUARE FEET)  7. 00  3, 085  0  0  0  0  0  0  0  0  0  0  0  0  0	0. 064994 LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)  8. 00  0  0  0  0  0  0  0  0  0  0  0  0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 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	11. 556888 ADMI TTI NG (ADMI SSI ONS)	7. 462885 CASHI ERI NG/ACC OUNTS RECEI VABLE (GROSS CHARGES) 5. 05	0.310561 Reconciliation 5A.06	298. 500000 OTHER ADMI NI STRATI VE AND GENERAL (ACCUM. COST) 5. 06 487, 355 731, 180 187, 510 78, 493 12, 410 57 64, 911	2, 912. 750000  OPERATION OF PLANT (SQUARE FEET)  7. 00  3, 085  0  0  0  0  0  0  0  0  0  0  0  0  0	0. 064994 LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)  8. 00  0  0  0  0  0  0  0  0  0  0  0  0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 11. 00 12. 00 13. 00 14. 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	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 Health Promotion Activities	11. 556888 ADMI TTI NG (ADMI SSI ONS)	7. 462885 CASHI ERI NG/ACC OUNTS RECEI VABLE (GROSS CHARGES) 5. 05	0.310561 Reconciliation 5A.06	298. 500000 OTHER ADMI NI STRATI VE AND GENERAL (ACCUM. COST) 5. 06 487, 355 731, 180 187, 510 78, 493 12, 410 57 64, 911	2, 912. 750000  OPERATION OF PLANT (SQUARE FEET)  7. 00  3, 085  0  0  0  0  0  0  0  0  0  0  0  0  0	0. 064994 LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)  8. 00  0  0  0  0  0  0  0  0  0  0  0  0	1. 00 2. 00 3. 00 4. 00 5. 00 9. 00 10. 00 11. 00 12. 00 12. 00 14. 00 15. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 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	11. 556888 ADMI TTI NG (ADMI SSI ONS)	7. 462885 CASHI ERI NG/ACC OUNTS RECEI VABLE (GROSS CHARGES) 5. 05	0.310561 Reconciliation 5A.06	298. 500000 OTHER ADMI NI STRATI VE AND GENERAL (ACCUM. COST) 5. 06 487, 355 731, 180 187, 510 78, 493 12, 410 57 64, 911	2, 912. 750000  OPERATION OF PLANT (SQUARE FEET)  7. 00  3, 085  0  0  0  0  0  0  0  0  0  0  0  0  0	0. 064994 LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)  8. 00  0  0  0  0  0  0  0  0  0  0  0  0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 11. 00 12. 00 13. 00 14. 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	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 Health Promotion Activities Day Care Program	11. 556888 ADMI TTI NG (ADMI SSI ONS)	7. 462885 CASHI ERI NG/ACC OUNTS RECEI VABLE (GROSS CHARGES) 5. 05	0.310561 Reconciliation 5A.06	298. 500000 OTHER ADMI NI STRATI VE AND GENERAL (ACCUM. COST) 5. 06 487, 355 731, 180 187, 510 78, 493 12, 410 57 64, 911	2, 912. 750000  OPERATION OF PLANT (SQUARE FEET)  7. 00  3, 085  0  0  0  0  0  0  0  0  0  0  0  0  0	0. 064994 LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)  8. 00  0  0  0  0  0  0  0  0  0  0  0  0	1. 00 2. 00 3. 00 4. 00 5. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 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 Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify)	11. 556888 ADMI TTI NG (ADMI SSI ONS)	7. 462885 CASHI ERI NG/ACC OUNTS RECEI VABLE (GROSS CHARGES) 5. 05	0.310561 Reconciliation 5A.06	298. 500000 OTHER ADMI NI STRATI VE AND GENERAL (ACCUM. COST) 5. 06 487, 355 731, 180 187, 510 78, 493 12, 410 57 64, 911 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 912. 750000  OPERATION OF PLANT (SQUARE FEET)  7. 00  3, 085  0  0  0  0  0  0  0  0  0  0  0  0  0	O. 064994  LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)  8. 00  0  0  0  0  0  0  0  0  0  0  0  0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 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 Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine	11. 556888 ADMI TTI NG (ADMI SSI ONS)	7. 462885 CASHI ERI NG/ACC OUNTS RECEI VABLE (GROSS CHARGES) 5. 05 1, 438, 182 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0.310561 Reconciliation  5A.06  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	298. 500000 OTHER ADMI NI STRATI VE AND GENERAL (ACCUM. COST) 5. 06 487, 355 731, 180 187, 510 78, 493 12, 410 57 64, 911	2, 912. 750000  OPERATION OF PLANT (SQUARE FEET)  7. 00  3, 085  0  0  0  0  0  0  0  0  0  0  0  0  0	0. 064994  LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)  8. 00  0  0  0  0  0  0  0  0  0  0  0  0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 00 19. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 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 Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19)	11. 556888 ADMI TTI NG (ADMI SSI ONS)	7. 462885 CASHI ERI NG/ACC OUNTS RECEI VABLE (GROSS CHARGES) 5. 05 1, 438, 182 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 1, 438, 182	0.310561 Reconciliation  5A.06  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	298. 500000 OTHER ADMI NI STRATI VE AND GENERAL (ACCUM. COST) 5. 06 487, 355 731, 180 187, 510 78, 493 12, 410 57 64, 911 0 0 0 0 0 0 0 0 0 0 1, 561, 916	2, 912. 750000  OPERATION OF PLANT (SQUARE FEET)  7. 00  3, 085  0  0  0  0  0  0  0  0  0  0  0  0  0	0. 064994  LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)  8. 00  0  0  0  0  0  0  0  0  0  0  0  0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 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 Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine	11. 556888 ADMI TTI NG (ADMI SSI ONS)	7. 462885 CASHI ERI NG/ACC OUNTS RECEI VABLE (GROSS CHARGES) 5. 05 1, 438, 182 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0.310561 Reconciliation  5A.06  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	298. 500000 OTHER ADMI NI STRATI VE AND GENERAL (ACCUM. COST) 5. 06 487, 355 731, 180 187, 510 78, 493 12, 410 57 64, 911	2, 912. 750000  OPERATION OF PLANT (SQUARE FEET)  7. 00  3, 085  0  0  0  0  0  0  0  0  0  0  0  0  0	0. 064994  LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)  8. 00  0  0  0  0  0  0  0  0  0  0  0  0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00

DEARBORN COUNTY HOSPITAL Health Financial Systems ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL Provider CCN: 15-0086 Peri od: Worksheet H-2 From 01/01/2016 Part II Date/Time Prepared: BASIS HHA CCN: 15-7055 12/31/2016 3/12/2018 9:20 am Home Health PPS Agency I HOUSEKEEPI NG DI ETARY CAFETERI A NURSI NG CENTRAL PHARMACY Cost Center Description SERVICE & (SQUARE (MEALS (MAN HOURS) ADMI NI STRATI ON (100%) SERVED) **SUPPLY** FEET) (GROSS HOURS) (100%)15.00 9.00 10.00 11.00 13.00 14.00 1.00 Administrative and General 3, 085 1. 00 2.00 Skilled Nursing Care 0 0 0 0 0 2.00 0 0 Physical Therapy 3.00 0 3.00 4.00 Occupational Therapy 0 4.00 Speech Pathology Medical Social Services 5.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 5.00 6.00 0 ol 6.00 0 7.00 Home Health Aide 7.00 8.00 Supplies (see instructions) 8.00 Drugs 0 0 9.00 9.00 0 0 10.00 10.00 DMF 11.00 Home Dialysis Aide Services 0 11.00 Respiratory Therapy Private Duty Nursing 0 0 12.00 12.00 0 13.00 0 0 0 13.00 14.00 Clinic 14.00 15.00 Health Promotion Activities 0 15.00

	near th fromotron Activities	U	l 4	٩	o	٠	1	13.00
	Day Care Program	0	0	0	0	0	0	
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17. 00
18.00	Homemaker Service	0	0	0	0	ol	0	18. 00
19.00	All Others (specify)	0	0	0	0	o	0	19. 00
19.50	Tel emedi ci ne	0	o	o	О	ol	ĺ 0	19. 50
20.00	Total (sum of lines 1-19)	3, 085	0	o	О	ol	ĺ	20.00
21.00	Total cost to be allocated	27, 848	o	o	0	ol	ĺ o	21. 00
22.00	Unit cost multiplier	9. 026904	0. 000000	0. 000000	0.000000	0. 000000	0. 000000	22. 00
	Cost Center Description	MEDI CAL	SOCIAL SERVICE	•				
	•	RECORDS &						
		LI BRARY	(TIME					
		(ADJUSTED	SPENT)					
		CHARGES)	ŕ					
		16. 00	17. 00					
1.00	Administrative and General	1, 438, 182	0					1. 00
2.00	Skilled Nursing Care	0	0					2. 00
3.00	Physi cal Therapy	0	0					3. 00
4.00	Occupational Therapy	0	0					4.00
5.00	Speech Pathology	0	0					5. 00
6.00	Medical Social Services	0	O					6.00
7.00	Home Health Aide	0	o					7. 00
8.00	Supplies (see instructions)	0	o					8. 00
9.00	Drugs	0	o					9. 00
10.00	DME	0	o					10.00
11.00	Home Dialysis Aide Services	0	o					11. 00
12.00	Respiratory Therapy	0	o					12.00
13.00	Private Duty Nursing	0	o					13. 00
14.00	Clinic	0	o					14. 00
15.00	Health Promotion Activities	0	0					15. 00
16.00	Day Care Program	0	0					16. 00
17.00	Home Delivered Meals Program	0	0					17. 00
18.00	Homemaker Service	0	0					18. 00
19.00	All Others (specify)	0	ol					19. 00
	Tel emedi ci ne	0	o					19. 50
20.00	Total (sum of lines 1-19)	1, 438, 182	o					20.00
	Total cost to be allocated	13, 115						21. 00
22. 00	Unit cost multiplier	0. 009119						22. 00
	'	1						•

	Financial Systems TONMENT OF PATIENT SERVICE COST	S	DEARBORN COUN		CCN: 15-0086	Peri od:	worksheet H-3	
				HHA CCN:	15-7055	From 01/01/2016 To 12/31/2016	Part I Date/Time Prep 3/12/2018 9:20	pared:
				Ti tl	e XVIII	Home Health Agency I	PPS	o am
	Cost Center Description	From, Wkst. H-2, Part I,	Facility Costs (from Wkst.	Shared Ancillary	Total HHA Costs (cols.	Total Visits	Average Cost Per Visit	
		col. 28, line	`	Costs (from	+ 2)	1	(col. 3 ÷ col.	
		0	1.00	Part II)	3 00	4.00	4) 5 00	
	PART I - COMPUTATION OF LESSER			2.00 GGREGATE OF TI	3.00 HE PROGRAM LIN	4.00 MITATION COST, OF	5. 00	
	BENEFICIARY COST LIMITATION Cost Per Visit Computation							
. 00	Skilled Nursing Care	2. 00	1, 214, 742		1, 214, 74	42 4, 108	295. 70	1.00
. 00	Physi cal Therapy	3. 00			311, 5		157. 97	2.00
. 00	Occupational Therapy	4.00			0 130, 40		191. 49	
. 00 . 00	Speech Pathology Medical Social Services	5. 00 6. 00		,	20,0	18 118 95 16	174. 73 5. 94	
. 00	Home Heal th Aide	7. 00	l l		107, 83			
. 00	Total (sum of lines 1-6)		1, 785, 216	(	1, 785, 2	16 8, 133		7. 00
					Program Visi	rt B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject  Deductibles  Coinsurance	to Subject to & Deductibles		
		0	1. 00	2.00	3. 00	4. 00	5. 00	
00	Limitation Cost Computation	I	17140		0	0		1 0 0
. 00 . 01	Skilled Nursing Care Skilled Nursing Care		50031		0 1, 70	-		8. 00 8. 0
. 02	Skilled Nursing Care		50034			59		8. 0
. 03	Skilled Nursing Care		50035		0	0		8. 0
. 04 . 00	Skilled Nursing Care Physical Therapy		99915 17140		0	0		8. 0 9. 0
. 00	Physical Therapy		50031		-	68		9.0
. 02	Physical Therapy		50034			78		9. 0
. 03	Physi cal Therapy		50035		0	0		9. 0
. 04	Physical Therapy		99915 17140		0	0		9. 0 10. 0
0. 00 0. 01	Occupational Therapy Occupational Therapy		50031			68		10.0
0. 02	Occupational Therapy		50034		1	40		10.0
0. 03	Occupational Therapy		50035		О	0		10.0
0. 04	Occupational Therapy		99915		0	0		10.0
1. 00 1. 01	Speech Pathology Speech Pathology		17140 50031		0  0  :	0 34		11. 0 11. 0
1. 02	Speech Pathology		50034		1	42		11.0
1. 03	Speech Pathology		50035	(	0	0		11.0
1. 04	Speech Pathology		99915		0	0		11.0
2.00	Medical Social Services Medical Social Services		17140 50031		0	0		12. 0 12. 0
2. 01	Medical Social Services		50031		0	1		12.0
2. 03	Medical Social Services		50035		0	0		12.0
2. 04	Medical Social Services		99915		0	0		12. C
3.00	Home Heal th Aide		17140		0	0		13.0
3. 01 3. 02	Home Health Aide Home Health Aide		50031 50034	(		10 10		13. 0 13. 0
3. 03	Home Heal th Ai de		50035	(		0		13. 0
3. 04	Home Heal th Ai de		99915		0	0		13.0
4. 00	Total (sum of lines 8-13)  Cost Center Description	From Wkst. H-2	Facility Costs	Shared	0 4,72 Total HHA	22 Total Charges	Ratio (col. 3	14. 00
	cost center bescription	Part I, col. 28, line	(from Wkst. H-2, Part I)	Ancillary Costs (from	Costs (cols. + 2)		÷ col . 4)	
		0	1.00	<u>Part II)</u> 2.00	3.00	4.00	5. 00	
	Supplies and Drugs Cost Comput	ati ons						
_ ^^	Cost of Medical Supplies	8. 00	0		0	0 0	0. 000000	1 15 C

FIONMENT OF PATIENT SERVICE COST:	2						
	3		Provi der CO	CN: 15-0086	Period: From 01/01/2016	Worksheet H-3   Part	
			HHA CCN:	15-7055	To 12/31/2016		pared:
			Ti tl e	XVIII	Home Health	PPS	<u>o ani</u>
		Program Visits		Cost of	Agency I		
		D	D	Servi ces	Dt D		
Cost Center Description	Part A			Part A		Subject to	
		Deductibles & D	eductibles &		Deductibles &	Deductibles &	
	/ 00			0.00			
PART I - COMPUTATION OF LESSER							
BENEFICIARY COST LIMITATION							
		2 5/2			0 757 07/	<u>,                                    </u>	1
	0						1. 0
	Ö	408					3. (
Speech Pathology	0	76			0 13, 279		4.0
1	0	1					5. (
	0					1	6. ( 7. (
		4, 722			1,000,30		7.0
	6. 00	7. 00	8. 00	9. 00	10.00	11.00	
							١.,
9							8. (
							8.
Skilled Nursing Care							8.
Skilled Nursing Care							8.
1 3 . 3							9.
1 3							9. 9.
							9.
Physi cal Therapy							9.
Occupational Therapy							10.
1							10. 10.
1							10.
Occupational Therapy							10.
Speech Pathology							11.
1 .							11.
							11. 11.
1 .							11.
Medical Social Services							12.
Medical Social Services							12.
1							12. 12.
1							12.
Home Health Aide							13.
Home Health Aide							13.
1							13.
1							13. 13.
							14.
	Prog	ram Covered Char	ges	Cost of			
				Servi ces			
		Part	В		Part B		
Cost Center Description	Part A	Not Subject to	Subject to	Part A		Subject to	
•		Deductibles & D	eductibles &		Deductibles &	Deductibles &	
	6.00			0.00	Coi nsurance		
Supplies and Drugs Cost Computa		7.00	8.00	9.00	10.00	11.00	
		0	0		0 (	0	15.
	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description  Limitation Cost Computation Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology	PART I - COMPUTATION OF LESSER OF AGGREGATE IN BENEFICIARY COST LIMITATION  Cost Per Visit Computation  Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6)  Cost Center Description  Cost Center Description  Limitation Cost Computation  Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech	Cost Center Description    Part A	Cost Center Description  Part A    Part B   Not Subject to Deductibles & Deductibles & Coinsurance Coi	Cost Center Description  Cost Center Description  Cost Center Description  Part A  Not Subject to Subject to Deduct bles & Deduct bles & Deduct bles & Coinsurance & Coins	Program Visits	Program Visits

PPORT	IONMENT OF PATIENT SERVICE COST	S		Provi der	CCN: 15-0086	Peri od:	Worksheet H-3	
				HHA CCN:	15-7055	From 01/01/2016 To 12/31/2016	Part I Date/Time Prepa	
				Ti ·	tle XVIII	Home Health	3/12/2018 9: 20 PPS	am
	Cost Center Description	Total Program				Agency I		
	cost center bescription	Cost (sum of						
		col s. 9-10)						
		12. 00						
	PART I - COMPUTATION OF LESSER	OF AGGREGATE P	ROGRAM COST, AGG	REGATE OF	THE PROGRAM LI	MITATION COST, OR	!	
	BENEFICIARY COST LIMITATION							
. 00	Cost Per Visit Computation Skilled Nursing Care	757, 879						1.
. 00	Physical Therapy	165, 237						2.
. 00	Occupational Therapy	78, 128						3. (
. 00	Speech Pathology	13, 279						4.
. 00	Medical Social Services	53						5.
. 00	Home Health Aide	54, 008						6. (
. 00	Total (sum of lines 1-6)	1, 068, 584						7.
	Cost Center Description							
		12. 00						
	Limitation Cost Computation							
00	Skilled Nursing Care							8.
01	Skilled Nursing Care							8.
02	Skilled Nursing Care							8.
03	Skilled Nursing Care Skilled Nursing Care							8. 8.
00	Physical Therapy							9.
01	Physical Therapy							9. 9.
02	Physical Therapy							9.
03	Physical Therapy							9.
04	Physical Therapy							9.
0.00	Occupational Therapy							10.
0. 01	Occupational Therapy						1	10.
0. 02	Occupational Therapy						1	10.
0. 03	Occupational Therapy						1	10.
0. 04	Occupational Therapy						l .	10.
1.00	Speech Pathology						l .	11.
. 01	Speech Pathology						I	11.
1. 02	Speech Pathology						I	11.
1. 03	Speech Pathology						I	11.
1. 04	Speech Pathology						· · · · · · · · · · · · · · · · · · ·	11.
2. 00 2. 01	Medical Social Services Medical Social Services							12. 12.
2. 01	Medical Social Services							12. 12.
2. 02	Medical Social Services						· · · · · · · · · · · · · · · · · · ·	12. 12.
2. 03	Medical Social Services							12.
3. 00	Home Heal th Aide							13.
3. 01	Home Heal th Aide							13.
3. 02	Home Health Aide						• • • • • • • • • • • • • • • • • • •	13.
3. 03	Home Health Aide						• • • • • • • • • • • • • • • • • • •	13.
3. 04	Home Health Aide						• • • • • • • • • • • • • • • • • • •	13.
	Total (sum of lines 8-13)	1						14.

Heal th	Financial Systems		DEARBORN COUN	TY HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORT	TIONMENT OF PATIENT SERVICE COST	S		Provi der C		Peri od:	Worksheet H-3	
				HHA CCN:	15-7055	From 01/01/2016 To 12/31/2016		narodi
				nna ccin.	15-7055	10 12/31/2010	3/12/2018 9: 20	
				Title	e XVIII	Home Health	PPS	
						Agency I		
	Cost Center Description	From Wkst. C,	Cost to Charge		HHA Shared	Transfer to		
		Part I, col.	Ratio	Charge (from	Ancillary	Part I as		
		9, line		provi der	Costs (col.	1 Indicated		
				records)	x col. 2)			
		0	1. 00	2. 00	3. 00	4. 00		
	PART II - APPORTIONMENT OF COST				TAL DEPARTMEN			l
1.00	Physi cal Therapy	66. 00	0. 397858	(		0 col. 2, line 2	. 00	1. 00
2.00	Occupational Therapy	67. 00	0. 600281	(		0 col. 2, line 3	. 00	2. 00
3.00	Speech Pathology	68. 00	0. 507207	C		0 col. 2, line 4	. 00	3. 00
4.00	Cost of Medical Supplies	71.00	0. 792261	C		0 col. 2, line 1	5. 00	4. 00
5.00	Cost of Drugs	73. 00	0. 466285	(	)	0 col. 2, line 1	6. 00	5. 00

	Financial Systems DEARBORN COUNTY		N. 1E 000/		u of Form CMS-2	
LCULA	TION OF HHA REIMBURSEMENT SETTLEMENT	Provider CC	N: 15-0086 15-7055	Period: From 01/01/2016 To 12/31/2016	Worksheet H-4 Part I-II Date/Time Pre	
					3/12/2018 9: 2	
		Title	XVIII	Home Health Agency I	PPS	
			D+ A		t B	
			Part A	Not Subject to Deductibles &	Deductibles &	
		+	1. 00	Coi nsurance 2.00	Coi nsurance 3.00	
ı	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUST	OMARY CHARGES		2.00	3.00	
Ī	Reasonable Cost of Part A & Part B Services					
1	Reasonable cost of services (see instructions)			0 0		
	Total charges Customary Charges			0 0	0	2
	Amount actually collected from patients liable for payment fo	r services		0 0	0	1 :
	on a charge basis (from your records)					
00	Amount that would have been realized from patients liable for for services on a charge basis had such payment been made in			0 0	0	4
	with 42 CFR §413.13(b)					١.
	Ratio of line 3 to line 4 (not to exceed 1.000000) Total customary charges (see instructions)		0.0000	0. 000000	0. 000000 0	!
	Excess of total customary charges over total reasonable cost	(complete		0 0	0	-
	only if line 6 exceeds line 1)					
	Excess of reasonable cost over customary charges (complete on 1 exceeds line 6)	ly if line		0 0	0	8
0	Primary payer amounts			0 0	0	(
				Part A Services	Part B Servi ces	
				1.00	2. 00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			_		١
4	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers			0	0 707, 129	
	Total PPS Reimbursement - Full Episodes with Outliers			0	25, 917	
4	Total PPS Reimbursement - LUPA Episodes			0	26, 054	
1	Total PPS Reimbursement - PEP Episodes			0	4, 314	
1	Total PPS Outlier Reimbursement - Full Episodes with Outliers			0	8, 319 0	
	Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments			0	0	1
	DME Payments			0	0	18
	Oxygen Payments			0	0	1
	Prosthetic and Orthotic Payments			0	0	2
1	Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21)	ui ance)		0	0 771, 733	
	Excess reasonable cost (from line 8)			0	0	
	Subtotal (line 22 minus line 23)			0	771, 733	
	Coinsurance billed to program patients (from your records)				771 722	2!
	Net cost (line 24 minus line 25) Reimbursable bad debts (from your records)			0	771, 733	2
	Reimbursable bad debts for dual eligible beneficiaries (see i	nstructions)				28
	Total costs - current cost reporting period (line 26 plus lin			0	771, 733	
1	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	0	
1	Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration	s)		0	0	
	Subtotal (see instructions)			0	0 771, 733	
	Sequestration adjustment (see instructions)			0	15, 435	
. 02	Demonstration payment adjustment amount after sequestration			0	0	31
	Interim payments (see instructions)			0	756, 298	
	Tentative settlement (for contractor use only)	and 22)		0	0	
. 00	Balance due provider/program (line 31 minus lines 31.01, 32,		D. L 15 0	0	0	
. 00	Protested amounts (nonallowable cost report items) in accorda					

Health Financial Systems DEARBORN COUNTAINALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES Peri od: From 01/01/2016 To 12/31/2016 Date/Ti me Prepared: 3/12/2018 9: 20 am PPS Provider CCN: 15-0086 HHA CCN: 15-7055

				Home Health Agency I	PPS	
		Inpatien	t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	756, 298 0	1. 00 2. 00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider					3. 00
3. 01				0	0	3. 01
3. 02				0	0	3. 02
3. 03 3. 04				0	0	3. 03 3. 04
3. 05				0	l ől	3. 05
	Provider to Program					
3.50				0	0	3. 50
3.51				0	0	3. 51
3. 52 3. 53				0	0	3. 52 3. 53
3. 54				0		3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			Ö	o	3. 99
	3. 50-3. 98)					
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)		1	0	756, 298	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
5. 01	Program to Provider			0	0	5. 01
5. 01				0		5. 01
5. 03				0	Ö	5. 03
	Provider to Program					
5. 50				0	0	5. 50
5. 51				0	0	5. 51
5. 52 5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0		5. 52 5. 99
6. 00	5.50-5.98) Determined net settlement amount (balance due) based on		'	O		6. 00
	the cost report. (1)				_	
6. 01 6. 02	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM			0 0	0	6. 01 6. 02
6. 02 7. 00	Total Medicare program liability (see instructions)			0	756, 298	6. 02 7. 00
7.00	install mean odi o program i rability (see ilisti detions)			Contractor Number	NPR Date (Mo/Day/Yr)	7.00
		(	)	1. 00	2.00	
8. 00	Name of Contractor					8. 00

Health Financial Systems
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS Provider CCN: 15-0086 Peri od: Worksheet 0 From 01/01/2016 To 12/31/2016 Date/Time Prepared: 3/12/2018 9:20 am Hospi ce CCN: 15-1531

					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL (col.	RECLASSIFI -	SUBTOTAL	
				1 plus col. 2)	CATI ONS		
	T	1.00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS	T		TT	_1		
1.00	CAP REL COSTS-BLDG & FIXT*		0	-	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0	0	3.00
4.00	ADMI NI STRATI VE & GENERAL*	94, 552	29, 757	124, 309	0	124, 309	4. 00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0	6.00
7. 00 8. 00	HOUSEKEEPI NG*	0	0	0	0	0	7. 00
8. 00 9. 00	DI ETARY*	0	0	0	0	0	8. 00 9. 00
	NURSING ADMINISTRATION*	0	0	0	U		
10.00	ROUTINE MEDICAL SUPPLIES*	20 005	0	20.005	0	0	10.00
11.00	MEDICAL RECORDS*	20, 085	0	20, 085	0	20, 085	11.00
12.00	STAFF TRANSPORTATION*	0	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	0	13.00
14. 00 15. 00	PHARMACY*	0	12 500	12 500	0	12 500	14.00
16. 00	PHYSICIAN ADMINISTRATIVE SERVICES* OTHER GENERAL SERVICE*	0	12, 500		0	12, 500	15.00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES	٩	166, 266	166, 266	U	166, 266	16. 00 17. 00
17.00	DIRECT PATIENT CARE SERVICES  DIRECT PATIENT CARE SERVICE COST CENTERS						17.00
25. 00	INPATIENT CARE-CONTRACTED**	ol	0	0	ol	0	25. 00
26. 00	PHYSI CI AN SERVI CES**		0	0	0	0	26.00
27. 00	NURSE PRACTITIONER**		0		0	0	27. 00
28. 00	REGI STERED NURSE**	136, 212	0	136, 212	0	136, 212	28. 00
29. 00	LPN/LVN**	130, 212	0	130, 212	0	130, 212	29.00
30.00	PHYSI CAL THERAPY**		0	0	0	0	30.00
31. 00	OCCUPATIONAL THERAPY**		0	Ö	0	0	31.00
32. 00	SPEECH/LANGUAGE PATHOLOGY**	0	0	Ö	0	0	32. 00
33. 00	MEDICAL SOCIAL SERVICES**	44, 539	0	44, 539	0	44, 539	33. 00
34. 00	SPIRITUAL COUNSELING**	8, 965	0	8, 965	0	8, 965	34.00
35. 00	DI ETARY COUNSELI NG**	0	0	0,750	0	0	35. 00
36. 00	COUNSELING - OTHER**	0	0	o	0	0	36. 00
37. 00	HOSPICE AIDE & HOMEMAKER SERVICES**	10, 571	0	10, 571	0	10, 571	37. 00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	0	0	38. 00
39. 00	PATIENT TRANSPORTATION**	o	0	0	0	0	39. 00
40. 00	I MAGI NG SERVI CES**	0	0	0	0	0	40.00
41.00	LABS & DI AGNOSTI CS**	o	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	o	65, 624	65, 624	-64, 847	777	42.00
43.00	OUTPATIENT SERVICES**	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	o	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0	45. 00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	O	0	0	0	0	46. 00
	NONREI MBURSABLE COST CENTERS	<u>'</u>					1
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0	61. 00
62.00	FUNDRAI SI NG*	0	0	0	0	0	62. 00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	O	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	O	0	0	0	0	64. 00
65.00	OTHER PHYSICIAN SERVICES*	O	0	0	0	0	65. 00
66.00	RESI DENTI AL CARE*	O	0	0	0	0	66. 00
67.00	ADVERTI SI NG*	0	0	0	0	0	67. 00
68.00	TELEHEALTH/TELEMONI TORI NG*	0	0	0	0	0	68. 00
69. 00	THRI FT STORE*	0	0	0	0	0	69. 00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0	70. 00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)*	0	5, 134	5, 134	0	5, 134	71. 00
100.00	TOTAL	314, 924	279, 281	594, 205	-64, 847	529, 358	100.00
* Tran	sfer the amounts in column 7 to Wkst. 0-5, co	lumn 1. line as	appropri ate.				

<sup>\*</sup> Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.
\*\* See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

				Hospi ce I	
		ADJUSTMENTS	TOTAL (col. 5		
			± col. 6)		
		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS		1		
1.00	CAP REL COSTS-BLDG & FIXT*	0			1. 00
2.00	CAP REL COSTS-MVBLE EQUIP*	0			2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0			3.00
4.00	ADMINISTRATIVE & GENERAL*	0	124, 309		4. 00
5.00	PLANT OPERATION & MAINTENANCE*	0	0		5. 00
6.00	LAUNDRY & LINEN SERVICE*	0	0		6. 00
7.00	HOUSEKEEPI NG*	0	0		7. 00
8.00	DI ETARY*	0	0		8. 00
9.00	NURSI NG ADMI NI STRATI ON*	0	0		9. 00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0		10.00
11. 00	MEDI CAL RECORDS*	0	20, 085		11. 00
12. 00	STAFF TRANSPORTATION*	0	0		12. 00
13. 00	VOLUNTEER SERVICE COORDINATION*	0	0		13. 00
14. 00	PHARMACY*	0	1		14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES*	0			15. 00
16. 00	OTHER GENERAL SERVICE*	0	166, 266		16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES				17. 00
	DIRECT PATIENT CARE SERVICE COST CENTERS	T	1		
25. 00	INPATIENT CARE-CONTRACTED**	0	1		25. 00
26. 00	PHYSI CI AN SERVI CES**	0	_		26. 00
27. 00	NURSE PRACTITIONER**	0	-		27. 00
28. 00	REGI STERED NURSE**	0			28. 00
29. 00	LPN/LVN**	0	-		29. 00
30.00	PHYSI CAL THERAPY**	0			30.00
31. 00	OCCUPATIONAL THERAPY**	0			31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0			32.00
33.00	MEDICAL SOCIAL SERVICES**	0			33.00
34.00	SPIRITUAL COUNSELING**	0	1		34.00
35. 00	DI ETARY COUNSELI NG**	0			35. 00
36.00	COUNSELING - OTHER**	0			36.00
37. 00	HOSPICE AIDE & HOMEMAKER SERVICES**	0			37.00
38. 00	DURABLE MEDI CAL EQUI PMENT/OXYGEN**	0			38.00
39. 00	PATIENT TRANSPORTATION**	0			39.00
40.00	I MAGING SERVI CES**	0			40.00
41.00	LABS & DI AGNOSTI CS**	0			41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE**	0			42.00
43.00	OUTPATIENT SERVICES**	0			43.00
44. 00	PALLIATIVE CUMOTUEDADY**	0			44.00
45. 00 46. 00	PALLIATIVE CHEMOTHERAPY**	0			45. 00
46. 00	OTHER PATIENT CARE SERVICES (SPECIFY)**		l o		46. 00
60. 00	NONREI MBURSABLE COST CENTERS BEREAVEMENT PROGRAM *	0	0		60.00
61. 00	VOLUNTEER PROGRAM *	0			61. 00
62. 00	FUNDRAI SI NG*	0			62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0			63.00
64. 00	PALLIATIVE CARE PROGRAM*	0			64.00
65. 00	OTHER PHYSICIAN SERVICES*	0	-		65. 00
66. 00	RESI DENTI AL CARE*	0			66.00
67. 00	ADVERTI SI NG*	0	-		67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG*	0			68. 00
69. 00	THRIFT STORE*	0	1 ~1		69.00
70. 00	NURSING FACILITY ROOM & BOARD*	0			70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)*	-5, 134	1		71.00
	TOTAL	-5, 134			100.00
	,	+			

<sup>\*</sup> Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate. \*\* See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

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Peri od: Worksheet 0-1 From 01/01/2016

45.00

0 100.00

0

0 46.00

То 12/31/2016 Date/Time Prepared: 3/12/2018 9:20 am Hospi ce I SALARI ES OTHER SUBTOTAL (col RECLASSI FI -SUBTOTAL 1 + col. CATI ONS 1.00 2.00 5. 00 3 00 4.00 DIRECT PATIENT CARE SERVICE COST CENTERS 25.00 INPATIENT CARE-CONTRACTED 25.00 PHYSICIAN SERVICES 26.00 0 26.00 0 NURSE PRACTITIONER 0 27.00 27.00 0 0 28.00 REGISTERED NURSE 0 0 28.00 29.00 LPN/LVN 0 29.00 0 0 30.00 PHYSI CAL THERAPY 0 30.00 OCCUPATIONAL THERAPY 0 0 31.00 0 31.00 0 32.00 SPEECH/LANGUAGE PATHOLOGY 0 32.00 33.00 MEDICAL SOCIAL SERVICES 0 0 0 33.00 SPIRITUAL COUNSELING 0 0 34.00 0 34.00 35.00 DIETARY COUNSELING 0 35.00 36.00 COUNSELING - OTHER 0 36.00 HOSPICE AIDE & HOMEMAKER SERVICES 0 0 37.00 37.00 0 0 DURABLE MEDICAL EQUIPMENT/OXYGEN 0 38.00 38.00 0 0 39.00 PATIENT TRANSPORTATION 0 0 39.00 40.00 IMAGING SERVICES 40.00 LABS & DIAGNOSTICS 0 0 41.00 41.00 0 MEDICAL SUPPLIES-NON-ROUTINE 0 42.00 0 42.00 43.00 OUTPATIENT SERVICES 0 43.00 PALLIATIVE RADIATION THERAPY 0 0 44.00 0 44.00

0

PALLIATIVE CHEMOTHERAPY

46.00 OTHER PATIENT CARE SERVICES (SPECIFY)

45.00

100.00 TOTAL

		ADJUSTMENTS	TOTAL (col. 5	
		ADJUSTNIENTS	± col. 6)	
		6, 00	7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS	0.00	7.00	
25. 00	I NPATI ENT CARE-CONTRACTED			25. 00
26. 00	PHYSI CI AN SERVI CES	0	0	26. 00
27. 00	NURSE PRACTITIONER		o	27. 00
28. 00	REGI STERED NURSE	0	o	28. 00
29. 00	LPN/LVN	0	o	29. 00
30. 00	PHYSI CAL THERAPY	0	o	30.00
31.00	OCCUPATIONAL THERAPY	0	o	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	o	32. 00
33.00	MEDICAL SOCIAL SERVICES	0	o	33. 00
34.00	SPIRITUAL COUNSELING	0	o	34.00
35.00	DI ETARY COUNSELING	0	o	35. 00
36.00	COUNSELING - OTHER	0	o	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	o	37. 00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	o	38. 00
39.00	PATI ENT TRANSPORTATION	0	o	39. 00
40.00	I MAGI NG SERVI CES	0	o	40.00
41.00	LABS & DIAGNOSTICS	0	o	41. 00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	o	42.00
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45. 00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46. 00
100.00	TOTAL *	0	0	100.00

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 50.

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 50.

Peri od: Worksheet 0-2

From 01/01/2016 To 12/31/2016 Date/Time Prepared: 3/12/2018 9:20 am Hospi ce CCN: 15-1531 Hospi ce I

					nospi ce i		
		SALARI ES	OTHER	SUBTOTAL (col.	RECLASSIFI -	SUBTOTAL	
				1 + col . 2)	CATI ONS		
		1.00	2. 00	3.00	4. 00	5. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	I NPATI ENT CARE-CONTRACTED						25. 00
26.00	PHYSI CI AN SERVI CES	0	0	0	0	0	26. 00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27. 00
28.00	REGI STERED NURSE	130, 352	0	130, 352	0	130, 352	28. 00
29. 00	LPN/LVN	0	0	0	0	0	29. 00
30.00	PHYSI CAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATI ONAL THERAPY	0	0	0	0	0	31. 00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32. 00
33.00	MEDICAL SOCIAL SERVICES	42, 623	0	42, 623	0	42, 623	33. 00
34.00	SPIRITUAL COUNSELING	8, 579	0	8, 579	0	8, 579	34.00
35.00	DI ETARY COUNSELI NG	O	0	0	0	0	35. 00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	10, 116	0	10, 116	0	10, 116	37. 00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	O	0	0	0	0	38. 00
39.00	PATIENT TRANSPORTATION	O	0	0	0	0	39. 00
40.00	I MAGI NG SERVI CES	o	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	o	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	o	65, 624	65, 624	-64, 847	777	42.00
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	o	0	0	0	0	44.00
45.00	PALLI ATI VE CHEMOTHERAPY	o	0	0	0	0	45. 00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	o	0	0	0	0	46.00
	TOTAL *	191, 670	65, 624	257, 294	-64, 847	192, 447	100.00
* Tran	sfor the amount in column 7 to Wkst 0-5 col	umn 1 ling 51					

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

		ADJUSTMENTS	TOTAL (col. 5		
			± col. 6)		
		6. 00	7. 00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED			2	25. 00
26.00	PHYSI CI AN SERVI CES	0	0	2	26. 00
27.00	NURSE PRACTITIONER	0	0	2	27. 00
28.00	REGI STERED NURSE	0	130, 352	2	28. 00
29.00	LPN/LVN	0	0	2	29. 00
30.00	PHYSI CAL THERAPY	0	0	3	30. 00
31.00	OCCUPATIONAL THERAPY	0	0	3	31. 00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	3	32. 00
33.00	MEDICAL SOCIAL SERVICES	0	42, 623	3	33. 00
34.00	SPIRITUAL COUNSELING	0	8, 579	3	34. 00
35.00	DI ETARY COUNSELING	0	0	3	35. 00
36.00	COUNSELING - OTHER	0	0	3	36. 00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	10, 116	3	37. 00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	3	38. 00
39.00	PATIENT TRANSPORTATION	0	0	3	39. 00
40.00	I MAGING SERVICES	0	0	4	40. 00
41.00	LABS & DIAGNOSTICS	0	0	4	41. 00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	777	4	42. 00
43.00	OUTPATIENT SERVICES	0	0	4	43. 00
44.00	PALLIATIVE RADIATION THERAPY	0	0	4	44. 00
45.00	PALLIATIVE CHEMOTHERAPY	0	o	4	45. 00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	o	4	46. 00
100.00	TOTAL *	0	192, 447	10	00.00

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

Hospi ce CCN: 15-1531

Peri od: Worksheet 0-4 From 01/01/2016 To 12/31/2016

Date/Time Prepared: 3/12/2018 9:20 am

					3/ 12/ 2010 7. 2	o am
				Hospi ce I		
	SALARI ES	OTHER	SUBTOTAL (col.	RECLASSIFI -	SUBTOTAL	
			1 + col . 2)	CATI ONS		
	1. 00	2.00	3. 00	4. 00	5. 00	
DIRECT PATIENT CARE SERVICE COST CENTERS						
25. 00   I NPATI ENT CARE-CONTRACTED	0	0	0	0	0	25. 00
26. 00 PHYSI CI AN SERVI CES	0	0	0	0	0	26. 00
27. 00 NURSE PRACTITIONER	0	0	0	0	0	27. 00
28. 00 REGI STERED NURSE	5, 860	0	5, 860	0	5, 860	28. 00
29. 00 LPN/LVN	0	0	0	0	0	29. 00
30. 00 PHYSI CAL THERAPY	0	0	0	0	0	30.00
31. 00 OCCUPATI ONAL THERAPY	0	0	0	0	0	31. 00
32.00 SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32. 00
33.00 MEDICAL SOCIAL SERVICES	1, 916	0	1, 916	0	1, 916	33. 00
34.00 SPIRITUAL COUNSELING	386	0	386	0	386	34.00
35. 00 DIETARY COUNSELING	0	0	0	0	0	35. 00
36. 00 COUNSELING - OTHER	0	0	0	0	0	36.00
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	455	0	455	0	455	37. 00
38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN						38. 00
39.00 PATIENT TRANSPORTATION	0	0	0	0	0	39. 00
40.00 I MAGING SERVICES	0	0	0	0	0	40.00
41.00 LABS & DIAGNOSTICS	O	0	0	0	0	41. 00
42.00 MEDICAL SUPPLIES-NON-ROUTINE	O	0	0	0	0	42.00
43. 00 OUTPATIENT SERVICES	O	0	0	0	0	43.00
44.00 PALLIATIVE RADIATION THERAPY	O	0	0	0	0	44.00
45.00 PALLIATIVE CHEMOTHERAPY	O	0	0	0	0	45. 00
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)	O	0	0	0	0	46. 00
100. 00 TOTAL *	8, 617	0	8, 617	0	8, 617	100.00
* Transfer the amount in column 7 to Wkst 0-5 col	ump 1 lino 52		•			•

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

		ADJUSTMENTS	TOTAL (col. 5	
			± col. 6)	
		6. 00	7. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25. 00	I NPATI ENT CARE-CONTRACTED	0	0	25. 00
26. 00	PHYSI CI AN SERVI CES	0	0	26. 00
27. 00	NURSE PRACTITIONER	0	0	27. 00
28. 00	REGI STERED NURSE	0	5, 860	28. 00
29. 00	LPN/LVN	0	0	29. 00
30.00	PHYSI CAL THERAPY	0	0	30.00
31. 00	OCCUPATI ONAL THERAPY	0	0	31. 00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32. 00
33.00	MEDICAL SOCIAL SERVICES	0	1, 916	33. 00
34.00	SPI RI TUAL COUNSELI NG	0	386	34.00
35. 00	DI ETARY COUNSELING	0	0	35. 00
36.00	COUNSELING - OTHER	0	0	36. 00
37. 00	HOSPICE AIDE & HOMEMAKER SERVICES	0	455	37. 00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN			38. 00
39. 00	PATI ENT TRANSPORTATION	0	0	39. 00
40.00	I MAGING SERVICES	0	0	40.00
41. 00	LABS & DIAGNOSTICS	0	0	41. 00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0	42. 00
43.00	OUTPATI ENT SERVI CES	0	0	43. 00
44. 00	PALLIATIVE RADIATION THERAPY	0	0	44. 00
45. 00	PALLI ATI VE CHEMOTHERAPY	0	0	45. 00
46. 00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46. 00
100.00	TOTAL *	0	8, 617	100. 00

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

Heal th	Financial Systems DEARBORN COU	INTY HOSPITAL		In Lie	eu of Form CMS-2	2552-10
	LLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET	Provi der CC		Peri od:	Worksheet 0-5	
EXPENS	ES FOR ALLOCATION	Hospi ce CCN		From 01/01/2016 To 12/31/2016	Date/Time Pre 3/12/2018 9:2	
				Hospi ce I		
	Descriptions		HOSPICE DIREC		TOTAL EXPENSES	
			EXPENSES (se		(sum of cols.	
			instructions	) EXPENSES FROM	1 + 2)	
				WKST B PART I		
				(see		
			1. 00	instructions)	2.00	
	GENERAL SERVICE COST CENTERS		1.00	2. 00	3. 00	
1. 00	CAP REL COSTS-BLDG & FIXT			0 3, 640	3, 640	1.00
2.00	CAP REL COSTS-BLDG & TTXT			0 2, 351	2, 351	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT			0 97, 803		3.00
4.00	ADMINISTRATIVE & GENERAL		124, 30			4.00
5. 00	PLANT OPERATION & MAINTENANCE		124, 30	0 9, 961	9, 961	5. 00
6. 00	LAUNDRY & LINEN SERVICE			0 7, 701	7, 701	6.00
7. 00	HOUSEKEEPI NG			0 2,844	2, 844	7. 00
8. 00	DIETARY			0 2,044	2,044	8.00
9. 00	NURSING ADMINISTRATION			0 0	o o	9.00
10. 00	ROUTI NE MEDI CAL SUPPLI ES			0 0	o o	10.00
11. 00	MEDI CAL RECORDS		20, 08	9, 331	29, 416	11.00
12. 00	STAFF TRANSPORTATION			0	0	12. 00
13. 00	VOLUNTEER SERVICE COORDINATION			o	o o	13.00
14.00	PHARMACY			0 0	0	14.00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES		12, 50	00	12, 500	15. 00
16.00	OTHER GENERAL SERVI CE		166, 26		l	16. 00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			0	0	17. 00
	LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE		192, 44	17	192, 447	51.00
52.00	HOSPICE INPATIENT RESPITE CARE			0	0	52. 00
53.00	HOSPICE GENERAL INPATIENT CARE		8, 61	7	8, 617	53.00
	NONREI MBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM			0	0	60.00
61. 00	VOLUNTEER PROGRAM			0	0	61. 00
62. 00	FUNDRAI SI NG			0	0	62.00
63. 00	HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS			0	0	63. 00
64. 00	PALLIATIVE CARE PROGRAM			U	0	64. 00
65. 00	OTHER PHYSICIAN SERVICES			U	0	65.00

66.00 0

67.00

69. 00 70. 00

71.00 0

99. 00

0 68. 00

0 0

698, 133 100. 00

173, 909

524, 224

66.00 RESIDENTIAL CARE

99.00 NEGATIVE COST CENTER

TELEHEALTH/TELEMONI TORI NG

71.00 OTHER NONREIMBURSABLE (SPECIFY)

69. 00 THRIFT STORE
70. 00 NURSING FACILITY ROOM & BOARD

67. 00 ADVERTISING

68.00

100. 00 TOTAL

Heal th FinancialSystemsDEARBORN COCOST ALLOCATION- HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Descriptions							3/12/2018 9: 20	o am
FIX   EQUIP   BENEFITS   DEPARTMENT						Hospi ce I		
CAP REL COSTS-BLDG & FIXT   3,640   3,640   1.00   2.00   3.00		Descriptions	TOTAL EXPENSES CA	AP REL BLDG &	CAP REL MVBLE	EMPLOYEE	SUBTOTAL	
1.00				FIX	EQUI P	BENEFI TS		
CAP REL COSTS-BLDG & FIXT						DEPARTMENT		
1.00			0	1. 00	2.00	3. 00	3A	
2.00		GENERAL SERVICE COST CENTERS						
3.00   EMPLOYEE BENEFI TS DEPARTMENT	1.00	CAP REL COSTS-BLDG & FIXT	3, 640	3, 640				1. 00
4. 00   ADMINI STRATIVE & GENERAL   172, 288   0   0   29, 364   201, 652   4. 00	2.00	CAP REL COSTS-MVBLE EQUIP	2, 351		2, 351			2. 00
S. 0.0   CLANT OPERATION & MAINTENANCE   9,961   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3.00	EMPLOYEE BENEFITS DEPARTMENT	97, 803	0	0	97, 803		3. 00
S. 0.0   CLANT OPERATION & MAINTENANCE   9,961   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	4.00	ADMINISTRATIVE & GENERAL	172, 288	0	0	29, 364	201, 652	4. 00
6. 00         LAUNDRY & LI NEN SERVI CE         0         0         0         0         0         6. 00           7. 00         HOUSEKEEPING         2,844         0         0         0         2,844         7. 00           9. 00         NURSI NG ADMI NI STRATI ON         0         0         0         0         0         0         0         9.00           10. 00         ROUTI INE MEDI CAL SUPPLIES         0         12.00         13.00         VOLUNTEER SERVI CE COORDI NATI ON         0         0         0         0         0         0         13.00         VOLUNTEER SERVI CE SERVI CES         12.500         0         0         0		PLANT OPERATION & MAINTENANCE	9, 961	0	0	0	9, 961	5. 00
7. 00         HOUSEKEEPING         2,844         0         0         0         2,844         7.00           8. 00         DI ETARY         0         0         0         0         0         0         9.00           9. 00         NURSI NG ADMINISTRATION         0         0         0         0         0         9.00           11. 00         ROUTI NE MEDI CAL SUPPLIES         0         10         0         0         0         0         0         0         0         0         12.00         0         0         0         0         0         0         12.00         0         0         0         0         0         12.00         0         0         0         0         12.00         0         0         0         0         12.00         0         0         0         0         14.00         0         0 <t< td=""><td>6.00</td><td></td><td>O</td><td>0</td><td>0</td><td>O</td><td></td><td>6, 00</td></t<>	6.00		O	0	0	O		6, 00
8.00   DIETARY   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		HOUSEKEEPING	2.844	0	0	0	2.844	7. 00
9.00         NURSI NG ADMINISTRATION         0         0         0         0         9.00           10.00         ROUTI NE MEDI CAL SUPPLIES         0         10.00         0         0         0         0         0         0         0         0         0         12.00         12.00         0         0         0         0         0         0         0         12.00         13.00         0         0         0         0         0         0         0         0         0         12.00         13.00         0         0         0         0         14.00         14.00         0         0         0         0         15.00         0         0         0         0         15.00         0         0         0         15.00         0         0         0         166.266         16.00         0         0         0         0         0         0         0		y and the second	_, _,	0	o o	0		
10.00   NOUTINE MEDICAL SUPPLIES   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0	ا م	0	- 1	
11.00   MEDI CAL RECORDS   29, 416   0   0   6,238   35, 654   11.00     12.00   STAFF TRANSPORTATION   0   0   0   0   0     13.00   VOLUNTEER SERVI CE COORDI NATI ON   0   0   0   0   0     14.00   PHARMACY   0   0   0   0   0     15.00   PHYSI CI AN ADMI NI STRATI VE SERVI CES   12,500   0   0   0   0     16.00   OTHER GENERAL SERVI CE   166,266   0   0   0   0     17.00   PATI ENT /RESI DENTI AL CARE SERVI CES   166,266   0   0   0   0     17.00   PATI ENT /RESI DENTI AL CARE SERVI CES   0   0   0     17.00   DATI ENT /RESI DENTI AL CARE SERVI CES   0   0   0     17.00   DATI ENT /RESI DENTI AL CARE SERVI CES   0   0   0   0     17.00   DATI ENT /RESI DENTI AL CARE SERVI CES   0   0   0   0     17.00   DATI ENT /RESI DENTI AL CARE SERVI CES   0   0   0   0     17.00   DATI ENT /RESI DENTI AL CARE SERVI CES   0   0   0   0     17.00   DATI ENT /RESI DENTI AL CARE SERVI CES   0   0   0   0   0     17.00   DATI ENT /RESI DENTI AL CARE SERVI CES   0   0   0   0   0     18.00   DATI ENT /RESI DENTI AL CARE SERVI CES   0   0   0   0   0     19.00   DATI ENT /RESI DENTI AL CARE SERVI CES   0   0   0   0   0     19.00   DATI ENT /RESI DENTI AL CARE SERVI CES   0   0   0   0   0     19.00   DATI ENT /RESI DENTI AL CARE SERVI CES   0   0   0   0   0     19.00   DATI ENT /RESI DENTI AL CARE PROGRAM   0   0   0   0   0     19.00   DATI ENT /RESI DENTI AL CARE PROGRAM   0   0   0   0   0     19.00   DATI ENT /RESI DENTI AL CARE PROGRAM   0   0   0   0   0     19.00   DATI ENT /RESI DENTI AL CARE PROGRAM   0   0   0   0   0     19.00   DATI ENT /RESI DENTI AL CARE PROGRAM   0   0   0   0   0     19.00   DATI ENT /RESI DENTI AL CARE PROGRAM   0   0   0   0     19.00   DATI ENT /RESI DENTI AL CARE PROGRAM   0   0   0   0     19.00   DATI ENT /RESI DENTI AL CARE PROGRAM   0   0   0   0     19.00   DATI ENT /RESI DENTI AL CARE PROGRAM   0   0   0   0     19.00   DATI ENT /RESI DENTI AL CARE   0   0   0   0     19.00   DATI ENT /RESI DENTI AL CARE   0   0   0   0     19.00   DATI ENT /RESI DENTI AL CARE   0   0   0   0				0	l ő	0	- 1	
12. 00   STAFF TRANSPORTATION			29 416	0	o o	6 238	- 1	
13. 00   VOLUNTEER SERVI CE COORDI NATI ON   0   0   0   0   0   0   13. 00     14. 00   PHARMACY   0   0   0   0   0   0   0     15. 00   PHYSI CI AN ADMI NI STRATI VE SERVI CES   12,500   0   0   0   0   12,500     15. 00   OTHER GENERAL SERVI CE   166, 266   0   0   0   0     17. 00   OTHER GENERAL SERVI CES   0   0   0   0     18. 00   OTHER GENERAL SERVI CES   0   0   0     19. 00   0   0   0   0     10. 00   0   0   0     10. 00   0   0   0     10. 00   0   0   0     10. 00   0   0   0     10. 00   0   0     10. 00   0   0     10. 00   0   0     10. 00   0   0     10. 00   0   0     10. 00   0   0     10. 00   0   0     10. 00   0   0     10. 00   0   0     10. 00   0     10. 00   0     10. 00   0   0     10. 00   0     10. 00   0     10. 00   0     10. 00   0   0     10. 00     10. 00   0     10.		1	27, 110	0	o o	0, 200		
14. 00   PHARMACY   0   0   0   0   0   14. 00   15. 00   15. 00   15. 00   16. 00				0	l o	0	ŭ,	
15. 00   PHYSI CI AN ADMI NI STRATI VE SERVI CES   12,500   0   0   0   12,500   15. 00     16. 00   OTHER GENERAL SERVI CE   166, 266   0   0   0   0   166, 266   16. 00     17. 00   PATI ENT/RESI DENTI AL CARE SERVI CES   0   0   0   0   0     16. 00   0   0   0   0   0     17. 00   ELEVEL OF CARE		1		0	l o	0	- 1	
16.00   OTHER GENERAL SERVICE   166, 266   0   0   0   166, 266   16.00		· · · · · · · · · · · · · · · · · · ·	12 500	0	١	0	- 1	
17. 00   PATIENT/RESIDENTIAL CARE SERVICES   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1		0	0	0		
LEVEL OF CARE     HOSPI CE CONTI NUOUS HOME CARE   0   0   0   50.00   51.00   55.00   55.00   192,447   59,525   251,972   51.00   52.00   192,447   59,525   251,972   51.00   192,447   193,640   2,351   2,676   17,284   17,2			100, 200	0		o o		
Description	17.00				0		0	17.00
51.00   HOSPI CE ROUTI NE HOME CARE   192, 447   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	50 00					٥	0	50.00
52. 00         HOSPI CE INPATIENT RESPITE CARE         0         0         0         0         0         52. 00           53. 00         HOSPI CE GENERAL INPATIENT CARE         8, 617         3, 640         2, 351         2, 676         17, 284         53. 00           NONREI MBURSABLE COST CENTERS         8, 617         3, 640         0         0         0         0         0         60. 00           61. 00         VOLUNTEER PROGRAM         0         0         0         0         0         0         0         61. 00           62. 00         FUNDRAI SI NG         0         0         0         0         0         0         0         62. 00           63. 00         HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS         0         0         0         0         0         0         0         62. 00           64. 00         PALLI ATI VE CARE PROGRAM         0         0         0         0         0         0         64. 00           65. 00         OTHER PHYSI CI AN SERVI CES         0         0         0         0         0         66. 00           67. 00         ADVERTI SI NG         0         0         0         0         0         0         67. 00 </td <td></td> <td></td> <td>1 "</td> <td></td> <td></td> <td>59 525</td> <td>- 1</td> <td></td>			1 "			59 525	- 1	
HOSPICE GENERAL INPATIENT CARE   8,617   3,640   2,351   2,676   17,284   53.00			172, 447	0	0	37, 323 O		
NONREI MBURSABLE COST CENTERS			8 617	3 640	2 351	2 676	- 1	
60. 00 BEREAVEMENT PROGRAM 0 0 0 0 0 0 0 60. 00 61. 00 62. 00 62. 00 FUNDRAI SI NG 0 0 0 0 0 0 0 62. 00 63. 00 64. 00 64. 00 65. 00 FUNDRAI SI NG 0 0 0 0 0 0 0 0 63. 00 64. 00 65. 00 0 0 0 0 0 0 0 0 0 0 64. 00 65. 00 0 0 0 0 0 0 0 0 64. 00 65. 00 0 0 0 0 0 0 0 0 65. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	33.00		0,017	3, 040	2, 331	2,070	17, 204	33.00
61. 00 VOLUNTEER PROGRAM 0 0 0 0 0 0 0 61. 00 62. 00 62. 00 63. 00 FUNDRAI SI NG 0 0 0 0 0 0 0 62. 00 63. 00 64. 00 0 0 0 0 0 63. 00 64. 00 65. 00 0 0 0 0 0 0 0 64. 00 65. 00 0 0 0 0 0 0 64. 00 65. 00 0 0 0 0 0 0 0 0 65. 00 66. 00 RESI DENTI AL CARE 0 0 0 0 0 0 0 0 65. 00 67. 00 ADVERTI SI NG 0 0 0 0 0 0 0 68. 00 68. 00 TELEHEALTH/TELEMONI TORI NG 0 0 0 0 0 68. 00	60 00			0	<u> </u>	٥	0	60.00
62. 00 FUNDRAI SI NG 0 0 0 0 0 62. 00 63. 00 64. 00 0 0 0 0 63. 00 64. 00 0 0 0 0 0 65. 00 0 0 0 65. 00 0 0 0 0 65. 00 0 0 0 0 65. 00 0 0 0 0 0 65. 00 0 0 0 0 0 0 66. 00 0 0 0 0 0 0 0 0				-	_	0	-	
63. 00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS 0 0 0 0 0 63. 00 64. 00 65. 00 0 0 0 0 64. 00 65. 00 0 0 0 0 0 65. 00 66. 00 RESI DENTI AL CARE 0 0 0 0 0 0 0 0 66. 00 67. 00 ADVERTI SI NG 0 0 0 0 0 0 0 0 68. 00 0 0 0 0 68. 00				0		0	- 1	
64. 00 PALLI ATI VE CARE PROGRAM 0 0 0 0 0 64. 00 65. 00 0 0 66. 00 0 0 65. 00 0 0 0 65. 00 0 0 0 65. 00 0 0 0 0 65. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0	١	0	-	
65. 00 OTHER PHYSICIAN SERVICES 0 0 0 0 0 65. 00 66. 00 67. 00 ADVERTISING 0 0 0 0 0 0 68. 00 68. 00 TELEHEALTH/TELEMONITORING 0 0 0 0 0 68. 00				0		0	-	
66. 00 RESI DENTI AL CARE 0 0 0 0 0 66. 00 67. 00 ADVERTI SI NG 0 0 0 0 0 67. 00 68. 00 TELEHEALTH/TELEMONI TORI NG 0 0 0 0 0 68. 00				0		0	-	
67. 00   ADVERTI SI NG   0 0 0 0 67. 00 68. 00   TELEHEALTH/TELEMONI TORI NG   0 0 0 0 68. 00				0	0	0	- 1	
68. 00   TELEHEALTH/TELEMONI TORI NG		· ·		0		0	-	
				0	0	0	ŭ	
	69.00	THRIFT STORE		0		0	0	68. 00 69. 00
		y and the second		0	1	U	-	
76.66 Note: No 176.211 Note: a South		4		^			ŭ,	
71. 00 OTHER NONREI MBURSABLE (SPECIFY) 0 0 0 0 71. 00 99. 00 NEGATI VE COST CENTER 0 99. 00				0		0	U	
			(00.133	2 (40	2 251	07 000	/OO 122	
100. 00  TOTAL   698, 133  3, 640  2, 351  97, 803  698, 133   100. 00	100.00	I I I I I I I I I I I I I I I I I I I	098, 133	3, 640	Į ∠, 35 I	97, 803	098, 133	100.00

Heal th FinancialSystemsDEARBORN COUNTYHOSPITALCOST ALLOCATION- HOSPITAL-BASED HOSPICE GENERALSERVICE COSTSProvider Provider CCN: 15-0086 Hospi ce CCN: 15-1531

						07 127 2010 7.2	-0 4
	·	1			Hospi ce I		
	Descriptions	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	OPERATION &	LINEN SERVICE			
		4.00	MAI NTENANCE	( 00	7.00	0.00	
	OFNEDAL CERVILOE COCT OFNEDO	4.00	5. 00	6. 00	7. 00	8. 00	
4 00	GENERAL SERVI CE COST CENTERS						4
1.00	CAP REL COSTS BLDG & FLXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	004 (50					3.00
4.00	ADMINISTRATIVE & GENERAL	201, 652	14 007	,			4. 00
5.00	PLANT OPERATION & MAINTENANCE	4, 046	14, 007				5. 00
6.00	LAUNDRY & LINEN SERVICE	1 1 1 5	C	C			6. 00
7.00	HOUSEKEEPI NG	1, 155		,	3, 999	,	7.00
8.00	DI ETARY	0		,	0	(	
9.00	NURSING ADMINISTRATION	0		,	0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	14 401		,	0		10.00
11. 00	MEDI CAL RECORDS	14, 481		,	0		11.00
12.00	STAFF TRANSPORTATION	0		,	0		12. 00 13. 00
13.00	VOLUNTEER SERVICE COORDINATION	0		,	0		14.00
14. 00	PHARMACY  BUYGL CLAN ADMINI CEDATINE CEDVI CEC	5 077		,	0		
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	5, 077		,	0		15.00
16.00	OTHER GENERAL SERVICE	67, 531		,	0		16.00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES	0	C	1	0		17. 00
FO 00	LEVEL OF CARE			I			
50.00	HOSPI CE CONTI NUOUS HOME CARE HOSPI CE ROUTI NE HOME CARE	102, 342					50. 00 51. 00
51.00	HOSPICE ROUTINE HOME CARE HOSPICE INPATIENT RESPITE CARE	102, 342	_			,	
52.00	HOSPICE TOPATIENT RESPITE CARE  HOSPICE GENERAL INPATIENT CARE	7 020	14 007	) C			1
53. 00	NONREI MBURSABLE COST CENTERS	7, 020	14, 007	1 0	3, 999		53.00
60. 00	BEREAVEMENT PROGRAM		C	<b>\</b>	0		60.00
61.00	VOLUNTEER PROGRAM	0			0		61.00
	FUNDRAI SI NG	0			0		62.00
62.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0		63.00
63. 00 64. 00	l control of the cont	0			0		64. 00
	PALLIATIVE CARE PROGRAM OTHER PHYSICIAN SERVICES	0		(	0		65. 00
65. 00		0			0	(	
66.00	RESI DENTI AL CARE	0		O	0		
67. 00	ADVERTI SI NG	0			0		67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG	0		,	0		68. 00 69. 00
69. 00	THRIFT STORE	١		'	U		
70.00	NURSING FACILITY ROOM & BOARD OTHER NONREIMBURSABLE (SPECIFY)		_			,	70.00
71. 00 99. 00	NEGATIVE COST CENTER					(	1
	NEGATIVE COST CENTER   TOTAL	201, 652	14, 007	) C		,	100.00
100.00	N TOTAL	201, 052	14,007	1	3, 999	1	1100.00

Heal th	Financial Systems	DEARBORN COUNTY	HOSPI TAL		In Lie	u of Form CMS-	2552-10
	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL	SERVICE COSTS	Provider CC	CN: 15-0086	Peri od:	Worksheet 0-6	
			II CON	1 15 1501	From 01/01/2016	Part I	
			Hospi ce CCN	l: 15-1531	To 12/31/2016	Date/Time Pre 3/12/2018 9:2	pared: O am
					Hospi ce I	07 127 2010 7.2	o am
	Descriptions	NURSI NG	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	
	·	ADMI NI STRATI ON	MEDI CAL	RECORDS	TRANSPORTATI ON	SERVI CE	
			SUPPLI ES			COORDI NATI ON	
		9. 00	10.00	11. 00	12.00	13. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FLXT						1. 00
2.00	CAP REL COSTS-MVBLE EQUIP						2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4.00	ADMINISTRATIVE & GENERAL						4. 00
5.00	PLANT OPERATION & MAINTENANCE						5. 00
6. 00	LAUNDRY & LINEN SERVICE						6. 00
7. 00	HOUSEKEEPI NG						7. 00
8.00	DI ETARY						8. 00
9.00	NURSING ADMINISTRATION	0					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	FO 44	\		10.00
11.00	MEDICAL RECORDS	0		50, 13	35		11.00
12.00	STAFF TRANSPORTATION	0			0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	0	13.00
14.00	PHARMACY	0			0	0	14.00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16. 00 17. 00	OTHER GENERAL SERVI CE PATI ENT/RESI DENTI AL CARE SERVI CES				U	U	16. 00 17. 00
17.00	LEVEL OF CARE						17.00
50. 00	HOSPICE CONTINUOUS HOME CARE	0	O		0 0	0	50.00
51. 00	HOSPICE CONTINUOUS HOME CARE	0	0	47, 93		0	51.00
52. 00	HOSPICE INPATIENT RESPITE CARE	0	0	47, 7	0 0	0	52.00
53. 00	HOSPICE GENERAL INPATIENT CARE	0	0	2, 20		0	
33.00	NONREI MBURSABLE COST CENTERS	<u> </u>	<u> </u>	2, 20	) <del>4</del>   0		33.00
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61. 00	VOLUNTEER PROGRAM	0			o	0	61.00
62. 00	FUNDRAI SI NG	0			o	0	62. 00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64. 00	PALLIATIVE CARE PROGRAM	0			0	0	64. 00
65. 00	OTHER PHYSICIAN SERVICES	l ol			o	0	65. 00
66. 00	RESI DENTI AL CARE	0			0	0	66.00
67.00	ADVERTI SI NG	l ol			0	0	67.00
68. 00	TELEHEALTH/TELEMONI TORI NG	o			0	0	68. 00
69.00	THRI FT STORE	ol			0	0	69. 00
70.00	NURSING FACILITY ROOM & BOARD						70. 00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			o	0	71. 00
99. 00	NEGATIVE COST CENTER	0	o		0 0	0	99. 00
100.00	TOTAL	0	0	50, 13	35 0	0	100. 00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS Provider CCN: 15-0086 Peri od: Worksheet 0-6 From 01/01/2016 Part I Hospi ce CCN: 15-1531 12/31/2016 Date/Time Prepared: To 3/12/2018 9:20 am Hospi ce I PHARMACY PHYSI CI AN OTHER GENERAL PATI ENT/ TOTAL Descriptions ADMI NI STRATI VE SERVI CE RESI DENTI AL SERVI CES CARE SERVICES 14. 00 16. 00 18. 00 15.00 17.00 GENERAL SERVICE COST CENTERS CAP REL COSTS-BLDG & FLXT 1.00 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 2.00 3.00 EMPLOYEE BENEFITS DEPARTMENT 3.00 ADMINISTRATIVE & GENERAL 4.00 4.00 5.00 PLANT OPERATION & MAINTENANCE 5.00 LAUNDRY & LINEN SERVICE 6.00 6.00 7.00 HOUSEKEEPI NG 7.00 8.00 DI ETARY 8.00 NURSING ADMINISTRATION 9.00 9.00 ROUTINE MEDICAL SUPPLIES 10.00 10.00 11.00 MEDICAL RECORDS 11.00 12.00 STAFF TRANSPORTATION 12.00 VOLUNTEER SERVICE COORDINATION 13.00 13.00 14.00 PHARMACY 14.00 15.00 PHYSICIAN ADMINISTRATIVE SERVICES 0 17, 577 15.00 OTHER GENERAL SERVICE 16.00 233, 797 16.00 PATIENT/RESIDENTIAL CARE SERVICES 17.00 17.00 LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE 50.00 50.00 0 HOSPICE ROUTINE HOME CARE 16, 804 223, 518 642, 567 51.00 51.00 HOSPICE INPATIENT RESPITE CARE 52.00  $\cap$ 0 52.00 53.00 HOSPICE GENERAL INPATIENT CARE 0 773 10, 279 55, 566 53.00 NONREI MBURSABLE COST CENTERS BEREAVEMENT PROGRAM 60.00 60.00 0 0 0 0 0 0 0 0 0 VOLUNTEER PROGRAM 0 61.00 0 61.00 62.00 FUNDRAI SI NG 0 0 62.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS 0 63.00 0 63.00 PALLIATIVE CARE PROGRAM 0 64.00 0 64.00 0 65.00 OTHER PHYSICIAN SERVICES 0 65.00 RESIDENTIAL CARE 0 66.00 0 0 0 66.00 67 00 ADVERTI SI NG 0 0 67.00

0 0

17, 577

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233, 797

0 68.00

0 69.00

0 70.00

Ω

0 99.00

698, 133 100. 00

71.00

TELEHEALTH/TELEMONI TORI NG

NURSING FACILITY ROOM & BOARD

OTHER NONREIMBURSABLE (SPECIFY)

THRIFT STORE

99.00 NEGATIVE COST CENTER

68.00

69.00

70.00

71 00

100.00 TOTAL

Health Financial Systems	DEARBORN COUNTY HO	OSPI TAL	In Lieu	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPIC STATISTICAL BASIS		Provider CCN: Hospice CCN:	From 01/01/2016 To 12/31/2016	Worksheet 0-6 Part II Date/Time Prepared: 3/12/2018 9:20 am

			nospi ce con	. 13-1331   1	0 12/31/2010	3/12/2018 9: 2	
					Hospi ce I		
	Cost Center Descriptions	CAP REL BLDG & C	AP REL MVBLE	EMPLOYEE	RECONCI LI ATI ON	ADMI NI STRATI VE	
	'	FIX	EQUI P	BENEFITS		& GENERAL	
		(SQUARE FEET) (	OOLLAR VALUE)	DEPARTMENT		(ACCUMULATED	
		/	,	(GROSS		COSTS)	
				SALARI ES)		, , ,	
		1. 00	2.00	3.00	4A	4. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FLXT	315					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		315				2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0.0	314, 924			3. 00
4. 00	ADMI NI STRATI VE & GENERAL		0	94, 552		496, 481	4. 00
5. 00	PLANT OPERATION & MAINTENANCE		0	71,002	201, 002	9, 961	5. 00
6. 00	LAUNDRY & LINEN SERVICE		0			7, 701	6.00
7. 00	HOUSEKEEPI NG		0			2, 844	7. 00
8. 00	DI ETARY	0	0			2, 644	8. 00
9.00	NURSING ADMINISTRATION	0	0			0	9. 00
10. 00	ROUTINE MEDICAL SUPPLIES	0	0			0	10.00
		0	0	20.005	0	_	
11. 00	MEDI CAL RECORDS	0	0	20, 085		35, 654	1
12.00	STAFF TRANSPORTATION	0	0	C	0	0	12.00
13. 00	VOLUNTEER SERVICE COORDINATION	0	0	(	0	0	13. 00
14. 00	PHARMACY	0	0	C	0	0	14. 00
	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	C	0	12, 500	1
	OTHER GENERAL SERVICE	0	0	C	0	166, 266	1
17. 00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	17. 00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE			C	0	0	50.00
	HOSPICE ROUTINE HOME CARE			191, 670	0	251, 972	51. 00
	HOSPICE INPATIENT RESPITE CARE	0	0	C	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	315	315	8, 617	0	17, 284	53.00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	C	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	C	0	0	61. 00
62.00	FUNDRAI SI NG	o	O	C	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	o	0	C	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	o	0	C	0	0	64. 00
65.00	OTHER PHYSICIAN SERVICES	o	О	C	0	0	65. 00
66. 00	RESI DENTI AL CARE	ol	o	C	0	0	66. 00
67. 00	ADVERTI SI NG	0	0	C	0	0	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG	o	0		0	0	68. 00
	THRI FT STORE		0	Č	0	0	69. 00
	NURSING FACILITY ROOM & BOARD		J		0		70.00
	OTHER NONREIMBURSABLE (SPECIFY)	0	n	^	0	0	1
	NEGATIVE COST CENTER		٩				99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	3, 640	2, 351	97, 803		201, 652	
	UNIT COST MULTIPLIER	11. 555556	7. 463492	0. 310561		0. 406163	
101.00	ONLY COST MODELLI FIELD	11. 333330	1. 403472	0. 310301	1	0. 400103	1101.00

Health Financial Systems	DEARBORN COUN	ITY HOSPITAL	_	In Lie	eu of Form CMS-2	2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SI	ERVICE COSTS	Provi de	r CCN: 15-0086	Peri od:	Worksheet 0-6	
STATISTICAL BASIS		llooni oo	CCN. 1E 1E31	From 01/01/2016 To 12/31/2016		nanad.
		HOSPI CE	CCN: 15-1531	To 12/31/2016	Date/Time Prep 3/12/2018 9:20	pareu: O am
				Hospi ce I		
Cost Center Descriptions	PLANT	LAUNDRY	& HOUSEKEEPI	NG DI ETARY	NURSI NG	
	OPERATION &	LINEN SERV	ICE (SQUARE FE	ET) (IN-FACILITY	ADMI NI STRATI ON	
	MAI NTENANCE	(IN-FACILI	TY	DAYS)		
	(SQUARE FEET)	DAYS)			(DI RECT NURS.	
					HRS. )	
	5. 00	6. 00	7. 00	8. 00	9. 00	

	Cost Center Descriptions	PLANT	LAUNDRY &	HOUSEKEEPI NG	DIETARY	NURSI NG	
		OPERATION &	LINEN SERVICE	(SQUARE FEET)	•	ADMI NI STRATI ON	
		MAI NTENANCE	(IN-FACILITY		DAYS)	(DI DECT NUDC	
		(SQUARE FEET)	DAYS)			(DI RECT NURS.	
		F 00	/ 00	7.00	0.00	HRS. )	
	CENIEDAL CEDIU CE COCE CENTEDO	5. 00	6. 00	7.00	8. 00	9. 00	
1. 00	GENERAL SERVICE COST CENTERS  CAP REL COSTS-BLDG & FLXT			I			1. 00
2.00	CAP REL COSTS-BLDG & FIXT						2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4. 00							
4. 00 5. 00	ADMINISTRATIVE & GENERAL PLANT OPERATION & MAINTENANCE	315					4. 00 5. 00
	LAUNDRY & LINEN SERVICE	315	0				6. 00
6. 00 7. 00	HOUSEKEEPING	0	0	315			7. 00
7. 00 8. 00	DI ETARY	0		315	0		7. 00 8. 00
9. 00		0		0	Ü		
	NURSI NG ADMI NI STRATI ON	0		0		0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
	MEDI CAL RECORDS	0		0		0	11. 00
	STAFF TRANSPORTATION	0		0		0	12. 00
13. 00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
	PHARMACY	0		0		0	14.00
	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15. 00
16. 00	OTHER GENERAL SERVICE	0		0		0	16. 00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		] 0			17. 00
FO 00	LEVEL OF CARE						FO 00
	HOSPI CE CONTI NUOUS HOME CARE					0	50.00
	HOSPICE ROUTINE HOME CARE				0	0	51.00
	HOSPICE INPATIENT RESPITE CARE	0 315			0		52. 00
53. 00	HOSPICE GENERAL INPATIENT CARE	315	0	315	0	0	53. 00
40.00	NONREI MBURSABLE COST CENTERS BEREAVEMENT PROGRAM			0		0	60. 00
	VOLUNTEER PROGRAM	0		0			
		0		0			61. 00
	FUNDRAISING HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	62. 00 63. 00
		0		0		0	
	PALLIATIVE CARE PROGRAM OTHER PHYSICIAN SERVICES	0		0		0	64. 00 65. 00
		0	0	0	0	"	
	RESI DENTI AL CARE	0	0	0	Ü		66. 00
	ADVERTI SI NG	0		0		0	67. 00
68. 00 69. 00	TELEHEALTH/TELEMONI TORI NG THRI FT STORE						68. 00 69. 00
		0		0		U	
	NURSING FACILITY ROOM & BOARD	_	,		^		70.00
	OTHER NONREIMBURSABLE (SPECIFY)	0		1	0	0	71. 00
	NEGATIVE COST CENTER	14 007	_	2 000	^		99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	14,007	0 000000	3, 999	0 000000		100.00
101.00	UNIT COST MULTIPLIER	44. 466667	0. 000000	12. 695238	0. 000000	0. 000000	101.00

Health Financial Systems	DEARBORN COUNTY	HOSPI TAL		In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE STATISTICAL BASIS	GENERAL SERVICE COSTS	Provider CCN: 15 Hospice CCN: 1	5-0086 15-1531	From 01/01/2016	Worksheet 0-6 Part II Date/Ti me Prepared: 3/12/2018 9:20 am

STATES	STICAL BASIS		Hospi ce CCI	N: 15-1531	To 12/31/2016	Date/Time Pre 3/12/2018 9:2	
					Hospi ce I	07 127 2010 7.2	. o a
	Cost Center Descriptions	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	PHARMACY	
	, , , , , , , , , , , , , , , , , , ,	MEDI CAL	RECORDS	TRANSPORTATI O	N SERVICE	(CHARGES)	
		SUPPLI ES	(PATIENT DAYS)		COORDI NATI ON		
		(PATIENT DAYS)	`	(MI LEAGE)	(HOURS OF		
		(		` ′	SERVICE)		
		10.00	11. 00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·		'			
1.00	CAP REL COSTS-BLDG & FLXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP					1	2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT					1	3.00
4.00	ADMINISTRATIVE & GENERAL					1	4.00
5.00	PLANT OPERATION & MAINTENANCE					1	5.00
6.00	LAUNDRY & LINEN SERVICE					1	6, 00
7. 00	HOUSEKEEPING					1	7. 00
8. 00	DI ETARY					1	8. 00
9. 00	NURSING ADMINISTRATION					1	9. 00
10.00	ROUTINE MEDICAL SUPPLIES	5, 459				1	10.00
11. 00	MEDI CAL RECORDS	0, 10,	5, 459			1	11. 00
12. 00	STAFF TRANSPORTATION		-,		0	1	12. 00
13. 00	VOLUNTEER SERVICE COORDINATION					1	13. 00
14. 00	PHARMACY					0	1
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES				ol ol	0	1
16. 00	OTHER GENERAL SERVICE					0	1
17. 00	PATIENT/RESIDENTIAL CARE SERVICES				1		17. 00
	LEVEL OF CARE			1			17.00
50.00	HOSPICE CONTINUOUS HOME CARE	0	0		0 0	0	50.00
51. 00	HOSPICE ROUTINE HOME CARE	5, 219	5, 219		o o	0	
52. 00	HOSPICE INPATIENT RESPITE CARE	0	0, =		ol ol	0	
53. 00	HOSPICE GENERAL INPATIENT CARE	240	240			0	
	NONREI MBURSABLE COST CENTERS	1				_	1
60.00	BEREAVEMENT PROGRAM				0 0	0	60.00
61.00	VOLUNTEER PROGRAM				o ol	0	61.00
62.00	FUNDRAI SI NG				o o	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS				o ol	0	63.00
64.00	PALLIATIVE CARE PROGRAM				o o	0	64.00
65.00	OTHER PHYSICIAN SERVICES				o o	0	65.00
66.00	RESI DENTI AL CARE				o ol	0	
67. 00	ADVERTI SI NG				o ol	0	
68. 00	TELEHEALTH/TELEMONI TORI NG				ol ol	0	
69.00	THRI FT STORE				o ol	0	69. 00
70. 00	NURSING FACILITY ROOM & BOARD						70. 00
71.00	OTHER NONREIMBURSABLE (SPECIFY)				o o	0	
99.00	NEGATIVE COST CENTER					1	99. 00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	O	50, 135	5	o o	0	100.00
101.00	UNIT COST MULTIPLIER	0. 000000	9. 183916	0.00000	0. 000000	0. 000000	101. 00

Health Financial	Systems		DEAR	BORN COUNTY	HOSPI TAL		In Lie	u of Form CM	S-2552-10
COST ALLOCATION STATISTICAL BASI	- HOSPI TAL-BASED S	HOSPI CE GENERAL	SERVI CE	COSTS		15-0086 15-1531	01/01/2016 12/31/2016	Worksheet C Part II Date/Time F 3/12/2018 9	repared:

						3/12/2018 9: 2	20 am
					Hospi ce I		
	Cost Center Descriptions	PHYSI CI AN	OTHER GENERAL	PATI ENT/			
		ADMI NI STRATI VE	SERVI CE	RESI DENTI AL			
		SERVI CES	(SPECI FY	CARE SERVICES			
		(PATIENT DAYS)	BASIS)	(IN-FACILITY			
			ŕ	DAYS)			
		15.00	16.00	17. 00			
	GENERAL SERVICE COST CENTERS			•			
1.00	CAP REL COSTS-BLDG & FLXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2. 00
3. 00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4.00	ADMINISTRATIVE & GENERAL						4. 00
5. 00	PLANT OPERATION & MAINTENANCE	4					5. 00
6. 00	LAUNDRY & LINEN SERVICE						6. 00
7. 00	HOUSEKEEPI NG						7. 00
8. 00	DIETARY						8. 00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11. 00	MEDI CAL RECORDS						11. 00
12. 00	STAFF TRANSPORTATION						12. 00
13. 00	VOLUNTEER SERVICE COORDINATION						13. 00
14. 00	PHARMACY						14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	5, 459					15. 00
16.00	OTHER GENERAL SERVICE		5, 459	)			16. 00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			C	)		17. 00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	)			50.00
51.00	HOSPICE ROUTINE HOME CARE	5, 219	5, 219				51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	ol c	)		52. 00
53. 00	HOSPICE GENERAL INPATIENT CARE	240	240				53. 00
	NONREI MBURSABLE COST CENTERS						1
60.00	BEREAVEMENT PROGRAM		0				60.00
61. 00	VOLUNTEER PROGRAM		0	ł			61. 00
62. 00	FUNDRAI SI NG		ĺ				62. 00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	4	0				63. 00
64. 00	PALLIATIVE CARE PROGRAM	•	0				64. 00
65. 00	OTHER PHYSICIAN SERVICES		0				65. 00
		0	0				
66.00	RESI DENTI AL CARE	0	0				66. 00
67. 00	ADVERTI SI NG		0	<u>'</u>			67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG		0	)			68. 00
69. 00	THRI FT STORE		0	ľ			69. 00
70. 00	NURSING FACILITY ROOM & BOARD						70. 00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0			71. 00
99. 00	NEGATIVE COST CENTER						99. 00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	17, 577					100. 00
101.00	UNIT COST MULTIPLIER	3. 219820	42. 827807	0.000000	)		101. 00

	Financial Systems	DEARBORN COUNT				n Lie	u of Form CMS-2	
	TONMENT OF HOSPITAL-BASED HOSPICE SHARED SERV	ICE COSTS BY	Provi der Co	CN: 15-0086	Peri od:		Worksheet 0-7	
LEVEL	OF CARE		Hospi ce CCI	N: 15-1531	From 01/01 To 12/31	/2016	Date/Time Pre 3/12/2018 9:2	pared: O am
					Hospi ce	· I		
				Charges by	/LOC (from	Provi	der Records)	
	Cost Center Descriptions	From Wkst. C, ( Part I, Col. 9 line	Ratio		HRHC		HI RC	
	T	0	1. 00	2.00	3. 00	)	4. 00	
	ANCILLARY SERVICE COST CENTERS		0 007050	ı				
1. 00 2. 00	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	66. 00 67. 00	0. 397858 0. 600281		0	0	0	2. 00
3.00	SPEECH PATHOLOGY	68. 00	0. 507207		0	0	0	
4.00	DRUGS CHARGED TO PATIENTS	73. 00	0. 466285		0	0	0	4. 00
5.00	DURABLE MEDICAL EQUIP-RENTED	96. 00						5. 00
6.00	LABORATORY	60. 00	0. 211621		0	0	0	6. 00
6. 01	BLOOD LABORATORY	60. 01	0. 000000		0	0	0	6. 01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71. 00	0. 792261		0	0	0	
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93. 00						8. 00
9.00	RADI OLOGY-THERAPEUTI C	55. 00	0. 167224		0	0	0	,
10.00		76. 00						10.00
11. 00	Totals (sum of lines 1-11)			L				11. 00
		Charges by LOC (from Provider Records)		Shared Serv	ice Costs by	y LOC		
	Cost Center Descriptions		HCHC (col 1 x	HRHC (col 1	xHLRC (col	1 x	HGIP (col. 1 x	
			col . 2)	col . 3)	col.		col. 5)	
		5. 00	6.00	7.00	8. 00		9. 00	
	ANCILLARY SERVICE COST CENTERS							
1.00	PHYSI CAL THERAPY	0	0		0	0	0	1.00
2.00	OCCUPATI ONAL THERAPY	0	0		0	o	0	2. 00
3.00	SPEECH PATHOLOGY	0	0		0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0		0	0	0	4. 00
5.00	DURABLE MEDICAL EQUIP-RENTED					l		5. 00
6.00	LABORATORY	0	0		0	0	0	6. 00
6 01	BLOOD LABORATORY	1 0	0	I	0	οl	0	6.01

0

0

0

0

6. 01

7.00

8. 00

9. 00

10.00

0 11.00

6.01

7.00

8.00

9.00

BLOOD LABORATORY

RADI OLOGY-THERAPEUTI C

11.00 Totals (sum of lines 1-11)

MEDICAL SUPPLIES CHARGED TO PATIENTS

OTHER OUTPATIENT SERVICE COST CENTER

10.00 OTHER ANCILLARY SERVICE COST CENTERS

Health Financial Systems	DEARBORN COUNTY	HOSPI TAL		In Lieu	u of Form CMS-2552-10
CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST		Provider C	CCN: 15-0086	Peri od: From 01/01/2016	Worksheet 0-8

Hospi ce CCN: 15-1531 To 12/31/2016 Date/Ti me Prepared: 3/12/2018 9: 20 am

					3/12/2018 9: 20	0 am
				Hospi ce I		
	·		TITLE XVIII	TITLE XIX	TOTAL	
			MEDI CARE	MEDI CAI D		
			1.00	2. 00	3. 00	
	HOSPICE CONTINUOUS HOME CARE		•			
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7	7, col. 6,			0	1. 00
	line 11)					
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)				0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)				0.00	3. 00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line	e 10)		0		4.00
5.00	Program cost (line 3 times line 4)			0		5. 00
	HOSPICE ROUTINE HOME CARE					
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7	7, col. 7,			642, 567	6. 00
	line 11)					
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)				5, 219	7. 00
8.00	Total average cost per diem (line 6 divided by line 7)				123. 12	8. 00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, lin	ne 11)	4, 54	3 104		9. 00
10.00	Program cost (line 8 times line 9)		559, 95	12, 804		10. 00
	HOSPICE INPATIENT RESPITE CARE					
11. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7	7, col. 8,			0	11. 00
	line 11)					
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)					12. 00
13.00	Total average cost per diem (line 11 divided by line 12)				0. 00	13. 00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, lin	ne 12)		0		14. 00
15.00	Program cost (line 13 times line 14)			0		15. 00
	HOSPICE GENERAL INPATIENT CARE					
16.00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7	7, col. 9,			55, 566	16. 00
	line 11)					
17. 00	Total unduplicated days (Wkst. S-9, col. 4, line 13)					17. 00
18. 00	Total average cost per diem (line 16 divided by line 17)				231. 53	
19. 00	Unduplicated program days (Wkst. S-9, col. as appropriate, lin	ne 13)	22			19. 00
20.00	Program cost (line 18 times line 19)		52, 32	2, 315		20. 00
	TOTAL HOSPICE CARE					
21. 00	Total cost (sum of line 1 + line 6 + line 11 + line 16)				698, 133	
22. 00	Total unduplicated days (Wkst. S-9, col. 4, line 14)				5, 459	
23. 00	Average cost per diem (line 21 divided by line 22)				127. 89	23. 00

Heal th	Financial Systems DEARBORN CO	DUNTY HOSPITAL	In Lie	u of Form CMS-2	2552-10
	ATION OF CAPITAL PAYMENT	Provi der CCN: 15-0086	Peri od: From 01/01/2016 To 12/31/2016	Worksheet L Parts I-III Date/Time Prep 3/12/2018 9:20	pared:
		Title XVIII	Hospi tal	PPS	
	DART I FULLY PROCEETIVE METUOR			1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
1. 00	CAPITAL FEDERAL AMOUNT Capital DRG other than outlier			956, 422	1.00
1. 01	Model 4 BPCI Capital DRG other than outlier			750, 422	1. 01
2.00	Capital DRG outlier payments			15. 200	
2. 01	Model 4 BPCI Capital DRG outlier payments	0	2. 01		
3.00	Total inpatient days divided by number of days in the cos	38. 14	3. 00		
4.00	Number of interns & residents (see instructions)	0.00	4. 00		
5.00	Indirect medical education percentage (see instructions)	0. 00			
6. 00	Indirect medical education adjustment (multiply line 5 by 1.01) (see instructions)	y the sum of lines 1 and 1.01	, columns 1 and	0	6. 00
7. 00	Percentage of SSI recipient patient days to Medicare Part 30) (see instructions)	t A patient days (Worksheet E	, part A line	0.00	7. 00
8.00	Percentage of Medicaid patient days to total days (see in	nstructions)		0.00	8. 00
9.00	Sum of lines 7 and 8	0. 00			
10.00	Allowable disproportionate share percentage (see instruct	0.00			
11.00	Disproporti onate share adjustment (see instructions)	071 (22	11.00		
12.00	Total prospective capital payments (see instructions)			971, 622	12. 00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST			11.00	
1.00	Program inpatient routine capital cost (see instructions)	)		0	1.00
2.00	Program inpatient ancillary capital cost (see instruction	ns)		0	2. 00
3.00	Total inpatient program capital cost (line 1 plus line 2)	)		0	3. 00
4.00	Capital cost payment factor (see instructions)			0	4. 00
5. 00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		1		
1.00	Program inpatient capital costs (see instructions)			0	1. 00 2. 00
2. 00 3. 00	Program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2)			0	3.00
4. 00	Applicable exception percentage (see instructions)	)		0.00	
5. 00	Capital cost for comparison to payments (line 3 x line 4)	)		0.00	5.00
6.00	Percentage adjustment for extraordinary circumstances (se			0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordi	inary circumstances (line 2 x	line 6)	0	7. 00
8.00	Capital minimum payment level (line 5 plus line 7)			0	8. 00
9.00	Current year capital payments (from Part I, line 12, as a			0	9. 00
10.00	Current year comparison of capital minimum payment level			0	10.00
11. 00	Carryover of accumulated capital minimum payment level on	ver capital payment (from pri	or year	0	11. 00
12. 00	Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capita	al navments (line 10 nlue lin	e 11)	0	12. 00
13. 00	Current year exception payment (if line 12 is positive,			0	13.00
14. 00	Carryover of accumulated capital minimum payment level of			0	14. 00
· · · ·	(if line 12 is negative, enter the amount on this line)	1 11 113 1 11 11 11	3 1	-	
15. 00				0	15. 00
	Current year operating and capital costs (see instruction Current year exception offset amount (see instructions)	ns)		0	16. 00 17. 00