## PART II - CERTIFICATION

(4) Reopened(5) Amended

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

## CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by DAVIESS COMMUNITY HOSPITAL (150061) for the cost reporting period beginning 01/01/2014 and ending 12/31/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Si gned)				
	Offi cer	or	Admi ni strator	of Provider(s)
Title				
Date				

		Title	XVIII			
Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
	1. 00	2. 00	3. 00	4. 00	5. 00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospi tal	0	-16, 546	145, 806	-63, 676	0	1.00
2.00 Subprovider - IPF	0	26, 328	0		0	2.00
3.00 Subprovider - IRF	0	-6, 012	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
10. 00 DCHMC I	0		-12, 507		0	10.00
10. 01 NDMC/ODON II	0		56, 620		0	10. 01
10.02 QUICK CARE III	0		16, 778		0	10. 02
10. 04 PEDIATRICS V	0		0		0	10.04
10.05 DAVIESS MARTIN VI	0		42, 348		0	10.05
200. 00 Total	0	3, 770				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.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 150061 Peri od: Worksheet S-2 From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/21/2015 12:29 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: 1.00 Street: 1314 E. WALNUT STREET P0 Box: 760 1.00 Zi p Code: 47501 2.00 City: WASHINGTON State: IN County: DAVIESS 2.00 Component Name CCN CBSA Provi der Date Payment System (P, Certi fi ed T, 0, or N) Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 DAVIESS COMMUNITY 150061 99915 07/01/1966 Ν Р 0 3.00 1 HOSPI TAI Subprovi der - IPF 99915 4.00 DCH - PSYCH 15S061 4 01/01/2003 Ν Р 0 4.00 Subprovi der - IRF DCH - REHAB 15T061 99915 5 01/01/2000 Ρ 5.00 0 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF DAVIESS COMMUNITY 15U061 99915 11/10/1999 Р N N 7.00 7 00 HOSPI TAI 8.00 Swing Beds - NF 8.00 9.00 Hospital -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 Hospi tal -Based OLTC 11.00 11.00 12.00 Hospital -Based HHA WHITE RIVER COMMUNITY 157189 99915 11/18/1987 Ρ Ν 12.00 HEALTH SVCS Separately Certified ASC 13.00 13 00 14.00 Hospi tal -Based Hospi ce HELPING HEART HOSPICE 151553 99915 07/11/1996 14.00 15.00 Hospital -Based Health Clinic - RHC DAVIESS COMMUNITY 158500 99915 12/17/2003 Ν 0 Ν 15.00 HOSPITAL MC Hospital-Based Health Clinic - RHC NORTH DAVIESS MEDICAL 153999 99915 Ν 15.01 15.01 12/17/2003 Ν 0 CENTER PETERSBURG MEDICAL 158501 99915 15.02 15.02 Hospital-Based Health Clinic - RHC 03/30/2004 N 0 N  $\Pi\Pi$ CLINIC Hospital-Based Health Clinic - RHC VGRAND AVENUE PEDLATRICS 99915 158503 01/27/2005 0 Ν 15.04 Hospital-Based Health Clinic - RHC 15.05 MARTIN MEDICAL CLINIC 158506 99915 10/31/2006 Ν 0 Ν 15.05 Hospital -Based Health Clinic - FQHC 16.00 Hospital-Based (CMHC) I 17.00 17.00 17. 10 Hospital -Based (CORF) I 17.10 18.00 Renal Dialysis 18 00 19.00 Other 19.00 From: To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2014 12/31/2014 20.00 21.00 Type of Control (see instructions) 21.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate N 22.00 22.00 share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y' for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting 22.01 period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Is this a newly merged hospital that requires final uncompensated care payments to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1. "Y" for ves or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result N Ν 22.03 of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 2 N 23.00 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

IOSPI T	Financial Systems DAVIESS AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	COMMUNITY ATA		CCN: 150061	Per	i od:		Worksl	orm CMS- heet S-2	
					Fro To	om 01/0 12/3	1/2014 1/2014	Part Date/ 5/21/2	l Time Pre 2015 12:	pared: 29 pm
		In-State				Out-of Medicaid State HMO days			Other .	
		Medicaid paid days	Medicaid eligible	State Medicaid		ate i cai d	HMO da	ys   Me	edi cai d days	
			unpai d	pai d days	eli	gible				
		1 00	days	2.22	<u> </u>	oai d			,	1
4. 00	If this provider is an IPPS hospital, enter the	1.00	2. 00	3.00		. 00 5	5. 00	945	6. 00	24.00
	in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2,		10			0		0	·	25. 00
	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.									
	nwo paru and erryrbre but unparu days in corumn 5.				L	Jrban/R	Rural S	Date c	of Geogr	
						1. (	00	2	. 00	0, 00
6. 00	Enter your standard geographic classification (not w cost reporting period. Enter "1" for urban or "2" fo		at the be	ginning of	ιne		2			26.00
7. 00	Enter your standard geographic classification (not w reporting period. Enter in column 1, "1" for urban o enter the effective date of the geographic reclassif	age) status r "2" for r	ural. If a	d of the co pplicable,	ost		2			27.00
5. 00	00   If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.								35.00	
					H	Begi ni			li ng: . 00	-
5. 00	Enter applicable beginning and ending dates of SCH s		cript line	36 for num	nber					36.00
7. 00	of periods in excess of one and enter subsequent dat If this is a Medicare dependent hospital (MDH), ente in effect in the cost reporting period.		r of perio	ds MDH stat	tus		0			37.00
8. 00	Enter applicable beginning and ending dates of MDH s of periods in excess of one and enter subsequent dat		cript line	38 for num	mber				, (h)	38.00
					-	Y/ 1. (			<u>//N</u> . 00	-
9. 00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i or "N" for no. Does the facility meet the mileage re	i)? Enter i quirements	n column 1 in accorda	"Y" for ye nce with 42	es 2	Y			Y	39.00
0. 00	CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes Is this hospital subject to the HAC program reductio "N" for no in column 1, for discharges prior to Octo no in column 2, for discharges on or after October 1	n adjustmen ber 1. Ente	t? Enter " r "Y" for	Y" for yes	or	N		N		40.00
							1. 00	2. 00		-
	Prospective Payment System (PPS)-Capital						1.00	2.00	, 3.00	
5. 00	Does this facility qualify and receive Capital payme with 42 CFR Section §412.320? (see instructions)	nt for disp	roporti ona	te share in	acco	ordance	N	N	N	45.00
. 00	Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.	•		,			N	N	N	46.00
	ls this a new hospital under 42 CFR §412.300 PPS cap Is the facility electing full federal capital paymen					D.	N N	N N	N N	47. 00 48. 00
5. 00	Teaching Hospitals Is this a hospital involved in training residents in	approved G	ME program:	s? Enter "	'Y" fo	or ves	l N			56.00
	or "N" for no. If line 56 is yes, is this the first cost reporting		. 0			,	N			57.00
00	GME programs trained at this facility? Enter "Y" fo	r yes or "N th of this	" for no i cost repor	n column 1. ting period	lfo d? Er	column nter "Y	1			37.00
7. 00	is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is " "N" complete Wkst D. Parts III & IV and D-2. Pt. I									1
		l, if appli bursement f	cabl e.		ces as	5	N			58.00

Health Financial Systems DAVIESS	COMMUN	ITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	F			Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Pre 5/21/2015 12:	pared:
	Y/N	IME	Direct GME	I ME	Direct GME	27 piii
	1. 00	2. 00	3. 00	4. 00	5. 00	
<ul> <li>61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)</li> <li>61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports</li> </ul>	N	0.00	0.0	0. 00	0.00	61.00
ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care		0.00	0. (	00		61. 02
FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.0	00		61.03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.0	00		61. 04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0. 00	0.0	00		61.05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00				61.06
	Pro	ogram Name	Program Code	IME FTE Count	Unweighted Direct GME FTE Count	
61.10 Of the FTEs in line 61.05, specify each new program		1. 00	2. 00	3. 00	4.00	61. 10
specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.  61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.				0. 00		61. 20
					1.00	
ACA Provisions Affecting the Health Resources and Se 62.00 Enter the number of FTE residents that your hospital	rvi ces trai ne	Administrationed in this cost	(HRSA) reporting pe	riod for which	0.00	62.00
your hospital received HRSA PCRE funding (see instruction 62.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC projects.)	ctions) a Teach gram. (	ning Health Cen (see instructio	ter (THC) int		0.00	62. 01
Teaching Hospitals that Claim Residents in Nonprovid 63.00 Has your facility trained residents in nonprovider so "Y" for yes or "N" for no in column 1. If yes, comple	ettings	during this c			N	63. 00
			Unwei ghted FTEs Nonprovi der	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	

	Nonprovi der	Hospi tai	COL. 2))	
	Si te			
	1.00	2. 00	3. 00	
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings	This base year	is your cost	reporting	
period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00 Enter in column 1, if line 63 is yes, or your facility trained resident	s 0.00	0.00	0. 000000	64.00
in the base year period, the number of unweighted non-primary care				
resident 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 rati	o			
of (column 1 divided by (column 1 + column 2)). (see instructions)				

	ar viaca by (coraiiir 5 i coraiiir								
	4)). (see instructions)								
						1.00	2.00	3.00	
	Inpatient Psychiatric Facility F	PPS							
70.00	Is this facility an Inpatient Ps	provi der?	Y			70.00			
	Enter "Y" for yes or "N" for no	).							
71.00	If line 70 yes: Column 1: Did th	most	N	N	0	71.00			
	recent cost report filed on or b	no. (see							
	42 CFR 412.424(d)(1)(iii)(c)) Co	hi ng							
	program in accordance with 42 CF								
	Column 3: If column 2 is Y, ente	er 1, 2, or 3, in colu	umn 3. (see instructi	ons) If this c	ost				
	reporting period covers the begi	nning of the fourth y	year, enter 4 in colu	mn 3, or if the	e fifth				
	or subsequent academic years of								
	instructions) For cost reporting	ı periods beginning om	n or after October 1,	2012, if this	cost				
	reporting period covers the begi			emic year of t	he new				
	teaching program in existence, e	enter 6 in column 3.	(see instructions)						
	Inpatient Rehabilitation Facilit								
	Is this facility an Inpatient Re		y (IRF), or does it c	ontain an IRF		Y			75.00
	subprovider? Enter "Y" for yes	and "N" for no.							

Health Financial Systems DAVIESS COMMUN	ITY HOSPITAL		In Lie	eu of Form CMS	S-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA			Peri od: From 01/01/2014	Worksheet S	
			To 12/31/2014	1 Date/Time Pi	
				5/21/2015 1:	2: 29 pm
76.00 If line 75 yes: Column 1: Did the facility have an approved	CME tooching	program in th	1.0		
recent cost reporting period ending on or before November 1 no. Column 2: Did this facility train residents in a new te CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no 1, 2, or 3, in column 3. (see instructions) If this cost re of the fourth year, enter 4 in column 3, or if the fifth or teaching program in existence, enter 5. (see instructions) on or after October 1, 2012, if this cost reporting period any subsequent academic year of the new teaching program in instructions)	5, 2004? Enter aching program c Column 3: In porting period subsequent ac For cost repor covers the beg	"Y" for yes in accordance column 2 is dovers the baddenic years ting periods ginning of the	or "N" for ce with 42 Y, enter beginning of the new beginning e sixth or	N O	76. 00
				1. 00	
Long Term Care Hospital PPS 80.00 Is this along term care hospital (LTCH)? Enter "Y" for ye	s and "N" for	no		N	80.00
80.00 Is this a long term care hospital (LTCH)? Enter "Y" for ye 81.00 Is this a LTCH co-located within another hospital for part "Y" for yes and "N" for no.  TEFRA Providers	ng period? Entei	N N	81.00		
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 (exclud §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				N	85. 00 86. 00
72 202 100			V 1. 00	XI X 2. 00	
Title V and XIX Services	-1 1	\/			00.00
90.00 Does this facility have title V and/or XIX inpatient hospit yes or "N" for no in the applicable column.			N	Y	90.00
91.00 Is this hospital reimbursed for title V and/or XIX through full or in part? Enter "Y" for yes or "N" for no in the app			N	N	91.00
92.00 Are title XIX NF patients occupying title XVIII SNF beds (dinstructions) Enter "Y" for yes or "N" for no in the applic		tion)? (see		Y	92.00
93.00 Does this facility operate an ICF/MR facility for purposes		d XIX? Enter	N	N	93. 00
"Y" for yes or "N" for no in the applicable column. 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes,	and "N" for m	no in the	N	N	94.00
applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the ap 96.00 Does title V or XIX reduce operating cost? Enter "Y" for ye applicable column.			O. O	O 0. 0	95. 00 96. 00
97.00 If line 96 is "Y", enter the reduction percentage in the ap	plicable colur	mn.	0.0	0. 0	97.00
Rural Providers  105.00 Does this hospital qualify as a Critical Access Hospital (C 106.00 If this facility qualifies as a CAH, has it elected the all		thod of paymer	N nt N		105.00 106.00
for outpatient services? (see instructions)  107.00 Column 1: If this facility qualifies as a CAH, is it eligi for I &R training programs? Enter "Y" for yes or "N" for n instructions) If yes, the GME elimination would not be on W the program would be cost reimbursed. If yes complete Wkst. this facility is a CAH, do I&Rs in an approved medical educ CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or instructions)	o in column 1. /kst. B, Pt. I, D-2, Pt. II. ation program	(see col. 25 and Column 2: I1 train in the			107.00
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 sch	edul e? See 42	2 N		108. 00
John Section 3412. 113(c). Enter 1 101 yes of N 101 ho.	Physi cal	Occupati ona	<del>-</del>	Respiratory	/
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	1. 00 N	2. 00 N	3. 00 N	4.00 N	109.00
				1. 00	
110.00 Did this hospital participate in the Rural Community Hospit the current cost reporting period? Enter "Y" for yes or "N"		on project (4	110A Demo)for	N	110.00
the current cost reporting perrous Litter 1 for yes of N	101 110.		1. (	00 2.00 3.00	0
Miscellaneous Cost Reporting Information  115.00 Is this an all-inclusive rate provider? Enter "Y" for yes of is yes, enter the method used (A, B, or E only) in column 2 and it is in the information and it is in the information and it is provided by the information and it is a second in the information and it is in the information and it is a second in the information and it is in the information and it is information.	. If column 2 int for long to	is "E", enter erm care (incl	in column udes	0	115. 00
Pub. 15-1, §2208.1.  116.00 Is this facility classified as a referral center? Enter "Y"  117.00 Is this facility legally-required to carry malpractice insu no.			"N" for Y		116. 00 117. 00
118.00 Is the malpractice insurance a claims-made or occurrence po claim-made. Enter 2 if the policy is occurrence.	licy? Enter 1	if the policy	y is 2		118. 00

Health Financial Systems DAVIESS COMMUN	ITY HOSPITAL		In Lieu	ı of Form CMS	S-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der	F	Period: From 01/01/2014 To 12/31/2014	Worksheet S- Part I Date/Time Pi 5/21/2015 12	repared:
		Premi ums	Losses	Insurance	2. 29 piii
		1.00	2.00	2.00	
118.01 List amounts of malpractice premiums and paid losses:		1. 00 214, 95	2. 00 3 0	3. 00	0118.01
			1. 00	2. 00	
118.02 Are mal practice premiums and paid losses reported in a cost			N N	2.00	118. 02
Administrative and General? If yes, submit supporting sche and amounts contained therein.	edule listing o	cost centers			
119.00 DO NOT USE THIS LINE					119. 00
120.00 s this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i			N	Υ	120. 00
"N" for no. Is this a rural hospital with < 100 beds that o	qualifies for t	the Outpatient			
Hold Harmless provision in ACA §3121 and applicable amendme Enter in column 2, "Y" for yes or "N" for no.	ents? (see inst	tructions)			
121.00 Did this facility incur and report costs for high cost impl	antable device	es charged to	Y		121. 00
patients? Enter "Y" for yes or "N" for no. Transplant Center Information					
125.00 Does this facility operate a transplant center? Enter "Y" f	or yes and "N'	for no. If	N		125. 00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 f this is a Medicare certified kidney transplant center, e	enter the certi	fication date			126. 00
in column 1 and termination date, if applicable, in column 127.00 of this is a Medicare certified heart transplant center, er	2.	fication data			127. 00
in column 1 and termination date, if applicable, in column	2.				
128.00 If this is a Medicare certified liver transplant center, er in column 1 and termination date, if applicable, in column		ication date			128. 00
129.00 If this is a Medicare certified lung transplant center, ent		cation date i	n		129. 00
column 1 and termination date, if applicable, in column 2. 130.00 on this is a Medicare certified pancreas transplant center,	enter the cer	rti fi cati on			130. 00
date in column 1 and termination date, if applicable, in co	olumn 2.				
131.00 If this is a Medicare certified intestinal transplant center date in column 1 and termination date, if applicable, in co		certification			131. 00
132.00 If this is a Medicare certified islet transplant center, er in column 1 and termination date, if applicable, in column		ication date			132. 00
133.00 If this is a Medicare certified other transplant center, er	nter the certif	ication date			133. 00
in column 1 and termination date, if applicable, in column 134.00 of this is an organ procurement organization (OPO), enter t		in column 1			134.00
and termination date, if applicable, in column 2.					
All Providers  140.00 Are there any related organization or home office costs as	defined in CMS	S Pub. 15-1,	N		140. 00
chapter 10? Enter "Y" for yes or "N" for no in column 1. If					
are claimed, enter in column 2 the home office chain number  1.00 2.0	00		3. 00		
If this facility is part of a chain organization, enter on office and enter the home office contractor name and contra		ough 143 the n	ame and address	of the home	
141.00 Name: Contractor's Name:	actor number.	Contracto	r's Number:		141.00
142.00 Street: P0 Box: 143.00 Ci ty: State:		Zi p Code:			142. 00 143. 00
1.0.00 0.10		21 p			110100
144.00 Are provider based physicians' costs included in Worksheet	A?			1. 00 Y	144. 00
145.00 If costs for renal services are claimed on Worksheet A, lir		costs for inpa	atient services	N	145. 00
only? Enter "Y" for yes or "N" for no.					
146.00 Has the cost allocation methodology changed from the previous	waly filed oo	t ranant?	1. 00 N	2. 00	144,00
Enter "Y" for yes or "N" for no in column 1. (See CMS Pub.					146. 00
the approval date (mm/dd/yyyy) in column 2. 147.00Was there a change in the statistical basis? Enter "Y" for	ves or "N" for	r no	N		147. 00
148.00 Was there a change in the order of allocation? Enter "Y" for	or yes or "N" f	for no.	N		148. 00
149.00 Was there a change to the simplified cost finding method? E	Enter "Y" for y	es or "N" for	N		149. 00
	Part A	Part B	Title V	Title XIX	
Does this facility contain a provider that qualifies for a	1.00 n exemption fro	2.00 om the applica	3.00 tion of the low	4.00 er of costs	
or charges? Enter "Y" for yes or "N" for no for each compon				3. 13)	155. 00
155.00 Hospital 156.00 Subprovider - IPF	N N	N N	N N	N N	156. 00
157. 00 Subprovi der - IRF	N	N	N	N	157. 00 158. 00
158. 00 SUBPROVI DER 159. 00 SNF	N	N	N	N	158.00
160.00HOME HEALTH AGENCY 161.00CMHC	N	N	N N	N	160. 00 161. 00
161. 10 CORF		N N	N N	N N	161. 00
			·		

Health Financial Systems	DAVI ESS C	OMMUNITY HOSPITAL			In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA  Provider CCN: 150061   Period: From 01/01/20' To 12/31/20'					Worksheet S- Part I Date/Time Pr 5/21/2015 12	epared:
						1. 00	
Mul ti campus		1.00					
165.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.	ampus hospital that h	nas one or more campu	uses in d	ifferent C	BSAs?	N	165. 00
	Name	County	State	Zip Code	CBSA	FTE/Campus	
	0	1. 00	2.00	3. 00	4. 00	5. 00	
166.00 ffline 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0. 0	0 166. 00
		1. 00					
Health Information Technology (HI							
167.00 Is this provider a meaningful use						Y	167. 00
168.00 If this provider is a CAH (line 1 reasonable cost incurred for the			e 16/ IS	"Y"), ente	r tne		0168.00
169.00 If this provider is a meaningful transition factor. (see instruction	user (line 167 is "Y"		(line 105	is "N"),	enter the	0. 5	60169.00
					gi nni ng	Endi ng	
					1. 00	2. 00	
170.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)	beginning date and en	nding date for the re	eporti ng	01/	01/2014	12/31/2014	170. 00
						1. 00	_
171.00  f   line 167 is "Y", does this pro   Medicare cost plans reported on W   (see instructions)						N	171. 00

Health Financial Systems	DAVIESS COMMUNITY HOSE				eu of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	ESTI ONNAI RE Pro	ovi der	F	eriod: rom 01/01/2014 o 12/31/2014		_
				) (A)	5/21/2015 12	
				Y/N 1. 00	Date	+
General Instruction: Enter Y for all YES res	nonses Enter N for al	I NO re	enoneae Enta	rall dates in	2.00	
mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	ponses. Enter N 101 at	I NO I E	esponses. Ente	all dates ill	trie	
Provider Organization and Operation						
1.00 Has the provider changed ownership immediate	ely prior to the beginn	ing of	the cost	N		1.00
reporting period? If yes, enter the date of			instructions)			
			Y/N	Date	V/I	
2 00	the Mediene December	1.6	1.00	2. 00	3. 00	2 00
2.00 Has the provider terminated participation in yes, enter in column 2 the date of terminati voluntary or "I" for involuntary.			N			2.00
3.00 Is the provider involved in business transaction contracts, with individuals or entities (e.g. or medical supply companies) that are related officers, medical staff, management personness.	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar					3.00
	family and other simil	ar				
relationships? (see instructions)			Y/N	Type	Date	
			1.00	2. 00	3. 00	
Financial Data and Reports			11.00	2.00	0.00	
4.00 Column 1: Were the financial statements pre Accountant? Column 2: If yes, enter "A" for or "R" for Reviewed. Submit complete copy or	Audited, "C" for Comp enter date available	iled,	Y	А		4.00
5.00 column 3. (see instructions) If no, see inst those on the filed financial statements? If	revenues different fr		N			5. 00
those on the fired financial statements? If	yes, submit reconcilla	tion.		Y/N	Legal Oper.	
				1. 00	2. 00	
Approved Educational Activities					2.00	
6.00 Column 1: Are costs claimed for nursing sch the legal operator of the program?	nool? Column 2: If yes	, is th	ne provider is	N		6.00
7.00 Are costs claimed for Allied Health Programs 8.00 Were nursing school and/or allied health pro	ograms approved and/or		d during the	N N		7. 00 8. 00
cost reporting period? If yes, see instructi 9.00 Are costs claimed for Intern-Resident progra		ent cos	st report? If	N		9. 00
yes, see instructions.  10.00 Was an Intern-Resident program been initiate period? If yes, see instructions.	ed or renewed in the cu	rrent d	cost reporting	N		10.00
11.00 Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see		an App	oroved	N		11.00
					Y/N	
Bad Debts					1.00	
12.00 Is the provider seeking reimbursement for ba 13.00 If line 12 is yes, did the provider's bad de				st reporting	Y N	12. 00 13. 00
period? If yes, submit copy.  14.00 If line 12 is yes, were patient deductibles	and/or co-payments wai	ved? I1	fyes, see ins	tructi ons.	N	14.00
Bed Complement  15.00 Did total beds available change from the pri	or cost reporting peri	od2 Lf	vas saa inst	ructions	N	15. 00
15.00   Drd total beds available change from the pri	Cost reporting peri	ou: II		t A	Part B	13.00
	Description		Y/N	Date	Y/N	
	0		1.00	2. 00	3. 00	
PS&R Data				1		4
16.00 Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see			N		N	16. 00
instructions)  17.00 Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is	5		Y	03/18/2015	Y	17. 00
yes, enter the paid-through date in columns 2 and 4. (see instructions)  18.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional			N		N	18. 00
claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.  19.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of			N		N	19. 00
other PS&R Report information? If yes, see instructions.  20.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe			N		N	20. 00
made to PS&R Report data for Other? Describe the other adjustments:						

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUES	TI ONNAI RE	Provi der	CCN: 150061	Peri od: From 01/01/2014 To 12/31/2014	Date/Time F 5/21/2015	Prepared:
				art A	Part B	
	Description	on	Y/N	Date	Y/N	
21.00 Was the cost report prepared only using the	0		1. 00 N	2. 00	3. 00 N	21.00
provider's records? If yes, see			IN IN		IN	21.00
i nstructi ons.						
					1. 00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITA	ALS ONLY (EXCEPT (	CHILDRENS I	HOSPITALS)		1.00	
Capital Related Cost	NES ONET (EXCELLE	JIII EDIKENS 1	10311 TALS)			
22.00 Have assets been relifed for Medicare purposes	s? If yes, see in	structi ons				22. 00
23.00 Have changes occurred in the Medicare deprecia	ation expense due	to apprais	sals made du	ring the cost		23. 00
reporting period? If yes, see instructions.						04.00
24.00 Were new leases and/or amendments to existing If yes, see instructions	reases entered r	nto during	this cost re	eporting period?		24. 00
25.00 Have there been new capitalized leases entered	d into during the	cost repo	rting period´	? If yes, see		25. 00
i nstructi ons.	Ü		0 .			
26.00 Were assets subject to Sec. 2314 of DEFRA acqui	ired during the c	ost report	ing period?	lf yes, see		26. 00
instructions. 27.00 Has the provider's capitalization policy chanc	and during the co	st roporti	na norioda I:	Evoc cubmit		27. 00
copy.	ged durring the co	st reportir	ing perious i	i yes, subiii t		27.00
Interest Expense						
28.00 Were new Loans, mortgage agreements or Letters	s of credit enter	ed into du	ring the cos	t reporting		28. 00
period? If yes, see instructions.				1		
29.00 Did the provider have a funded depreciation action action account? If			ebt Service I	Reserve Fund)		29. 00
30.00 Has existing debt been replaced prior to its			debt? If ve	s. see		30.00
i nstructi ons.		,		-,		
31.00 Has debt been recalled before scheduled maturi	ity without issua	nce of new	debt? If yes	s, see		31.00
instructions.						
Purchased Services 32.00 Have changes or new agreements occurred in pa	tient care servic	es furnish	ed through co	ontractual		32.00
arrangements with suppliers of services? If ye			ca tili oagii ci	onti actual		32.00
33.00 If line 32 is yes, were the requirements of So			ng to competi	itive bidding? If	-	33. 00
no, see instructions.						
Provider-Based Physicians  34.00 Are services furnished at the provider facili	ty under an arran	naman+ wi+	h provider b	asad physicians?		34.00
If yes, see instructions.	ty under an arran	gement with	ii provider-ba	aseu physicians:		34.00
35.00 If line 34 is yes, were there new agreements	or amended existi	ng agreeme	nts with the	provi der-based		35.00
physicians during the cost reporting period?	lf yes, see instr	uctions.			_	
				Y/N	Date	
Home Office Costs				1. 00	2. 00	
36.00 Were home office costs claimed on the cost re	port?					36.00
37.00 If line 36 is yes, has a home office cost sta		red by the	home office	?		37. 00
If yes, see instructions.						
38.00 If line 36 is yes, was the fiscal year end of				f		38. 00
the provider? If yes, enter in column 2 the fig. 39.00 If line 36 is yes, did the provider render set				s		39.00
, , , , , , , , , , , , , , , , , , ,	1 V. CC3 10 UTHEL C	iai ii compoi	nonts: IT yes	J,		37.00
see instructions.						
40.00   If line 36 is yes, did the provider render sellinstructions.	rvices to the hom	e office?	If yes, see			40.00

1.00

NI CHOLAS

BKD, LLP

317-383-4000

2.00

41.00

42.00

43.00

EI CHELMAN

NEI CHELMAN@BKD. COM

preparer.

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, respectively.

42.00 Enter the employer/company name of the cost report

43.00 Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.

Heal th	Financial Systems	DAVI E	SS COMMUN	ITY HOSPI	TAL		In Lieu	of Form CMS-	2552-10
HOSPI 1	AL AND HOSPITAL HEALTH CARE REIMBURSEMEN	T QUESTION	NAI RE	Prov	ider CCN: 150061	From	01/01/2014	Worksheet S-2 Part II Date/Time Pre 5/21/2015 12:	epared:
			art B Date		·				
	PS&R Data		4. 00						
	Was the cost report prepared using the Report only? If either column 1 or 3 is								16.00

		Part B			
		Date			
		4. 00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R				16. 00
	Report only? If either column 1 or 3 is yes,				
	enter the paid-through date of the PS&R				
	Report used in columns 2 and 4 (see				
	instructions)				
17.00	Was the cost report prepared using the PS&R	03/18/2015			17.00
	Report for totals and the provider's records				
	for allocation? If either column 1 or 3 is				
	yes, enter the paid-through date in columns				
	2 and 4. (see instructions)				
18.00	If line 16 or 17 is yes, were adjustments				18.00
	made to PS&R Report data for additional				
	claims that have been billed but are not				
	included on the PS&R Report used to file				
	this cost report? If yes, see instructions.				
19. 00					19.00
	made to PS&R Report data for corrections of				
	other PS&R Report information? If yes, see				
	i nstructi ons.				
20. 00	, , , , , , , , , , , , , , , , , , ,				20.00
	made to PS&R Report data for Other? Describe				
	the other adjustments:				
21. 00	Was the cost report prepared only using the				21.00
	provider's records? If yes, see				
	i nstructi ons.				
			2.00		
	Cost Danort Dranger Contact Information		3.00		
41. 00	Cost Report Preparer Contact Information Enter the first name, last name and the title	o/nocition	MANAGER		41.00
41.00	held by the cost report preparer in columns		WAINAGER		41.00
	respectively.	ı, z, anu s,			
42. 00	Enter the employer/company name of the cost	renort			42.00
42.00	preparer.	i epoi t			42.00
43. 00	Enter the telephone number and email address	of the cost			43.00
45.00	report preparer in columns 1 and 2, respecti				75.00
	1. opolic pi oparor ili coramino i ana 2, respecti	· · · · · ·	1	I .	1

| Peri od: | Worksheet S-3 | From 01/01/2014 | Part | To 12/31/2014 | Date/Time Prepared: Health Financial Systems DAVIESS OF HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provi der CCN: 150061

					То	12/31/2014	Date/Ti me 5/21/2015		
							I/P Days .	/	•
							0/P Visits	/	
	Component	Wankahaat A	No of Dod	Dod David		CALL House	Trips Title V		
	Component	Worksheet A Line Number	No. of Beds	Bed Days Available		CAH Hours	ii tie v		
		1.00	2. 00	3.00		4. 00	5. 00		
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00		37 13, 5	505	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)							ŀ	2.00
3. 00 4. 00	HMO IPF Subprovider HMO IRF Subprovider							ŀ	3. 00 4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF							o	5.00
6. 00	Hospital Adults & Peds. Swing Bed NF							ő	6. 00
7. 00	Total Adults and Peds. (exclude observation			37 13, 5	505	0. 00		ő	7. 00
	beds) (see instructions)								
8.00	INTENSIVE CARE UNIT	31.00		5 1, 8	325	0. 00		0	8.00
9. 00	CORONARY CARE UNIT								9.00
10. 00	BURN INTENSIVE CARE UNIT								10.00
11.00	SURGI CAL INTENSI VE CARE UNI T							l	11.00
12.00	OTHER SPECIAL CARE (SPECIFY)	42.00							12.00
13. 00 14. 00	NURSERY	43. 00		42 15, 3	20	0. 00		0	13. 00 14. 00
15. 00	Total (see instructions) CAH visits			42 15, 3	530	0.00		0	15. 00
16. 00	SUBPROVI DER - I PF	40.00		20 7, 3	300			0	16.00
17. 00	SUBPROVIDER - I RF	41.00		12 4, 3				ő	17. 00
18. 00	SUBPROVI DER								18.00
19.00	SKILLED NURSING FACILITY								19.00
20.00	NURSING FACILITY								20.00
21. 00	OTHER LONG TERM CARE								21.00
22. 00	HOME HEALTH AGENCY	101. 00						0	22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	444 00			_			l	23.00
24. 00 24. 10	HOSPICE	116. 00 30. 00		0	0				24. 00 24. 10
25. 00	HOSPICE (non-distinct part) CMHC - CMHC	30.00							25. 00
25. 10	CMHC - CORF	99. 10						0	25. 10
26. 00	DCHMC	88.00						ő	26.00
26. 01	NDMC/ODON	88. 01						ō	26. 01
26. 02	QUICK CARE	88. 02						0	26.02
26. 04	PEDI ATRI CS	88. 04						0	26.04
26. 05	DAVI ESS MARTIN	88. 05						0	26.05
26. 25	FEDERALLY QUALIFIED HEALTH CENTER							l	26. 25
27. 00	Total (sum of lines 14-26)			74					27. 00
28. 00 29. 00	Observation Bed Days Ambulance Trips							0	28. 00 29. 00
30. 00	Employee discount days (see instruction)							ŀ	30.00
31. 00	Employee discount days (see Fristraction)								31.00
32. 00	Labor & delivery days (see instructions)			О	О				32.00
32. 01	Total ancillary labor & delivery room								32. 01
	outpatient days (see instructions)								
33. 00	LTCH non-covered days			1					33.00

Health Financial Systems DAVIESS OF HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA In Lieu of Form CMS-2552-10 | Peri od: | Worksheet S-3 | From 01/01/2014 | Part | To 12/31/2014 | Date/Time Prepared: Provi der CCN: 150061

				''	3 12/31/2014	5/21/2015 12:	
		I/P Days	/ O/P Visits	/ Trips	Full Time E	Equi val ents	
		,		·		·	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	1, 784	271	3, 699			1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2 00	for the portion of LDP room available beds)	208	0/0				2 00
2. 00 3. 00	HMO and other (see instructions) HMO IPF Subprovider	396	968 0				2. 00 3. 00
4. 00	HMO IRF Subprovider	11	10				4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6. 00	Hospital Adults & Peds. Swing Bed SNF	U	0	0			6.00
7. 00	Total Adults and Peds. (exclude observation	1, 784	271	3, 699			7.00
7.00	beds) (see instructions)	1, 704	2/1	3, 077			7.00
8. 00	INTENSIVE CARE UNIT	501	61	871			8.00
9. 00	CORONARY CARE UNIT			071			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		59	835			13.00
14. 00	Total (see instructions)	2, 285	391	5, 405	0. 00	287. 55	
15. 00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	5, 021	399	5, 874	0.00	43. 39	16.00
17.00	SUBPROVIDER - IRF	2, 045	50	2, 539	0.00	17. 00	17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY	1, 259	115	2, 067	0.00	3. 32	22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE	0	0	3, 270	0. 00	4. 88	
24. 10	HOSPICE (non-distinct part)	0	0	0			24. 10
25. 00	CMHC - CMHC						25. 00
25. 10	CMHC - CORF	0	0	0	0. 00	l e	
26. 00	DCHMC	3, 463	1, 735	11, 988	0. 00		
26. 01	NDMC/ODON	2, 811	1, 056	10, 984	0. 00	l e	
26. 02	QUICK CARE	788	2, 166	8, 411	0. 00	9. 90	
26. 04	PEDI ATRI CS	0	5, 976	9, 919	0. 00	l e	
26. 05	DAVI ESS MARTIN	2, 522	864	7, 956	0. 00	8. 75	
26. 25	FEDERALLY QUALIFIED HEALTH CENTER				0.00	400.04	26. 25
27. 00	Total (sum of lines 14-26)		045	4 404	0. 00	402. 21	
28. 00	Observation Bed Days	0	315	1, 431			28. 00
29. 00 30. 00	Ambulance Trips	O O		108			29. 00 30. 00
	Employee discount days (see instruction)			108			
31. 00 32. 00	Employee discount days - IRF Labor & delivery days (see instructions)	0	76	145			31. 00 32. 00
32. 00	Total ancillary labor & delivery room	١	70	140			32.00
JZ. UI	outpatient days (see instructions)			Ü			32.01
33 00	LTCH non-covered days	0					33. 00
55. 55	1=155 5575. 54 44.35	١	1			ı	, 55. 55

Provi der CCN: 150061

				To	12/31/2014	Date/Time Pre 5/21/2015 12:	
		Full Time	<u> </u>	Di sch	arges	072172010 121	_ , p
		Equi val ents			ŭ		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	732	330	1, 561	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)			59	0		2.00
3.00	HMO I PF Subprovi der						3.00
4. 00	HMO I RF Subprovi der						4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7. 00	Total Adults and Peds. (exclude observation						7. 00
8. 00	beds) (see instructions)   INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT			•			10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	0.00	0	732	330	1, 561	14. 00
15. 00	CAH visits	0.00	· ·	102	000	1,001	15. 00
16. 00	SUBPROVIDER - I PF	0.00	0	341	27	422	16.00
17. 00	SUBPROVIDER - IRF	0.00	0	167	6	205	17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE	0. 00					24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25.00
25. 10	CMHC - CORF	0. 00					25. 10
26. 00	DCHMC	0.00					26.00
26. 01	NDMC/ODON	0.00					26. 01
26. 02	QUI CK CARE	0.00					26. 02
26. 04	PEDI ATRI CS	0.00					26. 04
26. 05	DAVIESS MARTIN	0.00					26. 05 26. 25
26. 25 27. 00	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26)	0.00					26. 25 27. 00
28. 00	Observation Bed Days	0.00					28. 00
29.00	Ambul ance Trips						28.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days (see Histruction)						31.00
32. 00	Labor & delivery days (see instructions)						32.00
32. 00	Total ancillary labor & delivery room	}					32. 00
02.01	outpatient days (see instructions)						-2.0.
33.00	LTCH non-covered days						33.00
	'	. '		. '		'	

HOSPI T	AL WAGE INDEX INFORMATION			Provi der		Period: From 01/01/2014	Worksheet S-3 Part II	
						o 12/31/2014	5/21/2015 12:	pared: 29 pm
		Worksheet A Line Number	Amount Reported	Reclassificat ion of	Adj usted Sal ari es	Paid Hours Related to	Average Hourly Wage	
			•	Sal ari es	(col . 2 ± col .	Salaries in	(col. 4 ÷ col. 5)	
				(from Worksheet	3)	col. 4	COI. 5)	
		1. 00	2. 00	A-6) 3. 00	4.00	5. 00	6. 00	
	PART II - WAGE DATA	1. 00	2. 00	0.00	1.00	0.00	0.00	
1. 00	SALARIES Total salaries (see	200.00	22, 891, 206	0	22, 891, 206	1, 033, 696. 00	22. 15	1.00
2. 00	instructions) Non-physician anesthetist Part			0		0.00		2.00
	A		0	0				
3. 00	Non-physician anesthetist Part B		0	0	C	0.00	0. 00	3. 00
4. 00	Physician-Part A - Administrative		0	0	C	0. 00	0. 00	4. 00
4. 01	Physicians - Part A - Teaching		0	0	C	0. 00		
5. 00 6. 00	Physician-Part B Non-physician-Part B		4, 950 0	0	4, 950	28. 00 0. 00		
7. 00	Interns & residents (in an	21. 00	0	ō	d	0. 00		
7. 01	approved program) Contracted interns and		0	О	C	0. 00	0. 00	7. 01
	residents (in an approved programs)							
8.00	Home office personnel		0	0	C	0.00		
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	0 5, 848, 083	0 74, 675	5, 922, 758	0. 00 3 210, 244. 00	0. 00 28. 17	
	instructions) OTHER WAGES & RELATED COSTS							
11. 00	Contract Labor: Direct Patient		22, 282	0	22, 282	390.00	57. 13	11. 00
12. 00	Care Contract Labor: Top Level		2, 128, 060	О	2, 128, 060	19, 583. 00	108. 67	12.00
	management and other management and administrative							
	servi ces			_	_			
13. 00	Contract Labor: Physician-Part A - Administrative		0	0	(	0.00	0.00	13. 00
14. 00	Home office salaries & wage-related costs		0	0	C	0.00	0. 00	14. 00
15. 00	Home office: Physician Part A		0	0	C	0. 00	0. 00	15. 00
16. 00	- Administrative Home office and Contract		0	О	C	0. 00	0. 00	16. 00
	Physicians Part A - Teaching WAGE-RELATED COSTS							<u> </u> 
17. 00	Wage-related costs (core) (see		4, 052, 780	0	4, 052, 780	)		17. 00
18. 00	instructions) Wage-related costs (other)		0	О	C	)		18. 00
19. 00	(see instructions) Excluded areas		1, 415, 017	0	1, 415, 017	,		19. 00
20. 00			0	ō	, , , , , , , , , , , , , , , , , , ,	)		20.00
21. 00	A  Non-physician anesthetist Part		0	О	C	)		21.00
22. 00	B Physician Part A -		0	0	(			22. 00
	Admi ni strati ve		0					22. 01
22. 01 23. 00	Physician Part A - Teaching Physician Part B		1, 183	0	1, 183	3		23. 00
24.00	Wage-related costs (RHC/FQHC) Interns & residents (in an		0	0	(			24. 00 25. 00
23.00	approved program)							25.00
26. 00	OVERHEAD COSTS - DIRECT SALARII Employee Benefits Department	<u>-S</u> 4. 00	186, 853	0	186, 853	8, 330. 00	22. 43	26.00
27. 00 28. 00	Administrative & General Administrative & General under	5. 00	1, 729, 719	-52, 274	1, 677, 445			27. 00 28. 00
	contract (see inst.)		0	0		0.00		
29. 00 30. 00	Maintenance & Repairs Operation of Plant	6. 00 7. 00	518, 207 0	0	518, 207			29. 00 30. 00
31.00	Laundry & Linen Service	8. 00	0	0	(	0.00	0. 00	31.00
32. 00 33. 00	Housekeepi ng Housekeepi ng under contract	9. 00	411, 145 0	0	411, 145 (	41, 213. 00 0. 00		32. 00 33. 00
34. 00	(see instructions) Dietary	10. 00	491, 090	-366, 188	124, 902	9, 783. 00	12. 77	34.00
35. 00	Dietary under contract (see	10.00	471,090	-300, 100	124, 702	0. 00		
36. 00	i nstructi ons) Cafeteri a	11. 00	0	290, 065	290, 065	22, 720. 00	12. 77	36.00
37.00	Maintenance of Personnel Nursing Administration	12. 00 13. 00	0 724, 657	0	C	0.00	0. 00	37. 00 38. 00
	indi strig Admirili strati on	13.00	724, 037	0	1 724, 007	20, 323. 00	27.32	

Health Financial Systems		DAVIESS COMMUN	IITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL WAGE INDEX INFORMATION			Provi der		Peri od:	Worksheet S-3	
					From 01/01/2014 To 12/31/2014		nared·
						5/21/2015 12:	
	Worksheet A	Amount	Recl assi fi cat		Pai d Hours	Average	
	Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
			Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
			(from	3)	col. 4	col. 5)	
			Worksheet				
			A-6)				
	1. 00	2. 00	3.00	4.00	5. 00	6. 00	
39.00 Central Services and Supply	14.00	246, 020	0	246, 02	0 14, 614. 00	16. 83	39. 00
40.00 Pharmacy	15.00	663, 096	0	663, 09	6 18, 349. 00	36. 14	40.00
41.00 Medical Records & Medical	16.00	520, 255	0	520, 25	5 28, 698. 00	18. 13	41.00
Records Library							
42.00 Social Service	17. 00	0	79, 210	79, 21	0 6, 298. 00	12. 58	42.00
43.00 Other General Service	18. 00	0	0		0.00	0. 00	43.00

Hoal th	Financial Systems		DAVIESS COMMUN	INTIDOOH VTII		In lia	u of Form CMS-2	2552_10
	TAL WAGE INDEX INFORMATION		DAVIESS COMMON		CCN: 150061	Peri od:	Worksheet S-3	
HUSPI I	AL WAGE INDEX INFURMATION			Pr ovi der		From 01/01/2014	Part III	
						To 12/31/2014	Date/Time Pre	nared·
						12/01/2011	5/21/2015 12:	
		Worksheet A	Amount	Recl assi fi cat	Adj usted	Pai d Hours	Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
			·	Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet			ŕ	
				A-6)				
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		22, 886, 256	0	22, 886, 250	1, 033, 668. 00	22. 14	1.00
	instructions)							
2.00	Excluded area salaries (see		5, 848, 083	74, 675	5, 922, 758	3 210, 244. 00	28. 17	2.00
	instructions)							
3.00	Subtotal salaries (line 1		17, 038, 173	-74, 675	16, 963, 498	823, 424. 00	20. 60	3.00
	minus line 2)							
4.00	Subtotal other wages & related		2, 150, 342	0	2, 150, 342	19, 973. 00	107. 66	4.00
	+- ( !+ )	l	1		1	,		

4, 052, 780

23, 241, 295

5, 491, 042

4, 052, 780

23, 166, 620

5, 441, 855

-74, 675 -49, 187 0.00

843, 397. 00

291, 577. 00

23. 89

27. 47

18. 66

5.00

6.00

7.00

costs (see inst.)
Subtotal wage-related costs
(see inst.)
Total (sum of lines 3 thru 5)
Total overhead cost (see

instructions)

5.00

6.00

7.00

Health Financial Systems	DAVIESS COMMUNITY HOSPITAL	In Lieu of Form CMS-2	2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 150061	Period: Worksheet S-3 From 01/01/2014 Part IV	
		To 12/31/2014 Date/Time Prep	pared:

PART I.V - WAGE RELATED COSTS   1.00   1.0		To 12/31/2014	Date/Time Prep 5/21/2015 12:	
PART IV - WAGE RELATED COSTS   Part A - Core List   RETIREMENT COST			Amount	
PART IV - WAGE RELATED COSTS   Part A - Core List   RETIREMENT COST			Reported	
Part A - Core List   RETIREMENT COST			1. 00	
RETIREMENT COST		PART IV - WAGE RELATED COSTS		
1.00		Part A - Core List		
2.00		RETI REMENT COST		
3.00   Nonqualified Defined Benefit Plan Cost (see instructions)   174, 413   3.00   2.00	1.00	401K Employer Contributions	0	1.00
A	2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)   401K/TSA Plan Administration fees   0   0   0   0   0   0   0   0   0	3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	174, 413	3.00
5.00       401K/TSA Plan Administration fees       0       5.00         6.00       Legal /Accounting/Management Fees-Pension Plan       37,203       6.00         HEALTH AND INSURANCE COST         8.00       Health Insurance (Purchased or Self Funded)       3,509,073       8.00         10.00       Dental, Hearing and Vision Plan       0       10.00         11.00       Life Insurance (If employee is owner or beneficiary)       31,515       11.00         12.00       Accident Insurance (If employee is owner or beneficiary)       48,881       13.00         13.00       Disability Insurance (If employee is owner or beneficiary)       48,881       13.00         14.00       Long-Term Care Insurance (If employee is owner or beneficiary)       122,810       15.00         15.00       Workers' Compensation Insurance       122,810       15.00         16.00       Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.       0       16.00         17.00       FICA-Employers Portion Only       1,478,061       18.00         18.00       Medicare Taxes - Employers Portion Only       1,478,061       18.00         19.00       Unemployment Insurance       24,528       20.00         10 Executive Deferred Compensation (Other Than Retirement Cost Repo	4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
1.00   Legal / Accounting / Management Fees-Pension Plan   37, 203   6.00		PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
Employee Managed Care Program Administration Fees   0   7.00     HEALTH AND INSURANCE COST	5.00	401K/TSA Plan Administration fees	0	5.00
HEALTH AND INSURANCE COST	6.00	Legal /Accounting/Management Fees-Pension Plan	37, 203	6. 00
8.00   Heal th Insurance (Purchased or Self Funded)   3,509,073   0.00     9.00   Prescription Drug Plan   0   9.00     10.00   Dental, Hearing and Vision Plan   0   10.00     11.00   Life Insurance (If employee is owner or beneficiary)   31,515   11.00     12.00   Accident Insurance (If employee is owner or beneficiary)   0   12.00     13.00   Disability Insurance (If employee is owner or beneficiary)   48,881     13.00   Long-Term Care Insurance (If employee is owner or beneficiary)   0   14.00     15.00   Workers' Compensation Insurance   122,810     16.00   Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106.   0     Non cumulative portion   1,478,061     18.00   Medicare Taxes - Employers Portion Only   1,478,061     18.00   Medicare Taxes - Employers Portion Only   1,478,061     18.00   State or Federal Unemployment Taxes   24,528     17.00   OTHER   24,528     18.00   OTHER   24,528     19.00   Day Care Cost and Allowances   0   22.00     10.00   Control on the part of the properties	7.00		0	7. 00
9.00   Prescription Drug Plan		HEALTH AND INSURANCE COST		
10.00   Dental, Hearing and Vision Plan   0   10.00     11.00   Life Insurance (If employee is owner or beneficiary)   31,515   11.00     12.00   Accident Insurance (If employee is owner or beneficiary)   0   12.00     13.00   Disability Insurance (If employee is owner or beneficiary)   48,881   13.00     14.00   Long-Term Care Insurance (If employee is owner or beneficiary)   0   14.00     15.00   Workers' Compensation Insurance   122,810   15.00     16.00   Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.   0   17.00     17.00   Non cumulative portion   17.00     18.00   Medicare Taxes - Employers Portion Only   1,478,061   18.00     19.00   Unemployment Insurance   0   19.00     20.00   State or Federal Unemployment Taxes   24,528     21.00   Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))     22.00   Day Care Cost and Allowances   0   22.00     23.00   Tuit ion Reimbursement   42,496   23.00     24.00   Part B - Other than Core Related Cost   24.00     24.00   Part B - Other than Core Related Cost   24.00     25.00   Part B - Other than Core Related Cost   25.00     26.00   Part B - Other than Core Related Cost   25.00     27.00   Part B - Other than Core Related Cost   27.00     28.00   Part B - Other than Core Related Cost   27.00     29.00   Part B - Other than Core Related Cost   27.00     29.00   Part B - Other than Core Related Cost   27.00     29.00   Part B - Other than Core Related Cost   27.00     29.00   Part B - Other than Core Related Cost   27.00     29.00   Part B - Other than Core Related Cost   27.00     29.00   Part B - Other than Core Related Cost   27.00     29.00   Part B - Other than Core Related Cost   27.00     29.00   Part B - Other than Core Related Cost   27.00     29.00   Part B - Other than Core Related Cost   27.00     29.00   Part B - Other than Core Related Cost   27.00     29.00   Part B - Other than Core Related Cost   27.00     29.00   Part B - Other th	8.00	Health Insurance (Purchased or Self Funded)	3, 509, 073	8. 00
11.00	9.00	Prescription Drug Plan	0	9. 00
12.00	10.00	Dental, Hearing and Vision Plan		
13.00 Disability Insurance (If employee is owner or beneficiary)  Long-Term Care Insurance (If employee is owner or beneficiary)  14.00 It. 00  15.00 'Workers' Compensation Insurance  Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.  Non cumul ative portion)  TAXES  17.00 Medicare Taxes - Employers Portion Only  Unemployment Insurance  State or Federal Unemployment Taxes  20.00 OTHER  21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))  Day Care Cost and Allowances  Total Wage Related cost (Sum of Lines 1 -23)  Part B - Other than Core Related Cost	11.00	Life Insurance (If employee is owner or beneficiary)	31, 515	11.00
Long-Term Care Insurance (If employee is owner or beneficiary)  15.00  16.00  Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106.  Non cumulative portion)  TAXES  17.00  FICA-Employers Portion Only  Medicare Taxes - Employers Portion Only  Unemployment Insurance  20.00  State or Federal Unemployment Taxes  OTHER  21.00  Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))  Day Care Cost and Allowances  Total Wage Related cost (Sum of Lines 1 -23)  Part B - Other than Core Related Cost	12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
15.00 'Workers' Compensation Insurance Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)  TAXES  17.00 FICA-Employers Portion Only Medicare Taxes - Employers Portion Only Unemployment Insurance 20.00 State or Federal Unemployment Taxes OTHER  21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))  22.00 Day Care Cost and Allowances Tuition Reimbursement Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost	13.00	Disability Insurance (If employee is owner or beneficiary)	48, 881	13.00
Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.  Non cumulative portion)  TAXES  17. 00 FICA-Employers Portion Only  18. 00 Medicare Taxes - Employers Portion Only  19. 00 Unemployment Insurance  20. 00 State or Federal Unemployment Taxes  21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))  22. 00 Day Care Cost and Allowances  Tuition Reimbursement  Total Wage Related cost (Sum of Lines 1 -23)  Part B - Other than Core Related Cost	14.00		0	14.00
Non cumulative portion) TAXES  17.00 FI CA-Employers Portion Only 18.00 Medicare Taxes - Employers Portion Only 19.00 Unemployment Insurance 20.00 State or Federal Unemployment Taxes  THER  21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))  22.00 Day Care Cost and Allowances 23.00 Tuit ion Reimbursement 24.00 Total Wage Related cost (Sum of Lines 1 -23)  Part B - Other than Core Related Cost	15.00		122, 810	15.00
TAXES	16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16.00
17.00				
18.00       Medicare Taxes - Employers Portion Only       1,478,061       18.00         19.00       Unemployment Insurance       0       19.00         20.00       State or Federal Unemployment Taxes       24,528       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         23.00       Tuition Reimbursement       42,496       23.00         24.00       Total Wage Related cost (Sum of Lines 1 -23)       5,468,980       24.00		·		
19.00 Unempl oyment I nsurance 0 24,528 24,528 20.00 State or Federal Unempl oyment Taxes 24,528 20.00 OTHER  21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 0 22.00 Tuition Reimbursement 42,496 23.00 Total Wage Related cost (Sum of Lines 1 -23) 5,468,980 24.00 Part B - Other than Core Related Cost				
20.00 State or Federal Unemployment Taxes  21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))  22.00 Day Care Cost and Allowances  Tuition Reimbursement  Total Wage Related cost (Sum of Lines 1 -23)  Part B - Other than Core Related Cost  24,528  20.00  21.00  22.00  23.00  5,468,980  24.00			1, 478, 061	
OTHER  21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))  22.00 Day Care Cost and Allowances  Tuition Reimbursement  24.00 Total Wage Related cost (Sum of Lines 1 -23)  Part B - Other than Core Related Cost  21.00 22.00  22.00 23.00  24.00 24.00				
21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))  22.00 Day Care Cost and Allowances  Tuition Reimbursement  Total Wage Related cost (Sum of Lines 1 -23)  Part B - Other than Core Related Cost  21.00  22.00  22.00  23.00  24.00	20.00		24, 528	20.00
instructions)) Day Care Cost and Allowances  Tuition Reimbursement  Total Wage Related cost (Sum of lines 1 -23) Part B - Other than Core Related Cost  instructions)  22.00 22.00 23.00 24.00 24.00		•		
22.00       Day Care Cost and Allowances       0       22.00         23.00       Tuition Reimbursement       42,496       23.00         24.00       Total Wage Related cost (Sum of lines 1 -23)       5,468,980       24.00         Part B - Other than Core Related Cost       22.00       24.00	21. 00		0	21.00
23.00 Tui ti on Rei mbursement 24.00 Total Wage Related cost (Sum of lines 1 -23) 24.00 Part B - Other than Core Related Cost 25.00 24.00				
24.00 Total Wage Related cost (Sum of lines 1 -23) 5, 468, 980 Part B - Other than Core Related Cost			-	
Part B - Other than Core Related Cost				
	24. 00		5, 468, 980	24.00
25.00 OTHER WAGE RELATED COSTS (SPECIFY)				
	25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

Health Financial Systems	DAVIESS COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 150061	Peri od:	Worksheet S-3

moun tin	Trianoral dystoms	11001 1 1712	2.0	u 01 101111 01110 .	
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 150061	Peri od: From 01/01/2014 To 12/31/2014		pared:
	Cost Center Description		Contract	Benefit Cost	
			Labor		
			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 - IPF		0	0	3. 00
4.00	Subprovi der - IRF		0	0	4.00
5. 00	Subprovider - (Other)		0	0	5. 00
6. 00	Swing Beds - SNF		0	0	6. 00
7.00	Swing Beds - NF		0	0	7. 00
8.00	Hospi tal -Based SNF				8. 00
9.00	Hospi tal -Based NF				9. 00
	Hospi tal -Based OLTC				10.00
	Hospi tal -Based HHA		0	0	11.00
	Separately Certified ASC				12.00
	Hospi tal -Based Hospi ce		0	0	
	Hospital-Based Health Clinic RHC		0	0	14.00
	Hospital-Based Health Clinic RHC 1		0	0	14. 01
	Hospital-Based Health Clinic RHC 2		0	0	14. 02
	Hospital-Based Health Clinic RHC 4		0	0	14. 04
	Hospital-Based Health Clinic RHC 5		0	0	14. 05
	Hospital-Based Health Clinic FQHC				15. 00
	Hospi tal -Based-CMHC				16. 00
	Hospi tal -Based-CMHC 10		0	0	16. 10
	Renal Dialysis				17. 00
18. 00	Other Other		0	0	18. 00

S/21/201   Home Health Agency	et S-4  de Prepare 5 12: 29 p  PPS  0.  1, 218 1. 0. 00 2. I ent)
Home Heal th Agency	1, 218 1. 0. 00 2. I ent)  1. 12 3. 0. 00 4. 0. 00 5. 1. 62 6.
1.00	1, 218 1. 0. 00 2. I ent)  1. 12 3. 0. 00 4. 0. 00 5. 1. 62 6.
Number of Employees (Full Time Equivalence   Total   Title V   Title XVIII   Title XIX   Other   Total	1, 218 1. 0. 00 2. I ent)  1. 12 3. 0. 00 4. 0. 00 5. 1. 62 6.
Title V   Title XVIII   Title XIX   Other   Total	1, 218 1. 0. 00 2. I ent)  1. 12 3. 0. 00 4. 0. 00 5. 1. 62 6.
1.00   2.00   3.00   4.00   5.00	1, 218 1. 0. 00 2. I ent)  1. 12 3. 0. 00 4. 0. 00 5. 1. 62 6.
Home Heal th Ai de Hours   0   689   115   414   0.00	1. 12 0. 00 4 0. 00 1. 62 6.
Unduplicated Census Count (see instructions)   0.00   69.00   0.00   0.00   0.00	1. 12 0. 00 4 0. 00 1. 62 6.
Enter the number of hours in your normal work week   Staff	1. 12 3. 0. 00 4. 0. 00 5. 1. 62 6.
Your normal work week	1. 12 3. 0. 00 4. 0. 00 5. 1. 62 6.
Your normal work week	1. 12 3. 0. 00 4. 0. 00 5. 1. 62 6.
Your normal work week	1. 12 3. 0. 00 4. 0. 00 5. 1. 62 6.
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES   0.00   1.12   0.00	1. 12 3. 0. 00 4. 0. 00 5. 1. 62 6.
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES   0.00   1.12   0.00	1. 12 3. 0. 00 4. 0. 00 5. 1. 62 6.
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES   0.00   1.12   0.00	1. 12 3. 0. 00 4. 0. 00 5. 1. 62 6.
Administrator and Assistant Administrator(s)	0. 00 4. 0. 00 5. 1. 62 6.
4.00   Director(s) and Assistant Director(s)   0.00   0.00     5.00   Other Administrative Personnel   0.00   0.00     6.00   Direct Nursing Service   1.62   0.00     7.00   Nursing Supervisor   0.00   0.00     8.00   Physical Therapy Service   0.32   0.00     9.00   Physical Therapy Supervisor   0.00   0.00     9.00   Occupational Therapy Supervisor   0.00   0.00     10.00   Occupational Therapy Supervisor   0.00   0.00     12.00   Speech Pathology Service   0.05   0.00     13.00   Speech Pathology Supervisor   0.00   0.00     14.00   Medical Social Service   0.00   0.00     15.00   Medical Social Service   0.00   0.00     16.00   Home Heal th Aide   0.59   0.00     17.00   Home Heal th Aide   0.59   0.00     18.00   Other (specify)   0.00   0.00     HOME HEALTH AGENCY CBSA CODES   1     1   Output	0. 00 4. 0. 00 5. 1. 62 6.
1.62   0.00	1. 62 6.
7. 00       Nursing Supervisor       0. 00       0. 00         8. 00       Physical Therapy Service       0. 32       0. 00         9. 00       Physical Therapy Supervisor       0. 00       0. 00         10. 00       Occupational Therapy Supervisor       0. 00       0. 00         11. 00       Occupational Therapy Supervisor       0. 00       0. 00         12. 00       Speech Pathology Service       0. 05       0. 00         13. 00       Speech Pathology Supervisor       0. 00       0. 00         14. 00       Medical Social Service       0. 00       0. 00         15. 00       Medical Social Service Supervisor       0. 00       0. 00         16. 00       Home Heal th Aide       0. 59       0. 00         17. 00       Home Heal th Aide Supervisor       0. 00       0. 00         18. 00       Other (specify)       0. 00       0. 00         HOME HEALTH AGENCY CBSA CODES       1       0. 00       0. 00         19. 00       Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.       99915       0. 00         20. 00       List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).       Full Episodes	
8.00   Physical Therapy Service   0.32   0.00     9.00   Physical Therapy Supervisor   0.00   0.00     10.00   Occupational Therapy Service   0.07   0.00     11.00   Occupational Therapy Supervisor   0.00   0.00     12.00   Speech Pathology Service   0.05   0.00     13.00   Speech Pathology Supervisor   0.00   0.00     14.00   Medical Social Service   0.00   0.00     15.00   Medical Social Service Supervisor   0.00   0.00     16.00   Home Health Aide   0.59   0.00     17.00   Home Health Aide Supervisor   0.00   0.00     18.00   Other (specify)   0.00   0.00     19.00   Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.   1     20.00   List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).   Full Episodes   Full Episodes	O. OOL /
10.00       Occupational Therapy Service       0.07       0.00         11.00       Occupational Therapy Supervisor       0.00       0.00         12.00       Speech Pathology Service       0.05       0.00         13.00       Speech Pathology Supervisor       0.00       0.00         14.00       Medical Social Service       0.00       0.00         15.00       Medical Social Service Supervisor       0.00       0.00         16.00       Home Health Aide       0.59       0.00         17.00       Home Health Aide Supervisor       0.00       0.00         18.00       Other (specify)       0.00       0.00         19.00       Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.       1         20.00       List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).       Full Episodes	0. 32 8.
11.00   Occupational Therapy Supervisor   0.00   0.00   0.00   12.00   Speech Pathology Service   0.05   0.00   0.00   13.00   Speech Pathology Supervisor   0.00	0. 00 9. 0. 07 10.
13.00       Speech Pathology Supervisor       0.00       0.00         14.00       Medical Social Service       0.00       0.00         15.00       Medical Social Service Supervisor       0.00       0.00         16.00       Home Heal th Aide       0.59       0.00         17.00       Home Heal th Aide Supervisor       0.00       0.00         18.00       Other (specify)       0.00       0.00         HOME HEALTH AGENCY CBSA CODES         Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.       1         20.00       List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).       99915	0.00 11.
14.00       Medical Social Service       0.00       0.00         15.00       Medical Social Service Supervisor       0.00       0.00         16.00       Home Heal th Aide       0.59       0.00         17.00       Home Heal th Aide Supervisor       0.00       0.00         18.00       Other (specify)       0.00       0.00         HOME HEALTH AGENCY CBSA CODES         19.00       Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.       1         20.00       List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).       99915	0. 05 12.
15.00 Medical Social Service Supervisor  16.00 Home Heal th Aide  17.00 Home Heal th Aide Supervisor  18.00 Other (specify)  19.00 Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.  20.00 List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).  Full Episodes	0. 00   13. 0. 00   14.
17. 00 Home Heal th Ai de Supervisor 0. 00	0.00 15.
18.00 Other (specify) 0.00 0.00  HOME HEALTH AGENCY CBSA CODES  19.00 Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.  20.00 List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).  Full Episodes	0. 59 16.
HOME HEALTH AGENCY CBSA CODES  19.00 Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.  20.00 List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).  Full Episodes	0. 00   17. 0. 00   18.
you provided services during the cost reporting period.  20.00 List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).  Full Episodes	
reporting period.  20.00 List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).  Full Episodes	19.
during this cost reporting period (line 20 contains the first code).  Full Episodes	
contains the first code). Full Episodes	20.
WITHOUT INITEDITION FREEDRICK DED INTO LIGHTS TO	
Outliers   Episodes   1-4)	
1.00 2.00 3.00 4.00 5.00	
PPS ACTIVITY DATA           21. 00 Skilled Nursing Visits         498         0         32         9	539 21.
22.00   Skilled Nursing Visit Charges   58,477   0   3,036   1,056   6	2, 569 22.
23. 00   Physical Therapy Visits   337   0   1   7   24. 00   Physical Therapy Visit Charges   39. 960   0   120   840   4	345 23.
24.00   Physical Therapy Visit Charges       39,960   0   120   840   4         25.00   Occupational Therapy Visits       72   0   5	0, 920   24. 77   25.
26.00 Occupational Therapy Visit Charges 8,640 0 0 600	9, 240 26.
27. 00   Speech Pathology Visits       27   0   0   0           28. 00   Speech Pathology Visit Charges       4, 342   0   0	27   27. 4, 342   28.
29.00 Medical Social Service Visits 1 0 0	1 29.
30.00 Medical Social Service Visit Charges 174 0 0 0	174 30.
31.00   Home Health Aide Visits   256   0   4   10   32.00   Home Health Aide Visit Charges   22,428   0   267   890   2	270   31. 3, 585   32.
33.00 Total visits (sum of lines 21, 23, 25, 27, 1, 191 0 37 31	1, 259 33.
29, and 31)   34.00   0ther Charges   0   0   0   0	0 34.
35.00 Total Charges (sum of lines 22, 24, 26, 28, 134,021 0 3,423 3,386 14	171 3/1
30, 32, and 34)	0, 830 35.
36.00 Total Number of Episodes (standard/non 64 10 1 outlier)	0, 830 35.
37.00 Total Number of Outlier Episodes 0	
38.00   Total Non-Routine Medical Supply Charges   1,621   0   20   0	0, 830 35.

105PI	TAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIF	IED HEALTH CENTER	Provi der	CCN: 150061	Peri od:	Worksheet S-	-8
	STICAL DATA			CCN: 158500	From 01/01/2014 To 12/31/2014		epared
					Rural Health Clinic (RHC) l	Cost	
					1.	00	
	Clinic Address and Identification						_
. 00	Street		0'		1402 GRAND AVE		1.0
			Ci 1	00	State 2.00	Zi p Code 3. 00	+
. 00	City, State, Zip Code, County	WAS	HI NGTON			47501	2.0
						1. 00	
00	FQHCs ONLY: Designation - Enter "R" for rural	or "U" for urbar	)				0 3.
					Grant Award	Date	
	Course of Fodoral Funda				1. 00	2. 00	
. 00	Source of Federal Funds Community Health Center (Section 330(d), PHS	Act)			0		4.0
. 00	Migrant Health Center (Section 329(d), PHS Ac				0		5.0
. 00	Health Services for the Homeless (Section 340				0		6.
. 00	Appalachian Regional Commission				0		7.
. 00	Look-Alikes				0		8.
00	OTHER (SPECIFY)				0		9. 9.
02					0		9.
03					0		9.
04					0		9.
05					0		9.
. 06					0		9.
. 07					0		9.
. 08 . 09					0		9. 9.
. 10					0		9.
					1.00	2. 00	+
0. 00	Does this facility operate as other than an Inno in column 1. If yes, indicate number of or subscripts of line 11 the type of other operations.	ther operations ir	column 2.	(Enter in	r N		0 10.0
		Sunday			londay	Tuesday	
		from	to	from	to	from	_
	Facility hours of operations (1)	1. 00	2. 00	3. 00	4. 00	5. 00	+
1. 00	Clinic			08: 00	17: 00	08: 00	11. (
					1.00	2. 00	
2. 00	Have you received an approval for an exception	on to the producti	vity standa	ard?	1.00 N	2.00	12. (
3. 00	11	d in CMS Pub. 100- umn 1. If yes, ent	04, chaptei er in colur	n 9, section nn 2 the			0 13.0
					der name	CCN number	
4 00	Provider name, CCN number				1. 00	2. 00	14.
4.00	Trovider Hame, Cell Hamber	Y/N	V	XVIII	XIX	Total Visits	
		1. 00	2. 00	3. 00	4. 00	5. 00	
5. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and	N	0		0 0		0 15.

Health Financial Systems	DAVIESS COMMUN	NITY HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALI	FIED HEALTH CEN	NTER Provi der	CCN: 150061	Peri od:	Worksheet S-8	3
STATI STI CAL DATA		0		From 01/01/2014	D. L. (Time D.	
		Componen	t CCN: 158500	To 12/31/2014	Date/Time Pre 5/21/2015 12:	
				Rural Health	Cost	
				Clinic (RHC) I		
		Cou	ınty			
		4.	00			
2.00 City, State, Zip Code, County		DAVI ESS				2.00
	Tuesday	Wedne	esday	Thur	sday	
	to	from	to	from	to	
	6. 00	7. 00	8. 00	9. 00	10.00	
Facility hours of operations (1)						
11.00 Clinic	17: 00	08: 00	17: 00	08: 00	17: 00	11.00
	Fri	day	Sa <sup>-</sup>	turday		
	from	to	from	to		
	11. 00	12. 00	13.00	14.00		
Facility hours of operations (1)						
11.00   Cl i ni c	08: 00	17: 00				11.00

10521	TAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIF	IED HEALTH CENTER	Provi der	CCN: 150061	Peri od:	Worksheet S-	-8
	STICAL DATA			CCN: 153999	From 01/01/2014 To 12/31/2014		repar
					Rural Health Clinic (RHC) II	Cost	
					1	00	
	Clinic Address and Identification						
. 00	Street				202 NORTH WEST	1	1
			Ci	ty 00	State 2.00	Zi p Code 3. 00	
. 00	City, State, Zip Code, County	ODO		00		47562	2
		1					
00	FOLICE ONLY Designation Fator UDI for govern	"II"				1.00	0 0
. 00	FQHCs ONLY: Designation - Enter "R" for rural	or u for urbar	1		Grant Award	Date	0 3
					1.00	2.00	
	Source of Federal Funds						
. 00 . 00	Community Health Center (Section 330(d), PHS Migrant Health Center (Section 329(d), PHS Ac				0		5
. 00	Health Services for the Homeless (Section 340				0	ł	6
. 00	Appal achi an Regi onal Commi ssi on	. (.),			Ö	1	7
. 00	Look-Alikes				0		8
. 00	OTHER (SPECIFY)				0		9
01					0		9
03					0		9
04					0		9
05					0		9
. 06 . 07					0		9
. 07					0		9
. 09					0	•	9
. 10					0		9
					1. 00	2. 00	
0. 00	Does this facility operate as other than an an in column 1. If yes, indicate number of or subscripts of line 11 the type of other operations.	ther operations in	n column 2.	(Enter in	n N		0 10
		Sunday		M	londay	Tuesday	
		from	to	from	to	from	
	Facility hours of operations (1)	1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00	Clinic			08: 00	17: 00	08: 00	11
					1. 00	2. 00	_
2. 00	Have you received an approval for an exception	on to the producti	vity standa	ard?	N N	2.00	12
3. 00	1 ''	d in CMS Pub. 100- umn 1. If yes, ent	-04, chapte ter in colu	n 9, section nn 2 the	N		0 13
					der name	CCN number	
4 00	Provider name, CCN number				1. 00	2. 00	14
4.00	Frovider Haille, CCN Haillbei	Y/N	V	XVIII	XIX	Total Visits	
		1. 00	2.00	3. 00	4. 00	5. 00	
5. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.		0		0 0		0 15

Health Financial Systems	DAVIESS COMMUN	II TY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALI	FIED HEALTH CEN	ITER Provi der	CCN: 150061	Peri od:	Worksheet S-8	
STATISTICAL DATA		Component	t CCN: 153999	From 01/01/2014 To 12/31/2014	Doto/Time Dro	nonod.
		Component	L CCN. 153999	10 12/31/2014	Date/Time Pre 5/21/2015 12:	
				Rural Health	Cost	
				Clinic (RHC) II		
		Cou	ınty			
		4.	00			
2.00 City, State, Zip Code, County		DAVI ESS				2.00
	Tuesday	Wedne	esday	Thur	sday	
	to	from	to	from	to	
	6. 00	7.00	8. 00	9. 00	10. 00	
Facility hours of operations (1)						
11.00 Clinic	17: 00	08: 00	17: 00	08: 00	17: 00	11.00
	Fri	day	Sa <sup>-</sup>	turday		
	from	to	from	to		
	11. 00	12. 00	13.00	14.00		
Facility hours of operations (1)						
11.00   Cl i ni c	08: 00	17: 00				11.00

IUSFI	FAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIF	IED HEALTH CENTER	Provi der	CCN: 150061	Peri od:	Worksheet S-	-8
	STI CAL DATA			CCN: 158501	From 01/01/2014 To 12/31/2014		repare
					Rural Health Clinic (RHC) III	Cost	
	Clinic Address and Identification					00	
00	Street				1805 S. STATE		1.
			Ci		State	Zip Code	
. 00	City, State, Zip Code, County	WAS	HI NGTON	00	2. 00	3. 00 47501	2.
		ļ.·· · · ·					
. 00	FQHCs ONLY: Designation - Enter "R" for rural	or "II" for urbar	<u> </u>			1. 00	0 3
. 00	FUNCS ONLY: Designation - Enter R Tor Tural	or o ror urbar	1		Grant Award	Date	0 3
					1.00	2. 00	
00	Source of Federal Funds	A - + >				1	٠,
. 00 . 00	Community Health Center (Section 330(d), PHS Migrant Health Center (Section 329(d), PHS Ac				0	1	5
. 00	Health Services for the Homeless (Section 340				Ö	1	6
. 00	Appalachian Regional Commission				0	,	7.
. 00	Look-Alikes				0	1	8
00	OTHER (SPECIFY)				0		9.
02					0	,	9
03					0	,	9
04					0		9.
05					0		9.
06 07					0		9.
08					0	,	9
. 09					0	,	9.
. 10					0		9.
					1.00	2. 00	
0. 00	Does this facility operate as other than an an in column 1. If yes, indicate number of or subscripts of line 11 the type of other operations.	ther operations ir	n column 2.	(Enter in	r N		0 10
	Suppose the control of the type of other open	Sunday	por a cring in		londay	Tuesday	
		from	to	from	to	from	
	Facility hours of operations (1)	1. 00	2. 00	3. 00	4. 00	5. 00	+
1. 00	Clinic			08: 00	17: 00	08: 00	11.
					1.00	2.00	
2. 00	Have you received an approval for an exception	on to the producti	vity standa	ard?	1.00 N	2. 00	12.
3. 00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report. numbers below.	d in CMS Pub. 100- umn 1. If yes, ent	-04, chaptei ter in colur	~ 9, section mn 2 the			0 13
					ider name	CCN number	
4 00	Provider name, CCN number				1. 00	2. 00	14.
4.00	Provider fiame, con fiamber	Y/N	V	XVIII	XIX	Total Visits	
		1. 00	2. 00	3. 00	4.00	5. 00	
5. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the		0		0 0		0 15

Health Financial Systems	DAVIESS COMMUN	II TY HOSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALI	FIED HEALTH CEN	ITER Provi der		Peri od:	Worksheet S-8	3
STATI STI CAL DATA		0		From 01/01/2014	D. L. (Time D.	
		Componen	t CCN: 158501	To 12/31/2014	Date/Time Pre 5/21/2015 12:	
				Rural Health	Cost	2 / p
				Clinic (RHC) III		
		Cou	inty			
		4.	00			
2.00 City, State, Zip Code, County		DAVI ESS				2.00
	Tuesday	Wedn	esday	Thur	sday	
	to	from	to	from	to	
	6. 00	7. 00	8. 00	9. 00	10.00	
Facility hours of operations (1)						
11.00 Clinic	17: 00	08: 00	17: 00	08: 00	17: 00	11.00
	Fri	day	Sat	turday		
	from	to	from	to		
	11. 00	12. 00	13. 00	14.00		
Facility hours of operations (1)						
11. 00   Cl i ni c	08: 00	17: 00				11.00

	n Financial Systems TAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIF	DAVIESS COMMUNITY		CCN: 150061	Peri od:	Worksheet		JJZ-1
	STICAL DATA	TED HEALTH CENTER		t CCN: 158503	From 01/01/2014		Prep	
					Rural Health	Cos		<b>,</b>
					Clinic (RHC) V			
	Clinic Address and Identification				1.	00	4	
1.00	Street				1402 GRAND AVE			1. 0
				ty	State	Zi p Code		
2 00	City, State, Zip Code, County	WAC	1. HI NGTON	00	2.00	3. 00 47501	_	2. 0
2. 00	crty, State, Zrp code, county	JWAS	HI ING I ON			147501		2.0
	T					1. 00		
3. 00	FQHCs ONLY: Designation - Enter "R" for rural	or "U" for urbar	1		Cront Award	Date	0	3. 0
					Grant Award 1.00	2. 00		
	Source of Federal Funds							
4. 00	Community Health Center (Section 330(d), PHS				0	1		4.0
5. 00 6. 00	Migrant Health Center (Section 329(d), PHS Ac Health Services for the Homeless (Section 340				0	1		5. 0 6. 0
7. 00	Appal achi an Regional Commission	May, IIIS ACL)				1		7. 0
3. 00	Look-Alikes				0	1		8. 0
9. 00	OTHER (SPECIFY)				0	1		9. 0
0.01					0	1	ŀ	9.0
. 02 . 03					0	1	ŀ	9. 0 9. 0
. 04					0	1	l	9.0
. 05					0		İ	9.0
. 06					0			9. 0
0. 07					0	1	ŀ	9.0
. 08 . 09					0	1	ŀ	9. 0 9. 0
9. 10					0	1		9. 10
					1.00	2. 00		
10. 00	Does this facility operate as other than an F	RHC or FOHC? Enter	"Y" for v	es or "N" for	1.00 r N	2.00	0	10.00
	no in column 1. If yes, indicate number of ot subscripts of line 11 the type of other opera	ther operations in ation(s) and the o	n column 2.	(Enter in ours.)				
		Sunday	+0		londay	Tuesday		
		1.00	2. 00	from 3.00	4. 00	from 5.00	_	
	Facility hours of operations (1)		2.00	0.00		0.00		
11.00	Clinic			08: 00	17: 00	08: 00		11.00
					1. 00	2. 00	$\dashv$	
12.00	Have you received an approval for an exception	on to the producti	vity stand	ard?	N	2.00		12.00
13. 00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report. numbers below.	umn 1. If yes, ent	ter in colu	mn 2 the	N		0	13.00
					ider name	CCN number	-	
14 00	Danid dan mana CCN mumban				1. 00	2. 00	_	14.0
14.00	Provi der name, CCN number	Y/N	V	XVIII	XIX	Total Visit		14.0
		1. 00	2.00	3.00	4.00	5. 00	13	
15. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the		0		0 0		0	15.0
	number of total visits for this provider. (see instructions)							

Health Financial Systems	DAVIESS COMMUN	IITY HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALI	FIED HEALTH CEN	ITER Provi der		Peri od:	Worksheet S-8	
STATI STI CAL DATA				From 01/01/2014	5 . (7) 5	
		Component	t CCN: 158503	To 12/31/2014	Date/Time Pre 5/21/2015 12:	
				Rural Health	Cost	27 pm
				Clinic (RHC) V		
		Cou	inty			
		4.	00			
2.00 City, State, Zip Code, County		DAVI ESS				2.00
	Tuesday	Wedne	esday	Thur	sday	
	to	from	to	from	to	
	6. 00	7. 00	8. 00	9. 00	10.00	
Facility hours of operations (1)						
11. 00 Cl i ni c	17: 00	08: 00	17: 00	08: 00	17: 00	11.00
	Fri	day	Sa <sup>-</sup>	turday		
	from	to	from	to		
	11. 00	12. 00	13. 00	14.00		
Facility hours of operations (1)						
11. 00 Clinic	08: 00	17: 00				11.00

	h Financial Systems TAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIF	DAVIESS COMMUNITY FIED HEALTH CENTER		CCN: 150061	Peri od:	worksheet S-	
.,,,,,,,	STICAL DATA			CCN: 158506	From 01/01/2014 To 12/31/2014		epared
					Rural Health Clinic (RHC) VI	Cost	
					1.	00	-
	Clinic Address and Identification						
. 00	Street				12546 E US HWY		1.0
				ty	State	Zi p Code	
. 00	City, State, Zip Code, County	1.000	GOOTEE	00	2.00	3. 00 47553	2.
. 00	crty, State, Zrp code, county	įLOO!	JOUTEL		110	47333	2.
						1. 00	
00	FQHCs ONLY: Designation - Enter "R" for rura	l or "U" for urbar	1				3.
					Grant Award	Date	_
	Source of Federal Funds				1.00	2. 00	
. 00	Community Health Center (Section 330(d), PHS	Act)			0		4.0
. 00	Migrant Health Center (Section 329(d), PHS A				0		5.
. 00	Health Services for the Homeless (Section 34				0		6.
. 00	Appalachian Regional Commission				0		7.
. 00	Look-Alikes				0		8.
. 00 . 01	OTHER (SPECIFY)				0		9. 9.
. 02							9.
03					Ö		9.
04					0		9.
05					0		9.
. 06					0		9.
. 07					0		9.
. 08 . 09					0		9. 9.
. 10					ő		9.
					1.00	2.00	
0.00	Does this facility operate as other than an	RHC or FOHC2 Enter	"V" for w	es or "N" for	1.00 N	2.00	10.0
0. 00	no in column 1. If yes, indicate number of o subscripts of line 11 the type of other oper	ther operations in	column 2.	(Enter in	, and the second		10.
		Sunday			onday	Tuesday	
		from	to	from	to	from	+-
	Facility hours of operations (1)	1. 00	2. 00	3. 00	4. 00	5. 00	+
	Clinic			08: 00	17: 00	08: 00	11. (
1. 00							
1. 00	The second of th				1.00	2. 00	10
	Have you received an approval for an excepti	on to the broducti			N N	,	12. ( 13. (
2. 00	le this a consolidated cost report as define					1	13.
2. 00		d in CMS Pub. 100-					
2. 00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report.	d in CMS Pub. 100- umn 1. If yes, ent	er in colu	mn 2 the			
2. 00	30.8? Enter "Y" for yes or "N" for no in col	d in CMS Pub. 100- umn 1. If yes, ent	er in colu	nn 2 the ders and			
2. 00	30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report.	d in CMS Pub. 100- umn 1. If yes, ent	er in colu	nn 2 the ders and Provi	der name	CCN number	
2. 00	30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.	d in CMS Pub. 100- umn 1. If yes, ent	er in colu	nn 2 the ders and Provi		CCN number 2.00	14.0
2. 00 3. 00	30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report.	d in CMS Pub. 100- umn 1. If yes, ent	er in colu	nn 2 the ders and Provi	der name	<b>_</b>	
2. 00	30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.  Provider name, CCN number	d in CMS Pub. 100- umn 1. If yes, ent List the names of Y/N 1.00	er in colui Fall provid	nn 2 the ders and Provi	der name 1.00  XIX 4.00	2.00 Total Visits 5.00	
2. 00 3. 00	30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.  Provider name, CCN number  Have you provided all or substantially all	d in CMS Pub. 100- umn 1. If yes, ent List the names of Y/N 1.00	rer in colui Fall provid	nn 2 the ders and  Provi  XVIII  3.00	der name 1.00	2.00 Total Visits 5.00	
2. 00 3. 00 4. 00	30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.  Provider name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in	d in CMS Pub. 100- umn 1. If yes, ent List the names of Y/N 1.00	er in coluical provider all provider V	nn 2 the ders and  Provi  XVIII  3.00	der name 1.00  XIX 4.00	2.00 Total Visits 5.00	
2.00	30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.  Provider name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and	d in CMS Pub. 100- umn 1. If yes, ent List the names of Y/N 1.00	er in coluical provider all provider V	nn 2 the ders and  Provi  XVIII  3.00	der name 1.00  XIX 4.00	2.00 Total Visits 5.00	14.
2. 00 3. 00 4. 00	30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.  Provider name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by	d in CMS Pub. 100- umn 1. If yes, ent List the names of Y/N 1.00	er in coluical provider all provider V	nn 2 the ders and  Provi  XVIII  3.00	der name 1.00  XIX 4.00	2.00 Total Visits 5.00	
2. 00 3. 00 4. 00	30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.  Provider name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and	d in CMS Pub. 100- umn 1. If yes, ent List the names of Y/N 1.00	er in coluical provider all provider V	nn 2 the ders and  Provi  XVIII  3.00	der name 1.00  XIX 4.00	2.00 Total Visits 5.00	
2. 00 3. 00 4. 00	30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.  Provider name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and	d in CMS Pub. 100- umn 1. If yes, ent List the names of Y/N 1.00	er in coluical provider all provider V	nn 2 the ders and  Provi  XVIII  3.00	der name 1.00  XIX 4.00	2.00 Total Visits 5.00	

Health Financial Systems	DAVIESS COMMUN	NITY HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALI	FIED HEALTH CEN	NTER Provi der	CCN: 150061	Peri od:	Worksheet S-8	3
STATI STI CAL DATA				From 01/01/2014		
		Componen	t CCN: 158506	To 12/31/2014	Date/Time Pre 5/21/2015 12:	
				Rural Health	Cost	29 piii
				Clinic (RHC) VI	0031	
	_	Cor		CITIIC (KIC) VI		
			00			
2 00 City State 7in Code County	_	MARTIN	00			2.00
2.00 City, State, Zip Code, County	1					2.00
	Tuesday		esday		sday	
	to	from	to	from	to	
	6. 00	7.00	8. 00	9. 00	10.00	
Facility hours of operations (1)						
11.00 Clinic	17: 00	08: 00	17: 00	08: 00	17: 00	11.00
	Fri	day	Sa <sup>-</sup>	turday		
	from	to	from	to		
	11. 00	12. 00	13. 00	14. 00		
Facility hours of operations (1)						
11.00 Clinic	08: 00	17: 00				11. 00

Heal th	Financial Systems		DAVIESS COMMUN	IITY H	OSPI TAL		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL IDENTIFICATION DATA				Provi der	CCN: 150061	Peri od:	Worksheet S-9	
					Component	CCN: 151553	From 01/01/2014 To 12/31/2014		nared:
					component	. 0011. 131333	10 12/31/2014	5/21/2015 12:	29 pm
							Hospi ce I		
		Unduplicated							
		Days							
		Title XVIII	Title XIX		e XVIII	Title XIX	All Other	Total (sum of	
				Sk	illed	Nursi ng		cols. 1, 2 &	
				Nι	ırsi ng	Facility		5)	
				Fa	cility				
		1. 00	2. 00		3. 00	4. 00	5. 00	6. 00	
	PART I - ENROLLMENT DAYS								
1.00	Continuous Home Care	0	0		0		0	0	1.00
2.00	Routine Home Care	2, 927	0		0		0 431	3, 358	2.00
3.00	Inpatient Respite Care	0	0		0		0 0	ol	3.00
4.00	General Inpatient Care	19	0		0		0 3	22	4.00
5.00	Total Hospice Days	2, 946	0		0		0 434	3, 380	5.00

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9.00

Total Hospice Days Part II - CENSUS DATA

Hospi ce Care

to Medicare

5/line 6)

Number of Patients Receiving

Total Number of Unduplicated Continuous Care Hours Billable

Average Length of Stay (line

Unduplicated Census Count

	Heal th	Financial Systems DAVIESS COMMUNITY H	OSPI TAL		In Lie	u of Form CMS-2	2552-10
Discompensated and Indigent care cost computation   1.00				CCN: 150061			
Uncompensated and Indigent care cost computation   1.00						Dato/Timo Pro	narod:
Uncompensated and indigent care cost computation   0.00   0.00   0.048936   1.00   0.00   0.048936   1.00   0.00					10 12/31/2014		
0. 436936   1.00						1. 00	
Medical d (see Instructions for each line)   2.00   Net revenue from Medicaid   7, 262, 206   2.00   Net revenue from Medicaid   7, 263, 206   7, 3.00   7							
Net revenue from Medicald   7, 626, 200   2.00	1. 00		ded by li	ne 202 colum	n 8)	0. 436936	1.00
1	2.00					7, 626, 206	2.00
1, 1   1, 1   1, 2   2, 2   1, 2	3.00	Did you receive DSH or supplemental payments from Medicaid?				Υ	3.00
Medical dicharges	4.00	If line 3 is "yes", does line 2 include all DSH or supplemental	payments	from Medicai	d?	Υ	4.00
Medical d cost (line 1 times line 6)   0   0   0   0   0   0   0   0   0	5.00	If line 4 is "no", then enter DSH or supplemental payments from	Medi cai d			0	5. 00
8.00	6.00					14, 729, 525	6.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)   9,00						6, 435, 860	
State Children's Heal th Insurance Program (SCHIP) (see instructions for each line)   0   0,00	8.00		ine 7 min	nus sum of li	nes 2 and 5; if	0	8. 00
9.00   Net revenue from stand-alone SCHIP   0   0.00   0		,					
10.00   Stand-alone SCHIP charges   0   10.00   11.00   Stand-alone SCHIP cost (line 1 times line 10)   12.00   11.0	0.00		ons for e	each line)		0	0.00
11.00   Stand-alone SCHIP cost (line 1 times line 10)   11.00   12.00   Inference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)   12.00   12.00   13.00   14.00   14.00   14.00   14.00   15.00   14.00   14.00   15.00   14.00   15.0							
12.00   Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then of the state or local government indigent care program (see instructions for each line)   13.00   Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)							
enter zero) Other state or local government indigent care program (see instructions for each line)  13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)  14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)  15.00 State or local indigent care program cost (line 1 times line 14)  16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero) Uncompensated care (see instructions for each line)  17.00 Private grants, donations, or endowment income restricted to funding charity care 0 17.00  18.00 Government grants, appropriations or transfers for support of hospital operations 0 18.00  19.00 Total unreinbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 0 19.00  19.00 Total initial obligation of patients approved for charity care (at full 1, 213, 410 0 2.00 3.00  20.00 Total initial obligation of patients approved for charity care (at full 2, 213, 410 0 1, 2			Tipo 11 m	ninus Lino O	if < zoro thon		
Other state or local government indigent care program (see instructions for each line)   Net revenue from state or local indigent care program (Not included in lines 2, 5 or 9)	12.00		Time ii ii	iiilus IIIle 9,	II < Zero then	0	12.00
13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10) 15.00 State or local indigent care program cost (line 1 times line 14) 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0 16.00 lifference between net revenue and costs for state or local indigent care program (line 15 minus line 0 16.00 lifference between net revenue and costs for state or local indigent care program (line 15 minus line 0 16.00 lifterence between net revenue and costs for state or local indigent care program (line 15 minus line 0 16.00 lifterence line 13; if < zero then enter zero)  17.00 Private grants, donations, or endowment income restricted to funding charity care (line 1 state line 20) 18.00 Government grants, appropriations or transfers for support of hospital operations 0 18.00 lifter (line 1 patients approved for Medicaid state and local indigent care programs (sum of lines 0 19.00 lifterence lines 1 lines 2 lines 1 lines 1 lines 2 lines 1 lines 2 lines 1 lines 2 lines 1 lines 1 lines 2 lines 1 lines 2 lines 1 lines 1 lines 2 lines 1 lines 2 lines 2 lines 1 lines 2 lines 1 lines 2 lines 1 lines 2 lines 1 lines 1			ructions f	or each line	)		
14.00   Charges for patients covered under state or local indigent care program (Not included in lines 6 or 100   14.00   100	13.00					0	13.00
15.00 State or local indigent care program cost (line 1 times line 14)  16.00 DIfference between net revenue and costs for state or local indigent care program (line 15 minus line 1 incompensated care (see instructions for each line)  17.00 Private grants, donations, or endowment income restricted to funding charity care  18.00 Government grants, appropriations or transfers for support of hospital operations  19.00 Total unrelimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)  19.00 Total initial obligation of patients approved for charity care (at full 2.10, 2.00 3.00 3.00  20.00 Total initial obligation of patients approved for charity care (at full 2.10, 2.00 3.00 3.00 cost of initial obligation of patients approved for charity care (line 1 530, 183 0 530, 183 21.00 11.00 2.00 2.00 3.00 530, 183 21.00 11.00 2.00 2.00 23.00 Cost of charity care (line 21 minus line 22) 530, 183 0 530, 183 23.00 24.00 Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?  24.00 Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?  25.00 Total bad debt expense for the entire hospital complex (see instructions) 3, 299, 586 26.00 271, 802 27.00 Medicare bad debts expense (line 26 minus line 27) 3, 207, 784 28.00 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 1, 283, 131 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 1, 283, 131 30.00 1, 283, 131 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 1, 283, 131 30.00 1, 283, 131 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 1, 283, 131 30.00 1, 283, 284, 280, 280, 280, 280, 280, 280, 280, 280						0	14.00
16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line large program (line large program (line large program (line large program (line large program large program large program large program large program (line large program large prog		10)		•			
13; if < zero then enter zero   Uncompensated care (see instructions for each line)   17.00   17.00   17.00   18.00   Government grants, donations, or endowment income restricted to funding charity care   0   17.00   18.00   18.00   19.00   Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines   0   19.00	15.00	State or local indigent care program cost (line 1 times line 14)	)			0	15.00
Uncompensated care (see instructions for each line) Private grants, donations, or endowment income restricted to funding charity care  17. 00 18. 00 19. 00 10 Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines)  19. 00 10 Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines)  19. 00 19. 0	16.00		gent care	e program (li	ne 15 minus line	0	16.00
17.00 Private grants, donations, or endowment income restricted to funding charity care Government grants, appropriations or transfers for support of hospital operations 0 18.00 19.00 Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 0 19.00 1							
18.00 Government grants, appropriations or transfers for support of hospital operations 19.00 Total unrelimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 0 19.00 8, 12 and 16)    Uninsured patients   Insured patients   Foot   Patients   Patients   Patients	17 00					0	17.00
Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)    Uninsured patients			9	,			
8, 12 and 16)    Uninsured patients   Total (col. 1 patients   Patients   Footal (col. 1 patients   Patients   Footal (col. 1 patients   Patients   Patients   Footal (col. 2 patients   Patients   Patients   Footal (col. 2 patients   Patients   Patients   Footal (col. 2 patients   Patie					ume (eum of linos		
patients	19.00		rnar gent	. care progra	iiiis (suiii or rrries		19.00
20.00 Total initial obligation of patients approved for charity care (at full 1, 213, 410 0 1, 213, 410 20.00 charges excluding non-reimbursable cost centers) for the entire facility 21.00 Cost of initial obligation of patients approved for charity care (line 1 times line 20) 530, 183 0 530, 183 21.00 22.00 Partial payment by patients approved for charity care 0 0 0 0 22.00 23.00 Cost of charity care (line 21 minus line 22) 530, 183 0 530, 183 23.00 24.00 Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?  25.00 If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit 0 25.00 26.00 Total bad debt expense for the entire hospital complex (see instructions) 3, 299, 586 26.00 27.00 Medicare bad debts for the entire hospital complex (see instructions) 271, 802 27.00 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 2 times line 28) 1, 322, 948 29.00 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 1, 853, 131 30.00							
20.00 Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility 21.00 Cost of initial obligation of patients approved for charity care (line 1 times line 20) 22.00 Partial payment by patients approved for charity care 23.00 Cost of charity care (line 21 minus line 22)  24.00 Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?  25.00 If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions)  27.00 Medicare bad debts for the entire hospital complex (see instructions)  28.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)  29.00 Cost of uncompensated care (line 23 column 3 plus line 29)  1, 213, 410  0 1, 213, 410  0 530, 183  0 530, 183  0 0 0 22.00  1, 00  20.00 E30, 183  21.00  1.00  22.00  1.00  23.00 E30, 183  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			-				
charges excluding non-reimbursable cost centers) for the entire facility  21. 00 Cost of initial obligation of patients approved for charity care (line 1 times line 20)  22. 00 Partial payment by patients approved for charity care  23. 00 Cost of charity care (line 21 minus line 22)  24. 00 Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?  25. 00 If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit 0 25. 00 Total bad debt expense for the entire hospital complex (see instructions)  27. 00 Medicare bad debts for the entire hospital complex (see instructions)  28. 00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)  29. 00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)  30. 00 Cost of uncompensated care (line 23 column 3 plus line 29)  30. 00 Cost of uncompensated care (line 23 column 3 plus line 29)  530, 183  530, 183  0 530, 183  21. 00  530, 183  21. 00  530, 183  21. 00  530, 183  21. 00  530, 183  21. 00  530, 183  21. 00  530, 183  21. 00  530, 183  21. 00  530, 183  21. 00  530, 183  21. 00  530, 183  530,	20.00	Total initial ablication of actions and according to	(-+ E.I.I				20.00
21.00 Cost of initial obligation of patients approved for charity care (line 1 times line 20)  22.00 Partial payment by patients approved for charity care 0 0 0 0 22.00 23.00 Cost of charity care (line 21 minus line 22) 530, 183 0 530, 183 23.00  24.00 Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?  25.00 If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit 0 25.00 Total bad debt expense for the entire hospital complex (see instructions) 3, 299, 586 26.00 27.00 Medicare bad debts for the entire hospital complex (see instructions) 271, 802 27.00 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27) 3, 027, 784 28.00 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 1, 322, 948 29.00 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 1, 853, 131 30.00	20.00			1, 213, 4	10	1, 213, 410	20.00
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22.00 Partial payment by patients approved for charity care 0 0 0 0 22.00 23.00 Cost of charity care (line 21 minus line 22) 530, 183 0 530, 183 23.00  24.00 Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?  25.00 If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit 0 25.00 27.00 Medicare bad debt expense for the entire hospital complex (see instructions) 3, 299, 586 26.00 27.00 Medicare bad debts for the entire hospital complex (see instructions) 271, 802 27.00 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27) 3, 027, 784 28.00 29.00 Cost of uncompensated care (line 23 column 3 plus line 29) 1, 853, 131 30.00	21.00			330, 10	55	330, 103	21.00
23.00 Cost of charity care (line 21 minus line 22)  24.00 Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?  25.00 If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit 0 25.00 Total bad debt expense for the entire hospital complex (see instructions) 3, 299, 586 26.00 27.00 Medicare bad debts for the entire hospital complex (see instructions) 271, 802 27.00 28.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27) 3,027,784 28.00 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 1,322,948 29.00 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 1,853,131 30.00	22. 00				0 0	0	22. 00
24.00 Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?  25.00 If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit 0 25.00 Total bad debt expense for the entire hospital complex (see instructions) 3, 299, 586 26.00 Medicare bad debts for the entire hospital complex (see instructions) 271, 802 27.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27) 3,027,784 28.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 1,322,948 29.00 Cost of uncompensated care (line 23 column 3 plus line 29) 1,853,131 30.00	23.00		İ	530, 18	33 0	530, 183	23. 00
24.00 Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?  25.00 If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit 0 25.00 Total bad debt expense for the entire hospital complex (see instructions) 3, 299, 586 26.00 Medicare bad debts for the entire hospital complex (see instructions) 271, 802 27.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27) 3,027,784 28.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 1,322,948 29.00 Cost of uncompensated care (line 23 column 3 plus line 29) 1,853,131 30.00						1 00	
imposed on patients covered by Medicaid or other indigent care program?  25.00 If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit 0 25.00  26.00 Total bad debt expense for the entire hospital complex (see instructions) 3, 299, 586 26.00  27.00 Medicare bad debts for the entire hospital complex (see instructions) 271, 802 27.00  28.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27) 3, 027, 784 28.00  29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 1, 322, 948 29.00  30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 1, 853, 131 30.00	24 00	Does the amount in line 20 column 2 include charges for nationt	days hevo	and a Length	of stay limit		24 00
25.00 If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions) 3, 299, 586 26.00 Medicare bad debts for the entire hospital complex (see instructions) 271, 802 27.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27) 3, 027, 784 28.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 1, 853, 131 30.00	24.00			na a rengtii	or stay rimit	.,	24.00
26.00 Total bad debt expense for the entire hospital complex (see instructions)  27.00 Medicare bad debts for the entire hospital complex (see instructions)  28.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)  29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)  30.00 Cost of uncompensated care (line 23 column 3 plus line 29)  3, 299, 586 26.00  271, 802 27.00  3, 027, 784 28.00  1, 322, 948 29.00  1, 853, 131 30.00	25.00			ogram's Lenc	th of stay limit	0	25.00
28.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27) 3,027,784 28.00 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 1,853,131 30.00	26.00				,	3, 299, 586	26.00
29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 1,322,948 29.00 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 1,853,131 30.00	27.00	7.00 Medicare bad debts for the entire hospital complex (see instructions)					
30.00   Cost of uncompensated care (line 23 column 3 plus line 29)   1,853,131   30.00	28. 00	Non-Medicare and non-reimbursable Medicare bad debt expense (lir	ne 26 minu			3, 027, 784	28.00
	29. 00		ense (line	1 times lir	ie 28)	1, 322, 948	
31.00   Total unreimbursed and uncompensated care cost (line 19 plus line 30)   1,853,131   31.00							
	31.00	Total unreimbursed and uncompensated care cost (line 19 plus lir	ne 30)			1, 853, 131	31.00

Health Financial Systems	DAVIESS COMMUNITY	Y HOSPITAL		In Lie	u of Form CMS-	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALAN	CE OF EXPENSES	Provi der		Peri od:	Worksheet A	
				From 01/01/2014 To 12/31/2014	Date/Time Pre	nared:
				10 12/31/2014	5/21/2015 12:	
Cost Center Description	Sal ari es	0ther	,	Recl assi fi cat	Recl assi fi ed	
			+ col . 2)	i ons (See	Trial Balance	
				A-6)	(col. 3 +-	
	1. 00	2. 00	3.00	4. 00	col . 4) 5.00	
GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
1. 00 00100 NEW CAP REL COSTS-BLDG & FIXT		1, 479, 443	1, 479, 44	3 543, 827	2, 023, 270	1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP		2, 257, 561	1		2, 288, 205	1
3.00 00300 OTHER CAPITAL RELATED COSTS		0		0	0	3. 00
4.00   00400 EMPLOYEE BENEFITS DEPARTMENT	186, 853	5, 468, 980	5, 655, 83	3 0	5, 655, 833	
5. 00   00500   ADMINISTRATIVE & GENERAL	1, 729, 719	9, 849, 004			11, 217, 110	1
6. 00 00600 MAI NTENANCE & REPAI RS	518, 207	567, 139			1, 085, 346	1
7. 00 00700 OPERATION OF PLANT	0	779, 055	1		779, 055	
8. 00   00800   LAUNDRY & LI NEN SERVI CE 9. 00   00900   HOUSEKEEPI NG	411, 145	170, 970 118, 524	1		170, 970 529, 669	1
10. 00   01000 DI ETARY	491, 090	573, 568	1		270, 782	1
11. 00 01100 CAFETERI A	0	070,000		628, 846	628, 846	1
13.00 01300 NURSING ADMINISTRATION	724, 657	45, 490	770, 14		770, 147	1
14.00 01400 CENTRAL SERVICES & SUPPLY	246, 020	182, 660	428, 680	0	428, 680	14.00
15. 00   01500 PHARMACY	663, 096	301, 241		7 0	964, 337	15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	520, 255	132, 301	1		652, 556	1
17. 00 01700 SOCI AL SERVI CE	0	186	180	6 79, 210	79, 396	17. 00
INPATIENT ROUTINE SERVICE COST CENTERS	2 211 240	214 552	2 527 70	2 -494, 610	2 022 102	20.00
30.00   03000   ADULTS & PEDIATRICS 31.00   03100   INTENSIVE CARE UNIT	2, 211, 240 644, 777	316, 552 37, 853			2, 033, 182 682, 357	1
40. 00   04000   SUBPROVI DER - I PF	2, 052, 344	286, 539				
41. 00   04100   SUBPROVI DER -   RF	819, 983	630, 372	1		1, 450, 355	1
43. 00   04300   NURSERY	0	19, 577			262, 708	•
ANCILLARY SERVICE COST CENTERS	<u> </u>	•		<u> </u>	·	1
50. 00 05000 OPERATING ROOM	919, 775	1, 271, 797			1, 942, 224	50.00
51. 00   05100   RECOVERY ROOM	0	4, 890			4, 890	•
52. 00   05200   DELIVERY ROOM & LABOR ROOM	0	0	1	251, 081	251, 081	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	668, 285	549, 211	1			1
56. 00   05600   RADI 01 SOTOPE 60. 00   06000   LABORATORY	283, 163 890, 826	196, 654 930, 463	1		479, 817 1, 953, 131	1
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	070, 020	256, 924			256, 924	1
64. 00 06400 I NTRAVENOUS THERAPY	0	34, 035			34, 035	1
65. 00 06500 RESPIRATORY THERAPY	572, 013	126, 779	1		698, 792	1
66. 00 06600 PHYSI CAL THERAPY	661, 083	55, 708	716, 79 <sup>-</sup>	1 20, 706	737, 497	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	253, 103	4, 554	1			
68. 00 06800 SPEECH PATHOLOGY	61, 332	44, 704	1		109, 409	
69. 00   06900   ELECTROCARDI OLOGY 71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENT	67, 358	61, 437	1		128, 795	1
71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 O7200 IMPL. DEV. CHARGED TO PATIENT	S 0	1, 671, 574	1, 671, 57	442, 353	1, 478, 569 442, 353	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	1, 269, 389	1, 269, 389		· ·	
76. 00 03020 CARDI AC REHAB	44, 329	4, 189	1			
OUTPATIENT SERVICE COST CENTERS		•				1
88. 00 08800 DCHMC	432, 329	365, 611	797, 940	0	797, 940	88. 00
88. 01   08801   NDMC/ODON	747, 961	116, 265			864, 226	
88. 02   08802   QUI CK   CARE	524, 934	121, 664			646, 598	
88. 04   08803   PEDI ATRI CS	450, 152	123, 488			573, 640	
88. 05   08804   DAVIESS MARTIN 90. 00   09000   CLINIC	457, 622 228, 297	91, 087 54, 071	1		548, 709 247, 610	
91. 00   09100   EMERGENCY	1, 062, 485	666, 595	1		1, 729, 080	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		000, 373	1, 727, 000		1, 727, 000	92.00
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTE		152, 480	523, 49 <sup>-</sup>	7 -221, 350	302, 147	
OTHER REIMBURSABLE COST CENTERS	<u> </u>	•		<u> </u>	·	1
99. 10 09910 CORF	0	0	) (	0 0	0	99. 10
101.00 10100 HOME HEALTH AGENCY	178, 814	47, 808	226, 62	2 –28, 622	198, 000	101. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300   INTEREST EXPENSE	212 242	945, 054	1		472, 167	
116.00 11600 HOSPICE 118.00 SUBTOTALS (SUM OF LINES 1-117)	219, 049 20, 313, 313	242, 108 32, 625, 554				
NONREI MBURSABLE COST CENTERS	20, 313, 313	32, 020, 054	1 52, 730, 80	-203, 250	52, 735, 017	1110.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	127, 770	127, 770	0	127, 770	192.00
194. 00 07951 OTHER NONREI MBURSABLE AND PHYSI CI AN	- I	714, 276				
200.00 TOTAL (SUM OF LINES 118-199)	22, 891, 206	33, 467, 600				

Provi der CCN: 150061

Cost Center Description					To 12/31/2014 Date/Time Pro 5/21/2015 12:	
CEMPRAL SERVICE COST CENTERS		Cost Center Description	Adjustments	Net Expenses	072172010 12.	Z 7 DIII
FINE RIAL SERVICE COST CENTERS		·	(See A-8)			
CRISTRAL SERVICE COST CENTERS						
1.00   1000	CENED	AL SERVICE COST CENTERS	6.00	7.00		
2.00 00200 (REW CAP REL COSTS-MARLE EQUIP 0 2,288,205 3.00 0330,00 03300,00 03300,00 03300,00 03300,00 03300,00 03300,00 03300,00 03300,00 03300,00 03300,00 0			0	2 023 270	nl	1 00
3. 00 03000 D'INER CAPITAL RELATED COSTS						
5.00			0			
0.00 00000 MAINTERMACE & REPAIRS 0 1,095,346 7.00 00000 GREATION OF PLANT 0 779,055 7.00 00000 GREATION OF PLANT 0 779,055 7.00 00000 GREATION OF PLANT 0 1779,055 7.00 00000 GREATION OF PLANT 0 1779,055 7.00 00000 GREATION OF PLANT 1 1.00 0.00 0000 GREATION 0 1.00 0000 GREATION 0 1.00 0000 GREATION 0 1.00 0000 GREATION 0 1.00 0.00 0.00 0.00 0.00 0.00 0.00 0			-175, 052	5, 480, 781	1	4.00
7. 0. 0     00700 (DePRATI ON OF PLANT     0     779, 065     7. 0       9. 00     00900 (LANDRY & LINEW) SERVICE     0     170, 970     8. 0       9. 00     00900 (LANDRY & LINEW) SERVICE     0     529, 669     9. 00       11. 00     00 1000 (LETRARY)     270, 762     10. 00       11. 00     01 1000 (AFFERS AND MINI STRATION)     271, 767     353, 879     11. 00       15. 00     01 1500 (CERTRAL SERVICES & SUPPLY)     -2, 767     961, 570     15. 00       16. 00     01 1500 (PARAMACY)     -2, 767     961, 570     15. 00       17. 00     01 1500 (PARAMACY)     -2, 767     961, 570     15. 00       18. 00     10 200 (BELCAL SECROS) & LIBRARY     -2, 2, 77     961, 570     15. 00       19. 00     10 200 (BELCAL SERVICE COST CENTERS)     -1, 855     2, 331, 327     30. 00       31. 00     330 00 (MULTS & PEDIATRICS     -1, 855     2, 331, 327     30. 00       31. 00     330 00 (MULTS & PEDIATRICS     -1, 855     2, 331, 327     31. 00       31. 00     330 00 (MULTS & PEDIATRICS     -1, 855     2, 201, 327     31. 00       31. 00     330 00 (MULTS & PEDIATRICS     -1, 85     2, 201, 327     31. 00       31. 00     330 00 (MULTS & PEDIATRICS     -1, 85     2, 201, 327     31			-593, 606	10, 623, 504	4	
9.00   00000   LAUNDRY & LINEN SERVICE   0   170,970   9.00   00000   DISEREPEN   MISSER   0   9.00   10.00   DISEREPEN   MISSER   0   9.00   10.00   DISEREPEN   MISSER   0   9.00   10.00   DISEREPEN   MISSER   0   10.00						
9.00 000000 HUISEKEPING 0 529, 669 9.00 11.00 010000 DIETARY 0 7.07, 782 10.00 11.00 011000 CAFETER A 7.07, 782 11.00 11.00 011000 CHSTRAIL SERVICES & SUPPLY 7.8, 325 355, 385 11.00 11.00 011000 PARABACY 7.07, 787 961, 570 15.00 11.00 011000 PARABACY 7.07, 787 961, 570 15.00 11.00 011000 MICHICAL RECORDS & LIBRARY 7.02, 787 961, 570 15.00 11.00 011000 MICHICAL RECORDS & LIBRARY 7.02, 787 961, 570 15.00 11.00 011000 MICHICAL RECORDS & LIBRARY 7.02, 787 961, 570 17.00 11.00 011000 MICHICAL RECORDS & LIBRARY 7.02, 787 961, 787 961 11.00 011000 MICHICAL RECORDS & LIBRARY 7.02, 787 961, 787 961 11.00 011000 MICHICAL RECORDS & LIBRARY 7.02, 787 961 11.00 011000 MICHICAL RECORDS & 1.07, 789 961 11.00 011000 MICHICAL RECORDS & 1.07, 789 961 11.00 011000 MICHICAL RECORDS & 1.07, 789 961 11.00 011000 MICHICAL RECORDS & 1.07, 789 961 11.00 01000 MICHICAL RECORDS & 1.07, 789 979 979 979 979 979 979 979 979 979						
10.00   01000   DIETARY   0   2770, 782   11.0   010   01300   CAFETERIA   1.1   0.0   01100   CAFETERIA   1.1   0.0   01300   NURSING ADMINISTRATION   7.70, 147   13.0   014.00   01400   CENTRAL SERVICES & SUPPLY   -2, 76, 79   01, 570   15.0   01500   PHARMACY   -2, 76, 79   01, 570   15.0   01500   PHARMACY   -2, 76, 79   01, 570   15.0   01700   SOCI AL SERVICE COST CENTERS   7.70, 306   7.70, 306   7.70, 307   31.0   01700   SOCI AL SERVICE COST CENTERS   7.70, 306   7.70, 306   7.70, 306   7.70, 307   31.0   01700   MTRISTNET CARE UNIT   6.67, 541   1.819, 400   40.0				•	•	
11.00   01100   CAFETERIA   -274, 967   353, 879   11.0   01.4			Ī			
13.0   01300 NURSIN & ADMINISTRATION   0   770, 147   13.0   13.0   15.0   01500 PHARMACY   -2, 767   961, 570   15.0   15.0   15.0   01500 PHARMACY   -2, 767   961, 570   15.0   16.0   01600 MEDI CALL SERVICE   0   79, 396   17.0						
14. 00   01-400  CENTRAL SERVI CES & SUPPLY   -78, 325   350, 355   11-0.00   10-00   PHARMACY   -2, 767   961, 1570   15-00   10-00   PHARMACY   -2, 767   961, 1570   15-00   10-00   PHARMACY   -2, 767   961, 1570   17-00   17-00   17-00   01-00   01-00   OLIVER SERVI CE   -2, -4, 75   627, 081   16-00   0.00   0.00   00-000   00-000   00-00   00-0000   00-0000   00-0000   00-0000   00-0000   00-0000   00-0000   00-0000   00-00000   00-00000			i			1
16. 00   01600   MEDICAL RECORDS & LIBRARY   -25, 475   627, 081   16. 00   17. 00   1700   1700   01700   SOICAL SERVICE   0   79, 396   17. 00   1700   1700   017	14. 00 01400	CENTRAL SERVICES & SUPPLY	-78, 325	350, 355	5	14.00
17. 00   1700   SOCIAL SERVI CE   0   79, 396   17. 00	15. 00 01500	PHARMACY	-2, 767	961, 570	0	15.00
IMPATI ENT ROUTINE SERVICE COST CENTERS   30,00   330,00   03100   0						
30.00   03000   ADULTS & PEDI ATRIC S   -1,855   2,031,327   31.00   40.00   04000   NTENSIVE CARE UNIT			0	79, 396	6	17. 00
31.00   03100   INTENSIVE CARE UNIT   0   682, 357   31.00			1 055	2 021 22	7	20.00
40.00   04000   04000   04000   04000   04000   0410			· · · · · · · · · · · · · · · · · · ·			
41.00   04100   SUBPROVIDER - I FIF   -166, 2c3   1, 284, 092   43.00   A3.00   A3.0			_			
A3. 00   A300   NURSERY						1
50.00   0500	1		· · · · · · · · · · · · · · · · · · ·			1
51.00   05100   RECOVERY ROOM   0   4,890   51.00   52.00   05200   DELIVERY ROOM & LABOR ROOM   0   251.081   52.00   52.00   05200   DELIVERY ROOM & LABOR ROOM   0   251.081   52.00   54.00   05400   RADIO LOCY_DIAGNOSTI C   0   1,316,974   54.00   56.00   05600   RADIO IO STORING, PROCESSI NG & TRANS.   0   256,924   63.00   06300   LABORATORY   7.15,000   0.34,035   64.00   06400   INTRAVENOUS THERAPY   0   34.035   64.00   06400   INTRAVENOUS THERAPY   -62,520   636,272   65.00   06500   RESPIRATORY THERAPY   -2.421   735,076   66.00   06600   PHSI CAL THERAPY   0   262,200   67.00   067.00					_	
S2.00   05200   DELI VERY ROOM & LABOR ROOM   0   251, 081   52, 00	1 1				l .	1
54.00   05400   RADIO LOCY-DIAGNOSTI C   0   1, 316, 974   56, 00   60.00   06000   CABORATORY   -5, 420   474, 397   66, 00   60.00   06000   CABORATORY   -15, 000   1, 938, 131   60, 00   63.00   06300   BLOOD STORI NG, PROCESSI NG & TRANS.   0   256, 924   63, 00   64.00   06400   INTRAVENOUS THERAPY   0   34, 035   64, 00   65.00   06500   RESPI RATORY THERAPY   -2, 421   735, 076   66, 00   66.00   06600   PHYSI CLA, THERAPY   -2, 421   735, 076   66, 00   67.00   06700   0CCUPATI ONAL THERAPY   0   262, 200   67, 00   68.00   06800   SPECER PATHOLOGY   0   109, 409   68, 00   69.00   06900   ELECTROCARDI OLOGY   -53, 958   74, 837   69, 00   72.00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   1, 269, 389   71, 00   73.00   07300   DRUGS CHARGED TO PATI ENTS   0   442, 353   72, 00   73.00   07300   DRUGS CHARGED TO PATI ENTS   0   442, 353   73, 00   75.00   07300   CRUSCH CREHAB   0   48, 518   76, 00   0017PATI ENT SERVI CE COST CENTERS   0   797, 940   88, 00   88.00   08800   DCHMC   0   68, 00   88.01   08800   DCHMC   0   68, 00   88.02   08802   OUNDO   0   68, 00   88.03   08803   DRUGS CHARGES   0   646, 598   88, 02   88.04   08803   PEDI ATRI CS   0   646, 598   88, 02   88.05   08804   DAVIES SS MARTI N   0   548, 709   90, 00   99.00   09000   CLI NI C   0   0   0   99.00   09000   CLI NI C   0   0   0   99.00   09000   CLI NI C   0   0   0   99.00   09000   DEBRENCHY   0   0   198, 000   99.10   09100   CRRESEN   0   0   0   99.10   09100   CRRESEN   0   0   0   99.10   09100   CRRESEN   0   0   0   110.00   10100   HOME HEALTH AGENCY   0   99, 100   110.00   10100   HOME HEALTH AGENCY   0   198, 000   111.00   10100   HOME HEALTH AGENCY   0   100, 000   110.00   10100   HOME HEALTH AGENCY   0   100, 000   110.00   10100   HOME HEALTH AGENCY   0   127, 770   11100   10100   10000   10000   10000   10000   11100   10100   10000   1000					l .	
56.00   05600   RABIO I SOTOPE   -5, 420   474, 397   60.00						
60. 00   06000   LABORATORY   -15,000   1,938,131   60. 00   63. 00   06300   BLOOD STORI NG, PROCESSI NG & TRANS.   0   256,924   63. 00   64. 00   06400   INTRAVENOUS THERAPY   0   34,035   64. 00   65. 00   06500   RESPIRATORY THERAPY   -62,520   636,272   65. 00   66. 00   06600   PHYSI CAL THERAPY   -2,421   735,076   66. 00   66. 00   06600   PHYSI CAL THERAPY   -2,421   735,076   66. 00   66. 00   06600   PHYSI CAL THERAPY   -2,421   735,076   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   0   262,200   67. 00   68. 00   06800   SPECET PATHOLOGY   0   109,409   68. 00   69. 00   06900   ELECTROCARDI OLOGY   -53,958   74,837   69. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   1,478,569   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATIENT   0   442,353   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   1,269,389   73. 00   74. 00   07300   DRUGS CHARGED TO PATIENTS   0   1,269,389   73. 00   75. 00   07300   DRUGS CHARGED TO PATIENTS   0   1,269,389   73. 00   76. 00   30200   CARDIA CREHAB   0   48,518   76.00   00   00   00   00   00   00   00						
64. 00   06400   INTRAVENOUS THERAPY   0   34, 035   65. 00   65. 00   06500   RESPI RATORY THERAPY   -62, 520   636, 272   65. 00   66. 00   06600   PHYSI CAL THERAPY   -2, 421   735, 076   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   0   262, 200   67. 00   68. 00   06600   SPEECH PATHOLOGY   0   0   0   0   69. 00   06900   ELECTROCARDI OLOGY   -53, 958   74, 837   69. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   1, 478, 569   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   1, 269, 389   73. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   1, 269, 389   73. 00   76. 00   03020   CARDIA CREHAB   0   48, 518   76. 00   0000						1
65. 00   66500   RESPIRATORY THERAPY   -62, 520   636, 272   65. 00   66. 00   66600   PHYSI CAL THERAPY   -2, 421   735, 076   66. 00   67. 00   67. 00   67. 00   67. 00   67. 00   67. 00   67. 00   67. 00   67. 00   67. 00   68. 00   6800   SPECH PATHOLOGY   0   109, 409   68. 00   69. 00   6900   ELECTROCARDI OLOGY   -53, 958   74, 837   69. 00   71. 00   71. 00   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   1, 478, 569   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   1, 478, 569   73. 00   73. 00   7300   DRUGS CHARGED TO PATIENTS   0   1, 269, 389   73. 00   73. 00   7300   DRUGS CHARGED TO PATIENTS   0   1, 269, 389   73. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   482, 518   76. 00   76. 00   77. 00   7300   DRUGS CHARGED TO PATIENTS   0   482, 518   76. 00   76. 00   77	63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	256, 924	4	63.00
66. 00   06600   PHYSI CAL THERAPY   -2, 421   735, 076   66. 00   67. 00   6700   06700   06200   06200   063			0	34, 035	5	64.00
67. 00   06700   OCCUPATI ONAL THERAPY   0   262, 200   67. 00   68. 00   06800   SPEECH PATHOLOGY   0   109, 409   68. 00   69. 00   06900   ELECTROCARDI OLOGY   -53, 958   74, 837   69. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   1, 478, 569   77. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   422, 353   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   1, 269, 389   73. 00   76. 00   03020   CARDI AC REHAB   0   48, 518   76. 00   01   00   00						1
68. 00			l			
69. 00   06900   ELECTROCARDIOLOGY						
71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   1, 478, 569   72. 00   720   IMPL. DEV. CHARGED TO PATIENT   0   442, 353   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   1, 269, 389   73. 00   03020   CARDI AC REHAB   0   48, 518   76. 00   03020   CARDI AC REHAB   0   48, 518   76. 00   08801   DMRC/DDON   88. 00   08801   DMRC/DDON   0   864, 226   88. 01   08801   NDMC/DDON   0   864, 226   88. 01   08802   QUI CK CARE   0   646, 598   88. 02   08803   PEDI ATRI CS   0   573, 640   88. 05   08804   DAVI ESS MARTI N   0   548, 709   88. 05   08804   DAVI ESS MARTI N   0   548, 709   88. 05   09. 00   09000   CLI NI C   0   247, 610   99. 00   09100   EMERGENCY   -3, 560   1, 725, 520   99. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART)   92. 00   93. 00   04040   OTHER OUTPATI ENT SERVI CE COST CENTER   -130, 796   171, 351   93. 00   0740   DOME		_				
72. 00 07200   IMPL. DEV. CHARGED TO PATI ENT 0   442, 353   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS 0   1, 269, 389   73. 00   76. 00   03020   CARDI AC REHAB 0   0   48, 518   76. 00   03020   CARDI AC REHAB   0   76. 00   0   0   0   0   0   0   0   0   0	1		l			1
73. 00	1					1
SECOND   CONTRIBUT SERVICE COST CENTERS   SECOND   CONTRIBUTE SERVICE COST CENTERS   SECOND   CONTRIBUTE SERVICE COST CENTERS   SECOND   CONTRIBUTE SERVICE COST CENTERS   SECOND   CONTRIBUTE SERVICE COST CENTERS   SECOND   CONTRIBUTE SERVICE COST CENTERS   SECOND   CONTRIBUTE SERVICE COST CENTERS   SECOND   CONTRIBUTE SERVICE COST CENTERS   SECOND   CONTRIBUTE SERVICE COST CENTERS   SECOND   CONTRIBUTE SERVICE COST CENTERS   SECOND   CONTRIBUTE SERVICE COST CENTER   SECOND	73.00 07300	DRUGS CHARGED TO PATIENTS	0	1, 269, 389	9	73. 00
88. 00			0	48, 518	8	76. 00
88. 01 08801 NDMC/ODON 0 864, 226 88. 01 880.02 QUI CK CARE 0 646, 598 88. 02 88. 04 08803 PEDI ATRI CS 0 573, 640 88. 05 880.04 DAVI ESS MARTI N 0 548, 709 88. 05 90. 00 09000 CLI NI C 0 247, 610 90. 00 91. 00 09100 EMERGENCY -3, 560 1, 725, 520 91. 00 09200 DBSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 09200 DBSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 000 0000 CUT PARTI ENT SERVI CE COST CENTER -130, 796 171, 351 92. 00 000 0000 CORF 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			_		-	
88. 02 08802 OUI CK CARE 0 646, 598 88. 02 88. 04 08803 PEDI ATRI CS 0 573, 640 88. 04 88. 05 08804 DAVI ESS MARTI N 0 548, 709 88. 05 90. 00 09000 CLI NI C 0 0 247, 610 90. 00 91. 00 09100 EMERGENCY -3, 560 1, 725, 520 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 93. 00 04040 OTHER OUTPATI ENT SERVI CE COST CENTER -130, 796 171, 351 93. 00  OTHER REI MBURSABLE COST CENTERS  99. 10 09910 CORF 0 0 99. 10 101. 00 10100 HOME HEALTH AGENCY 0 198, 000 99. 10  SPECI AL PURPOSE COST CENTERS  113. 00 11300 I NTEREST EXPENSE -472, 167 0 113. 00 116. 00 11600 HOSPI CE 0 461, 157 116. 00 118. 00  NONREI MBURSABLE COST CENTERS  192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 127, 770 192. 00 194. 00 07951 OTHER NONREI MBURSABLE AND PHYSI CI AN 0 3, 495, 419 194. 00						1
88. 04 08803 PEDI ATRI CS 0 573, 640 88. 04 88. 05 08804 DAVI ESS MARTI N 0 548, 709 88. 05 90. 00 09000 CLI NI C 0 247, 610 90. 00 91. 00 09100 EMERGENCY -3, 560 1, 725, 520 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 93. 00 04040 OTHER OUTPATI ENT SERVI CE COST CENTER -130, 796 171, 351 93. 00 OTHER REI MBURSABLE COST CENTERS 0 99. 10 101. 00 10100 HOME HEALTH AGENCY 0 198, 000 SPECI AL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE -472, 167 0 113. 00 116. 00 11600 HOSPI CE 0 0 461, 157 116. 00 118. 00 NONREI MBURSABLE COST CENTERS 1192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 127, 770 194. 00 194. 00 07951 OTHER NONREI MBURSABLE AND PHYSI CI AN 0 194. 00						1
88. 05						
90. 00   09000   CLINIC   0   247, 610   90. 00   91. 00   991. 00   09100   EMERGENCY   -3, 560   1, 725, 520   91. 00   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   92. 00   0000   OTHER OUTPATIENT SERVICE COST CENTER   -130, 796   171, 351   93. 00   OTHER REIMBURSABLE COST CENTERS   99. 10   09910   CORF   0   0   0   198, 000   101. 00   OTHER PURPOSE COST CENTERS   113. 00   11300   INTEREST EXPENSE   -472, 167   0   113. 00   OTHER PURPOSE COST CENTERS   0   461, 157   0   116. 00   OTHER PURPOSE COST CENTERS   118. 00   OTHER PURPOSE COST CENTERS   118. 00   OTHER PURPOSE COST CENTERS   0   461, 157   OTHER PURPOSE COST CENTERS   118. 00   OTHER PURPOSE COST CENTERS   118. 00   OTHER PURPOSE COST CENTERS   0   OTHER PURPOSE COST CENTERS   OT						
92. 00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART)   92. 00   04040   OTHER OUTPATI ENT SERVI CE COST CENTER   -130, 796   171, 351   93. 00   OTHER REI MBURSABLE COST CENTERS   99. 10   09910   CORF   0   0   198, 000   101. 00   OTHER REI MBURSABLE COST CENTERS   99. 10   113. 00   OTHER REI MBURSABLE COST CENTERS   0   0461, 157   OTHER REI MBURSABLE AND PHYSI CI AND   0461, 157   OTHER ROORE I			0			
93. 00 0 04040 OTHER OUTPATIENT SERVICE COST CENTER  99. 10 09910 CORF 101. 00 10100 HOME HEALTH AGENCY 101. 00 10100 HOME HEALTH AGENCY 113. 00 11300 I NTEREST EXPENSE 114. 00 11600 HOSPI CE 115. 00 SUBTOTALS (SUM OF LINES 1-117) 116. 00 NONREI MBURSABLE COST CENTERS  117. 351	91.00 09100	EMERGENCY	-3, 560	1, 725, 520	0	91.00
OTHER REIMBURSABLE COST CENTERS   99. 10   09910   CORF   0   0   198,000   101.00   10100   HOME   HEALTH   AGENCY   0   198,000   101.00   SPECIAL   PURPOSE COST CENTERS   -472,167   0   113.00   11300   INTEREST   EXPENSE   -472,167   0   113.00   116.00   HOSPI CE   0   461,157   116.00   SUBTOTALS (SUM OF LINES 1-117)   -4,092,468   48,643,149   118.00   NONREI   MBURSABLE   COST CENTERS   122.00   19200   PHYSI CI   ANS'   PRI VATE OFFI CES   0   127,770   192.00   194.00   07951   OTHER   NONREI   MBURSABLE   AND   PHYSI CI   AND   194.00   194.0						
99. 10 101. 00			-130, 796	171, 351	1	93.00
101. 00   10100   HOME   HEALTH   AGENCY   0   198, 000   101. 00   SPECIAL   PURPOSE   COST   CENTERS   113. 00   11300   INTEREST   EXPENSE   -472, 167   0   113. 00   116. 00   116. 00   118. 00   SUBTOTALS (SUM OF LINES 1-117)   -4, 092, 468   48, 643, 149   118. 00   NONREI   MBURSABLE   COST   CENTERS   122. 00   19200   PHYSI   CI   ANS   PRI VATE   OFFI   CES   0   127, 770   194. 00   194. 00   07951   OTHER   NONREI   MBURSABLE   AND   PHYSI   CI   AND			_	,		00 10
SPECIAL PURPOSE COST CENTERS   113. 00   11300   INTEREST EXPENSE   -472, 167   0   113. 00   116. 00   116. 00   116. 00   116. 00   116. 00   118. 00						
113. 00 116. 00 116. 00 118. 00 118. 00 118. 00    NONREI MBURSABLE COST CENTERS   CAPTON CONTROL OF CONTROL O			0	170,000	<u> </u>	101.00
116. 00   11600   HOSPI CE			-472, 167	(		113. 00
NONREI MBURSABLE COST CENTERS         192.00         19200 PHYSI CI ANS' PRI VATE OFFI CES         0         127,770         192.00           194.00 07951 OTHER NONREI MBURSABLE AND PHYSI CI AN         0         3,495,419         194.00	116. 00 11600	HOSPI CE		461, 157	7	
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 127, 770 192. 00 194. 00 07951 OTHER NONREI MBURSABLE AND PHYSI CI AN 0 3, 495, 419 194. 00			-4, 092, 468	48, 643, 149	9	118. 00
194. 00 07951 OTHER NONREIMBURSABLE AND PHYSICIAN 0 3, 495, 419 194. 00						
200. 00   101/1c (300) 01 LINES (10-177)   -4,072,400  32,200,330    200. 00						
	200.00	1017L (30W OI LINES 110-177)	7, 072, 400	52, 200, 330	<b>~</b> I	<sub>1</sub> 200.00

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

						5/21/2015 12:29 pm
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
	A - DIETARY RECLASS					
1.00	CAFETERI A	11. 00	290, 065	338, 781		1.00
2.00	OTHER NONREI MBURSABLE AND	194.00	76, 123	88, 907		2.00
	PHYSI CI AN		·	·		
	TOTALS		366, 188	427, 688		
	B - INTEREST EXPENSE RECLASS		222, 122	.=.,		
1. 00	NEW CAP REL COSTS-BLDG &	1, 00	0	446, 522		1.00
1.00	FLXT	1.00	٩	110, 022		1.00
2. 00	NEW CAP REL COSTS-MVBLE	2. 00	o	26, 365		2. 00
2.00	EQUI P	2.00	٩	20, 000		2.00
	TOTALS — — — —	+		472, 887		
	C - BILLING COSTS RECLASS		<u> </u>	472,007		
1. 00	OTHER NONREIMBURSABLE AND	194. 00	27, 027	20 742		1.00
1.00	PHYSI CI AN	194.00	21,021	28, 742		1.00
	TOTALS	+				
			27, 027	28, 742		
	D - LAB/XRAY RECLASS	(0.00	440.044	40.77/		
1.00	LABORATORY	60. 00	118, 066	13, 776		1. 00
2.00	RADI OLOGY-DI AGNOSTI C	<u>54.</u> 00	<u>89, 0</u> 83	1 <u>0, 3</u> 95		2.00
	TOTALS		207, 149	24, 171		
	E - SHARED THERAPY RECLASS					
1.00	PHYSI CAL THERAPY	66. 00	17, 612	3, 094		1.00
2.00	OCCUPATI ONAL THERAPY	67. 00	3, 514	1, 029		2.00
3.00	SPEECH PATHOLOGY	6800	<u>3, 0</u> 16	357		3.00
	TOTALS		24, 142	4, 480		
	F - OBSTETRICS RECLASS					
1.00	NURSERY	43. 00	223, 499	19, 632		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52. 00	230, 807	20, 274		2.00
	TOTALS		454, 306	39, 906		
	G - INSURANCE RECLASS			•		
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	97, 305		1.00
	FLXT			,		
2.00	NEW CAP REL COSTS-MVBLE	2. 00	o	4, 279		2.00
	EQUI P			., =		
3.00	OTHER NONREIMBURSABLE AND	194, 00	0	179, 013		3.00
	PHYSI CI AN			,		
	TOTALS	+		280, 597		
	I - IMPLANTABLE DEVICES			200,077		
1. 00	IMPL. DEV. CHARGED TO	72. 00	0	442, 353		1.00
55	PATI ENT	, 2. 55	Ĭ	, 000		1:00
2. 00	7.11 2.11	0. 00	0	0		2.00
2.00	TOTALS — — — —			442, 353		2.00
	J - SOCIAL SERVICES RECLASS		<u> </u>	442, 555		
1. 00	SOCIAL SERVICES RECLASS	17. 00	79, 210	0		1.00
2. 00	SOUTAL SERVICE	0.00	79, 210	0		2.00
3. 00	1	0.00	0	0		3.00
	1	0.00		0		4. 00
4.00			O O			
5. 00		0.00		0		5. 00
	TOTALS		79, 210	0		
	K - PHYSICIAN FEE		0 . ===1	-1		
1. 00	OTHER NONREI MBURSABLE AND	194. 00	34, 758	0		1.00
	PHYSI CI AN					
2. 00	SUBPROVI DER - I PF	4000	17 <u>1, 9</u> 79	0		2.00
	TOTALS		206, 737	0		
500 00	Grand Total: Increases		1, 364, 759	1, 720, 824		500.00

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

					10	5/21/2015	
		Decreases		•		,, <b>,</b> , , , , , , , , , , , , , , , , ,	
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
	A - DIETARY RECLASS						
1.00	DI ETARY	10. 00	366, 188	427, 688	0		1. 00
2.00		0. 00	0	C			2. 00
	TOTALS		366, 188	427, 688			
	B - INTEREST EXPENSE RECLASS	<u> </u>	<u>.                                      </u>				
1.00	INTEREST EXPENSE	113. 00	0	472, 887	7 11		1.00
2.00		0. 00	0	C	11		2.00
	TOTALS	$   \top$	0	472, 887			
	C - BILLING COSTS RECLASS		<u>.</u>				
1.00	ADMINISTRATIVE & GENERAL	5. 00	27, 027	28, 742			1.00
	TOTALS	$   \top$	27, 027	28, 742			
	D - LAB/XRAY RECLASS		<u> </u>				
1.00	OTHER NONREIMBURSABLE AND	194. 00	207, 149	24, 171	0		1.00
	PHYSI CI AN						
2.00		0.00	o	C	o o		2.00
	TOTALS	$   \top$	207, 149	24, 171			
	E - SHARED THERAPY RECLASS		<u> </u>				
1.00	HOME HEALTH AGENCY	101. 00	24, 142	4, 480	0		1.00
2.00		0.00	o	C	o o		2.00
3.00		0.00	О	C	o		3.00
	TOTALS		24, 142	4, 480			
	F - OBSTETRICS RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	454, 306	39, 906	0		1.00
2.00		0.00	0	C	o		2. 00
	TOTALS		454, 306	39, 906			
	G - INSURANCE RECLASS				<u>'</u>		
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	280, 597	7 12		1.00
2.00		0.00	0	·	12		2. 00
3. 00		0.00	o	C	12		3. 00
	TOTALS			280, 597			
	I - IMPLANTABLE DEVICES	<u> </u>	· ·		<u>'</u>		
1.00	OPERATING ROOM	50.00	0	249, 348	0		1.00
2.00	MEDICAL SUPPLIES CHARGED TO	71. 00	o	193, 005	5 0		2. 00
	PATI ENTS						
	TOTALS			442, 353			
	J - SOCIAL SERVICES RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5. 00	25, 247	C	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	398	C	o		2. 00
3.00	INTENSIVE CARE UNIT	31. 00	273	C	o		3.00
4.00	SUBPROVI DER - I PF	40.00	3, 921	C	o		4.00
5.00	OTHER OUTPATIENT SERVICE	93. 00	49, 371	C	o		5. 00
	COST CENTER			_			
	TOTALS	+	79, 210		<del>                                     </del>		
	K - PHYSICIAN FEE		, 1	-			
1.00	CLINIC	90.00	34, 758	C	0		1.00
2. 00	OTHER OUTPATIENT SERVICE	93. 00	171, 979	C	l l		2.00
	COST CENTER		, , , ,	_			
	TOTALS	+	206, 737				
500.00	Grand Total: Decreases		1, 364, 759	1, 720, 824	1		500.00
	•						

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 150061

					o 12/31/2014	Date/Time Pre	pared:
				A		5/21/2015 12:	29 pm
		D	D	Acqui si ti ons	T. 1.1	D:	
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances	0.00	2.00	4.00	Retirements	
	DADT I ANALYCIC OF QUANCEC IN CARLTAL ACCE	1. 00	2. 00	3. 00	4. 00	5. 00	
4 00	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						4 00
1.00	Land	1, 280, 955	0	0	0	0	1.00
2. 00	Land Improvements	687, 865	0	0	0	0	2.00
3. 00	Buildings and Fixtures	38, 572, 140	130, 272	0	130, 272	0	3.00
4. 00	Building Improvements	39, 119	0	0	0	0	4.00
5.00	Fixed Equipment	3, 823, 019	379, 220		379, 220		5.00
6.00	Movable Equipment	26, 274, 142	658, 435	0	658, 435	109, 026	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	70, 677, 240	1, 167, 927	0	1, 167, 927	109, 026	8.00
9.00	Reconciling Items	0	0	C	0	0	9.00
10.00	Total (line 8 minus line 9)	70, 677, 240	1, 167, 927	0	1, 167, 927	109, 026	10.00
		Endi ng	Ful I y				
		Bal ance	Depreciated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00	Land	1, 280, 955	0				1.00
2.00	Land Improvements	687, 865	0				2.00
3.00	Buildings and Fixtures	38, 702, 412	0				3.00
4.00	Building Improvements	39, 119	0				4.00
5.00	Fi xed Equi pment	4, 202, 239	0				5.00
6.00	Movable Equipment	26, 823, 551	0				6.00
7. 00	HIT designated Assets	ol	0				7.00
8. 00	Subtotal (sum of lines 1-7)	71, 736, 141	0				8.00
9. 00	Reconciling Items	0	0				9. 00
10.00	Total (line 8 minus line 9)	71, 736, 141	0				10.00
	1 ( 2	, , , , , , , , , , , , , , , ,	ŭ	ı		ı ı	

Heal th	Health Financial Systems		IITY HOSPITAL		In Lieu of Form CMS-25		
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 01/01/2014	Worksheet A-7	
					To 12/31/2014		pared:
			Sl	JMMARY OF CAPI	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
					(see	instructions)	
					instructions)		
		9. 00	10. 00	11. 00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	RKSHEET A, COLU	MN 2, LINES 1 a	and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	1, 252, 720	6, 000	220, 72	3 0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1, 836, 005	338, 826		0 0	82, 730	2.00
3.00	Total (sum of lines 1-2)	3, 088, 725	344, 826	220, 72	3 0	82, 730	3.00
		SUMMARY O	F CAPITAL				
	Cost Conton Description	Other	Total (1)				
	Cost Center Description		Total (1)				
		Capi tal -Rel at					
		ed Costs (see instructions)	9 through 14)				
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WO			 			
1 00		KNSHEET A, CULUI					1.00
1.00	NEW CAP REL COSTS MARIE FOLLO	0	1, 479, 443	•			
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	2, 257, 561				2.00
3. 00	Total (sum of lines 1-2)	1 0	3, 737, 004	I			3. 00

Heal th	n Financial Systems	DAVIESS COMMUN	IITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 01/01/2014 Fo 12/31/2014		pared:
					_	5/21/2015 12:	29 pm_
		COMI	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
	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 & FLXT	44, 912, 590	0	,			1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	26, 823, 551	0	26, 823, 55	0. 373920	0	2.00
3.00	Total (sum of lines 1-2)	71, 736, 141	0	71, 736, 14	1 1. 000000	0	3.00
		ALLOCATION OF OTHER CAPITAL		SUMMARY C	OF CAPITAL		
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
	•		Capi tal -Rel at				
			ed Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS O	ENTERS		•	<u>'</u>		
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	(	1, 252, 720	6,000	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		1, 836, 005	338, 826	2.00
3.00	Total (sum of lines 1-2)	0	0		3, 088, 725	344, 826	3.00
			SL	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
	, , , , , , , , , , , , , , , , , , ,		(see		Capi tal -Rel at		
			instructions)	ĺ	ed Costs (see		
			,		instructions)		
		11. 00	12. 00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	NEW CAP REL COSTS-BLDG & FLXT	667, 245	97, 305	(	0	2, 023, 270	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	26, 365		82, 730	0		2.00
3.00	Total (sum of lines 1-2)	693, 610	101, 584	82, 730	0	4, 311, 475	3.00
	·				1		

Health Financial Systems
ADJUSTMENTS TO EXPENSES Provi der CCN: 150061

					) 12/31/2014	5/21/2015 12:	
				Expense Classification on To/From Which the Amount is 1			
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2) 1. 00	2. 00	3.00	4. 00	Ref. 5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			NEW CAP REL COSTS-BLDG &	1. 00		1.00
2. 00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2. 00	0	2.00
3. 00	Investment income - other (chapter 2)		0		0. 00	0	3.00
4. 00	Trade, quantity, and time	В	-78, 325	CENTRAL SERVICES & SUPPLY	14. 00	0	4.00
5. 00	discounts (chapter 8) Refunds and rebates of		0		0. 00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by suppliers (chapter 8)		0		0. 00	0	6. 00
7. 00	Telephone services (pay stations excluded) (chapter		0		0. 00	0	7. 00
8. 00	21) Television and radio service (chapter 21)	Α	-8, 370	ADMINISTRATIVE & GENERAL	5. 00	0	8. 00
9. 00 10. 00	Parking Lot (chapter 21)	A-8-2	-2, 462, 273		0. 00	O O	
11. 00			0		0. 00	0	11.00
12. 00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13. 00 14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee		-274, 967 0	CAFETERI A	0. 00 11. 00 0. 00	0	14.00
16. 00	supplies to other than		О		0. 00	0	16. 00
17. 00	patients Sale of drugs to other than patients	В	-2, 767	PHARMACY	15. 00	0	17. 00
18. 00	Sale of medical records and abstracts	В	-25, 475	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	1		0		0. 00	0	19. 00
	Vending machines Income from imposition of interest, finance or penalty	А	-433	ADMINISTRATIVE & GENERAL	0. 00 5. 00		
22. 00	charges (chapter 21) Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0. 00	0	22. 00
23. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
24. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
25. 00	limitation (chapter 14) Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
26. 00	(chapter 21) Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG &	1. 00	0	26. 00
27. 00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
28. 00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28.00
29. 00 30. 00	Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	0. 00 67. 00		29. 00 30. 00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30. 99

Heal th	Health Financial Systems			IITY HOSPITAL	In Lieu of Form CMS-2552-10		
ADJUST	MENTS TO EXPENSES				Peri od:	Worksheet A-8	}
					From 01/01/2014		norod.
					To 12/31/2014	Date/Time Pre 5/21/2015 12:	
				Expense Classification or	Worksheet A	37 2 17 20 13 12.	2 / piii
				To/From Which the Amount is			
					,		
		5 , 6					
Cost Center Description Basis/Code			Amount	Cost Center	Li ne #	Wkst. A-7	
		(2) 1. 00	2. 00	3. 00	4.00	Ref. 5.00	
31. 00	Adjustment for speech	A-8-3		SPEECH PATHOLOGY	68. 00	5.00	31.00
31.00	pathology costs in excess of	A-0-3		SPEECH FAIHOLOGI	00.00		31.00
	limitation (chapter 14)						
32 00	CAH HIT Adjustment for		0		0.00	0	32.00
02.00	Depreciation and Interest				0.00	· ·	02.00
33.00	ADVERTI SI NG EXPENSES	A	-297, 746	ADMINISTRATIVE & GENERAL	5. 00	0	33.00
34.00	PHYSICIAN RECRUITMENT EXPENSES			ADMINISTRATIVE & GENERAL	5. 00	0	34.00
35.00	PUBLIC RELATIONS	Α	-16, 050	ADMINISTRATIVE & GENERAL	5. 00	0	35.00
35. 01	NON-ALLOWABLE COSTS	Α	-8, 892	ADMINISTRATIVE & GENERAL	5. 00	0	35. 01
35. 02	NON-ALLOWABLE COSTS	Α	-2, 421	PHYSI CAL THERAPY	66. 00	0	35. 02
35.03	DONATI ONS	Α	-7, 100	ADMINISTRATIVE & GENERAL	5. 00	0	35.03
35.04	PHYSICIAN BENEFITS	Α	-175, 052	EMPLOYEE BENEFITS DEPARTMEN	T 4.00	0	35.04
36.00	CPR CLASS INCOME	В	-3, 560	EMERGENCY	91. 00	0	36.00
36. 01	MISC. INCOME	В	-17, 803	ADMINISTRATIVE & GENERAL	5. 00	0	36. 01
36. 02	INTEREST EXPENSE OFFSET	Α	-472, 167	INTEREST EXPENSE	113. 00	0	36. 02
	NON-ALLOWABLE COSTS	Α		ADULTS & PEDIATRICS	30.00	0	38. 00
	LOBBYING EXPENSE	Α		ADMINISTRATIVE & GENERAL	5. 00	0	07.00
40.00	DEBT ISSUANCE COST	Α	21, 425	ADMINISTRATIVE & GENERAL	5. 00	0	40.00

-4, 092, 468

50.00

50.00 TOTAL (sum of lines 1 thru 49)

(Transfer to Worksheet A,

AMORTI ZATI ON

column 6, line 200.)

<sup>(1)</sup> Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).

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

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

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT | Peri od: | Worksheet A-8-2 | From 01/01/2014 | To 12/31/2014 | Date/Time Prepared: Provi der CCN: 150061

					7	To 12/31/2014	Date/Time Pre   5/21/2015 12:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
	MRSt. 7 Erne #	I denti fi er	Remuneration	Component	Component	ROL AMOUNT	ider Component	
		- admirri di	Tromarior a cr orr	00porrorre	oomponone.		Hours	
	1.00	2.00	3. 00	4. 00	5. 00	6. 00	7. 00	
1. 00		SUBPROVIDER - IPF	687, 541	687, 541	0	0	0	1. 00
2.00	41.00	SUBPROVI DER - I RF	166, 263	166, 263	0	0	0	2.00
3.00	50.00	OPERATING ROOM	1, 340, 775	1, 340, 775	0	0	0	3.00
4.00	56. 00	RADI OI SOTOPE	5, 420	5, 420	0	0	0	4.00
5.00		RESPI RATORY THERAPY	62, 520	62, 520	0	0	0	5.00
6.00	69. 00	ELECTROCARDI OLOGY	53, 958	53, 958	0	0	0	6.00
7.00	93. 00	OTHER OUTPATIENT SERVICE	130, 796	130, 796	0	0	0	7.00
		COST CENTER						
8. 00		LABORATORY	15, 000	15, 000	0	-	0	8. 00
9. 00	0.00		0	0	0	0	0	9. 00
10.00	0.00		0	0	0	1	0	10.00
200.00			2, 462, 273					200.00
	Wkst. A Line #		Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er	Li mi t	Unadjusted RCE		Component	of Malpractice	
				Limit	Continuing	Share of col.	Insurance	
	1.00	2.00	0.00	0.00	Education	12 13. 00	14.00	
1 00	1. 00	2.00 SUBPROVI DER - I PF	8. 00	9.00	12.00		14.00	1. 00
1. 00 2. 00		SUBPROVIDER - IPF		0				2. 00
3. 00		OPERATING ROOM		0		-	· -	3. 00
4. 00	•	RADI OI SOTOPE		0	_	0	0	4. 00
5. 00		RESPIRATORY THERAPY		0		,	0	5. 00
6. 00		ELECTROCARDI OLOGY		0		0	0	6. 00
7. 00		OTHER OUTPATIENT SERVICE		0	_	0	0	7. 00
7.00	70.00	COST CENTER		Ĭ		l	J	7.00
8. 00	60.00	LABORATORY		0	0	0	0	8. 00
9. 00	0.00			Ō	0	0	0	9. 00
10.00	0.00			0	0	0	0	10.00
200.00				0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1. 00		SUBPROVI DER - I PF	0	0	_			1.00
2. 00		SUBPROVI DER - I RF	0	0	_			2.00
3. 00		OPERATING ROOM	0	0	_	1,010,770		3. 00
4.00		RADI OI SOTOPE		0	_	-,		4.00
5. 00		RESPIRATORY THERAPY		0	_	,		5.00
6.00		ELECTROCARDI OLOGY		0	_	,		6.00
7. 00	93.00	OTHER OUTPATIENT SERVICE COST CENTER		0	0	130, 796		7. 00
8.00	60.00	LABORATORY	0	0	0	15, 000		8.00
9.00	0.00			0	0	0		9.00
10.00	0.00		0	0	_	_		10.00
200.00				0	0	2, 462, 273		200.00

| Peri od: | Worksheet B | From 01/01/2014 | Part | To | 12/31/2014 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 150061

					To	12/31/2014	Date/Time Pre	pared:
				CAPI TAL REL	ATED COSTS		5/21/2015 12:	29 pm
		Cost Center Description	Net Expenses	NEW BLDG &	NEW MVBLE	EMPLOYEE	Subtotal	
			for Cost Allocation	FLXT	EQUI P	BENEFITS DEPARTMENT		
			(from Wkst A			<i>52.7</i> 7 2 1		
			col. 7)					
	CENED	AL SERVICE COST CENTERS	0	1. 00	2. 00	4. 00	4A	
1. 00		NEW CAP REL COSTS-BLDG & FIXT	2, 023, 270	2, 023, 270				1.00
2. 00		NEW CAP REL COSTS-MVBLE EQUIP	2, 288, 205	_, ===, ===	2, 288, 205			2.00
4. 00		EMPLOYEE BENEFITS DEPARTMENT	5, 480, 781	5, 176		5, 485, 957		4. 00
5.00	1	ADMINISTRATIVE & GENERAL	10, 623, 504	116, 049		405, 314	13, 025, 261	5.00
6. 00 7. 00		MAINTENANCE & REPAIRS OPERATION OF PLANT	1, 085, 346 779, 055	63, 611 409, 044	0 0	125, 212 0	1, 274, 169 1, 188, 099	6. 00 7. 00
8. 00		LAUNDRY & LINEN SERVICE	170, 970	4, 403	Ö	o	175, 373	8.00
9.00		HOUSEKEEPI NG	529, 669	14, 576	973	99, 343	644, 561	9. 00
10.00		DIETARY	270, 782	38, 221	0	30, 180	339, 183	
11. 00 13. 00		CAFETERIA NURSI NG ADMI NI STRATI ON	353, 879 770, 147	14, 001 28, 124	0 8, 153	70, 087 175, 096	437, 967 981, 520	11. 00 13. 00
14. 00		CENTRAL SERVICES & SUPPLY	350, 355	42, 285	· ·	59, 445	452, 085	14.00
15.00	01500	PHARMACY	961, 570	17, 112	83, 514	160, 221	1, 222, 417	15.00
16. 00	1	MEDICAL RECORDS & LIBRARY	627, 081	93, 318		125, 707	884, 888	16. 00
17. 00		SOCIAL SERVICE	79, 396	0	142	19, 139	98, 677	17. 00
30. 00		I ENT ROUTI NE SERVI CE COST CENTERS ADULTS & PEDI ATRI CS	2, 031, 327	89, 312	8, 470	424, 425	2, 553, 534	30.00
31. 00	1	INTENSIVE CARE UNIT	682, 357	22, 542		155, 729	860, 628	
40.00	1	SUBPROVI DER - I PF	1, 819, 400	92, 790		536, 507	2, 473, 406	
41.00	1	SUBPROVI DER - I RF	1, 284, 092	81, 779		198, 129	1, 564, 000	41.00
43.00		NURSERY	262, 708	8, 975	449	54, 003	326, 135	43.00
50. 00		LARY SERVICE COST CENTERS  OPERATING ROOM	601, 449	118, 133	20, 287	222, 242	962, 111	50.00
51.00	05100	RECOVERY ROOM	4, 890	16, 133	2, 680	222, 242	23, 994	51.00
52. 00		DELIVERY ROOM & LABOR ROOM	251, 081	92, 922		55, 769	407, 298	
54.00		RADI OLOGY-DI AGNOSTI C	1, 316, 974	114, 701	11, 730	183, 000	1, 626, 405	54.00
56.00		RADI OI SOTOPE	474, 397	10, 729		68, 420	575, 843	
60.00	1	LABORATORY	1, 938, 131	32, 112		243, 775	2, 214, 276	60.00
63. 00 64. 00		BLOOD STORING, PROCESSING & TRANS. INTRAVENOUS THERAPY	256, 924 34, 035	1, 876 0		0	260, 621 47, 685	63. 00 64. 00
65.00		RESPIRATORY THERAPY	636, 272	24, 673		138, 213	799, 158	65.00
66.00		PHYSI CAL THERAPY	735, 076	31, 603	0	163, 990	930, 669	66.00
67. 00		OCCUPATI ONAL THERAPY	262, 200	6, 732		62, 005	330, 937	67.00
68. 00		SPEECH PATHOLOGY	109, 409	4, 771	1, 367	15, 548	131, 095	
69. 00 71. 00		ELECTROCARDIOLOGY MEDICAL SUPPLIES CHARGED TO PATIENTS	74, 837 1, 478, 569	5, 845 0	5, 384 460	16, 275 0	102, 341 1, 479, 029	69. 00 71. 00
71.00		IMPL. DEV. CHARGED TO PATIENTS	442, 353	0	0	0	442, 353	
73. 00		DRUGS CHARGED TO PATIENTS	1, 269, 389	3, 026		Ö	1, 272, 415	
76.00		CARDI AC REHAB	48, 518	21, 684	0	10, 711	80, 913	76. 00
		TIENT SERVICE COST CENTERS	707.040	45.043		404.440	242.242	
88. 00	1	DCHMC	797, 940	45, 867		104, 462	948, 269	
88. 01 88. 02		NDMC/ODON QUI CK CARE	864, 226 646, 598	32, 847 50, 487	9, 245 0	180, 727 126, 838	1, 087, 045 823, 923	
88. 04	1	PEDI ATRI CS	573, 640	18, 309		108, 768	700, 717	88. 04
88. 05		DAVIESS MARTIN	548, 709	24, 051	20, 472	110, 573	703, 805	
90.00		CLINIC	247, 610	35, 440	5, 443	46, 764	335, 257	90. 00
91.00		EMERGENCY	1, 725, 520	79, 667	0	256, 724	2, 061, 911	91.00
92. 00 93. 00		OBSERVATION BEDS (NON-DISTINCT PART) OTHER OUTPATIENT SERVICE COST CENTER	171, 351	55, 003	0	36, 163	0 262, 517	92.00 93.00
73.00		REIMBURSABLE COST CENTERS	171, 351	55, 003	<u> </u>	30, 103	202, 317	73.00
	09910	CORF	0	0		0	0	99. 10
101.00		HOME HEALTH AGENCY	198, 000	12, 869	0	37, 373	248, 242	101. 00
110 00		AL PURPOSE COST CENTERS	1					110.00
		I NTEREST EXPENSE HOSPI CE	461, 157	5, 515	0	52, 928	519, 600	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	48, 643, 149	1, 986, 604	2, 168, 206	4, 879, 805	47, 880, 332	
	-	IMBURSABLE COST CENTERS		., , 55, 561		., 3, 7, 300	, 355, 562	
		PHYSICIANS' PRIVATE OFFICES	127, 770	0	16, 388	0	144, 158	
		OTHER NONREIMBURSABLE AND PHYSICIAN	3, 495, 419	36, 666	103, 611	606, 152	4, 241, 848	
200. 00 201. 00		Cross Foot Adjustments Negative Cost Centers		0	0	0		200. 00 201. 00
201.00		TOTAL (sum lines 118-201)	52, 266, 338	2, 023, 270	- 1	5, 485, 957	52, 266, 338	
_52.00	1	1.1 (54 1.1.65 1.16 201)	32, 200, 000	2, 323, 210	2, 200, 200	5, 100, 707	32, 200, 000	

| Peri od: | Worksheet B | From 01/01/2014 | Part | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Da Provi der CCN: 150061

					T	o 12/31/2014	Date/Time Pre 5/21/2015 12:	
	Cost Cente	er Description	ADMI NI STRATI V	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	2 / piii
		·	E & GENERAL	REPAI RS	PLANT	LINEN SERVICE		
	OFNEDAL CEDIUSE	OOCT OFNITERS	5. 00	6. 00	7. 00	8. 00	9. 00	
	GENERAL SERVICE	EL COSTS-BLDG & FLXT						1.00
		EL COSTS-BEDG & TTXT						2.00
		BENEFITS DEPARTMENT						4.00
	00500 ADMI NI STRA		13, 025, 261					5. 00
6.00	00600 MAI NTENANG	CE & REPAIRS	422, 934	1, 697, 103				6. 00
7. 00	00700 OPERATI ON	OF PLANT	394, 365	377, 601	1, 960, 065			7. 00
	00800 LAUNDRY &		58, 211	4, 064		243, 685		8. 00
	00900 HOUSEKEEPI	NG	213, 948			0	891, 951	9.00
	01000 DI ETARY 01100 CAFETERI A		112, 585			975	24, 171	
	01300 NURSING AL	MI NI STRATI ON	145, 374 325, 795	l	1	0	8, 854 17, 786	
		ERVICES & SUPPLY	150, 060	l		0	26, 741	14.00
	01500 PHARMACY	ERVI 023 & 3011 21	405, 756	l	1	o	10, 822	
		CORDS & LIBRARY	293, 720	l	1	0	59, 015	
	01700 SOCIAL SEF		32, 754	0	0	0	0	17. 00
		NE SERVICE COST CENTERS						
	03000 ADULTS & F		847, 592	l			56, 481	30.00
	03100   I NTENSI VE 04000   SUBPROVI DE		285, 667 820, 995		1	24, 368 24, 368	14, 256 58, 681	
	04100 SUBPROVI DE		519, 137	l			51, 717	
	04300 NURSERY		108, 254				5, 676	43.00
	ANCILLARY SERVI	CE COST CENTERS					.,	
	05000 OPERATI NG		319, 353	1		34, 116	74, 706	
	05100 RECOVERY F		7, 964	1		0	10, 386	
		ROOM & LABOR ROOM	135, 194			0	58, 765	1
	05400 RADI 0L0GY-		539, 851	105, 883		1, 462	72, 538	
	05600 RADI 01 SOTO 06000 LABORATOR		191, 139 734, 982			0	6, 785 20, 308	
		RING, PROCESSING & TRANS.	86, 508	1		0	1, 187	63.00
	06400 I NTRAVENOL		15, 828	l	1	o	0	64. 00
65. 00	06500 RESPI RATOR	RY THERAPY	265, 264	ł	33, 833	0	15, 603	65. 00
	06600 PHYSI CAL 1		308, 916	29, 173	43, 335	0	19, 986	66. 00
	06700 OCCUPATI ON		109, 848	l	1	0	4, 257	
	06800 SPEECH PAT		43, 514			0	3, 017	
	06900 ELECTROCAF	IPPLIES CHARGED TO PATIENTS	33, 970	l	1	0 0	3, 697	69. 00 71. 00
		CHARGED TO PATTENTS	490, 933 146, 830	ł		0	0	71.00
		RGED TO PATIENTS	422, 351	ł			1, 914	73.00
	03020 CARDI AC RE		26, 857	l	1	O	13, 713	
		CE COST CENTERS						
	08800 DCHMC		314, 758			0	29, 007	88. 00
	08801 NDMC/ODON	_	360, 822	l		0	20, 773	
	08802 QUI CK CARE 08803 PEDI ATRI CS		273, 484 232, 588	•		0	31, 928 11, 579	
	08804 DAVIESS MA		232, 588	l		0	15, 210	
	09000 CLI NI C		111, 282			o	22, 412	
	09100 EMERGENCY		684, 408			24, 368	50, 382	
		ON BEDS (NON-DISTINCT PART)						92. 00
		PATIENT SERVICE COST CENTER	87, 137	50, 775	75, 423	0	34, 784	93. 00
		BLE COST CENTERS				ما	0	00 10
	09910 CORF 10100 HOME HEALT	TH ACENCY	82, 399			0		99. 10 101. 00
	SPECIAL PURPOSE		02, 377	11,660	17,047	U <sub>I</sub>	0, 137	101.00
	11300 I NTEREST E							113. 00
	11600 H0SPI CE		172, 470			0		116. 00
118. 00	SUBTOTALS	(SUM OF LINES 1-117)	11, 569, 410	1, 663, 256	1, 909, 787	243, 685	868, 764	118. 00
	NONREI MBURSABLE		47.050			ما	^	102.00
		S' PRIVATE OFFICES REIMBURSABLE AND PHYSICIAN	47, 850 1, 408, 001	33, 847	50, 278	0	23, 187	192. 00 194. 00
200.00		: Adjustments	1, 400, 001	33,047	50, 276	١	23, 107	200.00
201.00		Cost Centers	0			О	0	201. 00
202. 00		n lines 118-201)	13, 025, 261	1, 697, 103	1, 960, 065	243, 685	891, 951	

| Period: | Worksheet B | From 01/01/2014 | Part | To | 12/31/2014 | Date/Time Prepared: Provi der CCN: 150061

			Te	12/31/2014	Date/Time Pre	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI O N	CENTRAL SERVI CES & SUPPLY	5/21/2015 12: PHARMACY	29 pm
	10. 00	11. 00	13.00	14.00	15. 00	
GENERAL SERVICE COST CENTERS						
1. 00   00100   NEW CAP REL COSTS-BLDG & FIXT 2. 00   00200   NEW CAP REL COSTS-MVBLE EQUIP 4. 00   00400   EMPLOYEE BENEFITS DEPARTMENT 5. 00   00500   ADMINISTRATIVE & GENERAL						1. 00 2. 00 4. 00 5. 00
6. 00   00600   MAI NTENANCE & REPAI RS 7. 00   00700   OPERATI ON OF PLANT 8. 00   00800   LAUNDRY & LI NEN SERVI CE						6. 00 7. 00 8. 00
9. 00   00900   HOUSEKEEPI NG 10. 00   01000   DI ETARY	564, 608					9. 00 10. 00
11. 00 01100 CAFETERI A	0	624, 317				11.00
13.00 O1300 NURSING ADMINISTRATION 14.00 O1400 CENTRAL SERVICES & SUPPLY	0	20, 065 11, 056		736, 959		13. 00 14. 00
15. 00 01500 PHARMACY		13, 882		444	1, 692, 582	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	o	21, 711		11	0	16.00
17. 00 01700 SOCI AL SERVI CE	0	4, 743	0	51	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS	140 414	75 517	204 440	17 51/	0	20.00
30. 00   03000   ADULTS & PEDIATRICS 31. 00   03100   NTENSIVE CARE UNIT	168, 614 51, 597	75, 517 22, 975		17, 516 4, 189	0	30. 00 31. 00
40. 00   04000 SUBPROVI DER -   PF	244, 968	68, 279		7, 260	0	40.00
41. 00   04100   SUBPROVI DER -   I RF	99, 429	26, 752		3, 459	0	41.00
43. 00 04300 NURSERY	0	8, 466	32, 113	4, 888	0	43.00
ANCILLARY SERVICE COST CENTERS 50.00 OPERATING ROOM	0	31, 649	120, 053	19, 005	0	50. 00
51. 00   05100   RECOVERY   ROOM		31,049	1	276	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	o o	8, 742	_	0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	o	31, 702		12, 922	0	54.00
56. 00   05600   RADI 01 SOTOPE	0	8, 016			0	56.00
60.00 06000 LABORATORY	0	41, 819		134, 010	0	60. 00 63. 00
63. 00   06300   BLOOD STORING, PROCESSING & TRANS. 64. 00   06400   NTRAVENOUS THERAPY		0	0	58, 932	0	64.00
65. 00 06500 RESPIRATORY THERAPY	o	18, 253	_	7, 873	0	65.00
66. 00   06600 PHYSI CAL THERAPY	o	20, 529		252	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	7, 021	0	29	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	1, 445		0	0	68.00
69. 00   06900   ELECTROCARDI OLOGY 71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		2, 300	0	684 423, 881	0	69. 00 71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	o	0	ő	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	O	0	0	0	1, 692, 582	73.00
76. 00 03020 CARDI AC REHAB	0	1, 345	5, 102	126	0	76. 00
OUTPATIENT SERVICE COST CENTERS  88.00 OS800 DCHMC	O	15 212		556	0	00 00
88. 01   08801   NDMC/ODON		15, 213 17, 437	1	2, 070	0	88. 00 88. 01
88. 02   08802   QUI CK   CARE	o	15, 575	1	1, 493	0	88. 02
88. 04   08803   PEDI ATRI CS	O	10, 492	0	1, 092	0	88.04
88. 05   08804   DAVI ESS   MARTI N	0	13, 772		872	0	88. 05
90. 00   09000   CLI NI C 91. 00   09100   EMERGENCY	0	2, 561 33, 449			0	90. 00 91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		33, 447	120,003	7, 740	O .	92.00
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER OTHER REIMBURSABLE COST CENTERS	0	5, 524	0	54	0	93. 00
99. 10 09910 CORF	0	0		0	0	99. 10
101.00 10100 HOME HEALTH AGENCY	0	5, 231	19, 841	95	0	101. 00
SPECIAL PURPOSE COST CENTERS  113.00 11300 INTEREST EXPENSE	Г					113. 00
116. 00 11600 H0SPI CE	o	7, 683	29, 142	14, 529	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	564, 608	573, 204			1, 692, 582	
NONREI MBURSABLE COST CENTERS				· •		
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192.00
194.00 07951 OTHER NONREIMBURSABLE AND PHYSICIAN 200.00 Cross Foot Adjustments	0	51, 113	0	3, 360		194. 00 200. 00
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers	٥	Ω	n	٥	n	200. 00 201. 00
202.00 TOTAL (sum lines 118-201)	564, 608	624, 317	1, 409, 693	736, 959	1, 692, 582	
	. '			,	'	

	OCATION - GENERAL SERVICE COSTS	DAVIESS COMMUNI		CCN: 150061 P	eriod:	Worksheet B	2552-10
COST ALL	OCATION - GENERAL SERVICE COSTS		riovidei		rom 01/01/2014	Part I Date/Time Pre 5/21/2015 12:	
	Cost Center Description	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	27 Jiii
		16. 00	17. 00	24.00	25. 00	26. 00	
1. 00	ENERAL SERVICE COST CENTERS  D1000 NEW CAP REL COSTS-BLDG & FIXT  D2000 NEW CAP REL COSTS-WDBLE EQUIP  D4000 EMPLOYEE BENEFITS DEPARTMENT  D5000 ADMINISTRATIVE & GENERAL  D6000 MAINTENANCE & REPAIRS  D7000 OPERATION OF PLANT  D8000 LAUNDRY & LINEN SERVICE  D9000 HOUSEKEEPING  D10000 DIETARY  CAFETERIA  13000 NURSING ADMINISTRATION  14000 CENTRAL SERVICES & SUPPLY  PHARMACY  16000 MEDICAL RECORDS & LIBRARY  17000 SOCIAL SERVICE	1, 473, 454 0	136, 225				1. 00 2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 13. 00 14. 00 15. 00 16. 00
	NPATIENT ROUTINE SERVICE COST CENTERS	47 (2)	225	4 260 140	٥	4 240 140	20.00
31. 00 03 40. 00 04 41. 00 04 43. 00 04	3000 ADULTS & PEDIATRICS 3100 INTENSIVE CARE UNIT 4000 SUBPROVIDER - IPF 4100 SUBPROVIDER - IRF 4300 NURSERY	47, 626 35, 991 109, 393 39, 658 8, 676	225 150 2, 901 0 0	4, 368, 149 1, 438, 693 4, 282, 152 2, 617, 629 514, 801	0 0	4, 368, 149 1, 438, 693 4, 282, 152 2, 617, 629 514, 801	31.00 40.00 41.00
	NCILLARY SERVICE COST CENTERS	120 027	ما	1 052 072	٥	1 052 072	FO 00
50. 00   05 51. 00   05 52. 00   05 54. 00   05 56. 00   05 60. 00   06 63. 00   06 64. 00   06 67. 00   06 68. 00   07 72. 00   07 73. 00   07 74. 00   08 88. 01   08 88. 02   08 88. 04   08 88. 04   08 88. 05   08 90. 00   09 91. 00   09	5000 OPERATING ROOM 5100 RECOVERY ROOM 5100 RECOVERY ROOM 5200 DELIVERY ROOM & LABOR ROOM 5400 RADIOLOGY-DIAGNOSTIC 6400 RADIOLOGY-DIAGNOSTIC 65000 LABORATORY 5300 BLOOD STORING, PROCESSING & TRANS. 1 NTRAVENOUS THERAPY 6500 RESPIRATORY THERAPY 6500 PHYSICAL THERAPY 6500 PHYSICAL THERAPY 6500 ELECTROCARDIOLOGY 6700 OCCUPATIONAL THERAPY 6500 ELECTROCARDIOLOGY 67100 MEDICAL SUPPLIES CHARGED TO PATIENTS 67200 IMPL. DEV. CHARGED TO PATIENTS 67200 IMPL. DEV. CHARGED TO PATIENTS 67200 CARDIAC REHAB 67200 DRUGS CHARGED TO PATIENTS 67300 DCHMC 67300 DCHMC 67300 DCHMC 67300 OCH CARE 67400 CLINIC 67500 DAVIESS MARTIN 67500 DRUGS CARE 67500 DAVIESS MARTIN 67500 DAVIESS MARTIN 67500 DRUGS CHARGENCY 67500 DRUGS CHARGENCY 67500 DAVIESS MARTIN 67500 DRUGS CHARGENCY 67500 DRU	120, 837 9, 785 8, 960 202, 102 60, 511 267, 837 12, 454 10, 301 45, 130 38, 139 17, 983 3, 941 16, 054 56, 909 9, 734 97, 081 1, 117 20, 145 18, 125 20, 018 16, 950 14, 570 24, 913 104, 006	0 0 0 0 0 0 0 543 0 0 0 0 0 0 0 0 0	1, 952, 872 90, 087 865, 319 2, 870, 407 898, 559 3, 645, 541 424, 007 74, 357 1, 207, 890 1, 390, 999 485, 520 193, 958 172, 458 2, 450, 752 598, 917 3, 493, 287 178, 925  1, 433, 185 1, 581, 636 1, 282, 258 1, 015, 427 1, 037, 024 585, 778 3, 275, 941	0 0 0 0 0 0 0 0 0 0 0	1, 952, 872 90, 087 865, 319 2, 870, 407 898, 559 3, 645, 541 424, 007 74, 357 1, 207, 890 1, 390, 999 485, 520 193, 958 172, 458 2, 450, 752 598, 917 3, 493, 287 178, 925  1, 433, 185 1, 581, 636 1, 282, 258 1, 015, 427 1, 037, 024 585, 778 3, 275, 941	51. 00 52. 00 54. 00 56. 00 60. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 71. 00 72. 00 73. 00 76. 00 88. 01 88. 02 88. 04 88. 05 90. 00
	4040 OTHER OUTPATIENT SERVICE COST CENTER THER REIMBURSABLE COST CENTERS	14, 972	40, 611	571, 797	0	571, 797	93.00
99. 10 09 101. 00 10		0 2, 221	0 36, 718	0 432, 413		0 432, 413	
113. 00 11 116. 00 11 118. 00	1300 INTEREST EXPENSE 1600 HOSPICE SUBTOTALS (SUM OF LINES 1-117) DNREIMBURSABLE COST CENTERS	11, 558 1, 467, 697	55, 077 136, 225	826, 201 46, 256, 939	0		
192. 00 19	OPPOSITE MONTAGE OF CENTERS  79200 PHYSICIANS' PRIVATE OFFICES  7951 OTHER NONREIMBURSABLE AND PHYSICIAN  Cross Foot Adjustments  Negative Cost Centers  TOTAL (sum lines 118-201)	0 5, 757 0 1, 473, 454	0 0 0 136, 225	192, 008 5, 817, 391 0 0 52, 266, 338	0 0 0	0	194. 00 200. 00 201. 00
202.00	TOTAL (Suil TITIES TTO-201)	1, 4/3, 434	130, 225	JZ, ZUU, JSO	ı Vı	JZ, ZUU, JSO	<sub>1</sub> 202.00

| Peri od: | Worksheet B | From 01/01/2014 | Part | I | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 150061

				To	12/31/2014	Date/Time Pre 5/21/2015 12:	
			CAPI TAL REI	ATED COSTS		3/21/2013 12.	29 μιι
	Cost Center Description	Directly	NEW BLDG &	NEW MVBLE	Subtotal	EMPLOYEE	
		Assigned New Capital	FLXT	EQUI P		BENEFITS DEPARTMENT	
		Related Costs				DEPARTMENT	
		0	1. 00	2.00	2A	4. 00	
	GENERAL SERVICE COST CENTERS						
1. 00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		E 174	0	F 17/	F 17/	2.00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	0	5, 176 116, 049	l	5, 176 1, 996, 443		4. 00 5. 00
6. 00	00600 MAI NTENANCE & REPAI RS	0	63, 611		63, 611	118	6.00
7. 00	00700 OPERATION OF PLANT	0	409, 044	1	409, 044	0	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	4, 403	0	4, 403	0	8. 00
9. 00	00900 HOUSEKEEPI NG	0	14, 576	1	15, 549	94	9. 00
10.00	01000 DI ETARY	0	38, 221	0	38, 221	28	10.00
11. 00 13. 00	O1100   CAFETERI A   O1300   NURSI NG   ADMI NI STRATI ON	0	14, 001	0 153	14, 001	66	11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	28, 124 42, 285		36, 277 42, 285	165 56	14.00
15. 00	01500 PHARMACY	0	17, 112	1	100, 626		15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	93, 318		132, 100		16.00
17. 00	01700 SOCI AL SERVI CE	0	0	142	142	18	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS		00.010	0.470	07.700		
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0	89, 312 22, 542		97, 782 22, 542		30.00 31.00
40.00	04000 SUBPROVI DER – I PF	0	92, 790	l	117, 499		40.00
41. 00	04100 SUBPROVI DER - I RF	0	81, 779		81, 779		41.00
	04300 NURSERY	0	8, 975	l	9, 424	51	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	118, 133		138, 420		50.00
51. 00 52. 00	O5100   RECOVERY ROOM   O5200   DELIVERY ROOM & LABOR ROOM	0	16, 424 92, 922		19, 104 100, 448	0 53	51.00 52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	92, 922 114, 701		126, 431	173	54.00
56. 00	05600 RADI OI SOTOPE	0	10, 729		33, 026		56.00
60.00	06000 LABORATORY	0	32, 112		32, 370		60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	1, 876	1, 821	3, 697	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0		13, 650		64.00
65.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	24, 673	1	24, 673		65.00
66. 00 67. 00	06700 OCCUPATI ONAL THERAPY	0	31, 603 6, 732	1	31, 603 6, 732	155 59	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	0	4, 771	1	6, 138		68.00
69. 00	06900 ELECTROCARDI OLOGY	0	5, 845		11, 229		69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	460	460		71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	0		0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS 03020 CARDIAC REHAB	0	3, 026		3, 026 21, 684	0 10	73. 00 76. 00
76.00	OUTPATIENT SERVICE COST CENTERS	U	21, 684	J U	21,084	10	76.00
88. 00	08800 DCHMC	0	45, 867	0	45, 867	99	88. 00
88. 01	08801 NDMC/ODON	0	32, 847	9, 245	42, 092	171	88. 01
	08802 QUI CK CARE	0	50, 487		50, 487		88. 02
	08803 PEDI ATRI CS	0	18, 309		18, 309		
88. 05 90. 00	O8804   DAVIESS MARTIN   O9000   CLINIC	0	24, 051 35, 440		44, 523 40, 883		1
91.00	09100 EMERGENCY	0	79, 667		79, 667	242	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		77,007		0	212	92.00
	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	55, 003	0	55, 003	34	ł
	OTHER REIMBURSABLE COST CENTERS						
	09910 CORF	0		1	0		
101.00	10100 HOME HEALTH AGENCY	0	12, 869	0	12, 869	35	101. 00
113 00	SPECIAL PURPOSE COST CENTERS 11300   NTEREST EXPENSE						113. 00
	11600 HOSPI CE	0	5, 515	0	5, 515	50	116.00
118.00	1	0	1, 986, 604		4, 154, 810		118.00
	NONREI MBURSABLE COST CENTERS						
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	16, 388	16, 388		192.00
	07951 OTHER NONREIMBURSABLE AND PHYSICIAN	0	36, 666	103, 611	140, 277		194. 00
200. 00 201. 00			0	0	0		200. 00 201. 00
201.00		0			4, 311, 475		201.00
_52.50	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	١	_,,,	_, _,200,200	., 5.1, 175	5, 170	, 50

Health Financial Systems DAVIESS COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150061 | Period: From 01/01/2014 | To 12/31/2014 | Date/Time Prepared:

					T	o 12/31/2014	Date/Time Pre 5/21/2015 12:	pared:
		Cost Center Description	ADMI NI STRATI V	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	29 μιι
		<u>'</u>	E & GENERAL	REPAI RS	PLANT	LINEN SERVICE		
	OFNED	AL CERVILOE COCT CENTERS	5. 00	6. 00	7. 00	8. 00	9. 00	
1. 00		AL SERVICE COST CENTERS  NEW CAP REL COSTS-BLDG & FIXT						1.00
2. 00		NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00		EMPLOYEE BENEFITS DEPARTMENT		•				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1, 996, 825					5.00
6.00		MAINTENANCE & REPAIRS	64, 837	128, 566				6. 00
7. 00	1	OPERATION OF PLANT	60, 458					7.00
8. 00 9. 00		LAUNDRY & LINEN SERVICE HOUSEKEEPING	8, 924 32, 799	308 1, 019		15, 169 0	54, 540	8. 00 9. 00
10.00		DI ETARY	17, 260			61	1, 478	1
11. 00		CAFETERI A	22, 286			0	541	•
13.00	01300	NURSING ADMINISTRATION	49, 946	1, 967	9, 800	0	1, 088	13.00
14. 00		CENTRAL SERVICES & SUPPLY	23, 005			0	1, 635	1
15.00	1	PHARMACY	62, 204			0	662	•
16. 00 17. 00		MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	45, 028 5, 021	6, 526 0		0	3, 609 0	ł
17.00		I ENT ROUTINE SERVICE COST CENTERS	5,021	0		l o	0	17.00
30.00		ADULTS & PEDIATRICS	129, 939	6, 246	31, 123	6, 825	3, 454	30.00
31.00		INTENSIVE CARE UNIT	43, 794	1, 576		1, 517	872	1
40.00		SUBPROVI DER - I PF	125, 862				3, 588	1
41.00		SUBPROVI DER - I RF	79, 586	· ·			3, 162	1
43. 00		NURSERY LARY SERVICE COST CENTERS	16, 596	628	3, 128	0	347	43.00
50.00		OPERATING ROOM	48, 958	8, 261	41, 169	2, 124	4, 568	50.00
51. 00	1	RECOVERY ROOM	1, 221	1, 149		0	635	•
52.00	05200	DELIVERY ROOM & LABOR ROOM	20, 726	6, 498	32, 381	0	3, 593	52.00
54.00		RADI OLOGY-DI AGNOSTI C	82, 761	8, 021		91	4, 435	1
56. 00		RADI OI SOTOPE	29, 302	750		0	415	•
60.00	1	LABORATORY	112, 676			0	1, 242	1
63. 00 64. 00		BLOOD STORING, PROCESSING & TRANS. INTRAVENOUS THERAPY	13, 262 2, 426	131 0		0	73 0	63. 00 64. 00
65. 00	1	RESPIRATORY THERAPY	40, 666			o	954	•
66. 00		PHYSI CAL THERAPY	47, 358			0	1, 222	•
67.00		OCCUPATI ONAL THERAPY	16, 840	471	2, 346	0	260	67.00
68. 00		SPEECH PATHOLOGY	6, 671	334		0	184	1
69.00	1	ELECTROCARDI OLOGY	5, 208			0	226	•
71. 00 72. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENT	75, 262 22, 510	0   0	•	0	0	71.00 72.00
73. 00		DRUGS CHARGED TO PATIENTS	64, 748	_		o	117	•
76. 00		CARDI AC REHAB	4, 117	1, 516		0	839	76.00
		TIENT SERVICE COST CENTERS						
88. 00		DCHMC	48, 254			0	1, 774	1
88. 01		NDMC/ODON	55, 315			0	1, 270	1
88. 02 88. 04	1	QUI CK CARE PEDI ATRI CS	41, 926 35, 657	3, 531 1, 280		0	1, 952 708	1
88. 05		DAVIESS MARTIN	35, 814	1, 682		ő	930	
90.00	09000	CLINIC	17, 060			0	1, 370	90.00
		EMERGENCY	104, 922	5, 571	27, 762	1, 517	3, 081	91.00
		OBSERVATION BEDS (NON-DISTINCT PART)	10.050		10.4/7		0.407	92.00
93. 00		OTHER OUTPATIENT SERVICE COST CENTER	13, 358	3, 846	19, 167	0	2, 127	93.00
99. 10		REIMBURSABLE COST CENTERS	0	0	0	0	0	99. 10
	1	HOME HEALTH AGENCY	12, 632			o		101.00
		AL PURPOSE COST CENTERS	,		.,	-		
	1	INTEREST EXPENSE						113.00
		HOSPI CE	26, 440			0		116.00
118. 00		SUBTOTALS (SUM OF LINES 1-117)	1, 773, 635	126, 002	485, 331	15, 169	53, 122	118. 00
192 00		IMBURSABLE COST CENTERS PHYSICIANS' PRIVATE OFFICES	7, 336	0	0	٥	0	192. 00
	1	OTHER NONREIMBURSABLE AND PHYSICIAN	215, 854			ol	1. 418	194. 00
200.00		Cross Foot Adjustments	]	_, 30 .	1=,		.,	200.00
201.00	1	Negative Cost Centers	0	0	_	o		201. 00
202.00	)	TOTAL (sum lines 118-201)	1, 996, 825	128, 566	498, 108	15, 169	54, 540	202. 00

Provi der CCN: 150061

					12/31/2014	5/21/2015 12:	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI O N	CENTRAL SERVI CES & SUPPLY	PHARMACY	
		10. 00	11. 00	13. 00	14. 00	15.00	
	GENERAL SERVICE COST CENTERS						
1. 00 2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY	73, 040					1.00 2.00 4.00 5.00 6.00 7.00 8.00 9.00
11.00	01100 CAFETERI A	0	42, 752				11.00
13.00	01300 NURSING ADMINISTRATION	O	1, 374				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	757	0	85, 430		14.00
15.00	01500 PHARMACY	0	951	0	51	171, 805	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	1, 487		1	0	16.00
17.00	01700 SOCI AL SERVI CE	0	325	0	6	0	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	04.040	- 170		0.004		
30.00	03000 ADULTS & PEDI ATRI CS	21, 813	5, 170		2, 031	0	
31. 00 40. 00	03100   INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	6, 675	1, 573		486 842	0	31.00 40.00
	04100 SUBPROVI DER – T PF	31, 689 12, 863	4, 676 1, 832		401	0	41.00
	04300 NURSERY	12, 803	1, 632 580		567	0	43.00
43.00	ANCILLARY SERVICE COST CENTERS	<u> </u>	300	2, 272	307	0	43.00
50.00	05000 OPERATING ROOM	0	2, 167	8, 569	2, 203	0	50.00
51.00	05100 RECOVERY ROOM	O	0		32	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	599	2, 367	o	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	2, 171	8, 583	1, 498	0	54.00
56.00	05600 RADI OI SOTOPE	0	549		144	0	56.00
60.00	06000 LABORATORY	0	2, 864		15, 535	0	60.00
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	6, 832	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY		1, 250		913	0	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY		1, 406 481		29	0	67.00
68. 00	06800 SPEECH PATHOLOGY		99	-	0	0	68.00
69. 00	06900 ELECTROCARDI OLOGY	0	157	l o	79	0	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	49, 136	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	О	o	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	o	171, 805	73.00
76.00	03020 CARDI AC REHAB	0	92	364	15	0	76.00
	OUTPATIENT SERVICE COST CENTERS			1 -1	1		
88. 00	08800 DCHMC	0	1, 042		64	0	
88. 01 88. 02	08801   NDMC/ODON	0	1, 194		240	0	88. 01 88. 02
88. 04	08803 PEDIATRICS		1, 067 718		173 127	0	88. 04
	08804 DAVIESS MARTIN		943		101	0	88. 05
	09000 CLI NI C	0	175		932	0	1
	09100 EMERGENCY	0	2, 291		898	0	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	378	0	6	0	93. 00
	OTHER REIMBURSABLE COST CENTERS						
	09910 CORF	0	0		0		99. 10
101.00	10100 HOME HEALTH AGENCY	0	358	1, 416	11	0	101.00
112 00	SPECIAL PURPOSE COST CENTERS 11300   INTEREST EXPENSE	T T		I	T		113.00
	11600 HOSPI CE	0	526	2, 080	1, 684	0	116.00
118. 00		73, 040	39, 252		85, 040	171, 805	
110.00	NONREI MBURSABLE COST CENTERS	70,010	07, 202	100, 017	00, 010	171,000	1110.00
192. 00	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	0	0	192.00
	07951 OTHER NONREIMBURSABLE AND PHYSICIAN	0	3, 500	0	390		194. 00
200. 00							200. 00
201.00		0	0	_	0		201. 00
202. 00	TOTAL (sum lines 118-201)	73, 040	42, 752	100, 617	85, 430	171, 805	202.00

Heal th F	Financial Systems	DAVIESS COMMUNI	TY HOSPITAL		In Lie	u of Form CMS-	2552-10
ALLOCATI	ION OF CAPITAL RELATED COSTS		Provi der		Period: From 01/01/2014 To 12/31/2014		epared:
	Cost Center Description	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	29 pili
	ENEDAL CEDULCE COCT CENTERS	16. 00	17. 00	24. 00	25. 00	26. 00	
1. 00 0 2. 00 0 4. 00 0 5. 00 0 6. 00 0 7. 00 0 8. 00 0 9. 00 0 11. 00 0 11. 00 0 14. 00 0	ENERAL SERVICE COST CENTERS  10100 NEW CAP REL COSTS-BLDG & FIXT  10200 NEW CAP REL COSTS-MVBLE EQUIP  10400 EMPLOYEE BENEFITS DEPARTMENT  10500 ADMINISTRATIVE & GENERAL  10600 MAINTENANCE & REPAIRS  10700 OPERATION OF PLANT  10800 LAUNDRY & LINEN SERVICE  10900 HOUSEKEEPING  11100 CAFETERIA  111300 NURSING ADMINISTRATION  11400 CENTRAL SERVICES & SUPPLY						1. 00 2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00
1	11600 MEDICAL RECORDS & LIBRARY	221, 389					16. 00
	11700 SOCIAL SERVICE NPATIENT ROUTINE SERVICE COST CENTERS	0	5, 512	2			17. 00
30. 00 0 31. 00 0 40. 00 0 41. 00 0 43. 00 0	3000 ADULTS & PEDIATRICS 3100 INTENSIVE CARE UNIT 4000 SUBPROVIDER - IPF 4100 SUBPROVIDER - IRF 4300 NURSERY	7, 154 5, 406 16, 433 5, 957 1, 303	9 6 117 C C	98, 66 360, 03 228, 74	9 0 9 0 4 0	98, 669 360, 039 228, 744	31. 00 40. 00 41. 00
	NCILLARY SERVICE COST CENTERS 15000 OPERATING ROOM	18, 152	C	274, 80	1 0	274, 801	50.00
52. 00 0 54. 00 0 56. 00 0 60. 00 0 63. 00 0 64. 00 0 65. 00 0 66. 00 0 67. 00 0 68. 00 0	## 105100 RECOVERY ROOM   ## 105200 DELI VERY ROOM & LABOR ROOM   ## 105400 RADI OLOGY-DI AGNOSTI C   ## 105600 RADI OI SOTOPE   ## 106300 BLOOD STORI NG, PROCESSI NG & TRANS.   ## 106400 I NTRAVENOUS THERAPY   ## 106500 RESPI RATORY THERAPY   ## 106600 PHYSI CAL THERAPY   ## 106700 OCCUPATI ONAL THERAPY   ## 106800 SPEECH PATHOLOGY   ## 106800 SPEECH PATHOLOGY   ## 106800 SPECCH PATHOLOGY	1, 470 1, 346 30, 360 9, 090 40, 284 1, 871 1, 547 6, 779 5, 729 2, 701 592 2, 412	0 0 0 0 0 22 0 0 0	168, 01 304, 49 79, 25 229, 95 26, 52 17, 64 85, 68 100, 72 29, 89	1 0 0 5 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	168, 011 304, 495 79, 250 229, 959 26, 520 17, 645 85, 688 100, 725 29, 893 15, 695	52.00 54.00 56.00 60.00 63.00 64.00 65.00 66.00 67.00 68.00
	17100 MEDICAL SUPPLIES CHARGED TO PATIENTS	8, 549	C				1
72. 00 0 73. 00 0 76. 00 0	17200 IMPL. DEV. CHARGED TO PATIENT 17300 DRUGS CHARGED TO PATIENTS 13020 CARDIAC REHAB UTPATIENT SERVICE COST CENTERS	1, 462 14, 583 168	C C C	255, 54	6 0	23, 972 255, 546	72. 00 73. 00
88. 00 0 88. 01 0 88. 02 0	18800 DCHMC 18801 NDMC/ODON 18802 QUI CK CARE	3, 026 2, 723 3, 007	0	119, 85	8 0 6 0	116, 748 119, 856	88. 01 88. 02
	18803 PEDIATRICS 18804 DAVIESS MARTIN	2, 546 2, 189	C	65, 82 94, 66			1
90.00 0	9000 CLI NI C	3, 742	C	79, 03	4 0	79, 034	90.00
92. 00 0 93. 00 0	19100 EMERGENCY 19200 OBSERVATION BEDS (NON-DISTINCT PART) 14040 OTHER OUTPATIENT SERVICE COST CENTER THER REIMBURSABLE COST CENTERS	15, 624 2, 249	1, 643	250, 63 97, 81	0		91. 00 92. 00 93. 00
99. 10 0	19910 CORF 0100 HOME HEALTH AGENCY	0 334	1, 486	1	0 4 0		99. 10 101. 00
113. 00 1 116. 00 1 118. 00	PECIAL PURPOSE COST CENTERS  1300   INTEREST EXPENSE  1600   HOSPI CE SUBTOTALS (SUM OF LINES 1-117)  ONREI MBURSABLE COST CENTERS	1, 736 220, 524	2, 229 5, 512	1			113. 00 116. 00 118. 00
192. 00 1	OUNREIMBURSABLE COST CENTERS 9200 PHYSICIANS' PRIVATE OFFICES 17951 OTHER NONREIMBURSABLE AND PHYSICIAN Cross Foot Adjustments Negative Cost Centers TOTAL (sum lines 118-201)	0 865 0 221, 389	C C C 5, 512		6 0 0 0 0 0	378, 216 0 0	200. 00 201. 00

	ILLOOM	TION SINTISTICAL BASIS		Trovider	F	rom 01/01/2014 o 12/31/2014		pared: 29 pm
			CAPITAL RELA	ATED COSTS				
		Cost Center Description	NEW BLDG & FLXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	
			1. 00	2. 00	SALARI ES) 4. 00	5A	5. 00	
1. 00		AL SERVICE COST CENTERS NEW CAP REL COSTS-BLDG & FIXT	214, 602				I	1.00
2. 00		NEW CAP REL COSTS-BEDG & TTAT	214, 002	1, 109, 776				2.00
4. 00 5. 00		EMPLOYEE BENEFITS DEPARTMENT	549	011 000			20 241 077	4.00
6.00		ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS	12, 309 6, 747	911, 989 0			39, 241, 077 1, 274, 169	1
7.00	1	OPERATION OF PLANT	43, 386	0				1
8. 00 9. 00		LAUNDRY & LINEN SERVICE HOUSEKEEPING	467 1, 546	0 472		_	175, 373 644, 561	8. 00 9. 00
10.00	1	DIETARY	4, 054	0			339, 183	1
11. 00 13. 00		CAFETERIA NURSI NG ADMI NI STRATI ON	1, 485 2, 983	0 3, 954			437, 967 981, 520	1
14.00		CENTRAL SERVICES & SUPPLY	4, 485	0			452, 085	1
15. 00 16. 00	1	PHARMACY MEDICAL RECORDS & LIBRARY	1, 815 9, 898	40, 504 18, 809			1, 222, 417 884, 888	
17. 00	01700	SOCIAL SERVICE	0	69			98, 677	1
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	9, 473	4, 108	1, 756, 536	0	2, 553, 534	30.00
31.00	03100	INTENSIVE CARE UNIT	2, 391	0	644, 504	0	860, 628	31.00
40. 00 41. 00		SUBPROVI DER - I PF SUBPROVI DER - I RF	9, 842 8, 674	11, 984 0			2, 473, 406 1, 564, 000	1
43.00	04300	NURSERY	952	218				1
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	12, 530	9, 839	919, 775	0	962, 111	50.00
51.00		RECOVERY ROOM	1, 742	1, 300	C	0	23, 994	51.00
52. 00 54. 00		DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC	9, 856 12, 166	3, 650 5, 689			407, 298 1, 626, 405	1
56.00	05600	RADI OI SOTOPE	1, 138	10, 814	283, 163	0	575, 843	56.00
60. 00 63. 00		LABORATORY BLOOD STORING, PROCESSING & TRANS.	3, 406 199	125 883			2, 214, 276 260, 621	1
64.00	06400	INTRAVENOUS THERAPY	О	6, 620	C	0	47, 685	64.00
65. 00 66. 00		RESPI RATORY THERAPY PHYSI CAL THERAPY	2, 617 3, 352	0			799, 158 930, 669	1
67.00	06700	OCCUPATI ONAL THERAPY	714	0	256, 617	0	330, 937	67.00
68. 00 69. 00		SPEECH PATHOLOGY ELECTROCARDI OLOGY	506 620	663 2, 611	64, 348 67, 358		131, 095 102, 341	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	223	C	0	1, 479, 029	71.00
72. 00 73. 00		IMPL. DEV. CHARGED TO PATIENT DRUGS CHARGED TO PATIENTS	0 321	0			442, 353 1, 272, 415	
76. 00	03020	CARDI AC REHAB	2, 300	0				1
88. 00		TIENT SERVICE COST CENTERS DCHMC	4, 865	0	432, 329	0	948, 269	88. 00
88. 01	08801	NDMC/ODON	3, 484	4, 484	747, 961	0	1, 087, 045	88. 01
88. 02 88. 04	1	QUI CK CARE PEDI ATRI CS	5, 355 1, 942	0			823, 923 700, 717	1
88. 05	08804	DAVIESS MARTIN	2, 551	9, 929	457, 622	2 0	703, 805	88. 05
90. 00 91. 00		CLINIC EMERGENCY	3, 759 8, 450	2, 640 0	1		335, 257 2, 061, 911	1
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93. 00		OTHER OUTPATIENT SERVICE COST CENTER REIMBURSABLE COST CENTERS	5, 834	0	149, 667	0	262, 517	93.00
99. 10	09910	CORF	0	0				
101.00		HOME HEALTH AGENCY AL PURPOSE COST CENTERS	1, 365	0	154, 672	0	248, 242	]101.00
	11300	INTEREST EXPENSE		_		_		113.00
116. 00 118. 00	1	HOSPICE SUBTOTALS (SUM OF LINES 1-117)	585 210, 713	0 1, 051, 577				
	NONRE	IMBURSABLE COST CENTERS						
		PHYSICIANS' PRIVATE OFFICES OTHER NONREIMBURSABLE AND PHYSICIAN	0 3, 889	7, 948 50, 251			144, 158 4, 241, 848	
200.00		Cross Foot Adjustments	2, 551	,	_,,		,, _ , , , , , ,	200.00
201. 00 202. 00	1	Negative Cost Centers Cost to be allocated (per Wkst. B,	2, 023, 270	2, 288, 205	5, 485, 957	,	13, 025, 261	201.00
		Part I)						
203. 00 204. 00	1	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	9. 428011	2. 061862	0. 241626 5, 176		0. 331929 1, 996, 825	1
		Part II)						
205. 00	Ί	Unit cost multiplier (Wkst. B, Part			0. 000228		0. 050886	200.00
			·					

	Financial Systems ALLOCATION - STATISTICAL BASIS	DAVIESS COMMUN		CCN: 150061 F	In Lie	u of Form CMS-:   Worksheet B-1	
					rom 01/01/2014 o 12/31/2014	Date/Time Pre	pared:
	Cost Center Description	MAI NTENANCE & REPAI RS (SQUARE	OPERATION OF PLANT (SQUARE	LAUNDRY & LINEN SERVICE (POUNDS OF	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (MEALS SERVED)	29 pm
		6. 00	FEET) 7. 00	LAUNDRY) 8. 00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS						
5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MYBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	194, 997 43, 386 467 1, 546 4, 054 1, 485 2, 983 4, 485 1, 815 9, 898	151, 611 467 1, 546 4, 054 1, 485 2, 983 4, 485 1, 815 9, 898	438, 000 1, 752 6 C 6 C	149, 598 4, 054 1, 485 2, 983 4, 485 1, 815 9, 898	42, 600 0 0 0 0 0	11. 00 13. 00 14. 00 15. 00 16. 00
30. 00	O3000 ADULTS & PEDIATRICS	9, 473	9, 473	197, 100	9, 473	12, 722	30.00
31. 00 40. 00 41. 00	03100   NTENSI VE CARE UNI T 04000   SUBPROVI DER -   PF 04100   SUBPROVI DER -   RF 04300   NURSERY	2, 391 9, 842 8, 674 952	2, 391 9, 842 8, 674 952	43, 800 43, 800 43, 800	2, 391 9, 842 8, 674	3, 893 18, 483 7, 502 0	31. 00 40. 00 41. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	12, 530	12, 530	61, 320	12, 530	0	50.00
51. 00 52. 00 54. 00 56. 00 60. 00	O5100   RECOVERY ROOM   O5200   DELI VERY ROOM & LABOR ROOM   O5400   RADI OLOGY-DI AGNOSTI C   O5600   RADI OI SOTOPE   O6000   LABORATORY	1, 742 9, 856 12, 166 1, 138 3, 406	1, 742 9, 856 12, 166 1, 138 3, 406	2, 628 3	9, 856 3 12, 166 1, 138	0 0 0 0	52. 00 54. 00 56. 00
63. 00 64. 00 65. 00 66. 00 67. 00	O6300  BLOOD STORING, PROCESSING & TRANS.   O6400  INTRAVENOUS THERAPY   O6500  RESPIRATORY THERAPY   O6600  PHYSICAL THERAPY   O6700  OCCUPATIONAL THERAPY	199 0 2, 617 3, 352 714	199 C 2, 617 3, 352 714		0 2, 617 3, 352	0 0 0 0	64. 00 65. 00 66. 00
68. 00 69. 00 71. 00 72. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	506 620 0 0 321	506 620 0 0 321		506 620 0 0	0 0 0 0	68. 00 69. 00 71. 00 72. 00
	03020 CARDI AC REHAB	2, 300	2, 300	1		0	1
88. 00	OUTPATIENT SERVICE COST CENTERS  08800 DCHMC	4, 865	4, 865	i (	4, 865	0	88.00
88. 01 88. 02 88. 04 88. 05 90. 00	08801 NDMC/ODON 08802 QUI CK CARE 08803 PEDI ATRI CS 08804 DAVI ESS MARTI N 09000 CLI NI C	3, 484 5, 355 1, 942 2, 551 3, 759 8, 450	3, 484 5, 355 1, 942 2, 551 3, 759		3, 484 5, 355 1, 942 2, 551 3, 759	0 0 0 0 0	88. 01 88. 02 88. 04 88. 05 90. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					_	92.00
93. 00	O4040 OTHER OUTPATIENT SERVICE COST CENTER   OTHER REIMBURSABLE COST CENTERS	5, 834	5, 834	C	5, 834	0	93.00
101. 00	09910 CORF 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0 1, 365	1, 365		0 1, 365	0	101. 00
	0 11300   INTEREST EXPENSE 0 11600   HOSPI CE 0   SUBTOTALS (SUM OF LINES 1-117)   NONREI MBURSABLE COST CENTERS	585 191, 108					113. 00 116. 00 118. 00
	019200 PHYSICIANS' PRIVATE OFFICES 07951 OTHER NONREIMBURSABLE AND PHYSICIAN Cross Foot Adjustments	3, 889	3, 889	1			192. 00 194. 00 200. 00 201. 00
201.00	Cost to be allocated (per Wkst. B,	1, 697, 103	1, 960, 065	243, 685	891, 951	564, 608	
203. 00 204. 00		8. 703226 128, 566	12. 928251 498, 108	1		13. 253709 73, 040	203. 00 204. 00
205. 00		0. 659323	3. 285434	0. 034632	0. 364577	1. 714554	205. 00

	LLOCATION - STATISTICAL BASIS	DAVIESS COMMON		CCN: 150061 P	eri od:	Worksheet B-1	
				T <sub>1</sub>	rom 01/01/2014 o 12/31/2014	Date/Time Pre	pared:
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	5/21/2015 12: MEDI CAL	29 pm
	cost center bescription	(HOURS	ADMI NI STRATI O	SERVICES &	(COSTED	RECORDS &	
		PAI D)	N	SUPPLY	REQUIS.)	LI BRARY	
			(DI RECT	(COSTED		(GROSS	
		11. 00	NRSI NG HRS) 13. 00	REQUI S. ) 14. 00	15. 00	CHARGES) 16. 00	
	GENERAL SERVICE COST CENTERS	11.00	13.00	14.00	13.00	10.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
6. 00	00600 MAI NTENANCE & REPAI RS						6.00
7. 00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00
11. 00	01100 CAFETERI A	825, 236					11.00
	01300 NURSING ADMINISTRATION	26, 523					13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	14, 614		2, 906, 190			14.00
15.00	01500 PHARMACY	18, 349		1, 751	100	107 0/7 /51	15.00
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	28, 698 6, 269	0	42 201	0	107, 867, 651 0	1
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	0, 207		201	<u> </u>		17.00
30.00	03000 ADULTS & PEDIATRICS	99, 823	99, 823	69, 076	0	3, 486, 552	30.00
31.00	03100 INTENSIVE CARE UNIT	30, 369				2, 634, 741	1
40.00	04000 SUBPROVI DER - I PF	90, 253				8, 008, 259	1
41. 00 43. 00	04100   SUBPROVI DER   -	35, 361 11, 190			0 0	2, 903, 211 635, 162	1
10.00	ANCILLARY SERVICE COST CENTERS	11,170	11, 170	17,271	<u> </u>	000, 102	10.00
	05000 OPERATING ROOM	41, 834	41, 834		0	8, 846, 035	
51.00	05100 RECOVERY ROOM	0	1	1, 089	0	716, 300	
52. 00 54. 00	O5200   DELIVERY ROOM & LABOR ROOM   O5400   RADIOLOGY-DIAGNOSTIC	11, 555 41, 905			0 0	655, 931 14, 795, 181	
56. 00	05600 RADI OI SOTOPE	10, 596			0	4, 429, 810	1
60.00	06000 LABORATORY	55, 277		528, 467	o	19, 608, 772	1
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	232, 397	0	911, 702	1
64. 00 65. 00	06400   NTRAVENOUS THERAPY 06500 RESPIRATORY THERAPY	0 24, 127	0	0 31, 049	0	754, 070 3, 303, 803	1
66. 00	06600 PHYSI CAL THERAPY	27, 136		994	0	2, 792, 057	1
67. 00	06700 OCCUPATI ONAL THERAPY	9, 281		113	Ō	1, 316, 474	
68. 00	06800 SPEECH PATHOLOGY	1, 910		0	0	288, 470	1
69. 00 71. 00	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 040	0		0	1, 175, 251	1
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	1, 671, 574 0	0	4, 166, 127 712, 595	
73. 00	07300 DRUGS CHARGED TO PATIENTS	Ö	0	0	100	7, 106, 961	1
76. 00	03020 CARDI AC REHAB	1, 778	1, 778	497	0	81, 742	76. 00
00.00	OUTPATIENT SERVICE COST CENTERS	20, 100		2 104	٥	1 474 714	00.00
	08800   DCHMC   08801   NDMC/ODON	20, 109 23, 048		2, 194 8, 163	0	1, 474, 714 1, 326, 840	
88. 02	08802 QUI CK CARE	20, 587				1, 465, 431	
88. 04	08803 PEDI ATRI CS	13, 868		4, 306	0	1, 240, 873	88. 04
88. 05	08804 DAVIESS MARTIN	18, 204		3, 437	0	1, 066, 618	
90. 00 91. 00	09000   CLI NI C   09100   EMERGENCY	3, 385 44, 214		31, 711 30, 554	0	1, 823, 824 7, 613, 922	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	44, 214	44, 214	30, 334	Ŭ	7,013,722	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	7, 302	0	214	0	1, 096, 054	93.00
	OTHER REIMBURSABLE COST CENTERS	T		_			
	09910 CORF 10100 HOME HEALTH AGENCY	0 6, 914					
101.00	SPECIAL PURPOSE COST CENTERS	0, 714	0, 714	373	U	102, 302	1101.00
113.00	11300 I NTEREST EXPENSE						113.00
	11600 H0SPI CE	10, 155				846, 110	1
118. 00		757, 674	491, 224	2, 892, 938	100	107, 446, 174	118.00
192 00	NONREI MBURSABLE COST CENTERS  19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	O	0	192.00
	07951 OTHER NONREIMBURSABLE AND PHYSICIAN	67, 562	1			421, 477	
200.00							200.00
201.00		/04 017	1 400 (02	72/ 050	1 (02 502	1 470 454	201.00
202. 00	Cost to be allocated (per Wkst. B, Part I)	624, 317	1, 409, 693	736, 959	1, 692, 582	1, 473, 454	202.00
203.00		0. 756531	2. 869756	0. 253583	16, 925. 820000	0. 013660	203.00
204.00	Cost to be allocated (per Wkst. B,	42, 752		85, 430		221, 389	1
205 00	Part II)	0.051007	0.204020	0.00000	1 710 050000	0 000050	205 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 051806	0. 204829	0. 029396	1, 718. 050000	0. 002052	205.00
	1 (***)	1		•	'		'

Health Financial Systems

DAVIESS COMMUNITY HOSPITAL

In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150061

Period: Worksheet B-1

From 01/01/2014 12/31/2014 Date/Time Prepared: 5/21/2015 12:29 pm Cost Center Description SOCI AL SERVI CE (TIME SPENT) 17.00 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.00 2 00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 6.00 00600 MAINTENANCE & REPAIRS 6.00 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9 00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 01100 CAFETERI A 11.00 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 17.00 01700 SOCIAL SERVICE 7, 279 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 12 31.00 03100 INTENSIVE CARE UNIT 8 31.00 04000 SUBPROVI DER - I PF 40.00 155 40.00 04100 SUBPROVI DER - I RF 41.00 0 41.00 04300 NURSERY 43.00 0 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 0 50.00 51.00 05100 RECOVERY ROOM 0 51 00 05200 DELIVERY ROOM & LABOR ROOM 52.00 52.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 54.00 56.00 05600 RADI OI SOTOPE 0 56.00 06000 LABORATORY 60.00 60.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 06400 I NTRAVENOUS THERAPY 29 64.00 64.00 65 00 06500 RESPIRATORY THERAPY 000000 65 00 06600 PHYSI CAL THERAPY 66.00 66.00 67.00 06700 OCCUPATI ONAL THERAPY 67.00 68.00 06800 SPEECH PATHOLOGY 68.00 06900 ELECTROCARDI OLOGY 69 00 69 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 03020 CARDI AC REHAB 0 76.00 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 DCHMC 0 88.00 08801 NDMC/ODON 0 88.01 88.01 88. 02 08802 QUI CK CARE 88 02 88.04 08803 PEDI ATRI CS 0 88.04 88 05 08804 DAVIESS MARTIN 0 88.05 0 90.00 09000 CLI NI C 90.00 91.00 09100 EMERGENCY 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 04040 OTHER OUTPATIENT SERVICE COST CENTER 93.00 2, 170 93.00 OTHER REIMBURSABLE COST CENTERS 99. 10 09910 CORF 99.10 101.00 10100 HOME HEALTH AGENCY 1, 962 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113 00 116. 00 11600 HOSPI CE 2,943 116.00 SUBTOTALS (SUM OF LINES 1-117) 118.00 7, 279 118.00 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 192.00 194. 00 07951 OTHER NONREIMBURSABLE AND PHYSICIAN 0 194.00 200.00 Cross Foot Adjustments 200.00 Negative Cost Centers 201.00 201.00 202.00 Cost to be allocated (per Wkst. B, 136, 225 202.00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 18. 714796 203.00 Cost to be allocated (per Wkst. B, 204.00 5, 512 204.00 Part II) Unit cost multiplier (Wkst. B, Part 0.757247 205.00 205.00 11)

Health Financial Systems	DAVIESS COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 150061	Peri od: Worksheet C
		From 01/01/2014 Part I
		To 12/21/2014 Dota/Time Dropored.

TITLE XVIII   Hospital   Cost   Cos						To 12/31/2014	Date/Time Pre 5/21/2015 12:	pared:
INPATIENT ROUTINE SERVICE COST CENTERS   1.00L   2.00   3.00   4.00   5.00				Ti tl	e XVIII	Hospi tal		<u> 27 μπ</u>
Total Cost				11.61	7,,,,,			
INPATIENT ROUTINE SERVICE COST CENTERS   1.00   2.00   3.00   4.00   5.00		Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
E.PARTI ENT ROUTI NE SERVI CE COST CENTERS   1.00   2.00   3.00   4.00   5.00								
NATIENT ROUTINE SERVICE COST CENTERS			,					
INPATIENT ROUTINE SERVICE COST CENTERS   1.00   2.00   3.00   4.00   5.00								
NPATIENT ROUTINE SERVICE COST CENTERS   4, 368, 149   0, 4, 368, 149   0, 0, 00   0.				2. 00	3.00	4. 00	5. 00	
30.00   03000   ADULTS & PEDI ATRIC S   4, 368, 149   1, 368, 149   0   1, 438, 643   31, 00   310, 00   10   10   11   11   11   138, 693   31, 30   31, 00   310, 00   10   10   11   11   11   11   1	I NPAT	IENT ROUTINE SERVICE COST CENTERS	•					
31 00 03100   INTENSIVE CARE UNIT			4, 368, 149		4, 368, 14	9 0	4, 368, 149	30.00
A0 00   04000   SUBPROVI DER - I PF   4, 282, 152   4, 282, 152   0   4, 282, 152   0   04   00   04   00   04   00   04   00   04   00   04   00   04   00   04   00   04   00   04   00   04   00   04   00   04   00   05   05	31.00 03100	INTENSIVE CARE UNIT	1, 438, 693		1, 438, 69	3 0	1, 438, 693	31.00
14. 00   04100   SUBPROVIDER - IRF   2, 617, 629   2, 617, 629   0   2, 617, 629   14. 00   3.00   3.00   3.00   NURSERY   514, 801   0   5	40.00 04000	SUBPROVIDER - IPF	4, 282, 152		4, 282, 15	2 0		
A3 00   A300   NURSERY   514,801   514,801   0   514,801   43 00								
ANCILLARY SERVICE COST CENTERS								•
50.00   05000  0PERATI NG ROOM								
51.00   05100   RECOVERY ROOM   90,087   90,087   90,087   51.00			1, 952, 872		1, 952, 87	2 0	1, 952, 872	50.00
Section   Sect	51.00 05100	RECOVERY ROOM						51.00
S4.00   OS400   RADI OLOGY-DI AGNOSTI C   2, 870, 407   0, 2, 870, 407   0, 05600   RADI OLOGY-DI AGNOSTI C   2, 870, 407   3, 405, 541   0, 05600   RADIO I SOTOPE   898, 559   898, 559   0, 089, 559   56.00   0, 0000   CABORATORY   3, 645, 541   3, 645, 541   0, 3, 645, 541	52.00 05200	DELIVERY ROOM & LABOR ROOM	865, 319		865, 31	9 0	865, 319	52.00
56.00   05000   ABDRATORY   3,645,541   3,645,541   0 3,					2, 870, 40	7 0	2, 870, 407	54.00
60.00   06000   LABORATORY   3, 645, 541   3, 645, 541   0   3, 645, 541   60.00	56.00 05600	RADI OI SOTOPE						56.00
63.00   06300   BLOOD STORING, PROCESSING & TRANS.   424,007   424,007   0   424,007   63.00   640.00   06400   INTRAVENOUS THERAPY   74,357   74,357   0   74,357   65.00   650.00   06500   RESPIRATORY THERAPY   1,207,890   0   1,207,890   0   1,207,890   0   1,207,890   65.00   660.00   06600   PHYSI CAL THERAPY   1,390,999   0   1	60.00 06000	LABORATORY						60.00
65.00   06500   RESPIRATORY THERAPY   1, 207, 890   0   1, 207, 890   0   1, 307, 890   65.00   66.00   06600		BLOOD STORING, PROCESSING & TRANS.	424, 007		424, 00	7 0	424, 007	63.00
65.00   06500   RESPIRATORY THERAPY   1, 207, 890   0   1, 207, 890   0   1, 207, 890   65.00   66.00   06600   PHYSI CAL THERAPY   1, 390, 999   0   0   1, 390, 999   0   1,	64.00 06400	I NTRAVENOUS THERAPY	74, 357		74, 35	7 0	74, 357	64.00
67. 00   06700   0CCUPATI ONAL THERAPY   485, 520   0   485, 520   0   485, 520   0   68. 00   06800   SPECCH PATHOLOGY   193, 958   0   193, 958   0   193, 958   0   172, 458   172, 458   0   172, 458	65.00 06500	RESPI RATORY THERAPY		0	1, 207, 89	ol ol	1, 207, 890	65.00
68.00 06800 SPEECH PATHOLOGY 193, 958 0 193, 958 0 0 193, 958 68.00 69.00 06900 ELECTROCARDI OLOGY 172, 458 172, 458 172, 458 0 172,	66.00 06600	PHYSI CAL THERAPY	1, 390, 999	0	1, 390, 99	9 0	1, 390, 999	66.00
68.00 06800 SPEECH PATHOLOGY 193, 958 0 193, 958 0 0 193, 958 68.00 69.00 06900 ELECTROCARDI OLOGY 172, 458 172, 458 172, 458 0 172,	67.00 06700	OCCUPATI ONAL THERAPY	485, 520	0	485, 52	ol ol	485, 520	67.00
69. 00   06900   ELECTROCARDI OLOGY   172, 458   172, 458   0   172, 458   69. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   2, 450, 752   2, 450, 752   0   2, 450, 752   71. 00   7200   IMPL. DEV. CHARGED TO PATI ENTS   598, 917   598, 917   0   598, 917   70. 00   7300   DRUGS CHARGED TO PATI ENTS   3, 493, 287   3, 493, 287   0   3, 493, 287   73. 00   73. 00   03020   CARDI AC REHAB   178, 925   178, 925   0   178, 925   76. 00   03020   CARDI AC REHAB   178, 925   0   178, 925   76. 00   03020   CARDI AC REHAB   1, 433, 185   1, 433, 185   0   1, 433, 185   88. 01   08801   DMMC/ODON   1, 581, 636   1, 581, 636   0   1, 581, 636   88. 01   08801   NDMC/ODON   1, 581, 636   1, 581, 636   0   1, 581, 636   88. 01   88. 02   08802   QUI CK CARE   1, 282, 258   1, 282, 258   0   1, 282, 258   80. 02803   PEDI ATRI CS   1, 015, 427   0   1, 015, 427   0   1, 015, 427   88. 05   09000   CLI NI C   585, 778   585, 778   0   585, 778   0   585, 778   0   09100   EMERGENCY   3, 275, 941   3, 275, 941   0   3, 275, 941   0   3, 275, 941   0   3, 275, 941   0   3, 275, 941   0   3, 275, 941   0   3, 275, 941   0   3, 275, 941   0   3, 275, 941   0   3, 275, 941   0   0   0   0   0   0   0   0   0				0				
71. 00								
72.00   07200   IMPL. DEV. CHARGED TO PATIENT   598, 917   72.00   73.00   DRUGS CHARGED TO PATIENTS   3, 493, 287   3, 493, 287   0   3, 493, 287   73.00   03020   CARDI AC REHAB   178, 925   178, 925   0   178, 925   0   178, 925   0   0   178, 925   0   0   0   0   0   0   0   0   0								
73. 00   07300   DRUGS CHARGED TO PATIENTS   3, 493, 287   178, 925   178, 925   76. 00   178, 925   78. 00   178, 925   78. 0	72.00 07200	IMPL. DEV. CHARGED TO PATIENT						
76. 00 03020 CARDI AC REHAB 178, 925 178, 925 0 178, 925 76. 00 0UTPATI ENT SERVI CE COST CENTERS  88. 00 08800 DCHMC 1, 433, 185 0 1, 433, 185 0 1, 433, 185 88. 01 08801 NDMC/ODON 1, 581, 636 1, 581, 636 1, 581, 636 0 1, 581, 636 88. 01 08802 0UI CK CARE 1, 282, 258 1, 282, 258 0 1, 282, 258 80. 028802 0UI CK CARE 1, 282, 258 1, 015, 427 1, 015, 427 0 1, 015, 427 88. 04 08803 PEDI ATRI CS 1, 015, 427 1, 015, 427 0 1, 015, 427 88. 04 08804 DAVI ESS MARTI N 1, 037, 024 1, 037, 024 0 1, 037, 024 88. 05 08804 DAVI ESS MARTI N 1, 037, 024 1, 037, 024 0 1, 037, 024 88. 05 90. 00 09000 CLI NI C 585, 778 585, 778 585, 778 0 585, 778 90. 00 09100 EMERGENCY 3, 275, 941 3, 275, 941 0 3, 275, 941 91. 00 992. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 1, 218, 482 1, 218, 482 1, 218, 482 92. 00 04040 OTHER OUTPATI ENT SERVI CE COST CENTER 571, 797 571, 797 0 571, 797 93. 00 0710 DI HOME HEALTH AGENCY 432, 413 432, 413 432, 413 10. 00 10100 HOME HEALTH AGENCY 432, 413 432, 413 432, 413 10. 00 11100 HOME HEALTH AGENCY 432, 413 432, 413 432, 413 10. 00 11100 HOME HEALTH AGENCY 432, 413 432, 413 432, 413 13. 00 11300   INTEREST EXPENSE 113. 00 11300   INTEREST EXPENSE 113. 00 11600 HOSPI CE 826, 201 826, 201 113. 00 201. 00 Less Observation Beds 1, 218, 482 1, 218, 482 1, 218, 482 1, 218, 482 201. 00 201. 00 Less Observation Beds 1, 218, 482 1, 218, 482 1, 218, 482 201. 00 201. 00 Less Observation Beds 1, 218, 482 1, 218, 482 1, 218, 482 201. 00 201. 00 Less Observation Beds 1, 218, 482 1, 218, 482 1, 218, 482 201. 00 201. 00 Less Observation Beds 1, 218, 482 1, 218, 482 1, 218, 482 1, 218, 482 201. 00 201. 00 Less Observation Beds 1, 218, 482 201. 00 201. 00 Less Observation Beds 1, 218, 482 1, 218, 482 1, 218, 482 201. 00 201. 00 Less Observation Beds 1, 218, 482 201. 00 201. 00 Less Observation Beds 1, 218, 482 201. 00 201								
Section   Sect								
88. 00						-		
88. 01			1, 433, 185		1, 433, 18	5 0	1, 433, 185	88. 00
88. 02								
88. 04								
88. 05								
90. 00	88. 05 08804	DAVIESS MARTIN	1, 037, 024		1, 037, 02	4 0	1, 037, 024	88. 05
91. 00	90.00 09000	CLINIC	585, 778					
92. 00   09200   0BSERVATI ON BEDS   (NON-DI STI NCT PART)   1, 218, 482   1, 218, 482   92. 00   04040   OTHER OUTPATI ENT SERVI CE COST CENTER   571, 797   571, 797   0   571, 797   93. 00   0   0   0   0   0   0   0   0   0		•						
93. 00   04040   OTHER OUTPATIENT SERVICE COST CENTER   571, 797   571, 797   0   571, 797   93. 00								•
OTHER REIMBURSABLE COST CENTERS   99. 10   099. 10   101. 00   099. 10   101. 00   10100   HOME HEALTH AGENCY   432, 413   432, 413   432, 413   432, 413   101. 00   1300   INTEREST EXPENSE   113. 00   11600   HOSPI CE   826, 201   826, 201   826, 201   826, 201   826, 201   116. 00   200. 00   Subtotal (see instructions)   47, 475, 421   0   47, 475, 421   0   47, 475, 421   200. 00   201. 00   Less Observation Beds   1, 218, 482   1, 218, 482   201. 00								
99. 10						<u>'</u>		
SPECIAL PURPOSE COST CENTERS   113.00   11300   INTEREST EXPENSE   826, 201			0			O	0	99. 10
SPECIAL PURPOSE COST CENTERS   113.00   11300   INTEREST EXPENSE   826, 201	101. 00 10100	HOME HEALTH AGENCY	432, 413		432, 41	3	432, 413	101.00
113. 00		·				,		
200. 00 Subtotal (see instructions) 47, 475, 421 0 47, 475, 421 0 47, 475, 421 0 0 47, 475, 421 200. 00 201. 00 Less Observation Beds 1, 218, 482 1, 218, 482 201. 00								113.00
201.00 Less Observation Beds 1, 218, 482 1, 218, 482 1, 218, 482 201.00	116.00 11600	HOSPI CE	826, 201		826, 20	1	826, 201	116. 00
201.00 Less Observation Beds 1, 218, 482 1, 218, 482 1, 218, 482 1, 218, 482	200.00	Subtotal (see instructions)	47, 475, 421	0	47, 475, 42	1  o	47, 475, 421	200. 00
202.00   Total (see instructions)   46,256,939   0   46,256,939   0   46,256,939   202.00	201.00	Less Observation Beds	1, 218, 482		1, 218, 48	2		
	202. 00	Total (see instructions)	46, 256, 939	0	46, 256, 93	9  0	46, 256, 939	202. 00

					To 12/31/2014	Date/Time Pre 5/21/2015 12:	pared: 29 pm
			Ti tl	e XVIII	Hospi tal	PPS	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	·		·	+ col. 7)	Ratio	I npati ent	
				·		Rati o	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	3, 486, 552		3, 486, 552	2		30.00
31.00	03100 INTENSIVE CARE UNIT	2, 634, 741		2, 634, 741			31.00
40.00	04000 SUBPROVI DER - I PF	8, 008, 259		8, 008, 259			40.00
41.00	04100 SUBPROVI DER - I RF	2, 903, 211		2, 903, 211			41.00
43.00	04300 NURSERY	635, 162		635, 162	2		43.00
	ANCILLARY SERVICE COST CENTERS	· · · · · ·			<u>'</u>		1
50.00	05000 OPERATING ROOM	1, 303, 446	4, 915, 327	6, 218, 773	0. 314029	0.000000	50.00
51.00	05100 RECOVERY ROOM	125, 870	590, 430			0. 000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	575, 586	80, 345	655, 931		0. 000000	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 273, 263	12, 521, 918			0. 000000	54.00
56.00	05600 RADI OI SOTOPE	608, 175	3, 821, 635	4, 429, 810		0. 000000	56.00
60.00	06000 LABORATORY	4, 451, 562	15, 157, 210			0.000000	1
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	491, 601	420, 101	911, 702		0. 000000	
64. 00	06400 I NTRAVENOUS THERAPY	382, 012	372, 058			0. 000000	1
65. 00	06500 RESPI RATORY THERAPY	1, 938, 905	1, 364, 898			0. 000000	1
66.00	06600 PHYSI CAL THERAPY	895, 774	1, 896, 283			0. 000000	1
67. 00	06700 OCCUPATI ONAL THERAPY	690, 849	625, 625	1, 316, 474		0. 000000	1
68. 00	06800 SPEECH PATHOLOGY	112, 021	176, 449	288, 470		0. 000000	1
69. 00	06900 ELECTROCARDI OLOGY	347, 429	827, 822	1, 175, 251		0. 000000	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 487, 351	2, 678, 776	4, 166, 127		0. 000000	
71.00	07200 IMPL. DEV. CHARGED TO PATIENT	383, 207	329, 388	712, 595		0.000000	
73. 00	07300 DRUGS CHARGED TO PATIENTS	4, 751, 151	2, 355, 810	7, 106, 961		0. 000000	1
76. 00	03020 CARDI AC REHAB	4, 731, 131	81, 742	81, 742		0.000000	1
70.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	01, 742	01, 742	2. 100077	0.000000	70.00
88. 00	08800 DCHMC	O	1, 474, 714	1, 474, 714	1		88. 00
88. 01	08801 NDMC/ODON		1, 326, 840	1, 326, 840			88. 01
88. 02	08802 QUI CK CARE		1, 465, 431	1, 465, 431			88. 02
88. 04	08803 PEDI ATRI CS		1, 240, 873				88. 04
88. 05	08804 DAVIESS MARTIN		1, 240, 673				88. 05
90.00	09000 CLINIC	34, 500	1, 789, 324	1, 823, 824		0. 000000	1
91.00	09100 EMERGENCY	1, 254, 660	6, 359, 262	7, 613, 922		0.000000	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	167, 636	880, 088			0.000000	1
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	3, 200	1, 092, 854	1, 047, 722		0.000000	1
93.00	OTHER REIMBURSABLE COST CENTERS	3, 200	1, 092, 634	1, 090, 032	0. 32 1007	0.000000	93.00
99. 10	09910 CORF		0				99. 10
	10100 HOME HEALTH AGENCY	0	162, 582	162, 582			101.00
101.00		l d	102, 382	102, 382	<u> </u>		101.00
110 00	SPECIAL PURPOSE COST CENTERS						112 00
	11300 I NTEREST EXPENSE		04/ 440	04/ 44/			113.00
	11600 HOSPI CE	0	846, 110				116.00
200.00	, ,	39, 946, 123	65, 920, 513	105, 866, 636			200.00
201.00	i i	20.047.422	/F 000 F10	105 044 101			201.00
202.00	Total (see instructions)	39, 946, 123	65, 920, 513	105, 866, 636	P		202. 00

Health Financial Systems	DAVIESS COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 150061	From 01/01/2014	Worksheet C Part I Date/Time Prepared: 5/21/2015 12:29 pm	

INPATTENT ROUTINE SERVICE COST CENTERS					5/21/2015 12:29 pm
NPATIENT ROUTINE SERVICE COST CENTERS			Title XVIII	Hospi tal	PPS
INPATIENT ROUTINE SERVICE COST CENTERS   30.00   33000   30000   300000   ADULTS & PEDI ATRI CS   31.00   30000   30000   ADULTS & PEDI ATRI CS   31.00   30.00   30000   INTENSIVE CARE UNIT   31.00   40.00   40.00   10.00   ADULTS & PEDI ATRI CS   40.00   40.00   40.00   SURPROVI DER - I PF   41.00   40.00   40.00   40.00   SURPROVI DER - I PF   41.00   40.00   40.00   40.00   50.00	Cost Center Description				
INPATIENT ROUTINE SERVICE COST CENTERS   30.00   31.00   30.		Ratio			
30.00   03000   03000   03000   04000   0115		11. 00			
31.00   03100   INTENSIVE CARE UNIT	INPATIENT ROUTINE SERVICE COST (	CENTERS			
40. 00   04000   SUBPROVI DER - I PF   40. 00	30. 00 03000 ADULTS & PEDIATRICS				30.00
41.00   04100   SUBPROVI DER -   IRF	31.00 03100 INTENSIVE CARE UNIT				31.00
A3. 00   OASOO   NURSERY	40. 00   04000   SUBPROVI DER - I PF				40.00
A3. 00   OASOO   NURSERY	41. 00   04100   SUBPROVI DER - I RF				41.00
ANCILLARY SERVICE COST CENTERS   50.00					43.00
50.00   0500					
52.00   05200   05400   05400   RADIOLOGY_DIAGNOSTIC   0.194010   54.00   05400   RADIOLOGY_DIAGNOSTIC   0.194010   55.00   05600   RADIOLOGY_DIAGNOSTIC   0.202844   55.00   05600   RADIOLOGY_DIAGNOSTIC   0.185914   60.00   05600   RADIOLOGY_DIAGNOSTIC   0.185914   60.00   05600   RADIOLOGY_DIAGNOSTIC   0.185914   60.00   05600   05000   STORING, PROCESSING & TRANS.   0.465072   63.00   05600   05000		0. 314029			50.00
54.00   05400   RADIO I DOTOPE   0.194010   54.00	51. 00 05100 RECOVERY ROOM	0. 125767			51.00
54.00   05400   RADIO I DOTOPE   0.194010   54.00	52.00 05200 DELIVERY ROOM & LABOR ROOM	1. 319223			52.00
56.00   05.0					
60. 00   06000   LABORATORY   0. 185914   60. 00   63. 00   63.00   80.00   STORI NG, PROCESSI NG & TRANS.   0. 465072   63. 00   64.00   1NTRAVENOUS THERAPY   0. 098608   64. 00   66.00   06600   INTRAVENOUS THERAPY   0. 365606   65. 00   66.00   06600   PHYSI CALL THERAPY   0. 498199   66. 00   66.00   06600   PHYSI CALL THERAPY   0. 498199   66. 00   66.00   06600   PHYSI CALL THERAPY   0. 498199   66. 00   66.00   06000   SPEECH PATHOLOGY   0. 368803   67. 00   67. 00   68. 00   06900   SPEECH PATHOLOGY   0. 146741   69. 00	· •	1			
63.00   06300   BLOOD STORING, PROCESSING & TRANS.   0.465072   63.00   06400   INTRAVENOUS THERAPY   0.96608   66.00   06500   RESPIRATORY THERAPY   0.365606   65.00   06500   RESPIRATORY THERAPY   0.365606   06.00   06500   RESPIRATORY THERAPY   0.498199   0.6000   06900   ELECTROCARDIOLOGY   0.672368   0.6000   06900   ELECTROCARDIOLOGY   0.672368   0.672368   0.69.00   06900   ELECTROCARDIOLOGY   0.146741   0.69.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   0.588257   71.00   07200   IMPL. DEV. CHARGED TO PATIENTS   0.840473   72.00   07200   IMPL. DEV. CHARGED TO PATIENTS   0.491530   73.00   07300   DRUGS CHARGED TO PATIENTS   0.491530   73.00   07300   DRUGS CHARGED TO PATIENTS   0.491530   73.00   07300   DRUGS CHARGED TO PATIENTS   0.491530   73.00   07300   DRUGS CHARGED TO PATIENTS   0.491530   75.00   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   000000	• • • • • • • • • • • • • • • • • • •	1			
64. 00   06400   INTRAVENOUS THERAPY   0. 098608   64. 00   66500   06500   06500   06500   06600   06					
65. 00 06500 RESPIRATORY THERAPY 0. 365806 66. 00 06600 PHYSI CAL THERAPY 0. 498199 66. 00 06700 0CCUPATI ONAL THERAPY 0. 368803 67. 00 06700 0CCUPATI ONAL THERAPY 0. 368803 67. 00 06800 SPEECH PATHOLOGY 0. 672368 68. 00 06800 SPEECH PATHOLOGY 0. 146741 69. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 588257 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 588257 71. 00 07200 I IMPL. DEV. CHARGED TO PATI ENTS 0. 840473 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 491530 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 491530 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 491530 76. 00 03020 CARDI AC REHAB 2. 188899 76. 00 08800 DCHMC 88. 01 08801 NDMC/ODON 88. 01 08801 NDMC/ODON 88. 01 08802 QUI CK CARE 88. 00 08802 QUI CK CARE 88. 04 08803 PEDI ATRI CS 88. 04 08803 PEDI ATRI CS 88. 04 08803 PEDI ATRI CS 88. 04 08803 PEDI ATRI CS 88. 04 08803 PEDI ATRI CS 88. 05 08804 DAVI ESS MARTI N 88. 05 08000 CLI IN C 0. 321181 90. 00 9000 CLI IN C 0. 321181 90. 00 9100 EMERGENCY 0. 430257 91. 00 9920 0 095200 EMERGENCY 0. 430257 91. 00 9920 0 095200 SESENATI ON BEDS (NON-DI STI NCT PART) 1. 162980 92. 00 9920 0 09520 OSESENATI ON BEDS (NON-DI STI NCT PART) 1. 162980 92. 00 9920 0 09520 OSESENATI ON BEDS (NON-DI STI NCT PART) 1. 162980 92. 00 9920 0 09520 CLI IN C 0. 521687 92. 00 9920 0 09520 CL					
66. 00					
67. 00   06700   OCCUPATI ONAL THERAPY   0.368803   67. 00   68. 00   06800   SPECH PATHOLOGY   0.672368   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0.146741   69. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0.588257   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0.840473   72. 00   73. 00   07300   DRUSC CHARGED TO PATIENTS   0.491530   73. 00   76. 00   03020   CARDI AC REHAB   2.188899   76. 00   0000   0000   CLRDI AC REHAB   2.188899   76. 00   0000   08800   DCHMC   88. 00   088. 01   08801   NDMC/ODON   88. 01   088. 02   08802   DCH C C COST CENTERS   88. 04   088. 04   08803   PDI ATRI CS   88. 04   088. 05   08804   DAVI ESS MARTI N   88. 05   090. 00   09000   CLI NI C   0.321181   90. 00   09000   0100   EMERGENCY   0.430257   91. 00   09100   09100   EMERGENCY   0.430257   91. 00   092. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART)   1.162980   92. 00   093. 00   094040   OTHER C OUTPATI ENT SERVI CE COST CENTERS   099. 10   09100   CMERGENCY   0.521687   0.521687   0.521687   099. 10   09100   CMERGENCY   0.521687   0.521687   0.521687   099. 10   09100   CMERGENCY   0.521687   0.5216	• • • • • • • • • • • • • • • • • • •	1			
68. 00	• • • • • • • • • • • • • • • • • • •	1			
69. 00		1			
71. 00		1			
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 0. 840473 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 491530 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 491530 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 491530 73. 00 073020 CARDIAC REHAB 2. 188899 76. 00 0000 DUTPATIENT SERVICE COST CENTERS  88. 00 08800 DCHMC 88. 00 08800 DCHMC 88. 00 08801 NDMC/ODON 88. 01 08801 NDMC/ODON 88. 01 08802 QUI CK CARE 88. 04 08803 PEDIATRICS 88. 04 08803 PEDIATRICS 88. 04 08803 PEDIATRICS 88. 04 08804 DAVIESS MARTIN 88. 05 08804 DAVIESS MARTIN 90. 00 09000 CLI NI C 0. 321181 90. 00 09000 CLI NI C 90. 00 09000 CLI SERVATI ON BEDS (NON-DISTINCT PART) 90. 00 09000 CLI NI C 90. 00 09000 CLI NI C 90. 00 00 00 00 00 00 00 00 00 00 00 00 0		1			
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 491530 2. 188899 76. 00 03020 CARDI AC REHAB 2. 188899 76. 00 08800 DCHMC 88. 00 08800 DCHMC 88. 01 08801 NDMC/ODON 88. 01 08801 NDMC/ODON 88. 01 08802 QUI CK CARE 8. 02 08802 QUI CK CARE 8. 02 88. 04 08803 PEDI ATRI CS 88. 05 08804 DAVI ESS MARTI N 88. 04 09000 CLI NI C 90. 00 09000 CLI NI C 0. 321181 90. 00 09100 EMERGENCY 0. 430257 91. 00 99100 EMERGENCY 0. 430257 91. 00 99200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 1. 162980 92. 00 09000 CTHER REI MBURSABLE COST CENTER 0. 521687 99. 10 09910 CORF 99.		1			
76. 00 03020 CARDI AC REHAB 2. 188899 76. 00 0UTPATI ENT SERVI CE COST CENTERS 88. 00 08800 DCHMC 88. 01 08801 NDMC/ODON 88. 02 08802 QUI CK CARE 88. 04 08803 PEDI ATRI CS 88. 05 08804 DAVI ESS MARTI N 88. 05 08900 CLI NI C 0. 321181 90. 00 99000 CLI NI C 0. 430257 90. 00 9900 OPONO CLI NI C 0. 430257 91. 00 09100 EMERGENCY 0. 430257 91. 00 09200 OPONO					
SECOND   SUPPORT   SERVICE COST CENTERS   S					
88. 00		2. 188899			76.00
88. 01					
88. 02 08802 QUI CK CARE 88. 04 08803 PEDI ATRI CS 88. 04 08803 PEDI ATRI CS 88. 04 08803 PEDI ATRI CS 88. 05 08804 DAVI ESS MARTI N 88. 05 90. 00 09000 CLI NI C 0. 321181 90. 00 09100 EMERGENCY 91. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 1. 162980 92. 00 04040 OTHER OUTPATI ENT SERVI CE COST CENTER 0. 521687 93. 00 04040 OTHER REI MBURSABLE COST CENTERS 99. 10 101. 00 10100 HOME HEALTH AGENCY 99. 10 10100 HOME HEALTH AGENCY 99. 10 113. 00 11300 I NTEREST EXPENSE 113. 00 11300 I NTEREST EXPENSE 116. 00 11600 HOSPI CE 116. 00 200. 00 Subtotal (see instructions) Less Observation Beds 201. 00					
88. 04					
88. 05	· •				
90. 00   09000   CLINIC   0. 321181   90. 00   91. 00   91. 00   91. 00   92. 00   92. 00   92. 00   92. 00   92. 00   93. 00   04040   OTHER OUTPATIENT SERVICE COST CENTER   0. 521687   93. 00   09910   CORF   99. 10   10100   HOME HEALTH AGENCY   99. 10   10100   HOME HEALTH AGENCY   SPECIAL PURPOSE COST CENTERS   113. 00   11300   INTEREST EXPENSE   116. 00   116. 00   11600   HOSPICE   116. 00   200. 00   Subtotal (see instructions)   Less Observation Beds   201. 00   201. 00	• • • • • • • • • • • • • • • • • • •				
91. 00   09100   EMERGENCY   0. 430257   91. 00   92. 00   93. 00   04040   OTHER OUTPATIENT SERVICE COST CENTER   0. 521687   93. 00   07910   CORF   99. 10   07910   CORF   99. 10   07910   OTHER REI MBURSABLE COST CENTERS   101. 00   07910   OTHER SET EXPENSE   101. 00   07910   OTHER SET EXPENSE   113. 00   07910   OTHER SET EXPENSE   116. 00   07910   OTHER SET EXPENSE   07910					
92. 00   09200   0BSERVATI ON BEDS (NON-DI STINCT PART)   1. 162980   0. 521687   93. 00   04040   OTHER OUTPATIENT SERVICE COST CENTER   0. 521687   93. 00   07162   0. 07162					
93. 00					
OTHER REIMBURSABLE COST CENTERS   99. 10   101.00   10100   HOME HEALTH AGENCY   101.00   10100   HOME HEALTH AGENCY   101.00   SPECI AL PURPOSE COST CENTERS   113.00   11300   INTEREST EXPENSE   113.00   1000   HOSPI CE   116.00   1000					
99. 10	93.00 04040 OTHER OUTPATIENT SERVICE O	OST CENTER 0. 521687			93.00
101. 00					
SPECIAL PURPOSE COST CENTERS   113.00   11300   INTEREST EXPENSE   113.00   116.00   11600					
113. 00   11300   INTEREST EXPENSE					101. 00
116. 00       116.00         200. 00       Subtotal (see instructions)         201. 00       Less Observation Beds	SPECIAL PURPOSE COST CENTERS				
200.00         Subtotal (see instructions)         200.00           201.00         Less Observation Beds         201.00	113.00 11300 INTEREST EXPENSE				
201.00 Less Observation Beds 201.00					116.00
201.00 Less Observation Beds 201.00	200.00 Subtotal (see instructions	5)			200.00
202.00   Total (see instructions)					201.00
	202.00 Total (see instructions)				202.00

Health Financial Systems	OSPI TAL	In Lieu	eu of Form CMS-2552-10	
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 150061	Peri od:	Worksheet C
			From 01/01/2014	
				D . I . /T' D

					To 12/31/2014	Date/Time Pre 5/21/2015 12:	
			Ti t	le XIX	Hospi tal	Cost	27 p
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	<b>'</b>	(from Wkst.	Adj .		Di sal I owance		
		B, Part I,					
		col. 26)					
		1. 00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	4, 368, 149		4, 368, 14	9 0	4, 368, 149	30. 00
31.00	03100 INTENSIVE CARE UNIT	1, 438, 693		1, 438, 69	3 0	1, 438, 693	31.00
40.00	04000 SUBPROVI DER - I PF	4, 282, 152		4, 282, 15	2 0	4, 282, 152	40.00
41.00	04100 SUBPROVI DER - I RF	2, 617, 629		2, 617, 62	9 0	2, 617, 629	41.00
43.00	04300 NURSERY	514, 801		514, 80	1 0	514, 801	43.00
	ANCILLARY SERVICE COST CENTERS					-	
50.00	05000 OPERATING ROOM	1, 952, 872		1, 952, 87	2 0	1, 952, 872	50.00
51.00	05100 RECOVERY ROOM	90, 087		90, 08	7 0	90, 087	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	865, 319		865, 31	9 0	865, 319	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 870, 407		2, 870, 40	7 0	2, 870, 407	54.00
56.00	05600 RADI 0I SOTOPE	898, 559		898, 55	9 0	898, 559	56.00
60.00	06000 LABORATORY	3, 645, 541		3, 645, 54	1 0	3, 645, 541	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	424, 007		424, 00	7 0	424, 007	63.00
64.00	06400 I NTRAVENOUS THERAPY	74, 357		74, 35	7 0	74, 357	64.00
65.00	06500 RESPIRATORY THERAPY	1, 207, 890	0	1, 207, 89	0	1, 207, 890	65.00
66.00	06600 PHYSI CAL THERAPY	1, 390, 999	0	1, 390, 99	9 0	1, 390, 999	66.00
67.00	06700 OCCUPATI ONAL THERAPY	485, 520	0	485, 52	0	485, 520	67.00
68.00	06800 SPEECH PATHOLOGY	193, 958	0	193, 95	8 0	193, 958	68. 00
69.00	06900 ELECTROCARDI OLOGY	172, 458		172, 45	8 0	172, 458	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 450, 752		2, 450, 75	2 0	2, 450, 752	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	598, 917		598, 91	7 0	598, 917	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 493, 287		3, 493, 28	7 0	3, 493, 287	
76.00	03020 CARDI AC REHAB	178, 925		178, 92	5 0	178, 925	76. 00
	OUTPATIENT SERVICE COST CENTERS						1
88.00	08800 DCHMC	1, 433, 185		1, 433, 18	5 0	1, 433, 185	88. 00
88. 01	08801 NDMC/ODON	1, 581, 636		1, 581, 63	6 0	1, 581, 636	88. 01
88. 02	08802 QUI CK CARE	1, 282, 258		1, 282, 25	8 0	1, 282, 258	88. 02
88.04	08803 PEDI ATRI CS	1, 015, 427		1, 015, 42	7 0	1, 015, 427	88. 04
88. 05	08804 DAVIESS MARTIN	1, 037, 024		1, 037, 02	4 0	1, 037, 024	88. 05
90.00	09000 CLI NI C	585, 778		585, 77	8 0	585, 778	90.00
91.00	09100 EMERGENCY	3, 275, 941		3, 275, 94	1 0	3, 275, 941	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 218, 482		1, 218, 48	2	1, 218, 482	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	571, 797		571, 79	7 0	571, 797	93.00
	OTHER REIMBURSABLE COST CENTERS						1
99. 10	09910 CORF	0			0	0	99. 10
101.00	10100 HOME HEALTH AGENCY	432, 413		432, 41	3	432, 413	101.00
	SPECIAL PURPOSE COST CENTERS						]
113.00	11300   NTEREST EXPENSE						113.00
116.00	11600 H0SPI CE	826, 201		826, 20	1	826, 201	116.00
200.00	Subtotal (see instructions)	47, 475, 421	0	47, 475, 42	1 0	47, 475, 421	200.00
201.00	Less Observation Beds	1, 218, 482		1, 218, 48	2	1, 218, 482	201.00
202.00	Total (see instructions)	46, 256, 939	0	46, 256, 93	9 0	46, 256, 939	202.00
		•					-

Date/Time Prepared: 12/31/2014 5/21/2015 12:29 pm Title XIX Hospi tal Cost Charges Total (col. 6 Cost or Other TEFRA Cost Center Description Inpati ent Outpati ent I npati ent + col. 7) Ratio Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 3, 486, 552 3, 486, 552 30.00 31.00 03100 INTENSIVE CARE UNIT 2, 634, 741 2, 634, 741 31.00 04000 SUBPROVI DER - I PF 8,008,259 8,008,259 40.00 40.00 41.00 04100 SUBPROVI DER - I RF 2, 903, 211 2, 903, 211 41.00 04300 NURSERY 43.00 635, 162 635, 162 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 1, 303, 446 4, 915, 327 6, 218, 773 0 314029 0.000000 50.00 05100 RECOVERY ROOM 0. 125767 51.00 125, 870 590, 430 716, 300 0.000000 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 52 00 575, 586 80, 345 655, 931 1.319223 52 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 2, 273, 263 12, 521, 918 14, 795, 181 0.194010 0.000000 54.00 56.00 05600 RADI OI SOTOPE 608, 175 3, 821, 635 4, 429, 810 0. 202844 0.000000 56.00 60.00 06000 LABORATORY 0.185914 0.000000 60.00 4, 451, 562 15, 157, 210 19, 608, 772 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 491, 601 420, 101 911, 702 0.465072 0.000000 63.00 06400 I NTRAVENOUS THERAPY 382, 012 754,070 0.098608 64.00 372,058 0.000000 64.00 3, 303, 803 06500 RESPIRATORY THERAPY 1, 938, 905 0. 365606 0.000000 65.00 1, 364, 898 65.00 06600 PHYSI CAL THERAPY 66.00 895.774 1, 896, 283 2, 792, 057 0.498199 0.000000 66.00 06700 OCCUPATI ONAL THERAPY 690, 849 625, 625 1, 316, 474 0.368803 0.000000 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 112, 021 176, 449 288, 470 0.672368 0.000000 68.00 06900 ELECTROCARDI OLOGY 347.429 827, 822 1, 175, 251 69.00 0.146741 0.000000 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1, 487, 351 2, 678, 776 4, 166, 127 0.588257 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 383, 207 329, 388 712, 595 0.840473 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 4, 751, 151 2, 355, 810 7, 106, 961 0.491530 0.000000 73.00 73.00 03020 CARDI AC REHAB 76.00 81, 742 81, 742 2. 188899 0.000000 76.00 OUTPATIENT SERVICE COST CENTERS 1, 474, 714 1, 474, 714 88.00 08800 DCHMC 0. 971839 0.000000 88.00 08801 NDMC/ODON 0 1, 326, 840 1, 326, 840 0.000000 88.01 1.192032 88.01 08802 OULCK CARE 0 0.875004 88.02 1, 465, 431 1, 465, 431 0.000000 88.02 88.04 08803 PEDI ATRI CS 0 1, 240, 873 1, 240, 873 0.818317 0.000000 88.04 88.05 08804 DAVIESS MARTIN 0 1,066,618 1,066,618 0.972254 0.000000 88.05 90 00 09000 CLI NI C 34 500 1 789 324 1 823 824 0.321181 0.000000 90 00 09100 EMERGENCY 91.00 1, 254, 660 6, 359, 262 7, 613, 922 0.430257 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 167, 636 880, 088 1, 047, 724 1.162980 0.000000 92.00 92.00 04040 OTHER OUTPATIENT SERVICE COST CENTER 93.00 3, 200 1,092,854 1,096,054 0.521687 0.000000 93.00 OTHER REIMBURSABLE COST CENTERS 99. 10 09910 CORF 0 99.10 101.00 10100 HOME HEALTH AGENCY 0 162, 582 162, 582 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 846, 110 846, 110 116.00 200.00 Subtotal (see instructions) 39, 946, 123 65, 920, 513 105, 866, 636 200.00 201 00 Less Observation Beds 201.00

39, 946, 123

65, 920, 513

105, 866, 636

202.00

202.00

Total (see instructions)

Health Financial Systems	DAVIESS COMMUNITY HOSPITAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 150061	Peri od: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Prepared: 5/21/2015 12:29 pm

				5/21/2015 12:29 pm
		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
40. 00   04000   SUBPROVI DER - I PF				40.00
41. 00   04100   SUBPROVI DER -   RF				41.00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50.00   05000   OPERATING ROOM	0. 000000			50.00
51.00   05100   RECOVERY ROOM	0. 000000			51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0. 000000			52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
56. 00   05600   RADI 01 SOTOPE	0. 000000			56.00
60. 00   06000   LABORATORY	0. 000000			60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63.00
64.00 06400 INTRAVENOUS THERAPY	0. 000000			64.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65.00
66. 00   06600 PHYSI CAL THERAPY	0. 000000			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
68.00 06800 SPEECH PATHOLOGY	0. 000000			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO 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
76. 00 03020 CARDI AC REHAB	0. 000000			76.00
OUTPATIENT SERVICE COST CENTERS				
88. 00   08800   DCHMC	0. 000000			88.00
88. 01   08801   NDMC/ODON	0. 000000			88. 01
88. 02   08802   QUI CK CARE	0. 000000			88. 02
88. 04   08803   PEDI ATRI CS	0. 000000			88. 04
88. 05   08804   DAVIESS MARTIN	0. 000000			88. 05
90. 00  09000   CLI NI C	0. 000000			90.00
91. 00   09100   EMERGENCY	0. 000000			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.00
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000			93.00
OTHER REIMBURSABLE COST CENTERS				
99. 10  09910 CORF				99. 10
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	DAVIESS COMMUN	IITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der		Period: From 01/01/2014 To 12/31/2014		pared: 29 pm
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col. 2)			
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	332, 395	0	332, 39	5, 130	64. 79	30.00
31.00 INTENSIVE CARE UNIT	98, 669		98, 66	9 871	113. 28	31.00
40. 00   SUBPROVI DER - I PF	360, 039	0	360, 03	9 5, 874	61. 29	40.00
41. 00   SUBPROVI DER - I RF	228, 744	0	228, 74	4 2, 539	90. 09	41.00
43. 00 NURSERY	34, 916		34, 91	6 835	41. 82	43.00
200.00 Total (lines 30-199)	1, 054, 763		1, 054, 76	3 15, 249		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	1, 784					30.00
31.00 INTENSIVE CARE UNIT	501	56, 753				31.00
40. 00   SUBPROVI DER - I PF	5, 021	307, 737				40.00
41. 00   SUBPROVI DER - I RF	2, 045	184, 234				41.00
43. 00 NURSERY	0	1				43.00
200.00 Total (lines 30-199)	9, 351	664, 309				200. 00

Heal th	Financial Systems	DAVIESS COMMUN	IITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORT	IONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS			Period: From 01/01/2014 To 12/31/2014		
			Ti tl	e XVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
		Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
		(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
		B, Part II,	col. 8)	col. 2)			
		col. 26)					
		1. 00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	,	,				1
	05000 OPERATING ROOM	274, 801			· ·	· ·	1
	05100 RECOVERY ROOM	29, 334				2, 006	
	05200 DELIVERY ROOM & LABOR ROOM	168, 011	655, 931	0. 25614		1, 081	52.00
	05400 RADI OLOGY-DI AGNOSTI C	304, 495		0. 02058	· · · ·		1
	05600 RADI OI SOTOPE	79, 250					
60.00	06000 LABORATORY	229, 959			· · · ·	· ·	1
	06300 BLOOD STORING, PROCESSING & TRANS.	26, 520					
	06400 I NTRAVENOUS THERAPY	17, 645					1
65.00	06500 RESPI RATORY THERAPY	85, 688			· ·	19, 604	65.00
	06600 PHYSI CAL THERAPY	100, 725				2, 770	
	06700 OCCUPATI ONAL THERAPY	29, 893			· ·		1
	06800 SPEECH PATHOLOGY	15, 695			· ·		68. 00
	06900 ELECTROCARDI OLOGY	21, 772		0. 01852			1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	133, 407			· ·	· ·	
	07200 IMPL. DEV. CHARGED TO PATIENT	23, 972			· ·	· ·	
	07300 DRUGS CHARGED TO PATIENTS	255, 546		0. 03595		39, 181	73.00
76.00	03020 CARDI AC REHAB	36, 361	81, 742	0. 44482	6 0	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
	08800 DCHMC	119, 318				0	1 00.00
	08801 NDMC/ODON	116, 748				0	88. 01
	08802 QUI CK CARE	119, 856	1, 465, 431	0. 08178	9 0	0	88. 02
88. 04	08803 PEDI ATRI CS	65, 828				0	88. 04
	08804 DAVIESS MARTIN	94, 667	1, 066, 618			0	
	09000 CLI NI C	79, 034			· ·	· ·	1
	09100 EMERGENCY	250, 631			· ·		
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	92, 720				10, 685	
	04040 OTHER OUTPATIENT SERVICE COST CENTER	97, 811				51	
200.00	Total (lines 50-199)	2, 869, 687	87, 190, 019		8, 139, 136	214, 909	200.00

Health Financial Systems	DAVIESS COMMUN	IITY HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS			Period: From 01/01/2014 To 12/31/2014	Date/Time Pre 5/21/2015 12:	pared: 29 pm
			e XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng School	Allied Health Cost	Medical Education	Swing-Bed Adjustment Amount (see	Total Costs (sum of cols. 1 through 3,	
			Cost		minus col. 4)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	0	0		0	0	
31.00 03100 INTENSIVE CARE UNIT	0	0		0	0	31.00
40. 00   04000   SUBPROVI DER - I PF	0	0		0	0	40. 00
41. 00   04100   SUBPROVI DER - I RF	0	0		0	0	
43. 00   04300   NURSERY	0	0		0	0	43.00
200.00 Total (lines 30-199)	0	0		0	0	200.00
Cost Center Description	Total Patient	Per Diem	I npati ent	I npati ent		
	Days	(col. 5 ÷	Program Days			
		col. 6)		Pass-Through		
				Cost (col. 7		
	/ 00	7.00	0.00	x col. 8)		
INDATIENT DOUTINE CEDVICE COCT CENTERS	6. 00	7. 00	8. 00	9. 00		
I NPATI ENT ROUTI NE SERVI CE COST CENTERS  30. 00 03000 ADULTS & PEDI ATRI CS	F 120	0.00	1 70	4 0		1 20 00
30.00   03000   ADULTS & PEDIATRICS 31.00   03100   INTENSIVE CARE UNIT	5, 130 871					30. 00 31. 00
40. 00   04000   SUBPROVI DER - 1 PF	5, 874					40.00
41. 00   04000   SUBPROVI DER - 1 PF	2, 539	l .				41.00
43. 00   04300   NURSERY	835			0 0		43.00
200.00 Total (lines 30-199)		l .	9, 35	-		200.00
200.00   Total (Titles 30-199)	15, 249	1	9, 30	1	I	<sub>1</sub> 200.00

Health Financial Systems	DAVIESS COMMUNITY	HOSPI TAL	In Lieu	ı of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 150061	From 01/01/2014	Worksheet D Part IV Date/Time Prepared

			To	12/31/2014	Date/Time Pre 5/21/2015 12:	
		Ti tl	e XVIII	Hospi tal	PPS	<u> </u>
Cost Center Description	Non Physician	Nursi ng	Allied Health	All Other	Total Cost	
	Anesthetist	School		Medi cal	(sum of col 1	
	Cost			Educati on	through col.	
				Cost	4)	
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
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
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	54.00
56. 00   05600   RADI 01 SOTOPE	0	0	0	0	0	56.00
60. 00  06000  LABORATORY	0	0	0	0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00   06400   I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0	0	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	0	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	О	0	0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	О	0	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	TS 0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	О	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	О	0	0	0	0	73.00
76. 00   03020   CARDI AC REHAB	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
88. 00   08800   DCHMC	0	0	0	0	0	88. 00
88. 01   08801   NDMC/ODON	0	0	0	0	0	88. 01
88. 02   08802   QUI CK CARE	0	0	0	0	0	88. 02
88. 04   08803   PEDI ATRI CS	0	0	0	0	0	88. 04
88. 05   08804   DAVIESS MARTIN	0	0	0	0	0	88. 05
90. 00  09000   CLI NI C	0	0	0	0	0	90.00
91. 00   09100   EMERGENCY	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PAR	Γ) 0	0	0	0	0	92.00
93.00 04040 OTHER OUTPATIENT SERVICE COST CENTE	ER 0	0	0	0	0	93.00
200.00 Total (lines 50-199)	o	0	0	0	0	200.00
	·					

Health Financial Systems	DAVIESS COMMUNITY	HOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATI THROUGH COSTS	ENT ANCILLARY SERVICE OTHER PASS	Provi der CCN: 150061	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared:

				Т	o 12/31/2014	Date/Time Pre 5/21/2015 12:	
			Ti t	le XVIII	Hospi tal	PPS	27 piii
	Cost Center Description	Total	Total Charges	Ratio of Cost	Outpati ent	I npati ent	
	·	Outpati ent	(from Wkst.	to Charges	Ratio of Cost	Program	
		Cost (sum of	C, Part I,	(col. 5 ÷	to Charges	Charges	
		col. 2, 3 and	col. 8)	col. 7)	(col. 6 ÷		
		4)			col. 7)		
		6. 00	7. 00	8. 00	9. 00	10.00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	6, 218, 77	•		· ·	1
	05100 RECOVERY ROOM	0	716, 30				51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	655, 93	<b>I</b>		· ·	52.00
	05400 RADI OLOGY-DI AGNOSTI C	0	14, 795, 18				
	05600 RADI 0I S0T0PE	0	4, 429, 81	<b>I</b>		· ·	56.00
	06000 LABORATORY	0	19, 608, 77			, , , , ,	1
	06300 BLOOD STORING, PROCESSING & TRANS.	0	911, 70			' '	63.00
	06400 I NTRAVENOUS THERAPY	0	754, 07			181, 858	64.00
	06500 RESPI RATORY THERAPY	0	3, 303, 80				65.00
	06600 PHYSI CAL THERAPY	0	2, 792, 05				66.00
	06700 OCCUPATI ONAL THERAPY	0	1, 316, 47				67.00
68.00	06800 SPEECH PATHOLOGY	0	288, 47	0. 000000	0. 000000	14, 839	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	1, 175, 25	1 0.000000	0. 000000	139, 160	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4, 166, 12	7 0. 000000	0. 000000	625, 385	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	712, 59	5 0.000000	0.000000	264, 253	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	7, 106, 96	1 0.000000	0. 000000	1, 089, 662	73.00
76.00	03020 CARDI AC REHAB	0	81, 74	2 0.000000	0. 000000	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 DCHMC	0	1, 474, 71	4 0. 000000	0. 000000	0	88. 00
88. 01	08801 NDMC/ODON	0	1, 326, 84	0.000000	0.000000	0	88. 01
88. 02	08802 QUI CK CARE	0	1, 465, 43	0.000000	0. 000000	0	88. 02
88. 04	08803 PEDI ATRI CS	0	1, 240, 87	3 0.000000	0. 000000	0	88. 04
88. 05	08804 DAVIESS MARTIN	0	1, 066, 61	0.000000	0. 000000	0	88. 05
90.00	09000 CLI NI C	0	1, 823, 82	4 0.000000	0. 000000	34, 498	90.00
91.00	09100 EMERGENCY	0	7, 613, 92	2 0.000000	0. 000000	615, 834	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1, 047, 72	4 0. 000000	0. 000000	120, 737	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	1, 096, 05	4 0. 000000	0. 000000	574	93.00
200.00	Total (lines 50-199)	0	87, 190, 01	9		8, 139, 136	200.00

Health Financial Systems

DAVIESS COMMUNITY HOSPITAL

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

DAVIESS COMMUNITY HOSPITAL

In Lieu of Form CMS-2552-10

Period: From 01/01/2014 | Part IV | To 12/31/2014 | Part IV | To 12/31/2014 | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part

					5/21/2015 12:	:29 pm
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Inpatient	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	1, 655, 053	0			50.00
51.00   05100   RECOVERY ROOM	0	0	0			51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	0	0			52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	3, 573, 612	0			54.00
56. 00   05600   RADI 01 SOTOPE	0	1, 458, 119	0			56.00
60. 00  06000 LABORATORY	0	1, 775, 470	0			60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	198, 626	0			63.00
64.00   06400   I NTRAVENOUS THERAPY	0	111, 550	0			64.00
65. 00   06500   RESPI RATORY THERAPY	0	528, 683	0			65.00
66. 00   06600 PHYSI CAL THERAPY	0	0	0			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0			67.00
68. 00 06800 SPEECH PATHOLOGY	0	8, 653	0			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	231, 594	0			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	rs o	821, 054	0			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	O	130, 261	0			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	O	1, 205, 111	0			73.00
76. 00 03020 CARDI AC REHAB	0	43, 243	0			76. 00
OUTPATIENT SERVICE COST CENTERS						
88. 00   08800   DCHMC	0	0	0			88. 00
88. 01   08801   NDMC/ODON	0	0	0			88. 01
88. 02   08802   QUI CK CARE	0	0	0			88. 02
88. 04   08803   PEDI ATRI CS	0	0	0			88. 04
88. 05   08804   DAVI ESS   MARTI N	O	0	0			88. 05
90. 00  09000 CLI NI C	O	901, 955	0			90.00
91. 00 09100 EMERGENCY	O	1, 307, 903	0			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	Γ) 0	272, 297	0			92.00
93.00 04040 OTHER OUTPATIENT SERVICE COST CENTE	ER O	585, 808	0			93.00
200.00 Total (lines 50-199)	0	14, 808, 992	0			200.00

Health Financial Systems	DAVIESS COMMUNITY F	HOSPI TAL	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 150061		Worksheet D
			From 01/01/2014	Part V

					o 12/31/2014	Date/Time Pre 5/21/2015 12:	pared: 29 pm
			Ti tl	e XVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
		Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
		From	Services (see	Servi ces	Services Not		
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.		Ded. & Coins.	Ded. & Coins.		
		9		(see inst.)	(see inst.)		
		1. 00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0. 314029			1	519, 735	•
	05100 RECOVERY ROOM	0. 125767	0	1		0	51.00
	05200 DELIVERY ROOM & LABOR ROOM	1. 319223		1	-	0	52.00
	05400 RADI OLOGY-DI AGNOSTI C	0. 194010			,	693, 316	
	05600 RADI OI SOTOPE	0. 202844		1	,	295, 771	56.00
	06000 LABORATORY	0. 185914			-	330, 085	60.00
	06300 BLOOD STORING, PROCESSING & TRANS.	0. 465072		1	-	92, 375	
	06400 INTRAVENOUS THERAPY	0. 098608		1	1	11, 000	1
	06500 RESPI RATORY THERAPY	0. 365606			,	193, 290	
	06600 PHYSI CAL THERAPY	0. 498199		1	,	0	66.00
	06700 OCCUPATI ONAL THERAPY	0. 368803		(	0	0	67.00
	06800 SPEECH PATHOLOGY	0. 672368		1	0	5, 818	1
	06900 ELECTROCARDI OLOGY	0. 146741	231, 594		0	33, 984	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 588257	821, 054		0	482, 991	71.00
	07200 IMPL. DEV. CHARGED TO PATIENT	0. 840473			-	109, 481	72.00
	07300 DRUGS CHARGED TO PATIENTS	0. 491530		(	795	592, 348	1
76. 00	03020 CARDI AC REHAB	2. 188899	43, 243	C	0	94, 655	76.00
	OUTPATIENT SERVICE COST CENTERS						
	08800 DCHMC	0. 000000				0	88. 00
	08801 NDMC/ODON	0. 000000	l .			0	88. 01
	08802 QUI CK CARE	0. 000000				0	88. 02
	08803 PEDI ATRI CS	0. 000000	l .			0	88. 04
	08804 DAVIESS MARTIN	0. 000000				0	88. 05
	09000 CLI NI C	0. 321181	901, 955	1	-	289, 691	90.00
	09100 EMERGENCY	0. 430257	1, 307, 903		1	562, 734	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 162980		1	0	316, 676	•
	04040 OTHER OUTPATIENT SERVICE COST CENTER	0. 521687		1	-	305, 608	1
200.00			14, 808, 992	C	795	4, 929, 558	1
201.00					0		201. 00
	Only Charges						
202. 00	Net Charges (line 200 +/- line 201)		14, 808, 992	:  C	795	4, 929, 558	202.00

Health Financial Systems	DAVIESS COMMUNITY	In Lieu	u of Form CMS-2552-10	
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 150061	From 01/01/2014	Worksheet D Part V Date/Time Prepared:

					То	12/31/2014	Date/Time Pr 5/21/2015 12	
			Ti tl (	e XVIII		Hospi tal	PPS	
	Cos	sts						
Cost Center Description	Cost		Cost					
	Rei mbursed	Rei	mbursed					
	Servi ces	Serv	ices Not					
	Subject To	Sub	ject To					
	Ded. & Coins.	Ded.	& Coi ns.					
	(see inst.)	(see	inst.)					
	6. 00		7. 00					
ANCILLARY SERVICE COST CENTERS								
50. 00   05000   OPERATING ROOM	0	)	0					50.00
51. 00   05100   RECOVERY ROOM	0		0					51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0		o					52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0		o					54.00
56. 00   05600 RADI 0I SOTOPE	0	ol	o					56.00
60. 00 06000 LABORATORY	0	ol	o					60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	ol	o					63.00
64. 00 06400 I NTRAVENOUS THERAPY	0	ol	o					64.00
65. 00 06500 RESPIRATORY THERAPY	0		o					65. 00
66. 00 06600 PHYSI CAL THERAPY	0		o					66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0		0					67.00
68. 00 06800 SPEECH PATHOLOGY	0		0					68. 00
69. 00 06900 ELECTROCARDI OLOGY	0		0					69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0					71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0		o					72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0		391					73.00
76. 00   03020   CARDI AC   REHAB	0		0					76. 00
OUTPATIENT SERVICE COST CENTERS		1						70.00
88. 00 08800 DCHMC	0	ol .	0					88.00
88. 01   08801   NDMC/ODON	0	1	0					88. 01
88. 02   08802   QUI CK   CARE	0		0					88. 02
88. 04   08803   PEDI ATRI CS	0		0					88. 04
88. 05   08804   DAVI ESS   MARTI N	0		0					88. 05
90. 00   09000   CLI NI C	0		0					90.00
91. 00   09100   EMERGENCY	0		0					91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		0					92.00
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER	0		0					93.00
200.00 Subtotal (see instructions)		()	391					200.00
201. 00 Less PBP Clinic Lab. Services-Program		()	391					200.00
Only Charges		Ί						201.00
202.00 Net Charges (line 200 +/- line 201)	0	/	391					202.00
202.00   met charges (Time 200 +/ - Time 201)	1	Ί	371					1202.00

Real th Financial   Systems   DAVIESS COMMUNITY HOSPITAL							
Component   Col. 155061   From 01/01/2014   Date/Time Prepared: 5/21/2015   12:29 pm							2552-10
Component CCN: 15S061   To 12/31/2014   Date/Time Prepared: 5/21/2015 12:29 pm   Title XVIII   Subprovider - IPF   PS   PPS	APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der	CCN: 150061			
Cost Center Description			Componen	t CCN: 155061		Part II	nared:
Capital Related Cost (From Wast. B, Part II)			Componen	C CON. 155001			
Cost Center Description			Ti tl	e XVIII	Subprovi der -		
Related Cost (From Wiss)					I PF		
CFORM WKST.   B, Part II,   Col. 2   Col. 8   Col. 2   Col. 1   Col. 2	Cost Center Description						
B, Part II, col 26   Col 8   Col 2   Col 8   Col 2							
COL   26   COL   26   COL   2   COL   3   COL   3   COL   4   COL   5   CO		,			Charges	column 4)	
1,00   2,00   3,00   4,00   5,00			col. 8)	col . 2)			
ANCI LLARY SERVICE COST CENTERS							
50.00		1. 00	2. 00	3. 00	4. 00	5. 00	
51. 00   05100   RECOVERY ROOM   29, 334   716, 300   0.040952   0   0   51.00   52. 00   05200   DELIVERY ROOM & LABOR ROOM   168, 011   655, 931   0.256141   0   0   52.00   54. 00   05400   RADI OLOGY-DI AGNOSTI C   304, 495   14, 795, 181   0.02581   141, 113   2, 904   54.00   55. 00   05600   RADI OLOGY-DI AGNOSTI C   79, 250   4, 429, 810   0.017890   29, 962   536   56.00   60. 00   06000   LABORATORY   229, 959   19, 608, 772   0.011727   775, 642   9, 096   60.00   63. 00   06300   BLOOD STORI NG, PROCESSI NG & TRANS.   26, 520   911, 702   0.029088   22, 011   640   63.00   64. 00   06400   INTRAVENOUS THERAPY   17, 645   754, 070   0.023400   7, 918   185   64.00   65. 00   06600   PHYSI CAL THERAPY   100, 725   2, 792, 057   0.036076   30, 087   1, 085   66.00   66. 00   06600   PHYSI CAL THERAPY   100, 725   2, 792, 057   0.036076   30, 087   1, 085   66.00   67. 00   06700   0CCUPATI ONAL THERAPY   29, 893   1, 316, 474   0.022707   4, 252   97   67.00   69. 00   06900   ELECTROCARDI OLOGY   15, 695   288, 470   0.054408   10, 798   587   68.00   69. 00   06900   ELECTROCARDI OLOGY   21, 772   1, 175, 251   0.018525   45, 016   834   69.00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   133, 407   4, 166, 127   0.032022   78, 086   2, 500   71.00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   23, 972   712, 595   0.036404   0   0   0   72.00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   255, 546   7, 106, 961   0.035957   1, 761, 356   63, 333   73.00   74. 00   03020   CARDI AC REHAB   36, 361   81, 742   0.444826   0   0   0   76.00   88. 01   08801   NDMC/ODON   116, 748   1, 326, 840   0.087990   0   0.88.01   88. 02   08802   DUCHK CARE   119, 856   65, 828   1, 240, 873   0.053050   0   0.88.01   88. 04   08803   PEDI ATRI CS   65, 828   1, 240, 873   0.053050   0   0.88.01   88. 04   08803   PEDI ATRI CS   65, 828   1, 240, 873   0.063050   0   0.08909   0   0   88. 04   08803   PEDI ATRI CS   65, 828   1, 240, 873   0.063050   0   0.08909   0   0   88. 04   08803   PED				1			
52. 00   05200   DELI VERY ROOM & LABOR ROOM   168, 011   655, 931   0.256141   0   0   52. 00   54. 00   05400   RADI OLOGY-DI AGNOSTI C   304, 495   14, 795, 181   0.020581   141, 113   2, 904   54. 00   65. 00   05600   RADI OLOGY-DI AGNOSTI C   304, 495   14, 795, 181   0.020581   141, 113   2, 904   54. 00   66. 00   05600   RADI OLOGY-DI AGNOSTI C   79, 250   4, 429, 810   0.017890   29, 962   536   56. 00   66. 00   05600   RADIO IO SOTOPE   79, 250   4, 429, 810   0.017890   29, 962   536   56. 00   06. 00   05600   DELOGY ROOTH NO, PROCESSI NG & TRANS.   26, 520   911, 702   0.029088   22, 011   640   63. 00   63. 00   06. 00   0500   BLODD STORI NG, PROCESSI NG & TRANS.   26, 520   911, 702   0.029088   22, 011   640   63. 00   66. 00   06							
54.00       05400       RADI OLOGY-DI AGNOSTI C       304, 495       14, 795, 181       0.020581       141, 113       2, 904       54.00         56.00       05600       RADI OI SOTOPE       79, 250       4, 429, 810       0.017890       29, 962       536       56.00         60.00       06000       LABORATORY       229, 959       19, 608, 772       0.011727       775, 642       9,096       60.00         63.00       06300       BLOOD STORI NG, PROCESSI NG & TRANS.       26, 520       911, 702       0.029088       22,011       640       63.00         64.00       06400       INTRAVENOUS THERAPY       17, 645       754, 070       0.023400       7, 918       185       64.00         65.00       06500       RESPI RATORY THERAPY       100, 725       2, 792, 057       0.036076       30, 087       1, 085       66.00         66.00       06600       PHYSI CAL THERAPY       29, 893       1, 316, 474       0.022707       4, 252       97       67.00         67.00       06700       OCCUPATI ONAL THERAPY       29, 893       1, 316, 474       0.022707       4, 252       97       67.00         68.00       06800       SPEECH PATHOLOGY       21, 772       1, 175, 251       0.01825							
56.00       05600 RADI OI SOTOPE       79, 250       4, 429, 810       0. 017890       29, 962       536       56. 00         60.00       06000 LABORATORY       229, 959       19, 608, 772       0. 011727       775, 642       9, 096       60. 00         63.00       06300 BLODO STORI NG, PROCESSI NG & TRANS.       26, 520       911, 702       0. 029088       22, 011       640       63. 00         64.00       06400 INTRAVENOUS THERAPY       17, 645       754, 070       0. 023400       7, 918       185       64. 00         65.00       06500 RESPI RATORY THERAPY       85, 688       3, 303, 803       0. 025936       200, 105       5, 190       65. 00         66.00       06600 PRISTORIAL THERAPY       100, 725       2, 792, 057       0. 36076       30, 087       1, 085       66. 00         67.00       06700 OCCUPATI ONAL THERAPY       12, 893       1, 316, 474       0. 022707       4, 252       97       67. 00         68.00       06800 SPEECH PATHOLOGY       15, 695       288, 470       0. 018525       45, 016       834       69. 00         71.00       07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS       133, 407       4, 166, 127       0. 032022       78, 086       2, 500       71. 00         72.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td>-</td> <td></td>						-	
60. 00   06000   LABORATORY   229, 959   19, 608, 772   0. 011727   775, 642   9, 096   60. 00   63.00   63.00   81.000   STORING, PROCESSING & TRANS.   26, 520   911, 702   0. 029088   22, 011   640   63. 00   64. 00   06400   INTRAVENOUS THERAPY   17, 645   754, 070   0. 023400   7, 918   185   64. 00   66. 00   06500   RESPIRATORY THERAPY   85, 688   3, 303, 803   0. 025936   200, 105   5, 190   65. 00   66. 00   06600   PHYSI CAL THERAPY   100, 725   2, 792, 057   0. 036076   30, 087   1, 085   66. 00   66. 00   06600   PHYSI CAL THERAPY   29, 893   1, 316, 474   0. 022707   4, 252   97   67. 00   69. 00   06900   ELECTROCARDI OLOGY   15, 695   288, 470   0. 054408   10, 798   587   68. 00   68. 00   6800   SPEECH PATHOLOGY   21, 772   1, 175, 251   0. 018525   45, 016   834   69. 00   69. 00   69. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   133, 407   4, 166, 127   0. 032022   78, 086   2, 500   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   23, 972   712, 595   0. 033640   0   0   72. 00   07300   DRUGS CHARGED TO PATI ENTS   255, 546   7, 106, 961   0. 035957   1, 761, 356   63, 333   73. 00   07300   DRUGS CHARGED TO PATI ENTS   255, 546   7, 106, 961   0. 035957   1, 761, 356   63, 333   73. 00   07300   DRUGS CHARGED TO PATI ENTS   255, 546   7, 106, 961   0. 035957   1, 761, 356   63, 333   73. 00   0800   DCHMC   119, 318   1, 474, 714   0. 080909   0   0   88. 00   08800   DCHMC   119, 856   1, 465, 431   0. 081789   0   0   88. 01   08801   DCHMC   119, 856   1, 465, 431   0. 081789   0   0   88. 02   08802   DAVI ESS MARTIN   94, 667   1, 066, 618   0. 088754   0   0   90. 00   90. 00   90. 00   0000   DEMERGENCY   250, 631   7, 613, 922   0. 032917   193, 234   6, 361   91. 00   90							
63. 00							
64. 00   06400   INTRAVENOUS THERAPY   17, 645   754, 070   0.023400   7, 918   185   64. 00   65. 00   06500   RESPI RATORY THERAPY   85, 688   3, 303, 803   0.025936   200, 105   5, 190   65. 00   66. 00   06600   PHYSI CAL THERAPY   100, 725   2, 792, 057   0.036076   30, 087   1, 085   66. 00   67. 00   06700   OCCUPATI ONAL THERAPY   29, 893   1, 316, 474   0.022707   4, 252   97   67. 00   68. 00   06800   SPEECH PATHOLOGY   15, 695   288, 470   0.054408   10, 798   587   68. 00   69. 00   06900   ELECTROCARDI OLOGY   21, 772   1, 175, 251   0.018525   45, 016   834   69. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   133, 407   4, 166, 127   0.032022   78, 086   2, 500   71. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   23, 972   712, 595   0.033640   0   0   0.72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   255, 546   7, 106, 961   0.035957   1, 761, 356   63, 333   73. 00   76. 00   OUTPATIENT SERVICE COST CENTERS    88. 00   08800   DCHMC   119, 318   1, 474, 714   0.080909   0   0   88. 01   88. 01   08801   NDMC/ODON   116, 748   1, 326, 840   0.087990   0   0   88. 01   88. 02   08802   OUI CK CARE   119, 856   1, 465, 431   0.081789   0   0   88. 02   88. 04   08803   PEDI ATRI CS   65, 828   1, 240, 873   0.053050   0   0   88. 04   88. 05   08804   DAVI ESS MARTI N   94, 667   1, 066, 618   0.089754   0   0   90. 00   91. 00   09200   CHERC OUTPATIENT SERVICE COST CENTERS   97, 811   1, 096, 054   0.089239   2, 582   230   93. 00   93. 00   04040   OTHER OUTPATIENT SERVICE COST CENTER   97, 811   1, 096, 054   0.089239   2, 582   230   93. 00    94. 00   04040   OTHER OUTPATIENT SERVICE COST CENTER   97, 811   1, 096, 054   0.089239   2, 582   230   93. 00    95. 00   04040   OTHER OUTPATIENT SERVICE COST CENTER   97, 811   1, 096, 054   0.089239   2, 582   230   93. 00    95. 00   04040   OTHER OUTPATIENT SERVICE COST CENTER   97, 811   1, 096, 054   0.089239   2, 582   230   93. 00    96. 00   04040   OTHER OUTPATIENT SERVICE COST CENTER   97, 811   1, 096, 054   0.089							
65. 00 06500 RESPIRATORY THERAPY 85, 688 3, 303, 803 0. 0.25936 200, 105 5, 190 65. 00 66. 00 06600 PHYSI CAL THERAPY 100, 725 2, 792, 057 0. 0.36076 30, 087 1, 085 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 29, 893 1, 316, 474 0. 0.22707 4, 252 97 67. 00 06800 SPEECH PATHOLOGY 15, 695 288, 470 0. 0.54408 10, 798 587 68. 00 6800 SPEECH PATHOLOGY 21, 772 1, 175, 251 0. 0.18525 45, 016 834 69. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 133, 407 4, 166, 127 0. 032022 78, 086 2, 500 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 23, 972 712, 595 0. 033640 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENT 23, 972 712, 595 0. 033640 0 0 72. 00 07300 DRUGS CHARGED TO PATI ENTS 255, 546 7, 106, 961 0. 035957 1, 761, 356 63, 333 73. 00 07300 DRUGS CHARGED TO PATI ENTS 255, 546 7, 106, 961 0. 035957 1, 761, 356 63, 333 73. 00 07300 DRUGS CHARGED TO PATI ENTS 255, 546 7, 106, 961 0. 035957 1, 761, 356 63, 333 73. 00 07300 DRUGS CHARGED TO PATI ENTS 255, 546 7, 106, 961 0. 036909 0 0 0 88. 00 000 000 000 000 000 000 00							
66. 00   06600   PHYSICAL THERAPY   100, 725   2, 792, 057   0. 036076   30, 087   1, 085   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   29, 893   1, 316, 474   0. 022707   4, 252   97   67. 00   68. 00   06800   SPEECH PATHOLOGY   15, 695   288, 470   0. 054408   10, 798   587   68. 00   69. 00   06900   ELECTROCARDI OLOGY   21, 772   1, 175, 251   0. 018525   45, 016   834   69. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   133, 407   4, 166, 127   0. 032022   78, 086   2, 500   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   23, 972   712, 595   0. 033640   0   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   255, 546   7, 106, 961   0. 035957   1, 761, 356   63, 333   73. 00   07300   CARDI AC REHAB   36, 361   81, 742   0. 444826   0   0   0   76. 00   0   0   0   0   0   0   0   0   0							
67. 00							
68. 00							
69. 00   06900   ELECTROCARDI OLOGY   21, 772   1, 175, 251   0. 018525   45, 016   834   69. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   133, 407   4, 166, 127   0. 032022   78, 086   2, 500   71. 00   72. 00   72. 00   07200   MPL. DEV. CHARGED TO PATI ENT   23, 972   712, 595   0. 033640   0   0   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   255, 546   7, 106, 961   0. 035957   1, 761, 356   63, 333   73. 00   76. 00   00000   CARDI AC REHAB   0   0   0   0   0   0   0   0   0							
71. 00							
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 23, 972 712, 595 0. 033640 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 255, 546 7, 106, 961 0. 035957 1, 761, 356 63, 333 73. 00 03020 CARDI AC REHAB 36, 361 81, 742 0. 444826 0 0 0 0 76. 00 00 00 00 00 00 00 00 00 0 0 0 0 0				1			
73. 00   07300   DRUGS CHARGED TO PATIENTS   255, 546   7, 106, 961   0. 035957   1, 761, 356   63, 333   73. 00   76. 00   0000   0. 0000   0. 0000   0. 0000   0. 0000   0. 0000   0. 0000   0. 0000   0. 0000   0. 0000   0. 0000   0. 0000   0. 0000   0. 0000   0. 0000   0. 0000   0. 0000   0. 0000   0. 0000   0. 00000   0. 0000   0. 0000   0. 0000   0. 0000   0. 0000   0. 0000   0. 0000   0. 0000   0. 0000   0. 0000   0. 0000   0. 0000   0. 00000   0. 00000   0. 00000   0. 00000   0. 00000   0. 00000   0. 00000   0. 00000   0. 00000   0. 00000   0. 00000   0. 000000   0. 000000   0. 000000   0. 000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 00000000							
76. 00 03020 CARDI AC REHAB 36, 361 81, 742 0. 444826 0 0 76. 00 000000000000000000000000000				1		_	
S8. 00   ORDITION			7, 106, 961	1		63, 333	
88. 00   08800   DCHMC   119, 318   1, 474, 714   0. 080909   0   0   88. 00   08801   NDMC/ODON   116, 748   1, 326, 840   0. 087990   0   0   88. 01   08802   OUI CK CARE   119, 856   1, 465, 431   0. 081789   0   0   0   88. 02   08802   OUI CK CARE   119, 856   1, 465, 431   0. 081789   0   0   0   088. 02   08804   DAVI ESS MARTI N   94, 667   1, 066, 618   0. 088754   0   0   0   088. 05   08804   DAVI ESS MARTI N   94, 667   1, 066, 618   0. 088754   0   0   0   088. 05   08804   DAVI ESS MARTI N   94, 667   1, 823, 824   0. 043334   0   0   0   09. 00   09		36, 361	81, 742	0. 44482	26 0	0	76.00
88. 01   08801   08802   08802   0UI CK CARE   116, 748   1, 326, 840   0. 087990   0   0   88. 01   08803   00   08804   08803   PEDI ATRI CS   65, 828   1, 240, 873   0. 053050   0   0   88. 04   08804   DAVI ESS MARTI N   94, 667   1, 066, 618   0. 088754   0   0   0   088. 05   08804   08804   08805   08804   08805   08804   08805   088							
88. 02   08802   0UI CK CARE   119, 856   1, 465, 431   0. 081789   0   0   88. 02   08803   PEDI ATRI CS   65, 828   1, 240, 873   0. 053050   0   0   88. 04   08804   DAVI ESS MARTI N   94, 667   1, 066, 618   0. 088754   0   0   0   98. 05   0   0   0   0   0   0   0   0   0							
88. 04   08803   PEDI ATRI CS   65, 828   1, 240, 873   0. 053050   0   0   88. 04   88. 05   08804   DAVI ESS MARTI N   94, 667   1, 066, 618   0. 088754   0   0   88. 05   090. 00   09000   CLI NI C   79, 034   1, 823, 824   0. 043334   0   0   0   90. 00   09100   EMERGENCY   250, 631   7, 613, 922   0. 032917   193, 234   6, 361   91. 00   92. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART)   0   1, 047, 724   0. 000000   0   0   92. 00   93. 00   04040   OTHER OUTPATI ENT SERVI CE COST CENTER   97, 811   1, 096, 054   0. 089239   2, 582   230   93. 00   04040   0   0   0   0   0   0   0						0	
88. 05							
90. 00   09000   CLINIC   79, 034   1, 823, 824   0. 043334   0   0   90. 00   91. 00   91. 00   92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   0   1, 047, 724   0. 000000   0   92. 00   93. 00   04040   OTHER OUTPATIENT SERVICE COST CENTER   97, 811   1, 096, 054   0. 089239   2, 582   230   93. 00   04040						0	
91. 00   09100   EMERGENCY   250, 631   7, 613, 922   0. 032917   193, 234   6, 361   91. 00   92. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART)   0   1, 047, 724   0. 000000   0   0   92. 00   93. 00   04040   OTHER OUTPATI ENT SERVI CE COST CENTER   97, 811   1, 096, 054   0. 089239   2, 582   230   93. 00						0	
92.00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   0   1,047,724   0.000000   0   92.00   93.00   04040   OTHER OUTPATIENT SERVICE COST CENTER   97,811   1,096,054   0.089239   2,582   230   93.00							
93.00   04040   OTHER OUTPATIENT SERVICE COST CENTER   97,811   1,096,054   0.089239   2,582   230   93.00		250, 631	7, 613, 922	1		6, 361	
200.00   Total (lines 50-199)   2,776,967  87,190,019    3,307,074  93,795 200.00							
	200.00   Total (lines 50-199)	2, 776, 967	87, 190, 019	1	3, 307, 074	93, 795	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS		CCN: 150061 t CCN: 15S061	Period: From 01/01/2014 To 12/31/2014		pared: 29 pm
		Ti tl	e XVIII	Subprovi der - I PF	PPS	
Cost Center Description	Non Physician Anesthetist Cost	Nursi ng School	Allied Healt		Total Cost (sum of col 1 through col. 4) 5.00	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
ANOLIZARY SERVICE COST CENTERS  50. 00  050000 OPERATING ROOM  51. 00  05100 RECOVERY ROOM  52. 00  05200 DELIVERY ROOM & LABOR ROOM  54. 00  05400 RADIOLOGY-DIAGNOSTIC  56. 00  05600 RADIOLOGY-DIAGNOSTIC  663. 00  06400 LABORATORY  655. 00  06500 RESPIRATORY THERAPY  656. 00  06600 PHYSICAL THERAPY  666. 00  06600 PHYSICAL THERAPY  677. 00  06700 OCCUPATIONAL THERAPY  688. 00  06800 SPEECH PATHOLOGY  699. 00  07100 MEDICAL SUPPLIES CHARGED TO PATIENTS  773. 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 0 0 0 0 0 0 0 0 0		51. 00 52. 00 54. 00 56. 00 60. 00 63. 00 64. 00 65. 00 67. 00 68. 00 69. 00 71. 00 72. 00
76. 00 03020 CARDI AC REHAB	0	C		0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS	0 0 0 0 0 0 0			0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0	88. 01 88. 02 88. 04 88. 05 90. 00 91. 00 92. 00

Weelth Financial Systems	DAVIESS COMMUN	ILT HOODI VIII		India	u of Form CMS (	255 10
Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE			CCN: 150061	Peri od:	u of Form CMS-2 Worksheet D	2552-10
THROUGH COSTS	KVICE OTTEK TAS	11 OVI dei		From 01/01/2014	Part IV	
TIMOGGIT GOSTS		Componen		To 12/31/2014	Date/Time Pre	pared:
		T: 41	e XVIII	Subprovi der -	5/21/2015 12: PPS	29 pm
		11 (1	e xviii	I PF	PPS	
Cost Center Description	Total	Total Charges	Ratio of Cost	Outpatient	Inpati ent	
oost conten beschiptron	Outpati ent	(from Wkst.	to Charges	Ratio of Cost	Program	
	Cost (sum of	C, Part I,	(col. 5 ÷	to Charges	Charges	
	col. 2, 3 and	col. 8)	col. 7)	(col . 6 ÷	onal goo	
	4)			col . 7)		
	6. 00	7. 00	8.00	9. 00	10.00	
ANCILLARY SERVICE COST CENTERS	•					
50.00 05000 OPERATING ROOM	0	6, 218, 773	0.00000	0.000000	4, 912	50.00
51.00   05100   RECOVERY ROOM	0	716, 300	0.00000	0. 000000	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	655, 931				52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	14, 795, 181	0.00000	0. 000000	141, 113	54.00
56. 00   05600   RADI 0I SOTOPE	0	4, 429, 810			29, 962	56.00
60. 00   06000   LABORATORY	0	,			775, 642	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	911, 702				
64. 00   06400   I NTRAVENOUS THERAPY	0	, , , , , , ,			7, 918	64.00
65. 00 06500 RESPI RATORY THERAPY	0					65.00
66. 00 06600 PHYSI CAL THERAPY	0	2, 792, 057				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	1 ., 0 . 0 , . , .			4, 252	67.00
68. 00 06800 SPEECH PATHOLOGY	0	,			10, 798	
69. 00   06900   ELECTROCARDI OLOGY	0	1, 175, 251			45, 016	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4, 166, 127				
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	0				0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	,				
76. 00 03020 CARDI AC REHAB	0	81, 742	0.00000	0. 000000	0	76. 00
OUTPATIENT SERVICE COST CENTERS				0 000000		
88. 00   08800   DCHMC	0	, , , , ,				
88. 01   08801   NDMC/ODON	0	.,			0	88. 01
88. 02   08802   QUI CK   CARE	0	1, 100, 10.	1		0	88. 02
88. 04   08803   PEDI ATRI CS	0	1, ,			0	88. 04 88. 05
88. 05   08804   DAVI ESS   MARTI N 90. 00   09000   CLI NI C	0	1, 066, 618			0	90.00
91. 00   09100   EMERGENCY		1, 823, 824	1		193, 234	
92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)		.,			193, 234	1
93. 00   04040 OTHER OUTPATIENT SERVICE COST CENTER	0		1		2, 582	
200.00 Total (lines 50-199)		.,	1	0.000000	3, 307, 074	
200.00   10tal (11103 00 177)	1	07, 170, 017	I	1	3,307,074	<sub>1</sub> 200.00

Health Financial Systems	DAVIESS COMMUNITY	In Lieu	u of Form CMS-2	2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			CCN: 150061	Period: From 01/01/2014	Worksheet D Part IV	
111100011 00010		Component	t CCN: 15SO61	To 12/31/2014	Date/Time Prep 5/21/2015 12:	oared: 29 pm
		Ti tl	e XVIII	Subprovi der – I PF	PPS	
Cost Center Description	Inpatient 0	utpatient	Outpatient			

		11 (1	C XVIII	I PF	113	
Cost Center Description	I npati ent	Outpati ent	Outpati ent	1		
, , , , , , , , , , , , , , , , , , ,	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8	J	Costs (col. 9			
	x col. 10)		x col. 12)			
	11. 00	12. 00	13.00			
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	C	)	0		50.00
51.00   05100   RECOVERY ROOM	0	C		0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C		0		52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	C		0		54.00
56. 00 05600 RADI OI SOTOPE	0	C		o		56.00
60. 00   06000   LABORATORY	0	C		o		60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	C		o		63.00
64. 00 06400 I NTRAVENOUS THERAPY	0	C		o		64.00
65. 00 06500 RESPIRATORY THERAPY	O	C		o		65.00
66. 00 06600 PHYSI CAL THERAPY	O	C		o		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	O	C		o		67.00
68. 00 06800 SPEECH PATHOLOGY	0	C		o		68.00
69. 00 06900 ELECTROCARDI OLOGY	0	C		o		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		o		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	o	C		o		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	o	C		o		73.00
76. 00 03020 CARDI AC REHAB	0	C		0		76, 00
OUTPATIENT SERVICE COST CENTERS				-		
88. 00 08800 DCHMC	0	C		0		88. 00
88. 01   08801 NDMC/ODON	0	C		Ö		88. 01
88. 02   08802   QUI CK   CARE	O	C		o		88. 02
88. 04   08803   PEDI ATRI CS	O	C		o		88. 04
88. 05   08804 DAVIESS MARTIN	O	C		o		88. 05
90. 00   09000   CLI NI C	0	C		o		90.00
91. 00 09100 EMERGENCY	O	C		o		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	O	C		o		92.00
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER		C		ol		93.00
200.00 Total (lines 50-199)	O	C		o		200.00
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	-1		1	Ţ		

Heal th	Financial Systems	DAVIESS COMMUN	IITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPOR	FIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS		CCN: 150061 t CCN: 15T061	Peri od: From 01/01/2014 To 12/31/2014	Worksheet D Part II Date/Time Pre 5/21/2015 12:	pared: 29 pm
			Ti tl	e XVIII	Subprovi der – I RF	PPS	
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
		Related Cost (from Wkst.	(from Wkst.	to Charges	Program	(column 3 x	
			C, Part I,	(col . 1 ÷	Charges	column 4)	
		B, Part II, col. 26)	col. 8)	col . 2)			
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
50.00		274, 801	6, 218, 773	0. 04418	39 1, 150	51	50.00
51.00	05100 RECOVERY ROOM	29, 334				0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	168, 011	655, 931	0. 25614	41 0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	304, 495	14, 795, 181	0. 02058	62, 255	1, 281	54.00
56.00	05600 RADI OI SOTOPE	79, 250	4, 429, 810	0. 01789	90 12, 013	215	56.00
60.00	06000 LABORATORY	229, 959				2, 638	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	26, 520				656	
64.00	06400 I NTRAVENOUS THERAPY	17, 645					
65.00	06500 RESPI RATORY THERAPY	85, 688				3, 986	65.00
66.00	06600 PHYSI CAL THERAPY	100, 725				21, 703	
67.00	06700 OCCUPATI ONAL THERAPY	29, 893					
68.00	06800 SPEECH PATHOLOGY	15, 695				3, 250	
69.00	06900 ELECTROCARDI OLOGY	21, 772				53	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	133, 407					
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	23, 972 255, 546		1		0 19, 222	72. 00 73. 00
	03020 CARDI AC REHAB	36, 361	81, 742	1		19, 222	
76.00	OUTPATIENT SERVICE COST CENTERS	30, 301	01,742	0.44402	20  0	U	76.00
88. 00	08800 DCHMC	119, 318	1, 474, 714	0. 08090	09	0	88.00
88. 01	08801 NDMC/ODON	116, 748				Ö	
88. 02	08802 QUI CK CARE	119, 856				0	
88. 04	08803 PEDI ATRI CS	65, 828		1		0	88. 04
88. 05	08804 DAVIESS MARTIN	94, 667		1		0	88. 05
90.00	09000 CLI NI C	79, 034				0	90.00
91.00	09100 EMERGENCY	250, 631				270	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1, 047, 724	0. 00000	00	0	92.00
93.00		97, 811				0	
200.00	Total (lines 50-199)	2, 776, 967	87, 190, 019	1	2, 346, 135	69, 777	200.00

PPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provi der	CCN: 150061	Peri od:	Worksheet D	2552-10
HROUGH COSTS		Componen	t CCN: 15T061	From 01/01/2014 To 12/31/2014		
		Ti ti	e XVIII	Subprovi der -	PPS	
Cost Center Description	Non Physician	Nursi ng	Allied Heal	IRF th All Other	Total Cost	
oost denter bescription	Anesthetist	School	7.111 cd fiedi	Medi cal	(sum of col 1	
	Cost			Educati on	through col.	
				Cost	4)	
	1. 00	2. 00	3.00	4.00	5. 00	
ANCILLARY SERVICE COST CENTERS						
O. OO O5000 OPERATING ROOM	0	(	)	0	0	
1.00   05100   RECOVERY ROOM	0	(	)	0	0	
2.00 05200 DELIVERY ROOM & LABOR ROOM	0	(	)	0	0	52.00
4. 00   05400   RADI OLOGY-DI AGNOSTI C	0	(	)	0	0	
6. 00   05600   RADI 0I SOTOPE	0	(		0 0	0	56.00
0. 00   06000   LABORATORY	0	(		0 0	0	60.00
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	(		0 0	0	63.00
4. 00   06400   INTRAVENOUS THERAPY	0	(		0 0	0	
5. 00 06500 RESPI RATORY THERAPY	0	(		0 0	0	65.00
6. 00   06600   PHYSI CAL THERAPY	0	(		0 0	0	66.00
7. 00   06700 OCCUPATI ONAL THERAPY 8. 00   06800 SPEECH PATHOLOGY	0	(		0 0	0	
8. 00   06800   SPEECH PATHOLOGY 9. 00   06900   ELECTROCARDI OLOGY	0	(			0	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		,			0	
2.00 07200 IMPL. DEV. CHARGED TO PATIENT		·			0	
3. 00 07300 DRUGS CHARGED TO PATIENTS		(			0	
6. 00   03020   CARDI AC   REHAB		Č	ol .		-	
OUTPATIENT SERVICE COST CENTERS	١	·	21	<u> </u>		70.00
8. 00 08800 DCHMC	0	(		0 0	0	88.00
8. 01   08801   NDMC/ODON	o			0 0		
8. 02   08802 QUI CK CARE	O	(		0 0	0	88. 02
8. 04   08803   PEDI ATRI CS	0	(		0 0	0	88. 04
8.05   08804   DAVIESS MARTIN	0	(	o	0 0	0	88. 05
0. 00   09000   CLI NI C	0	(	o	0 0	0	90.00
1.00   09100   EMERGENCY	0	(	o	0 0	0	91.00
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	(	o	0 0	0	
3.00 04040 OTHER OUTPATIENT SERVICE COST CENTER	0	(	)	0 0		
00.00 Total (lines 50-199)	0	(		0 0	0	200.00

Health Financial Systems	DAVI ESS COMMUN		0011 4500/4		u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	RVICE OTHER PAS	S Provi der		Period: From 01/01/2014	Worksheet D Part IV	
THROUGH COSTS		Component		To 12/31/2014		nared·
		'			5/21/2015 12:	
		Ti tl	e XVIII	Subprovi der -	PPS	
				I RF		
Cost Center Description	Total	Total Charges			I npati ent	
	Outpati ent	(from Wkst.	to Charges	Ratio of Cost		
	Cost (sum of	C, Part I,	(col. 5 ÷	to Charges	Charges	
	col . 2, 3 and	col. 8)	col. 7)	(col. 6 ÷		
	4)			col. 7)		
	6. 00	7. 00	8. 00	9. 00	10.00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	0	-,,				1
51.00   05100   RECOVERY ROOM	0					51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0					52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0					54.00
56. 00   05600   RADI 0I SOTOPE	0	.,,				56.00
60. 00   06000   LABORATORY	0					60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0					63.00
64.00   06400   I NTRAVENOUS THERAPY	0	754, 070				64.00
65. 00 06500 RESPIRATORY THERAPY	0	3, 303, 803				65.00
66. 00 06600 PHYSI CAL THERAPY	0	2, 792, 057				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	., ,				
68. 00   06800   SPEECH PATHOLOGY	0	288, 470				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	1, 175, 251				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	.,				
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	712, 595	0. 00000	0. 000000	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	7, 106, 961	0.00000	0. 000000	534, 593	73.00
76. 00 03020 CARDI AC REHAB	0	81, 742	0. 00000	0. 000000	0	76.00
OUTPATIENT SERVICE COST CENTERS						
88. 00   08800   DCHMC	0	1, 474, 714	0.00000	0. 000000	0	88. 00
88. 01   08801   NDMC/ODON	0	1, 326, 840	0.00000	0. 000000	0	88. 01
88. 02   08802   QUI CK   CARE	0	1, 465, 431	0.00000	0. 000000	0	88. 02
88. 04   08803   PEDI ATRI CS	0	1, 240, 873	0.00000	0. 000000	0	88. 04
88.05   08804   DAVIESS MARTIN	0	1, 066, 618	0.00000	0. 000000	0	88. 05
90. 00 09000 CLI NI C	0	1, 823, 824	0.00000	0. 000000	0	90.00
91. 00 09100 EMERGENCY	0	7, 613, 922	0.00000	0. 000000	8, 205	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1, 047, 724	0.00000	0. 000000	0	92.00
93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER	0	1, 096, 054	0.00000	0. 000000		
200.00 Total (lines 50-199)	0	87, 190, 019			2, 346, 135	200.00

Н	lealth Financial Systems		DAVIESS COMMUN	IITY I	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLA THROUGH COSTS	RY SER	VICE OTHER PAS	SS			Peri od: From 01/01/2014 To 12/31/2014		pared:
_								5/21/2015 12:	29 pm
					Ti tl	e XVIII	Subprovi der -	PPS	
							IRF		
	Cost Center Description		Inpatient	0u	tpati ent	Outpati ent			
			Program	P	rogram	Program			
			Pass-Through	C	harges	Pass-Through	1		

				I RF	
Cost Center Description	I npati ent	Outpati ent	Outpati ent		
	Program	Program	Program		
	Pass-Through	Charges	Pass-Through		
	Costs (col. 8		Costs (col. 9		
	x col. 10)		x col. 12)		
	11. 00	12. 00	13. 00		
ANCILLARY SERVICE COST CENTERS					
50.00   05000   OPERATING ROOM	0	C	0		50.00
51.00   05100   RECOVERY ROOM	0	C	0		51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	C	0		52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	C	0		54.00
56. 00   05600   RADI 0I SOTOPE	0	C	0		56.00
60. 00   06000   LABORATORY	0	C	0		60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	C	0		63.00
64. 00   06400   I NTRAVENOUS THERAPY	0	C	0		64.00
65. 00   06500   RESPI RATORY THERAPY	0	C	0		65. 00
66. 00   06600 PHYSI CAL THERAPY	0	C	0		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	C	0		67.00
68.00   06800   SPEECH PATHOLOGY	0	C	0		68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	C	0		69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C	0		71.00
72.00 O7200 MPL. DEV. CHARGED TO PATIENT	0	C	0		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C	0		73. 00
76. 00 03020 CARDI AC REHAB	0	C	0		76. 00
OUTPATIENT SERVICE COST CENTERS					
88. 00   08800   DCHMC	0	C	0		88. 00
88. 01   08801   NDMC/0DON	0	C	0		88. 01
88. 02   08802   QUI CK CARE	0	C	0		88. 02
88. 04   08803   PEDI ATRI CS	0	C	0		88. 04
88.05   08804   DAVIESS MARTIN	0	C	0		88. 05
90. 00  09000  CLI NI C	0	C	0		90.00
91. 00   09100   EMERGENCY	0	C	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C	0		92.00
93.00 04040 OTHER OUTPATIENT SERVICE COST CENTER	0	C	0		93. 00
200.00   Total (lines 50-199)	0	C	0		200. 00

Health Financial Systems	DAVI ESS COMMUNI TY	HOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 150061	Peri od:	Worksheet D

To 12/31/2014 Date/Time Prepared: 5/21/2015 12:29 pm Title XIX Hospi tal Cost Charges Costs PPS Services PPS Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, inst.) Subject To Subject To Ded. & Coins. Ded. & Coins. Part I, col. 9 (see inst.) (see inst.) 1.00 2.00 4. 00 5.00 3.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 0. 314029 926, 865 05100 RECOVERY ROOM 51.00 0.125767 0 0 0 0 0 0 0 0 0 0 0 0 51.00 0 0 0 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 1. 319223 51, 046 0 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.194010 2, 259, 355 0 54.00 56.00 05600 RADI OI SOTOPE 0. 202844 477, 601 56.00 06000 LABORATORY 60. nn 0.185914 2, 162, 254 0 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0.465072 0 26, 467 0 63.00 64.00 06400 INTRAVENOUS THERAPY 0.098608 69, 863 64.00 65.00 06500 RESPIRATORY THERAPY 0.365606 281, 458 0 65.00 06600 PHYSI CAL THERAPY 0.498199 245, 839 66.00 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.368803 76, 960 0 67.00 06800 SPEECH PATHOLOGY 0.672368 60, 227 0 68.00 68.00 06900 ELECTROCARDI OLOGY 0 115, 974 69.00 69 00 0 146741 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.588257 0 517, 740 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0.840473 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0.491530 276, 041 0 73.00 03020 CARDI AC REHAB 2. 188899 ol 76.00 76.00 753 OUTPATIENT SERVICE COST CENTERS 88.00 08800 DCHMC 0. 971839 0 88.00 08801 NDMC/ODON 88. 01 88.01 1. 192032 0 08802 QUI CK CARE 88 02 0.875004 88 02 0 88.04 08803 PEDI ATRI CS 0.818317 0 88.04 88.05 08804 DAVIESS MARTIN 0.972254 0 88.05 90.00 09000 CLI NI C 0. 321181 232, 196 90.00 0 0 0 0 0 0 91.00 1, 677, 872 91.00 09100 EMERGENCY 0.430257 Ω 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1.162980 0 92.00 93. 00 04040 OTHER OUTPATIENT SERVICE COST CENTER 93.00 0.521687 0 18, 533 0 Subtotal (see instructions) 0 9, 477, 044 0 200.00 200.00 201.00 Less PBP Clinic Lab. Services-Program 201.00 Only Charges 202.00 Net Charges (line 200 +/- line 201) 9, 477, 044 0 202.00 0

Health Financial Systems	DAVIESS COMMUNITY H	HOSPI TAL	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 150061	Peri od: From 01/01/2014	Worksheet D Part V
			To 12/31/2014	Date/Time Prepared

				From 01/01/2014 To 12/31/2014		epared: 29 pm
			le XIX	Hospi tal	Cost	
	Cos					
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.) 6.00	(see inst.) 7.00	-			
ANCILLARY SERVICE COST CENTERS	6.00	7.00				
50. 00 05000 OPERATING ROOM	291, 062	(	1			50.00
51. 00   05100   RECOVERY   ROOM	271,002					51.00
52. OO   05200   DELIVERY ROOM & LABOR ROOM	67, 341		1			52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	438, 337					54.00
56. 00   05600 RADI 0I SOTOPE	96, 878					56.00
60. 00   06000   LABORATORY	401, 993					60.00
63. 00   06300   BLOOD STORING, PROCESSING & TRANS.	12, 309		1			63.00
64. 00 06400 I NTRAVENOUS THERAPY	6, 889		1			64.00
65. 00   06500   RESPIRATORY   THERAPY	102, 903		1			65.00
66. 00   06600   PHYSI CAL THERAPY	122, 477		1			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	28, 383		1			67.00
68. 00 06800 SPEECH PATHOLOGY	40, 495		1			68.00
69. 00   06900   ELECTROCARDI OLOGY	17, 018	,	1			69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	304, 564		1			71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	001,001		1			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	135, 682		1			73.00
76. 00   03020   CARDI AC   REHAB	1, 648		1			76.00
OUTPATIENT SERVICE COST CENTERS	.,		-1			1
88. 00 08800 DCHMC	0	(				88. 00
88. 01   08801 NDMC/ODON	0	Ċ				88. 01
88. 02   08802   QUI CK   CARE	0					88. 02
88. 04   08803   PEDI ATRI CS	0					88. 04
88. 05   08804 DAVIESS MARTIN	0	C				88. 05
90. 00   09000   CLI NI C	74, 577					90.00
91. 00 09100 EMERGENCY	721, 916					91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	(				92.00
93.00 04040 OTHER OUTPATIENT SERVICE COST CENTER	9, 668	(				93.00
200.00 Subtotal (see instructions)	2, 874, 140	(				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00   Net Charges (line 200 +/- line 201)	2, 874, 140	(	)			202.00

Health Financial Systems	DAVIESS COMMUNITY HOSPITAL	In Lie	u of Form CMS-2	552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 150061	Peri od:	Worksheet D-1	
		From 01/01/2014 To 12/31/2014	Date/Time Pre 5/21/2015 12:	oared: 29 pm
	Title XVIII	Hospi tal	PPS	
Cost Center Description				
			1. 00	
PART I - ALL PROVIDER COMPONENTS				
I NPATI ENT DAYS				
1.00 Inpatient days (including private room days	and swing-bed days, excluding newborn)		5, 130	1.00
2.00 Inpatient days (including private room days	excluding swing-bed and newborn days)		5, 130	2.00
3.00 Private room days (excluding swing-bed and	observation bed days). If you have only r	rivate room days.	0	3.00

	Cost Center Description		
	COST Center Description	1. 00	
	PART I - ALL PROVIDER COMPONENTS		
	I NPATI ENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5, 130	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-bed and newborn days)  Private room days (excluding swing-bed and observation bed days). If you have only private room days,	5, 130 0	2. 00 3. 00
3. 00	do not complete this line.	١	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3, 699	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5.00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6.00
0.00	reporting period (if calendar year, enter 0 on this line)	U <sub> </sub>	0.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7.00
	reporting period		
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8. 00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	1, 784	9.00
7. 00	newborn days)	1, 701	7.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
44.00	through December 31 of the cost reporting period (see instructions)		44 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
	through December 31 of the cost reporting period		
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
14. 00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15. 00	Total nursery days (title V or XIX only)	0	15.00
16. 00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0. 00	17.00
18. 00	reporting period  Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18. 00
10.00	reporting period	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0. 00	19.00
00.00	reporting period	0.00	00.00
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0. 00	20.00
21. 00	Total general inpatient routine service cost (see instructions)	4, 368, 149	21.00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line		22.00
	5 x line 17)		
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24.00
21.00	7 x line 19)	١	200
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
24 00	x line 20)   Total swing-bed cost (see instructions)		24 00
26. 00 27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	0 4, 368, 149	26. 00 27. 00
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	1,000,117	27.00
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00		0	
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	30.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00000	31.00 32.00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00	•
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00	•
35.00	Average per diem private room cost differential (line 34 x line 31)	0. 00	ı
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4, 368, 149	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	851. 49	
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)	1, 519, 058 0	39. 00 40. 00
41. 00		1, 519, 058	

7.00	rocarting against the cost in the cost in a swing-bed we type inpatrient days (including private room days) through becember 31 of the cost	۷	7.00
0.00	reporting period	0	0.00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	٥	8. 00
0 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and	1 704	9. 00
9. 00		1, 784	9.00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
10.00		۷	10.00
11 00	through December 31 of the cost reporting period (see instructions)	0	11 00
11. 00		٥	11. 00
10.00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		10.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
40.00	through December 31 of the cost reporting period		40.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
14 00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		14 00
	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16. 00
17 00	SWI NG BED ADJUSTMENT	0.00	17 00
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0. 00	17. 00
10 00	reporting period	0. 00	18. 00
16.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	16.00
10 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0. 00	19. 00
17.00	reporting period	0.00	19.00
20 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20. 00
20.00	reporting period	0.00	20.00
21 00	Total general inpatient routine service cost (see instructions)	4, 368, 149	21. 00
	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line		22. 00
22.00	5 x line 17)	ĭ	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line	ol	23. 00
	x line 18)	-	
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	ol	24.00
	7 x line 19)		
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	o	25.00
	x line 20)		
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4, 368, 149	27.00
	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	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	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
	Private room cost differential adjustment (line 3 x line 35)	ol	36.00
	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	4, 368, 149	37.00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	851. 49	38. 00
	Program general inpatient routine service cost (line 9 x line 38)	1, 519, 058	39.00
	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1, 519, 058	41.00
		'	

	Financial Systems	DAVIESS COMMUNIT		CON. 1500/1		u of Form CMS-2	
COMPUT	TATION OF INPATIENT OPERATING COST		Provi der		Period: From 01/01/2014	Worksheet D-1	
				-	Γο 12/31/2014	Date/Time Pre 5/21/2015 12:	pared:
			Ti tl	e XVIII	Hospi tal	PPS	
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)		(col. 3 x col. 4)	
		1. 00	2.00	3.00	4. 00	5. 00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	1, 438, 693	871	1, 651. 7	7 501	827, 537	43.00
44. 00		1, 430, 073	671	1,051.7	301	627, 537	44.00
45. 00							45.00
46. 00							46.00
47.00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						47. 00
	cost center bescription					1.00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3,	line 200)			2, 826, 331	48. 00
49. 00	Total Program inpatient costs (sum of lines	41 through 48)(s	ee instructi	ons)		5, 172, 926	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine s	ervices (fro	m Wkst D sum	of Parts I and	172, 338	50.00
30. 00		attent routine s	ici vices (iio	iii wkst. D, suii	or raits i and	172, 330	30.00
51.00	Pass through costs applicable to Program inp	atient ancillary	services (f	rom Wkst. D, s	um of Parts II	214, 909	51.00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				387, 247	52.00
53. 00	Total Program inpatient operating cost exclu		ated, non-ph	vsician anesth	etist, and	4, 785, 679	
	medical education costs (line 49 minus line	52) '					
E4 00	TARGET AMOUNT AND LIMIT COMPUTATION					0	54.00
	Program discharges Target amount per discharge					0. 00	
56. 00						0	•
	Difference between adjusted inpatient operat	ing cost and tar	get amount (	line 56 minus	line 53)	0	
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	porting ported o	anding 1006	undated and co	mnounded by the	0.00	
34.00	market basket	portring period e	murng 1990,	upuateu anu cc	illipourlued by the	0.00	37.00
60.00	1 3					0.00	l
61. 00	If line 53/54 is less than the lower of line					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)						
62.00							62.00
63. 00	Allowable Inpatient cost plus incentive paym	ent (see instruc	tions)			0	63.00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Decem	ber 31 of th	e cost reporti	ng period (See	0	64.00
	instructions)(title XVIII only)	Ü		•			
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	er 31 of the	cost reporting	period (See	0	65. 00
66. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi</pre>	ne costs (line 6	4 plus line	65)(title XVII	LonLy) For	o	66.00
00.00	CAH (see instructions)		, p. 45	00) (1. 1. 0 ////			00.00
67. 00	9 1	e costs through	December 31	of the cost re	porting period	0	67.00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after De	cember 31 of	the cost reno	rting period	0	68. 00
00.00	(line 13 x line 20)	0 00010 0.10. 20		:o ooo: . opo	g por ou		00.00
69. 00						0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil						70.00
71. 00	Adjusted general inpatient routine service c						71.00
72.00	Program routine service cost (line 9 x line	,					72.00
73. 00 74. 00	Medically necessary private room cost applic Total Program general inpatient routine serv	•	•	,			73.00 74.00
75. 00	Capital -related cost allocated to inpatient	•		•	art II, column		75.00
	26, line 45)		•				
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minu	,					78.00
79. 00	Aggregate charges to beneficiaries for exces	s costs (from pr	ovi der recor	ds)			79. 00
80.00	Total Program routine service costs for comp		st limitatio	n (line 78 mir	us line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I						81. 00 82. 00
83.00	Reasonable inpatient routine service costs (	see instructions					83.00
84.00	Program inpatient ancillary services (see in		->				84.00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum	•					85. 00 86. 00
55.00	PART IV - COMPUTATION OF OBSERVATION BED PAS						00.00
87. 00	Total observation bed days (see instructions	)				1, 431	87.00
88. 00 89. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	•	line 2)			851. 49 1, 218, 482	
07.00	Tobaci vation bod cost (Time of A Time oo) (se	c manactions)				1,210,402	1 07.00

Health Financial Systems	DAVIESS COMMUN	ITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2014 To 12/31/2014		pared: 29 pm_
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		27)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	332, 395	4, 368, 149	0. 07609	5 1, 218, 482	92, 720	90.00
91.00 Nursing School cost	0	4, 368, 149	0. 00000	0 1, 218, 482	0	91.00
92.00 Allied health cost	0	4, 368, 149	0.00000	0 1, 218, 482	0	92.00
93.00 All other Medical Education	0	4, 368, 149	0.00000	0 1, 218, 482	0	93.00

Health Financial Systems	DAVIESS COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 150061	Peri od: From 01/01/2014	Worksheet D-1
	Component CCN: 15SO61		
	Title XVIII	Subprovi der -	PPS
		I PF	

		II the Aviii	I PF	113	
	Cost Center Description			1 00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,			5, 874	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-be Private room days (excluding swing-bed and observation bed days		ivate room days	5, 874 0	2. 00 3. 00
3. 00	do not complete this line.	). It you have only pr	Tvate room days,	O	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed			5, 874	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room reporting period	days) through December	er 31 of the cost	0	5.00
6. 00	Total swing-bed SNF type inpatient days (including private room	days) after December	31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	dave) through Docombor	21 of the cost	0	7.00
7.00	reporting period	days) thi odgir becember	31 of the cost	O	7.00
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after December 3	31 of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	5, 021	9. 00
10. 00	newborn days)	v (including privato r	coom dove)	0	10.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII onl through December 31 of the cost reporting period (see instructi	ons)		U	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl December 31 of the cost reporting period (if calendar year, ent		room days) after	0	11.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period		e room days)	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13.00
14. 00	after December 31 of the cost reporting period (if calendar yea Medically necessary private room days applicable to the Program			0	14.00
15. 00	Total nursery days (title V or XIX only)	(excluding swing-bed	uays)	0	15.00
16. 00	Nursery days (title V or XIX only)			0	16. 00
17. 00	SWING BED ADJUSTMENT  Medicare rate for swing-bed SNF services applicable to services	through December 31 c	of the cost	0.00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to services	•			18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	through December 31 of	the cost	0.00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	after December 31 of t	the cost	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions)			4, 282, 152	21.00
22. 00	Swing-bed cost applicable to SNF type services through December	31 of the cost report	ing period (line	0	22. 00
23. 00	$5 \times 1$ ine 17) Swing-bed cost applicable to SNF type services after December 3	1 of the cost reportir	ng 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	na period (line	0	24.00
	7 x line 19)	·			
25. 00	Swing-bed cost applicable to NF type services after December 31 $x$ line 20)	of the cost reporting	period (line 8	0	25. 00
26.00	Total swing-bed cost (see instructions)	i 21 -i 1i 2()		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (I PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	ine 21 minus iine 26)		4, 282, 152	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	narges)		28. 00
	Private room charges (excluding swing-bed charges)			0	1
30.00	Semi-private room charges (excluding swing-bed charges)			0	
31.00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0.000000	1
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	1
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minu	s line 33)(see instruc	rtions)	0. 00 0. 00	ı
35. 00	Average per diem private room cost differential (line 34 x line		(113)	0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	01)		0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost an	d private room cost di	fferential (line		ı
	27 minus line 36)		·		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	TMENTS			
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS  Adjusted general inpatient routine service cost per diem (see i		ı	729. 00	38.00
39. 00	Program general inpatient routine service cost per diem (see i Program general inpatient routine service cost (line 9 x line 3	,		3, 660, 309	
40.00	Medically necessary private room cost applicable to the Program	*		0,000,307	40.00
	Total Program general inpatient routine service cost (line 39 +			3, 660, 309	ł

Heal th	Financial Systems	DAVIESS COMMUNI	ITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUT	CATION OF INPATIENT OPERATING COST				Period: From 01/01/2014	Worksheet D-1	
			,		To 12/31/2014	5/21/2015 12:	
			Ti tl	e XVIII	Subprovi der – I PF	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
40.00	AMIDOEDY (1: 11 - V o VIV - 1 )	1.00	2. 00	3. 00	4.00	5. 00	40.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	(	0.0	0 0	0	42.00
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	0	(	0.0	0 0	0	43. 00 44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
47.00	Cost Center Description						47.00
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	3, line 200)			1. 00 1, 289, 983	48. 00
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS			ons)		4, 950, 292	
50.00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sur	n of Parts I and	307, 737	50. 00
51. 00		atient ancillar	ry services (f	rom Wkst. D, s	sum of Parts II	93, 795	51.00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				401, 532	52.00
53. 00	Total Program inpatient operating cost exclu		elated, non-ph	ysician anestl	netist, and	4, 548, 760	1
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					-
	Program di scharges					0	1
55. 00 56. 00						0. 00 0	1
57.00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	arget amount (	line 56 minus	line 53)	0	57. 00 58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and co	ompounded by the	-	1
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report, up	odated by the	market basket		0. 00	60.00
61. 00	If line 53/54 is less than the lower of line	s 55, 59 or 60	enter the les	ser of 50% of		0	61. 00
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		is (Tines 54 x	( 60), OF 1% O	the target		
	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instru	uctions)			0 0	
	PROGRAM INPATIENT ROUTINE SWING BED COST						
	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)					0	
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	per 31 of the	cost reportino	g period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line	64 plus line	65)(title XVII	I only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	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 [	December 31 of	the cost repo	orting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (	(line 67 + lin	ie 68)		0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NI Skilled nursing facility/other nursing facil						70.00
71.00	Adjusted general inpatient routine service c	ost per diem (I		,			71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic		n (line 14 x l	ine 35)			72. 00 73. 00
74. 00	Total Program general inpatient routine serv	ice costs (line	e 72 + line 73	)			74.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	e costs (from	Worksheet B, A	Part II, column		75. 00
76. 00 77. 00	Per diem capital related costs (line 75 ÷ li						76. 00 77. 00
	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu	s line 77)					78.00
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp				nus line 70)		79. 00 80. 00
81.00	Inpatient routine service cost per diem limi	tati on		(11110-70-11111	11110 77)		81.00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (						82. 00 83. 00
84.00	Program inpatient ancillary services (see in	structions)					84.00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST				^	
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	diem (line 27 ÷					88. 00
89. 00	Observation bed cost (line 87 x line 88) (se	e instructions)	)			0	89. 00

Health Financial Systems	DAVIESS COMMUN	ITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der	CCN: 150061	Peri od:	Worksheet D-1	
		Component	t CCN: 15S061	From 01/01/2014 To 12/31/2014		
		Ti tl	e XVIII	Subprovi der -	PPS	
				I PF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		27)		Bed Cost	Through Cost	
		·		(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	360, 039	4, 282, 152	0. 0840	79 0	0	90.00
91.00 Nursing School cost	0	4, 282, 152	0. 00000	00	0	91.00
92.00 Allied health cost	0	4, 282, 152	0. 00000	00	0	92.00
93.00 All other Medical Education	0	4, 282, 152	0. 00000	00	0	93. 00

Health Financial Systems	DAVIESS COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 150061	Peri od: From 01/01/2014	Worksheet D-1
	Component CCN: 15T06		Date/Time Prepared: 5/21/2015 12:29 pm
	Title XVIII	Subprovi der -	PPS
		I RF	

			I RF		
	Cost Center Description		-	1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, Inpatient days (including private room days, excluding swing-be			2, 539 2, 539	1. 00 2. 00
2. 00 3. 00	Private room days (excluding private room days, excluding swing-be Private room days (excluding swing-bed and observation bed days		ivate room days	2, 539	3.00
0.00	do not complete this line.	y you have only p.	. rate . com dayo,	Ü	0.00
4. 00	Semi-private room days (excluding swing-bed and observation bed			2, 539	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room reporting period	days) through Decembe	r 31 of the cost	0	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private room	days) after December	31 of the cost	0	6. 00
7 00	reporting period (if calendar year, enter 0 on this line)	daya) +brayab Dagambar	21 of the cost	0	7 00
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	days) through becember	31 Of the Cost	U	7. 00
8.00	Total swing-bed NF type inpatient days (including private room	days) after December 3	1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	+l D (ll'		2.045	0.00
9. 00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swing-bed and	2, 045	9. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII onl	y (including private r	oom days)	0	10.00
44 00	through December 31 of the cost reporting period (see instructi				44.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl December 31 of the cost reporting period (if calendar year, ent		oom days) after	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12.00
	through December 31 of the cost reporting period				
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar yea			0	13. 00
14. 00	Medically necessary private room days applicable to the Program			0	14.00
15. 00	Total nursery days (title V or XIX only)	. 3	,	0	15. 00
16. 00	3 3 \ 37			0	16. 00
17. 00	SWING BED ADJUSTMENT  Medicare rate for swing-bed SNF services applicable to services	through December 31 o	f the cost	0. 00	17. 00
	reporting period	J			
18. 00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of	the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0. 00	19. 00
	reporting period				
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	after December 31 of t	he cost	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions)			2, 617, 629	1
22. 00	Swing-bed cost applicable to SNF type services through December	31 of the cost report	ing period (line	0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December 3	1 of the cost reportin	a period (line 6	0	23. 00
	x line 18)		]		
24. 00	Swing-bed cost applicable to NF type services through December $7 \times 1 = 19$	31 of the cost reporti	ng period (line	0	24.00
25. 00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)			0	26. 00
	General inpatient routine service cost net of swing-bed cost (	ine 21 minus line 26)		2, 617, 629	
	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT		<u>,                                     </u>		
	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	and observation bed ch	arges)	0	
30.00	Semi -pri vate room charges (excluding swing-bed charges)			0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000	ł
32.00	Average private room per diem charge (line 29 ÷ line 3)	,		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
34.00	Average per diem private room charge differential (line 32 minu	s line 33)(see instruc	tions)	0. 00	34.00
35.00	Average per diem private room cost differential (line 34 x line	31)		0. 00	35.00
36. 00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost an	d private room cost di	fferential (line	2, 617, 629	37.00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS	TMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see i			1, 030. 97	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 3	•		2, 108, 334	1
	Medically necessary private room cost applicable to the Program			2 109 224	•
41.00	Total Program general inpatient routine service cost (line 39 +	11110 4U)	1	2, 108, 334	41.00

Heal th	Financial Systems	DAVIESS COMMUN	ITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUT	TATION OF INPATIENT OPERATING COST				Period: From 01/01/2014	Worksheet D-1	
					Го 12/31/2014	5/21/2015 12:	
			Ti tl	e XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
10.00	Luipospy (III II A A VIV	1. 00	2. 00	3.00	4.00	5. 00	10.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	C	0.0	0	0	42.00
43. 00 44. 00	INTENSIVE CARE UNIT	0	C	0.0	0	0	43. 00 44. 00
45. 00	BURN INTENSIVE CARE UNIT						45.00
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
47.00	Cost Center Description						47.00
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	3, line 200)			1. 00 1, 005, 779	48. 00
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS			ons)		3, 114, 113	
50.00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sun	n of Parts I and	184, 234	50.00
51. 00		atient ancillar	rv services (f	rom Wkst. D. s	sum of Parts II	69, 777	51.00
	and IV)		, (.				
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		elated, non-ph	ysician anesth	netist, and	254, 011 2, 860, 102	52. 00 53. 00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)	·	-			
	Program di scharges					0	•
55. 00 56. 00	, 9					0.00	1
57.00	Difference between adjusted inpatient operat	ing cost and ta	arget 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 re	porting period	ending 1996,	updated and co	mpounded by the	0.00	58. 00 59. 00
40.00	market basket			•	, ,	0. 00	60.00
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line	s 55, 59 or 60	enter the les	ser of 50% of		0.00	61.00
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		ts (lines 54 x	: 60), or 1% of	the target		
	Relief payment (see instructions)					0	
	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST					0	63.00
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions) (title XVIII only)	ts through Dece	ember 31 of th	e cost reporti	ng period (See	0	64.00
65. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts after Decemb	per 31 of the	cost reportino	period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line	64 plus line	65)(title XVII	I only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	December 31	of the cost re	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after [	December 31 of	the cost repo	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NI Skilled nursing facility/other nursing facil						70.00
71.00	Adjusted general inpatient routine service c		ine 70 ÷ line	2)			71. 00 72. 00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic		n (line 14 x l	ine 35)			73.00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•		,	Part II column		74. 00 75. 00
	26, line 45)		costs (ITOIII	worksneet b, i	art II, cordiiii		
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li   Program capital-related costs (line 9 x line						76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minu	s line 77)					78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp				nus line 79)		79. 00 80. 00
81. 00 82. 00	Inpatient routine service cost per diem limi		1)				81. 00 82. 00
83.00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (	see instruction					83.00
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		nns)				84. 00 85. 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					0	87. 00
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷				0.00	88. 00
07.00	Observation bed cost (line 87 x line 88) (se	e mstructions)				0	89. 00

Health Financial Systems	DAVIESS COMMUN	IITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der	CCN: 150061	Peri od:	Worksheet D-1	
		Component	t CCN: 15T061	From 01/01/2014 To 12/31/2014	Date/Time Pre 5/21/2015 12:	
		Ti tl	e XVIII	Subprovi der -	PPS	
				<u> </u>		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		27)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	228, 744	2, 617, 629	0. 08738	36 0	0	90.00
91.00 Nursing School cost	0	2, 617, 629	0. 00000	00	0	91.00
92.00 Allied health cost	0	2, 617, 629	0. 00000	00	0	92.00
93.00 All other Medical Education	0	2, 617, 629	0. 00000	00	0	93.00

	Financial Systems	DAVIESS COMMUNITY HOSPITAL		In Lie	u of Form CMS-2	
INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150061	Peri od:	Worksheet D-3	1
				From 01/01/2014 To 12/31/2014	Date/Time Pre	narod:
				10 12/31/2014	5/21/2015 12:	
		Ti tl	e XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		Inpati ent	
	•		To Charges	Program	Program Costs	
				Charges	(col. 1 x	
					col . 2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00				782, 916		30.00
31.00				1, 548, 930		31.00
40.00	04000 SUBPROVI DER - I PF			0		40.00
41.00				42, 607		41.00
43.00						43.00
	ANCILLARY SERVICE COST CENTERS					1
50.00			0. 31402			
51.00	05100 RECOVERY ROOM		0. 12576		6, 159	
52. 00	05200 DELIVERY ROOM & LABOR ROOM		1. 31922		5, 568	
54.00			0. 19401			
56. 00	05600 RADI OI SOTOPE		0. 20284		76, 386	
60.00	06000 LABORATORY		0. 18591	· · ·		
63.00	06300 BLOOD STORING, PROCESSING & TRANS.		0. 46507		82, 561	63.00
64.00	06400 I NTRAVENOUS THERAPY		0. 09860			
65.00	06500 RESPI RATORY THERAPY		0. 36560		276, 344	
66.00	06600 PHYSI CAL THERAPY		0. 49819		38, 247	
67.00	06700 OCCUPATI ONAL THERAPY		0. 36880		11, 102	
68.00	06800 SPEECH PATHOLOGY		0. 67236		9, 977	
69. 00 71. 00			0. 14674		20, 420 367, 887	
71.00	07200 IMPL. DEV. CHARGED TO PATIENT		0. 58825 0. 84047		222, 098	
73.00			1		535, 602	
76. 00	03020 CARDIAC REHAB		0. 49153 2. 18889		l	
76.00	OUTPATIENT SERVICE COST CENTERS		2. 1888	99  0	0	76.00
88. 00			0.00000	20	0	88. 00
88. 01	08801 NDMC/ODON		0.00000		0	1
88. 02	08802 QUI CK CARE		0.00000		0	88. 02
88. 04	08803 PEDI ATRI CS		0.00000		0	1
88. 05			0.00000			1
90.00	09000 CLINIC		0. 32118		11, 080	
	09100 EMERGENCY		0. 43025		264, 967	
	00200 ORSEDVATION REDS (NON_DISTINCT DART)		1 1620		140 415	

1. 162980

0. 521687

120, 737

8, 139, 136 8, 139, 136

574

140, 415

299

2, 826, 331 200. 00 201. 00 202. 00

92.00

93.00

92.00 | 09200 | 09200 | 0BSERVATION BEDS (NON-DISTINCT PART)
93.00 | 04040 |
200.00 | Total (sum of lines 50-94 and 96-98)
201.00 | Less PBP Clinic Laboratory Services-Program only charges (line 61)
202.00 | Net Charges (line 200 minus line 201)

NPAIIE	NT ANCILLARY SERVICE COST APPORTIONMENT		CCN: 150061 t CCN: 15S061	Period: From 01/01/2014 To 12/31/2014	Worksheet D-3 Date/Time Pre	pare
		Ti tl	e XVIII	Subprovi der -	5/21/2015 12: PPS	29 p
	Cost Center Description		Ratio of Cos To Charges	st Inpatient	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2. 00	3. 00	
	NPATIENT ROUTINE SERVICE COST CENTERS					
1.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF			0 0 6, 054, 599		30 31 40
. 00 . 3. 00 .	04100 SUBPROVI DER - I RF 04300 NURSERY			0		41 43
	ANCILLARY SERVICE COST CENTERS		0.0140	00 4 040	4 540	
	D5000 OPERATING ROOM D5100 RECOVERY ROOM		0. 3140 0. 1257		1, 543 0	1
- 1	DS TOU RECOVERY ROOM & LABOR ROOM		1. 3192		0	
1	D5400 RADI OLOGY-DI AGNOSTI C		0. 1940		27, 377	
	D5600 RADI OI SOTOPE		0. 2028	·	6, 078	
	D6000 LABORATORY		0. 1859		144, 203	
	D6300 BLOOD STORING, PROCESSING & TRANS.		0. 4650	· ·	10, 237	
	06400 INTRAVENOUS THERAPY		0. 0986		781	64
.00	06500 RESPI RATORY THERAPY		0. 3656		73, 160	65
	06600 PHYSI CAL THERAPY		0. 4981		14, 989	66
00	06700 OCCUPATI ONAL THERAPY		0. 3688	03 4, 252	1, 568	67
.00	06800 SPEECH PATHOLOGY		0. 6723	68 10, 798	7, 260	68
. 00	D6900 ELECTROCARDI OLOGY		0. 1467	41 45, 016	6, 606	69
	D7100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 5882	57 78, 086	45, 935	71
. 00	D7200 IMPL. DEV. CHARGED TO PATIENT		0. 8404	73 0	0	72
	D7300 DRUGS CHARGED TO PATIENTS		0. 4915		865, 759	
	D3020 CARDI AC REHAB		2. 1888	99 0	0	76
	DUTPATIENT SERVICE COST CENTERS D8800 DCHMC		0.0000	00	0	88
	D8801 NDMC/ODON		0.0000		0	
	08802 QUI CK CARE		0.0000		0	
- 1	08803 PEDI ATRI CS		0.0000		0	
	D8804 DAVIESS MARTIN		0.0000		0	
	09000 CLINIC		0. 3211		0	
- 1	D9100 EMERGENCY		0. 4302		83, 140	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 1629	· ·	03, 140	
	04040 OTHER OUTPATIENT SERVICE COST CENTER		0. 5216		1, 347	
0.00	Total (sum of lines 50-94 and 96-98)		3. 52.10	3, 307, 074	1, 289, 983	
01.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0	.,, ,00	201
2.00	Net Charges (line 200 minus line 201)	,		3, 307, 074		202

NPATTENT	ANCILLARY SERVICE COST APPORTIONMENT		CCN: 150061 t CCN: 15T061	Period: From 01/01/2014 To 12/31/2014	Worksheet D-3 Date/Time Pre	
		· ·			5/21/2015 12:	29
		Titl	e XVIII	Subprovi der - I RF	PPS	
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges	Program Charges	Program Costs (col. 1 x	
				onar ges	col . 2)	
			1.00	2. 00	3. 00	
	PATIENT ROUTINE SERVICE COST CENTERS					١
	DOO ADULTS & PEDIATRICS			0		30
	IOO INTENSIVE CARE UNIT OOO SUBPROVIDER - IPF			0		31 40
	100 SUBPROVI DER - TPF			2, 211, 387		40
	800 NURSERY			2, 211, 307		43
	CILLARY SERVICE COST CENTERS					"`
	OOO OPERATING ROOM		0. 3140	29 1, 150	361	1 50
	OO RECOVERY ROOM		0. 1257		0	51
. 00   052	200 DELIVERY ROOM & LABOR ROOM		1. 3192	23 0	0	52
. 00   054	100 RADI OLOGY-DI AGNOSTI C		0. 1940	10 62, 255	12, 078	54
	600 RADI OI SOTOPE		0. 2028		2, 437	
	DOO LABORATORY		0. 1859		41, 825	
	BOO BLOOD STORING, PROCESSING & TRANS.		0. 4650		10, 483	
	100 I NTRAVENOUS THERAPY		0. 0986		592	
	500 RESPI RATORY THERAPY		0. 3656		56, 194	
	500 PHYSI CAL THERAPY 700 OCCUPATI ONAL THERAPY		0. 4981		299, 710	
	800 SPEECH PATHOLOGY		0. 3688 0. 6723		186, 526 40, 158	
	200 ELECTROCARDI OLOGY		0. 0723		40, 138	
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 5882			
	200 IMPL. DEV. CHARGED TO PATIENT		0. 8404		00,077	
	BOO DRUGS CHARGED TO PATIENTS		0. 4915		262, 768	
	020 CARDI AC REHAB		2. 1888		0	76
	PAȚIENT SERVICE COST CENTERS					
	BOO DCHMC		0.0000		0	
	801 NDMC/ODON		0.0000		0	
	302 QUI CK CARE		0.0000		0	
- 1	303 PEDIATRICS		0.0000		0	
	BOA DAVIESS MARTIN		0.0000		0	
	000 CLI NI C 100 EMERGENCY		0. 3211 0. 4302		0 3, 530	
	200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 1629		3,530	
	040 OTHER OUTPATIENT SERVICE COST CENTER		0. 5216		0	
0.00	Total (sum of lines 50-94 and 96-98)		0. 3210	2, 346, 135	1, 005, 779	
01.00	Less PBP Clinic Laboratory Services-Program only charge	es (line 61)		2, 340, 133	1,003,777	20
02.00	Net Charges (line 200 minus line 201)	(11110 01)	1	2, 346, 135		202

<del></del>	II TY HOSPI TAL	00N 450011		u of Form CMS-1	
NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150061	Period: From 01/01/2014	Worksheet D-3	3
			To 12/31/2014	Date/Time Pre	enarec
				5/21/2015 12:	
	Ti t	le XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	9	Program Costs	
			Charges	(col . 1 x	
		1. 00	2.00	col . 2) 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
0. 00 03000 ADULTS & PEDIATRICS			1, 153, 656		30.0
1. 00   03100   NTENSI VE CARE UNI T			252, 403		31. (
0. 00   04000   SUBPROVI DER - I PF			232, 403		40.0
1. 00   04100   SUBPROVI DER -   1 RF			0		41. (
3. 00 04300 NURSERY			253, 553		43. (
ANCI LLARY SERVI CE COST CENTERS			2007 000		1
0. 00 05000 OPERATING ROOM		0. 3140	29 337, 081	105, 853	T 50. (
I. 00   05100 RECOVERY ROOM		0. 1257	· ·	0	1
2.00 05200 DELIVERY ROOM & LABOR ROOM		1. 3192	23 197, 549	260, 611	52.
1. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1940	10 265, 008	51, 414	54.
5. 00   05600   RADI 0I SOTOPE		0. 2028	44 60, 279	12, 227	56.
0. 00   06000   LABORATORY		0. 1859	14 509, 253	94, 677	60.0
B. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 4650	72 63, 597	29, 577	63.0
1. 00 06400 I NTRAVENOUS THERAPY		0. 0986	08 65, 451	6, 454	64.0
5. 00   06500   RESPI RATORY THERAPY		0. 3656	06 146, 898	53, 707	65.
5. 00   06600 PHYSI CAL THERAPY		0. 4981	99 35, 512	17, 692	66.
7. 00   06700   OCCUPATI ONAL THERAPY		0. 3688		9, 289	
3. 00 06800 SPEECH PATHOLOGY		0. 6723			1
P. 00 06900 ELECTROCARDI OLOGY		0. 1467	· ·	3, 958	
I. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 5882			
2.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 8404		0	
3. 00 07300 DRUGS CHARGED TO PATIENTS		0. 4915	· ·	238, 127	1
5. 00   03020   CARDI AC REHAB		2. 1888	99 0	0	76.
OUTPATIENT SERVICE COST CENTERS		0.0710	20		1 00
3. 00   08800   DCHMC		0. 9718		0	
3. 01   08801   NDMC/ODON		1. 1920		0	1
3. 02   08802   QUI CK CARE 3. 04   08803   PEDI ATRI CS		0. 8750 0. 8183		0	
3. 04   08803   PEDIATRICS 3. 05   08804   DAVI ESS MARTI N		0.8183		0	
0. 00   08004 DAVIESS MARTIN 0. 00   09000   CLINIC		0. 9722		0	
1. 00   09100   EMERGENCY		0. 3211		66, 356	
2. OO   09200   OBSERVATION BEDS (NON-DISTINCT PART)		1. 1629	· ·	00, 330	1
B. 00   04040   OTHER OUTPATIENT SERVICE COST CENTER		0. 5216		0	
00.00 Total (sum of lines 50-94 and 96-98)		0. 52 10	2, 694, 813		
101.00 Less PBP Clinic Laboratory Services-Program only char	caes (line 61)		2, 094, 013	1, 140, 300	200.
12.00 Net Charges (line 200 minus line 201)	ges (ITHE OI)		2, 694, 813		201. (

NPATI	IENT ANCILLARY SERVICE COST APPORTIONMENT		CCN: 150061 t CCN: 15S061	Peri od: From 01/01/2014 To 12/31/2014	Worksheet D-3  Date/Time Pre 5/21/2015 12:	pare
		Ti t	Te XIX	Subprovi der -	Cost	<u>2</u> , ρ
	Cost Center Description	,	Ratio of Cos To Charges	st Inpatient	Inpatient Program Costs (col. 1 x col. 2)	
	THE PARTY FOR THE PROPERTY OF SOME SERVICES		1.00	2. 00	3. 00	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS					1
0.00				0		30. 31.
1.00	03100   I NTENSI VE CARE UNI T   04000   SUBPROVI DER - I PF			272 500		
1.00				373, 598 0		40.
3. 00				0		43
. 00	ANCI LLARY SERVI CE COST CENTERS			U		43
. 00	05000 OPERATING ROOM		0. 3140	29 37	12	50
. 00	05100 RECOVERY ROOM		0. 1257		0	
. 00	05200 DELIVERY ROOM & LABOR ROOM		1. 3192		Ö	
. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 1940		1, 466	
. 00	05600 RADI OI SOTOPE		0. 2028	·	208	
. 00	06000 LABORATORY		0. 1859		7, 942	60
00	06300 BLOOD STORING, PROCESSING & TRANS.		0. 4650		97	63
00	06400 I NTRAVENOUS THERAPY		0. 0986	08 276	27	64
. 00	06500 RESPI RATORY THERAPY		0. 3656	06 11, 958	4, 372	65
. 00	06600 PHYSI CAL THERAPY		0. 4981	99 1, 908	951	66
. 00			0. 3688		91	67
. 00	06800 SPEECH PATHOLOGY		0. 6723		399	
. 00			0. 1467		476	
. 00			0. 5882	· ·	1, 232	
. 00			0. 8404		0	
. 00	07300 DRUGS CHARGED TO PATIENTS		0. 4915	· ·	48, 089	
. 00	03020   CARDI AC REHAB   OUTPATI ENT SERVI CE COST CENTERS		2. 1888	99 0	0	76
00			0. 9718	39 0	0	88
01	08801 NDMC/ODON		1. 1920		0	
. 02	08802 QUI CK CARE		0. 8750		0	
04	08803 PEDI ATRI CS		0. 8183		Ö	
05	08804 DAVIESS MARTIN		0. 9722		0	
00	09000 CLI NI C		0. 3211		0	
00	09100 EMERGENCY		0. 4302		4, 191	1
. 00			1. 1629		0	
. 00			0. 5216		18	
0. 00				179, 483	69, 571	200
1. 00		es (line 61)		0		201
2.00	Net Charges (line 200 minus line 201)			179, 483		202

NPATIE	NT ANCILLARY SERVICE COST APPORTIONMENT		CCN: 150061 t CCN: 15T061	Peri od: From 01/01/2014 To 12/31/2014	Worksheet D-3  Date/Time Pre 5/21/2015 12:	par
		Ti t	Te XIX	Subprovi der -	Cost	
	Cost Center Description		Ratio of Cos To Charges	Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
	NIDATI ENT. DOUTLINE CEDIT OF COCT. CENTEDO		1.00	2. 00	3. 00	
	NPATIENT ROUTINE SERVICE COST CENTERS					١,,
	13000 ADULTS & PEDIATRICS 13100 INTENSIVE CARE UNIT			0		30
	14000 SUBPROVI DER - I PF			123		40
	14100 SUBPROVI DER – I RF			140, 473		41
	14300 NURSERY			140, 473		43
	NCI LLARY SERVI CE COST CENTERS					1 '`
	5000 OPERATING ROOM		0. 3140	29 97	30	50
1.00 0	5100 RECOVERY ROOM		0. 1257	67 19	2	5
. 00 0	5200 DELIVERY ROOM & LABOR ROOM		1. 3192	23 0	0	52
	5400 RADI OLOGY-DI AGNOSTI C		0. 1940	·	542	54
	5600 RADI OI SOTOPE		0. 2028		81	56
	6000 LABORATORY		0. 1859		2, 302	
	6300 BLOOD STORING, PROCESSING & TRANS.		0. 4650	·	609	
1	16400 I NTRAVENOUS THERAPY		0. 0986		18	
	16500 RESPI RATORY THERAPY		0. 3656		5, 616	
4	16600 PHYSI CAL THERAPY 16700 OCCUPATI ONAL THERAPY		0. 4981 0. 3688	·	17, 933	
	16800 SPEECH PATHOLOGY		0. 3000		11, 503 2, 687	
4	16900 ELECTROCARDI OLOGY		0. 1467		2, 007	
	17100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 5882		1, 132	
	17200 I MPL. DEV. CHARGED TO PATIENT		0. 8404		0	
	7300 DRUGS CHARGED TO PATIENTS		0. 4915		14, 902	73
. 00 0	3020 CARDI AC REHAB		2. 1888	99 0	0	76
	UTPAȚI ENT SERVI CE COST CENTERS					
	18800 DCHMC		0. 9718			
	18801 NDMC/ODON		1. 1920		0	
	18802 QUI CK CARE		0. 8750		0	
- 1	18803 PEDI ATRI CS		0. 8183		0	
	18804 DAVI ESS MARTI N		0. 9722		0	
- 1	19000 CLI NI C 19100 EMERGENCY		0. 3211 0. 4302		0 17	
	19200  BSERVATION BEDS (NON-DISTINCT PART)		1. 1629		0	
- 1	14040 OTHER OUTPATIENT SERVICE COST CENTER		0. 5216		0	
00.00	Total (sum of lines 50-94 and 96-98)		0. 32 10	136, 154	57, 396	
01.00	Less PBP Clinic Laboratory Services-Program only charge	s (line 61)		130, 134	37, 370	20
02.00	Net Charges (line 200 minus line 201)	2 (11110 01)	1	136, 154		202

		Ti tl	e XVIII	Hospi tal	5/21/2015 12: PPS	29 pm
			0			
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1.00	2. 00	
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurrin	a prior		0 2, 819, 296		1. 00 1. 01
1. 02	to October 1 (see instructions) DRG amounts other than outlier payments for discharges occurring	<b>.</b>		982, 589		1. 02
	after October 1 (see instructions)	J				
1. 03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)			0		1.03
1. 04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)			0		1. 04
2.00	Outlier payments for discharges. (see instructions)			О		2.00
2. 01 2. 02	Outlier reconciliation amount Outlier payment for discharges for Model 4 BPCI (see instruction	ns)		0		2. 01 2. 02
3.00	Managed Care Simulated Payments	·		ő		3.00
4. 00	Bed days available divided by number of days in the cost report period (see instructions)	i ng		38. 08		4.00
F 00	Indirect Medical Education Adjustment	rocent		0.00		F 00
5. 00	FTE count for allopathic and osteopathic programs for the most cost reporting period ending on or before 12/31/1996. (see instr			0.00		5.00
6. 00	FTE count for allopathic and osteopathic programs which meet th criteria for an add-on to the cap for new programs in accordance			0. 00		6. 00
	CFR 413.79(e)					
7. 00	MMA Section 422 reduction amount to the IME cap as specified un CFR $\S412.105(f)(1)(iv)(B)(1)$	der 42		0.00		7.00
7. 01	ACA Section 5503 reduction amount to the IME cap as specified u CFR $\S412.105(f)(1)(iv)(B)(2)$ If the cost report straddles July			0.00		7. 01
	then see instructions.					
8. 00	Adjustment (increase or decrease) to the FTE count for allopath osteopathic programs for affiliated programs in accordance with			0. 00		8.00
	413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67					
8. 01	(August 1, 2002). The amount of increase if the hospital was awarded FTE cap slot	s under		0.00		8. 01
	section 5503 of the ACA. If the cost report straddles July 1, 2 instructions.	011, see				
8. 02	The amount of increase if the hospital was awarded FTE cap slot			0. 00		8. 02
9. 00	closed teaching hospital under section 5506 of ACA. (see instru Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines			0.00		9. 00
	and 8,02) (see instructions)	•				
10. 00	FTE count for allopathic and osteopathic programs in the curren from your records	t year		0.00		10.00
11. 00 12. 00	FTE count for residents in dental and podiatric programs. Current year allowable FTE (see instructions)			0. 00 0. 00		11. 00 12. 00
13.00	Total allowable FTE count for the prior year.			0. 00		13.00
14. 00	Total allowable FTE count for the penultimate year if that year or after September 30, 1997, otherwise enter zero.	ended on		0. 00		14.00
15.00	Sum of lines 12 through 14 divided by 3.			0.00		15.00
16. 00 17. 00	Adjustment for residents in initial years of the program Adjusment for residents displaced by program or hospital closur	е		0. 00 0. 00		16. 00 17. 00
	Adjusted rolling average FTE count			0.00		18.00
19. 00 20. 00	Current year resident to bed ratio (line 18 divided by line 4). Prior year resident to bed ratio (see instructions)			0. 000000 0. 000000		19. 00 20. 00
21. 00	Enter the lesser of lines 19 or 20 (see instructions)			0. 000000		21.00
22. 00	IME payment adjustment (see instructions)			0		22.00
22. 01	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for Sectio	n 422 of	the MMA	0		22. 01
23. 00	Number of additional allopathic and osteopathic IME FTE residen		THE WINDA	0. 00		23. 00
24. 00	slots under 42 Sec. 412.105 (f)(1)(iv)(C).  IME FTE Resident Count Over Cap (see instructions)			0. 00		24.00
25. 00	If the amount on line 24 is greater than -O-, then enter the Lo	wer of		0.00		25. 00
26. 00	line 23 or line 24 (see instructions) 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 29. 00	IME add-on adjustment amount - Managed Care (see instructions) Total IME payment ( sum of lines 22 and 28)					28. 01 29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			o		29. 01
30. 00	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A pat	ient davs		4. 20		30.00
	(see instructions)	adys				
31. 00 32. 00	Percentage of Medicaid patient days (see instructions) Sum of lines 30 and 31		-	25. 36 29. 56		31.00
33.00	Allowable disproportionate share percentage (see instructions)			12. 00		33.00
34.00	Disproportionate share adjustment (see instructions)		1	114, 057		34.00

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150061	Peri od: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Pre	
		Title XVIII	Hospi tal	5/21/2015 12: PPS	29 pm
		II ti e XVIII	Pri or to	On/After	
			October 1	October 1	
		0	1. 00	2. 00	
	Uncompensated Care Adjustment				
35. 00	Total uncompensated care amount (see instructions)			7, 647, 644, 855	1
35. 01	Factor 3 (see instructions)		0. 000040791	0.000048650	1
35. 02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		369, 009	372, 057	35. 02
35. 03	Pro rata share of the hospital uncompensated care payment		275, 998	93, 779	35. 03
	amount (see instructions)				
36. 00	Total uncompensated care (sum of columns 1 and 2 on line		369, 777		36. 00
	35.03)	(1: 10 th			
40. 00	Additional payment for high percentage of ESRD beneficiary di Total Medicare discharges on Worksheet S-3, Part I	scharges (Times 40 throu	0		40.00
40.00	excluding discharges for MS-DRGs 652, 682, 683, 684 and				40.00
	685 (see instructions)				
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652,		0		41.00
	682, 683, 684 an 685. (see instructions)				
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		41.01
42. 00	Divide line 41 by line 40 (if less than 10%, you do not		0.00		42.00
12.00	qualify for adjustment)		0.00		12.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652,		0		43.00
	682, 683, 684 an 685. (see instructions)				
44. 00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0. 000000		44.00
45. 00	Average weekly cost for dialysis treatments (see		0.00		45.00
	instructions)		0.00		10.00
46.00	Total additional payment (line 45 times line 44 times line		0		46. 00
47.00	41.01)		4 005 740		47.00
47. 00 48. 00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and		4, 285, 719		47. 00 48. 00
40.00	MDH, small rural hospitals only. (see instructions)		0		40.00
49.00	Total payment for inpatient operating costs (see		4, 285, 719		49. 00
	instructions)				
50. 00	Payment for inpatient program capital (from Wkst. L, Pt. I		299, 268		50.00
E1 00	and Pt. II, as applicable)				51.00
51. 00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		U		51.00
52. 00	Direct graduate medical education payment (from Wkst. E-4,		0		52.00
	line 49 see instructions).				
53. 00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		0		54. 00 55. 00
55. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0		55.00
56. 00	Cost of physicians' services in a teaching hospital (see		0		56.00
	intructions)				
57. 00	Routine service other pass through costs (from Wkst. D,		0		57.00
E0 00	Pt. III, column 9, lines 30 through 35).		0		58.00
36.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0		36.00
59. 00	Total (sum of amounts on lines 49 through 58)		4, 584, 987		59.00
60.00	Primary payer payments		0		60.00
61. 00	Total amount payable for program beneficiaries (line 59		4, 584, 987		61.00
42.00	minus line 60)		424 904		42.00
62. 00 63. 00	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries		624, 896 9, 120		62.00
64. 00	Allowable bad debts (see instructions)		142, 887		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		92, 877		65.00
66. 00	Allowable bad debts for dual eligible beneficiaries (see		28, 536		66.00
(7.00	instructions)		4 040 040		/7 00
67. 00 68. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices		4, 043, 848		67. 00 68. 00
00.00	for applicable to MS-DRGs (see instructions)		0		00.00
69. 00	Outlier payments reconciliation (sum of lines 93, 95 and		0		69.00
	96). (For SCH see instructions)				
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70. 50	RURAL DEMONSTRATION PROJECT		0		70.50
70. 89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0		70. 89
70. 90	HSP bonus payment HVBP adjustment amount (see		0		70. 90
	instructions)				
70. 91	HSP bonus payment HRR adjustment amount (see instructions)		0		70. 91
70. 92	1		10 305		70. 92
70. 93 70. 94	, , ,		-18, 385 -9, 701		70. 93 70. 94
	Recovery of accelerated depreciation		-4, 701		70. 95
	i de la companya de l		, 91	1	

Heal th	Financial Systems DAVIESS COMMUN	TY HOSPITAL	In Li	eu of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 1500	Peri od: From 01/01/201 To 12/31/201		
		Title XVIII	Hospi tal	PPS	
			Prior to October 1	On/After October 1	
		0	1. 00	2. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)		2014 363, 26	9	70. 96
70. 97	(Enter in column 0 the corresponding federal year for the period ending on or after 10/1)		2015 118, 52	6	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)		4, 497, 55	7	71.00
71.01	Sequestration adjustment (see instructions)		89, 95	1	71.01
72.00	Interim payments		4, 424, 15	2	72.00
73.00	Tentative settlement (for contractor use only)			0	73.00
74. 00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)		-16, 54	6	74.00
75.00	Protested amounts (nonallowable cost report items) in		11, 40	6	75. 00
	accordance with CMS Pub. 15-2, chapter 1, §115.2				
00.00	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90. 00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see			0	90.00
91. 00	instructions) Capital outlier from Wkst. L, Pt. I, line 2				91.00
91.00	Operating outlier reconciliation adjustment amount (see				91.00
92.00	instructions)			٩	92.00
93.00	Capital outlier reconciliation adjustment amount (see			o	93.00
	instructions)				
94. 00	The rate used to calculate the time value of money (see instructions)		0.0	0	94.00
95. 00	Time value of money for operating expenses (see instructions)			0	95.00
96. 00	Time value of money for capital related expenses (see instructions)			0	96. 00
	Thisti dott ons)		Dri or to 10/	1 On/After 10/1	

	111311 4011 0113)				l
93.00	Capital outlier reconciliation adjustment amount (see		0		93.00
	instructions)				
94.00	The rate used to calculate the time value of money (see		0.00	,	94.00
	instructions)				
95.00	Time value of money for operating expenses (see		0	,	95.00
	instructions)				
96.00	Time value of money for capital related expenses (see		0	,	96.00
	instructions)			ļ	
			Prior to 10/1	On/After 10/1	
			1. 00	2. 00	
-	HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	0	100.00
	HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)		0	0	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instruct	i ons)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)		0. 0000	0.0000	103.00
104.00	104.00 HRR adjustment amount for HSP bonus payment (see instructions)			0	104.00
			,		

					T	o 12/31/2014	Date/Time Pre 5/21/2015 12:	
		1			e XVIII	Hospi tal	PPS	
		W/S E, Part A   line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Peri od On/After	Total (Col 2 through 4)	
		11110	z, rart ny	Errer er omorre		10/01		
1. 00	DRG amounts other than outlier	1.00	1. 00	2. 00	3. 00	4. 00	5. 00	1. 00
1.00	payments	1.00		U	U		U	1.00
1. 01	DRG amounts other than outlier payments for discharges	1. 01	2, 819, 296	0	2, 819, 296	0	2, 819, 296	1. 01
1. 02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	982, 589	0	0	982, 589	982, 589	1. 02
1. 03	1 DRG for Federal specific operating payment for Model 4 BPCI occurring prior to	1. 03	0	0	0	O	0	1. 03
1. 04	October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0	0	0	0	1. 04
2. 00	Outlier payments for discharges (see instructions)	2. 00	0	0	0	0	0	2.00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	0	0	0	2. 01
3. 00	Operating outlier reconciliation	2. 01	0	0	0	0	0	3. 00
4. 00	Managed care simulated payments	3. 00	0	0	0	0	0	4. 00
5. 00	Indirect Medical Education Adj Amount from Worksheet E, Part	ustment 21.00	0. 000000	0. 000000	0. 000000	0.000000		5. 00
6. 00	A, line 21 (see instructions) IME payment adjustment (see	22. 00	0	0	0	0	0	6. 00
6. 01	instructions) IME payment adjustment for	22. 01	0	0	0	0	0	6. 01
	managed care (see instructions) Indirect Medical Education Adj	untmont for th	a Add on for Co	action 100 of t	the MMA			
7. 00	IME payment adjustment factor	27. 00	0. 000000			0. 000000		7. 00
8. 00	(see instructions) IME adjustment (see	28. 00	0	0	0	0	0	8. 00
8. 01	instructions) IME payment adjustment add on for managed care (see	28. 01	0	0	0	0	0	8. 01
9. 00	instructions) Total IME payment (sum of	29. 00	0	0	0	0	0	9. 00
9. 01	lines 6 and 8) Total IME payment for managed	29. 01	0	0	0	0	0	9. 01
	care (sum of lines 6.01 and 8.01)							
10. 00	Disproportionate Share Adjustm Allowable disproportionate	ent 33.00	0. 1200	0. 1200	0. 1200	0. 1200		10.00
	share percentage (see instructions)	00.00	0.1200	0200	0. 1200	01.1200		.0.00
11. 00	Disproportionate share adjustment (see instructions)	34. 00	114, 057	0	84, 579	29, 478	114, 057	11. 00
11. 01	Uncompensated care payments	36.00	369, 777	0	275, 998	93, 779	369, 777	11. 01
12. 00	Additional payment for high pe Total ESRD additional payment	46.00	RD beneτiciary 0	di scharges 0	0	0	0	12.00
13. 00	(see instructions) Subtotal (see instructions)	47. 00	4, 285, 719	0	3, 179, 873	1, 105, 846	4, 285, 719	13.00
14. 00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48. 00	0	0	0	0	0	14.00
15. 00	Total payment for inpatient operating costs (see instructions)	49. 00	4, 285, 719	0	3, 179, 873	1, 105, 846	4, 285, 719	15. 00
16. 00	Payment for inpatient program capital	50. 00	299, 268	0	221, 969	77, 299	299, 268	16.00
17. 00	Special add-on payments for new technologies	54. 00	0	0	0	0	0	17. 00
17. 01 17. 02	Net organ aquisition cost Capital received from manufacturers for replaced	55. 00 68. 00	0	0	0	0	0	
	devices for applicable MS-DRGs							

	Financial Systems		DAVIESS COMMUN			In Lie	u of Form CMS-	2552-10
LOW VO	DLUME CALCULATION EXHIBIT 4			Provi der		Period: From 01/01/2014 To 12/31/2014		epared:
				Ti tl	e XVIII	Hospi tal	PPS	•
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		l i ne	E, Part A)	Entitlement	to 10/01	0n/After 10/01	through 4)	
		0	1. 00	2. 00	3.00	4. 00	5. 00	
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0	0		0 0	0	18. 00
19. 00				0	3, 401, 84	2 1, 183, 145	4, 584, 987	19 00
171 00	000101112	W/S L, line	(Amounts from L)	J	57 10 17 0 1	1,100,110	1, 60 1, 707	171.00
		0	1. 00	2.00	3.00	4. 00	5. 00	
20.00	Capital DRG other than outlier	1. 00	299, 268	0	221, 96	9 77, 299	299, 268	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	0	0		0	0	21.00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0		0 0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0. 0000	0. 000	0.0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	_		0 0	0	23.00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0.0000	0.0000	0. 000	0.0000		24.00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	0	0		0 0	0	25.00
26. 00	Total prospective capital payments (see instructions)	12. 00	299, 268	0	221, 96	9 77, 299	299, 268	26.00
		W/S E, Part A	(Amounts to					
		line	E, Part A)					
	T	0	1. 00	2. 00	3. 00	4. 00	5. 00	
27. 00 28. 00	Low volume adjustment factor Low volume adjustment (transfer amount to Wkst. E,	70. 96			0. 10678 363, 26		363, 269	27. 00 28. 00
29. 00	Pt. A, line) Low volume adjustment	70. 97				118, 526	118, 526	29.00
_ /. 00	(transfer amount to Wkst. E, Pt. A, line)	70.77				110, 320	110,020	27.50
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Υ					100.00

	, ,			Т	rom 01/01/2014 o 12/31/2014	Part A Exhibi Date/Time Pre 5/21/2015 12:	pared:
			Titl	e 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	1. 00 1. 01	2, 819, 296	2, 819, 296		2, 819, 296	1. 00 1. 01
1. 02	discharges occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	982, 589		982, 589	982, 589	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1. 03	O	C		0	1. 03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	О		O	0	1. 04
2. 00	Outlier payments for discharges (see linstructions)	2. 00	a	С	0	0	2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	a	С	0	0	2. 01
3.00	Operating outlier reconciliation	2. 01	0	C	-	0	3.00
4.00	Managed care simulated payments	3. 00	0	C	0	0	4.00
5. 00	Indirect Medical Education Adjustment Amount from Worksheet E, Part A, Line 21	21, 00	0.000000	0.000000	0.000000		F 00
5.00	(see instructions)	21.00	0. 000000	0. 000000	0. 000000		5. 00
6. 00	IME payment adjustment (see instructions)	22. 00			0	0	6. 00
6. 01	IME payment adjustment for managed care (see				o	0	
	instructions)						
	Indirect Medical Education Adjustment for the						
7. 00	IME payment adjustment factor (see instructions)	27. 00	0. 000000				7.00
8. 00 8. 01	IME adjustment (see instructions)	28. 00 28. 01	0	C	0	0	8. 00 8. 01
9. 00	IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8)	29. 00			0	0	9.00
9. 01	Total IME payment for managed care (sum of	29. 01			0	0	
7. 01	lines 6.01 and 8.01) Disproportionate Share Adjustment	27. 01					7.01
10.00	Allowable disproportionate share percentage	33. 00	0. 1200	0. 1200	0. 1200		10.00
11. 00	(see instructions) Disproportionate share adjustment (see	34. 00	114, 057	84, 579	29, 478	114, 057	11. 00
11. 01	instructions) Uncompensated care payments	36. 00	369, 777	275, 998	93, 779	369, 777	11. 01
11.01	Additional payment for high percentage of ES			273, 470	73, 777	307, 111	11.01
12. 00	Total ESRD additional payment (see instructions)	46. 00	O O	C	0	0	12. 00
13.00	Subtotal (see instructions)	47. 00	4, 285, 719	3, 179, 873	1, 105, 846	4, 285, 719	13.00
14. 00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48. 00	О	C	0	0	14. 00
15. 00	Total payment for inpatient operating costs (see instructions)	49. 00	4, 285, 719	3, 179, 873	1, 105, 846	4, 285, 719	15. 00
16.00	Payment for inpatient program capital	50. 00	299, 268	221, 969	77, 299	299, 268	16. 00
17. 00	Special add-on payments for new technologies	1	0	C	0	0	17. 00
17. 01	Net organ aquisition cost	55. 00	0	C	0	0	
17. 02	Capital received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	C C	0	0	17. 02
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0	C	0	0	18. 00
19. 00	SUBTOTAL			3, 401, 842	1, 183, 145	4, 584, 987	19. 00

	ancial Systems	DAVIESS COMMUN				u of Form CMS-2	2552-10
HOSPITAL A	CQUIRED CONDITION (HAC) REDUCTION CALCUL	ATION EXHIBIT 5			Period: From 01/01/2014 To 12/31/2014	Date/Time Pre 5/21/2015 12:	pared:
				e XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1. 00	2.00	3. 00	4. 00	
	tal DRG other than outlier	1. 00	299, 268	221, 96	9 77, 299	299, 268	
	el 4 BPCI Capital DRG other than outlier	1. 01	0		0	0	
	tal DRG outlier payments	2. 00	0		0	0	21.00
	el 4 BPCI Capital DRG outlier payments	2. 01	0		0	0	
	rect medical education percentage (see tructions)	5. 00	0. 0000	0. 000	0.0000		22.00
	rect medical education adjustment (see tructions)	6. 00	0		0	0	23. 00
	owable disproportionate share percentage e instructions)	10. 00	0. 0000	0. 000	0. 0000		24. 00
	oroportionate share adjustment (see tructions)	11. 00	0		0 0	0	25. 00
	al prospective capital payments (see tructions)	12. 00	299, 268	221, 96	9 77, 299	299, 268	26. 00
		Wkst. E, Pt.	(Amt. from				
		A, line	Wkst. E, Pt. A)				
		0	1. 00	2.00	3. 00	4. 00	
	volume adjustment prior to October 1	70. 96	363, 269			363, 269	
	volume adjustment on or after October 1	70. 97	118, 526		118, 526		
	P payment adjustment (see instructions)	70. 93	-18, 385	-17, 31	5 -1, 070		
	P payment adjustment for HSP bonus ment (see instructions)	70. 90	0		0	0	30. 01
31.00 HRR	adjustment (see instructions)	70. 94	-9, 701	-7, 04	-2, 653	-9, 701	31.00
	adjustment for HSP bonus payment (see tructions)	70. 91	0		0	0	31. 01
						(Amt. to Wkst. E, Pt.	

0 70. 99

32.00 HAC Reduction Program adjustment (see instructions)
100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.

1.00

Υ

2.00

3.00

0

A) 4. 00

32.00

100.00

Health Financial Systems	DAVIESS COMMUNITY HOSPITAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 1	From 01/01/2014	Worksheet E Part B Date/Time Prepared: 5/21/2015 12:29 pm
	Title XVII	II Hospital	DDS

			10 12/31/2014	5/21/2015 12:	
		Title XVIII	Hospi tal	PPS	27 piii
		THE ATTE	nospi tui	113	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1. 00	Medical and other services (see instructions)			391	1.00
2. 00	Medical and other services (see instructi	one)		4, 929, 558	•
3.00	PPS payments	UIIS)		4, 203, 707	3.00
	1 ' 3				•
4. 00	Outlier payment (see instructions)			10, 954	
5.00	Enter the hospital specific payment to cost ratio (see instruct	i ons)		0.824	•
6. 00	Line 2 times line 5			4, 061, 956	1
7. 00	Sum of line 3 plus line 4 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. IV	/, col. 13, line 200		0	
10.00	Organ acquisitions			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			391	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e charges				
12.00	Ancillary service charges			795	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, co	ol. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			795	14.00
	Customary charges				İ
15.00	Aggregate amount actually collected from patients liable for pa	yment for services on	a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for			0	•
	had such payment been made in accordance with 42 CFR §413.13(e)		= g		
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17.00
18. 00	Total customary charges (see instructions)			795	
19. 00	Excess of customary charges over reasonable cost (complete only	, if line 18 exceeds li	ne 11) (see	404	•
17.00	instructions)	TI TITLE TO EXCECUS TI	110 11) (300	104	17.00
20.00	Excess of reasonable cost over customary charges (complete only	, if line 11 exceeds li	ne 18) (see	0	20.00
20.00	instructions)	TI TITIC TI CACCCUS II	110 10) (300	l	20.00
21. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		391	21.00
22. 00	Interns and residents (see instructions)	This true true is a		0	
23. 00	Cost of physicians' services in a teaching hospital (see instru	ictions)		0	23.00
24. 00		ictrons)		4, 214, 661	•
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			4, 214, 001	24.00
25 00				0	25 00
25. 00	Deductibles and coinsurance (for CAH, see instructions)	CALL :+:		0	
26.00	Deductibles and Coinsurance relating to amount on line 24 (for			938, 596	1
27. 00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) pl	us the sum of lines 22	and 23} (Tor	3, 276, 456	27. 00
20.00	CAH, see instructions)	12 FO)			20.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, lin	ie 50)		0	ı
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
30.00	Subtotal (sum of lines 27 through 29)			3, 276, 456	
31.00	Primary payer payments			1, 025	1
32. 00	Subtotal (line 30 minus line 31)			3, 275, 431	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	(S)			
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)			0	
34.00	Allowable bad debts (see instructions)			228, 503	1
35. 00	Adjusted reimbursable bad debts (see instructions)			148, 527	•
36. 00	Allowable bad debts for dual eligible beneficiaries (see instru	ıcti ons)		88, 980	36.00
37.00	Subtotal (see instructions)			3, 423, 958	37.00
38.00	MSP-LCC reconciliation amount from PS&R			-21	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	39. 50
39. 98	Partial or full credits received from manufacturers for replace	ed devices (see instruc	ctions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	•	,	0	39. 99
40.00	Subtotal (see instructions)			3, 423, 979	40.00
40. 01	Sequestration adjustment (see instructions)			68, 480	1
41. 00	Interim payments			3, 209, 693	1
42. 00	Tentative settlement (for contractors use only)			0,20,,0,0	1
43. 00	Balance due provider/program (see instructions)			145, 806	•
44. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub 15-2	chanter 1	0	1
44.00	§115. 2	te with this rub. 13-2,	chapter i,	l	44.00
	TO BE COMPLETED BY CONTRACTOR				
90 00	Original outlier amount (see instructions)			0	90.00
	Outlier reconciliation adjustment amount (see instructions)				•
91.00	1				
92.00	The rate used to calculate the Time Value of Money			0.00	92.00 93.00
	Time Value of Money (see instructions) Total (sum of lines 91 and 93)			1	94.00
74. UU	Total (Said Of TITIES 71 and 75)		l	, 0	74.00

Peri od: Worksheet E-1
From 01/01/2014 Part I
To 12/31/2014 Date/Time Prepared: 5/21/2015 12: 29 pm

					5/21/2015 12: 2	29 pm
			e XVIII	Hospi tal	PPS	
		Inpatier	it Part A	Par	⁻t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		4, 389, 252		3, 209, 693	1.00
2.00	Interim payments payable on individual bills, either		0		0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	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	07/30/2014	34, 900		0	3. 01
3. 02			0		l ol	3. 02
3. 03			ĺ		0	3. 03
3. 04						3. 04
3. 05						3. 05
3. 05	Provider to Program				U	3.05
2 50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3.50	ADJUSTMENTS TO PROGRAM					
3. 51			1			3. 51
3. 52			0		0	3. 52
3. 53			0		0	3. 53
3. 54			0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		34, 900		0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		4, 424, 152		3, 209, 693	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02			0		0	5. 02
5. 03			0		0	5. 03
	Provider to Program					
5. 50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5.52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)	[				
6. 01	SETTLEMENT TO PROVIDER		0		145, 806	6. 01
6. 02	SETTLEMENT TO PROGRAM		16, 546		0	6. 02
7. 00	Total Medicare program liability (see instructions)		4, 407, 606		3, 355, 499	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
			)	1. 00	2.00	
8. 00	Name of Contractor					8. 00
		1		I .		

Health Financial Systems	DAVIESS COMMUNITY F	HOSPI TAL		In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES R	RENDERED		CCN: 150061 CCN: 15S061	From 01/01/2014	Worksheet E-1 Part I Date/Time Prepared: 5/21/2015 12:29 pm

					5/21/2015 12	: 29
		Ti tl	e XVIII	Subprovider -	PPS	
		Innation	t Part A	I PF	t B	
		Tripatrei	I Pai LA	Pai	l D	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
00	Total interim payments paid to provider		4, 323, 878	3	(	0 1
00	Interim payments payable on individual bills, either		(	D	(	0 2
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment	•				1 3
50	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	'		<u>'</u>	!	
)1	ADJUSTMENTS TO PROVIDER		(	D	(	0 3
)2			(	O		0 3
)3				O		0 3
)4			1	0	1	0 3
)5	Decided to the Decided			0	(	0 3
-0	Provider to Program ADJUSTMENTS TO PROGRAM					0 3
50 51	ADJUSTMENTS TO PROGRAM				1	0 3
52			1			0 3
53		•				0 3
54				o l	· ·	0 3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines				į (	0 3
	3. 50-3. 98)					
00	Total interim payments (sum of lines 1, 2, and 3.99)		4, 323, 878	3	(	0 4
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after	I		T		٠,
JU	desk review. Also show date of each payment. If none,					5
	write "NONE" or enter a zero. (1)					
	Program to Provider					
)1	TENTATI VE TO PROVI DER		(		(	0 5
)2			(	D	(	0 5
)3				0		0 5
	Provi der to Program	1		-1		
0	TENTATI VE TO PROGRAM			O O	1	0 5
1						0 5 0 5
52 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines					0 5
, 7	5. 50-5. 98)			1		ĭ `
00	Determined net settlement amount (balance due) based on					1 6
-	the cost report. (1)					`
)1	SETTLEMENT TO PROVIDER		26, 328	3	(	0 6
)2	SETTLEMENT TO PROGRAM		(	o	1	0 6
00	Total Medicare program liability (see instructions)		4, 350, 20			0 7
				Contractor	NPR Date	
			)	Number 1.00	(Mo/Day/Yr) 2.00	
	Name of Contractor		J	1.00	2.00	8

Health Financial Systems	DAVIESS COMMUNITY I	HOSPI TAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO PROVIDERS FOR	SERVI CES RENDERED	Provi der CCN: 150061	Peri od: From 01/01/2014	Worksheet E-1
		Component CCN: 15T061		
		Title XVIII	Subprovi der -	PPS

		Ti tl	e XVIII	Subprovi der - I RF	PPS	27 piii
		Inpatier	nt Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1. 00	Total interim payments paid to provider		2, 759, 35	4	0	
2.00	Interim payments payable on individual bills, either			0	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none, write "NONE" or enter a zero					
3. 00	List separately each retroactive lump sum adjustment					3.00
3.00	amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider		'	<u> </u>	'	1
3. 01	ADJUSTMENTS TO PROVIDER			0	0	3. 01
3.02				0	0	3. 02
3.03				0	0	3.03
3.04				0	0	
3. 05				0	0	3.05
	Provider to Program					
3. 50	ADJUSTMENTS TO PROGRAM		1	0	0	
3. 51				0	0	
3. 52				0	0	
3. 53				0	0	
3. 54 3. 99	Subtatal (our of lines 2 01 2 40 minus our of lines				0	
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			U	0	3.99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		2, 759, 35	4	0	4.00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		2,737,33	7		7.00
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR	<u>'</u>				1
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider				1	
5. 01	TENTATI VE TO PROVI DER			0	0	
5. 02				0	0	
5. 03	Danid dan da Baranan			0	0	5.03
5. 50	Provider to Program TENTATIVE TO PROGRAM		1	ol	l 0	5. 50
5. 51	TENTATIVE TO PROGRAW		1	0		
5. 52				0		
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			o l	0	
J	5. 50-5. 98)			-		5. //
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER			0	0	
6. 02	SETTLEMENT TO PROGRAM		6, 01		0	
7. 00	Total Medicare program liability (see instructions)		2, 753, 34		0	7.00
				Contractor	NPR Date	
			2	Number	(Mo/Day/Yr)	
0.00	Name of Contractor		0	1. 00	2. 00	0.00
8.00	Name of Contractor	l			1	8.00

Provi der CCN: 150061 | Peri od: | From 01/01/2014 | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part

		Componen	t 0014: 100001	12/01/2011	5/21/2015 12:	29 pm
				Swing Beds - SNF		
		Inpati er	nt Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4. 00	
1. 00	Total interim payments paid to provider			0	0	1.00
2. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for			0	0	2.00
	services rendered in the cost reporting period. If none, write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	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			0	0	
3. 02			1	0	0	
3. 03			1	0	0	
3.04				0	0	
3.05				0	0	3.05
	Provider to Program	l		-	1	
3. 50	ADJUSTMENTS TO PROGRAM		1	0	0	
3. 51				0	0	
3. 52				0	0	
3. 53			1	0	0	0.00
3. 54 3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	
	3. 50-3. 98)					
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as			0	0	4.00
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR	I	T		T	
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)					
5. 01	Program to Provider TENTATIVE TO PROVIDER			ol	0	5. 01
5. 02	TENTATIVE TO PROVIDER			0	0	
5. 02			1	0	0	
5. 05	Provider to Program	l	-	<u> </u>		3.03
5. 50	TENTATI VE TO PROGRAM			0	0	5.50
5. 51				O	0	
5. 52				Ö	0	
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			O	0	5. 99
6. 00	Determined net settlement amount (balance due) based on					6. 00
6. 01	the cost report. (1) SETTLEMENT TO PROVIDER			o	0	6 01
6. 01	SETTLEMENT TO PROVIDER		1	0	0	
7. 00	Total Medicare program liability (see instructions)		1	0	0	
7.00	Total medicale program frability (see instructions)			Contractor	NPR Date	7.00
				Number	l (Mo/Dav/Yr)	
			0	Number 1.00	(Mo/Day/Yr) 2.00	

Heal th	Financial Systems DAVIE	ESS COMMUNITY I	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provi der CCN	l: 150061	Peri od: From 01/01/2014	Worksheet E-1 Part II	
					To 12/31/2014		
			Title X	VIII	Hospi tal	PPS	
						1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COS						
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND						
1.00	Total hospital discharges as defined in AARA §410			l. 15 line	e 14	1, 561	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum o		2			2, 285	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6.					208	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum o	of lines 1, 8-1	2			4, 570	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8	3 line 200				105, 866, 636	5.00
6.00	Total hospital charity care charges from Wkst. S-	·10, col. 3 lir	ie 20			1, 213, 410	6.00
7. 00	CAH only - The reasonable cost incurred for the p	ourchase of cer	tified HIT to	echnol ogy	Wkst. S-2, Pt. I	0	7. 00
8. 00	1	tructions)				E74 E24	8. 00
9. 00	Calculation of the HIT incentive payment (see ins					574, 534	9. 00
10.00	Sequestration adjustment amount (see instructions	•	motruet	one)		11, 491	
10.00	Calculation of the HIT incentive payment after se	equestration (s	ee mstructi	3(15)		563, 043	10.00
20.00		ustions)				(2) 710	20.00
	Initial/interim HIT payment adjustment (see instr	uctions)				626, 719	30. 00 31. 00
31.00	Other Adjustment (specify)	ing 20 and lin	. 21) (222		20)	0	
3∠. UU	Balance due provider (line 8 (or line 10) minus l	The 30 and TT	ie 31) (See 11	istruction	15)	-63, 676	32. 00

Health Financial Systems	DAVIESS COMMUNITY H	IOSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING	BEDS	Provi der CCN: 150061	Peri od:	Worksheet E-2	
			From 01/01/2014		
		Component CCN: 15U061	To 12/31/2014	Date/Time Pre	pared:
		•		5/21/2015 12:	29 pm
		Title XVIII	Swing Beds - SNF	PPS	
			Part A	Part B	
			1. 00	2. 00	
COMPUTATION OF NET COST OF COVERED SERVICE	S				
1 00 Inpatient routine services - swing hed-SNE	(see instructions)		0	0	1 00

		Title XVIII	Swing Beds - SNF	PPS	
			Part A	Part B	
			1.00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		0	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200 for Pt. A,				3.00
	Part V, cols. 6 and 7, line 202 for Pt. B) (For CAH, see instruc				
4. 00	Per diem cost for interns and residents not in approved teaching	program (see		0. 00	4.00
	instructions)				
5.00	Program days		0	0	5. 00
6. 00	Interns and residents not in approved teaching program (see inst			0	6.00
7. 00	Utilization review - physician compensation - SNF optional metho	d only	0		7. 00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		0	0	8.00
9. 00	Primary payer payments (see instructions)		0	0	9. 00
10.00			0	0	10.00
11. 00		le to physician	0	0	11.00
	professional services)				
	Subtotal (line 10 minus line 11)		0	0	12.00
13.00		excl ude coi nsurance	0	0	13.00
	for physician professional services)				
	80% of Part B costs (line 12 x 80%)			0	14.00
	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		0	0	15. 00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
	Pioneer ACO demonstration payment adjustment (see instructions)		0	0	16. 50
	410A RURAL DEMONSTRATION PROJECT		0		16. 55
	Allowable bad debts (see instructions)		0		
17. 01	Adjusted reimbursable bad debts (see instructions)		0	0	17. 01
18. 00	J	tions)	0	0	
19. 00			0	0	
19. 01	Sequestration adjustment (see instructions)		0	0	
	Interim payments		0	0	20.00
	Tentative settlement (for contractor use only)		0	0	21.00
	Balance due provider/program (line 19 minus lines 19.01, 20, and		0	0	22.00
23. 00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub. 15-2,	0	0	23.00
	§115. 2				

Health Financial Systems	DAVI E	SS COMMUNITY HOSPIT	AL	In Lieu	ı of Form CMS-2	552-10
CALCULATION OF REIMBURSE	EMENT SETTLEMENT	Provi	der CCN: 150061	Peri od: From 01/01/2014	Worksheet E-3 Part II	
		Compo	onent CCN: 15SO61			oared: 29 pm
			Title XVIII	Subprovi der -	PPS	
				I PF		
				-		
					1. 00	
PART II - MEDICAR	E PART A SERVICES - IPF PPS					
1.00 Net Federal IPF P	PPS Payments (excluding outlier,	ECT, and medical ed	ucation payments)		4, 676, 455	1.00
2.00 Net IPF PPS Outli	er Payments				37, 252	2.00
3.00 Net IPF PPS ECT P	ayments				0	3.00
4.00 Unweighted intern	and resident FTE count in the m	ost recent cost rep	ort filed on or b	efore November	0. 00	4.00

		1. 00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	4, 676, 455	1.0
2. 00	Net IPF PPS Outlier Payments	37, 252	2.0
3. 00	Net IPF PPS ECT Payments	0	3.0
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November	0.00	4.0
	15, 2004. (see instructions)		
4. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by	0.00	4.0
	program or hospital closure, that would not be counted without a temporary cap adjustment under 42		
	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		
5. 00	New Teaching program adjustment. (see instructions)	0.00	5.0
6. 00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new	0. 00	
0.00	teaching program" (see instuctions)	0.00	0.0
7. 00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new	0. 00	7.0
7.00	teaching program" (see instuctions)	0.00	/.0
8. 00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0. 00	8.0
9. 00	Average Daily Census (see instructions)	16. 093151	
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0. 000000	
11. 00			11.0
	Teaching Adjustment (line 1 multiplied by line 10).	0	
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	4, 713, 707	
	Nursing and Allied Health Managed Care payment (see instruction)	U	13.0
	Organ acquisition (DO NOT USE THIS LINE)		14.0
	Cost of physicians' services in a teaching hospital (see instructions)		15.0
	Subtotal (see instructions)	4, 713, 707	
17. 00	Primary payer payments	0	
	Subtotal (line 16 less line 17).	4, 713, 707	
	Deducti bl es	234, 400	
20. 00	Subtotal (line 18 minus line 19)	4, 479, 307	20.0
21. 00	Coi nsurance	67, 184	21.0
22. 00	Subtotal (line 20 minus line 21)	4, 412, 123	22.0
23. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	41, 328	23.0
24. 00	Adjusted reimbursable bad debts (see instructions)	26, 863	24.0
25. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	25, 182	25.0
26. 00	Subtotal (sum of lines 22 and 24)	4, 438, 986	26.0
27. 00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	
28. 00	Other pass through costs (see instructions)	0	28.0
	Outlier payments reconciliation	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.0
	Pioneer ACO demonstration payment adjustment (see instructions)	0	30. 5
	Recovery of Accelerated Depreciation	0	
	Total amount payable to the provider (see instructions)	4, 438, 986	
	Sequestration adjustment (see instructions)	88, 780	
	Interim payments	4, 323, 878	
			1
	Tentative settlement (for contractor use only)	0	
34.00	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)	26, 328	
35. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	35.0
	§115. 2		
E0 00	TO BE COMPLETED BY CONTRACTOR	07.050	
	Original outlier amount from Worksheet E-3, Part II, line 2	37, 252	
	Outlier reconciliation adjustment amount (see instructions)		51.0
52.00	The rate used to calculate the Time Value of Money		52.0
53. 00	Time Value of Money (see instructions)	0	53.0

Heal th Fi	nancial Systems	DAVIESS COMMUNITY I	HOSPI TAL	In Lieu of Form CMS-2552-10			
CALCULATI	ON OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150061	Peri od:	Worksheet E-3		
				From 01/01/2014			
			Component CCN: 15T061	To 12/31/2014			
					5/21/2015 12:2	29 pm_	
			Title XVIII	Subprovi der -	PPS		
				IRF			
					1. 00		
PAF	RT III - MEDICARE PART A SERVICES - IRF PP	S					
1.00 Ne	t Federal PPS Payment (see instructions)				2, 838, 079	1.00	
2.00 Me	dicare SSI ratio (IRF PPS only) (see instr	ructions)			0. 0147	2.00	
0 00 1.					0.4.053		

		1. 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	2, 838, 079	1
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0. 0147	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	34, 057	3. 00
4.00	Outlier Payments	4, 998	1
5. 00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0. 00	5. 01
6.00	New Teaching program adjustment. (see instructions)	0. 00	6.00
7. 00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0. 00	7. 00
8. 00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0. 00	8. 00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9. 00
10.00	Average Daily Census (see instructions)	6. 956164	1
11. 00	Teaching Adjustment Factor (see instructions)	0. 000000	11. 00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	2, 877, 134	
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15. 00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	
17. 00	Subtotal (see instructions)	2, 877, 134	
18. 00	Pri mary payer payments	0	18. 00
19.00	Subtotal (line 17 less line 18).	2, 877, 134	19. 00
20.00	Deducti bl es	48, 608	20.00
21.00	Subtotal (line 19 minus line 20)	2, 828, 526	21.00
22.00	Coi nsurance	22, 528	22.00
23.00	Subtotal (line 21 minus line 22)	2, 805, 998	23. 00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	5, 438	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	3, 535	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	1, 964	26.00
27.00	Subtotal (sum of lines 23 and 25)	2, 809, 533	27. 00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28. 00
29.00	Other pass through costs (see instructions)	0	29. 00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31. 99	Recovery of Accelerated Depreciation	0	31. 99
32.00	Total amount payable to the provider (see instructions)	2, 809, 533	32.00
32. 01	Sequestration adjustment (see instructions)	56, 191	1
33.00	Interim payments	2, 759, 354	•
34.00	Tentative settlement (for contractor use only)	0	34.00
35. 00	Balance due provider/program line 32 minus lines 32.01, 33 and 34	-6, 012	1
36. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36. 00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	4, 998	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0. 00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

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

Peri od: From 01/01/2014 To 12/31/2014 Date/Time Prepared:

			10	12/31/2014	5/21/2015 12:	
		General Fund	Speci fi c	Endowment	Plant Fund	
		1 00	Purpose Fund	Fund	4.00	
	CURRENT ASSETS	1.00	2. 00	3. 00	4. 00	
1. 00	Cash on hand in banks	993, 896	0	0	0	1.00
2.00	Temporary investments	0	0	0	l	2.00
3.00	Notes receivable	0	0	0		3.00
4. 00	Accounts receivable	16, 044, 412		0	0	4.00
5. 00	Other receivable	2, 614, 117	1	0	0	5.00
6. 00 7. 00	Allowances for uncollectible notes and accounts receivable Inventory	-10, 013, 004 1, 074, 860	1	0	0	6. 00 7. 00
8. 00	Prepai d expenses	683, 644	1	0	0	8.00
9. 00	Other current assets	000,011	o o	0	Ö	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	11, 397, 925	0	0	0	11.00
	FI XED ASSETS					
12.00	Land	1, 280, 955	1	0	1	12.00
13. 00 14. 00	Land improvements Accumulated depreciation	687, 865 -659, 074	1	0	· ·	13. 00 14. 00
15. 00	Buildings	60, 354, 021		0	0	15.00
16. 00	Accumulated depreciation	-39, 243, 098		0	Ö	16.00
17.00	Leasehold improvements	39, 119		0	0	17.00
18.00	Accumulated depreciation	-33, 011	0	0	0	18.00
19. 00	Fi xed equipment	4, 306, 546		0	0	19.00
20.00	Accumulated depreciation	-3, 100, 042		0	0	20.00
21. 00 22. 00	Automobiles and trucks Accumulated depreciation	0	0	0	0	21. 00 22. 00
23. 00	Major movable equipment	26, 823, 551	0	0		23.00
24. 00	Accumulated depreciation	-22, 162, 291	0	0	Ö	24.00
25. 00	Minor equipment depreciable	0	0	0	Ō	25. 00
26.00	Accumulated depreciation	0	0	0	0	26. 00
27.00	HIT designated Assets	0	0	0	0	27. 00
28. 00	Accumulated depreciation	0	0	0	0	28. 00
29. 00	Minor equipment-nondepreciable	0 20 204 541	0	0	-	29.00
30. 00	Total fixed assets (sum of lines 12-29)  OTHER ASSETS	28, 294, 541	0	0	0	30.00
31. 00	Investments	4, 755, 338	0	0	0	31.00
32. 00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	297, 997	1	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	5, 053, 335	1	0	1	35.00
36. 00	Total assets (sum of lines 11, 30, and 35)  CURRENT LIABILITIES	44, 745, 801	0	0	0	36.00
37. 00	Accounts payable	1, 802, 279	0	0	0	37.00
38. 00	Salaries, wages, and fees payable	258, 741		0	Ö	38.00
39.00	Payrol I taxes payable	434, 739		0	0	39.00
40.00	Notes and Loans payable (short term)	1, 020, 114	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accel erated payments	0				42.00
43. 00 44. 00	Due to other funds Other current liabilities	2, 479, 626		0	0	43. 00 44. 00
45.00	Total current liabilities (sum of lines 37 thru 44)	5, 995, 499		0		
43.00	LONG TERM LIABILITIES	3, 773, 477				1 43.00
46.00	Mortgage payable	0	0	0	0	46. 00
47.00	Notes payable	0	0	0	0	47. 00
48.00	Unsecured Loans	0	0	0		48. 00
49. 00	Other long term liabilities	15, 002, 126		0		49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	15, 002, 126		0		50.00
51. 00	Total liabilites (sum of lines 45 and 50)  CAPITAL ACCOUNTS	20, 997, 625	0	0	0	51.00
52. 00	General fund balance	23, 748, 176	,			52.00
53.00	Specific purpose fund	20,710,170	0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58. 00
59. 00	Total fund balances (sum of lines 52 thru 58)	23, 748, 176	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and	44, 745, 801	1	0	ő	60.00
	59)					

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Provi der CCN: 150061

					-rom 01/01/2014 Го 12/31/2014	Date/Time Pre 5/21/2015 12:	
		Genera	l Fund	Speci al Pu	urpose Fund	Endowment Fund	
		1 00	2.00	3 00	4.00	5.00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)  Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)  Total deductions (sum of lines 12-17)	1.00 0 0 0 0 0 0	2. 00 25, 593, 635 -1, 845, 459 23, 748, 176		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0	5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)		23, 748, 176		0		19. 00
		Endowment Fund	PI ant	Fund			
		6. 00	7.00	8. 00			
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	000000000000000000000000000000000000000				1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0	000000000000000000000000000000000000000	(			10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0					18. 00 19. 00

| Peri od: | Worksheet G-2 | From 01/01/2014 | Parts | & II | To 12/31/2014 | Date/Time Prepared: Health Financial Systems DASTATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provi der CCN: 150061

		Т	o 12/31/2014	Date/Time Pre 5/21/2015 12:	
	Cost Center Description	Inpatient	Outpati ent	Total	2 / piii
	3331 3311 33331 1 21 311	1. 00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	5, 169, 438		5, 169, 438	1.00
2.00	SUBPROVI DER - I PF	8, 008, 259		8, 008, 259	2.00
3.00	SUBPROVI DER - I RF	2, 903, 211		2, 903, 211	3.00
4.00	SUBPROVI DER				4.00
5.00	Swing bed - SNF			0	5.00
6. 00	Swing bed - NF			0	6.00
7. 00	SKILLED NURSING FACILITY				7.00
8. 00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	16, 080, 908		16, 080, 908	10.00
	Intensive Care Type Inpatient Hospital Services	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		-,,	
11.00	INTENSIVE CARE UNIT	2, 634, 741		2, 634, 741	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGI CAL INTENSIVE CARE UNIT				14.00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15.00
16. 00	Total intensive care type inpatient hospital services (sum of lir	nes 2, 634, 741		2, 634, 741	16.00
	11-15)	_,,,		_,,	
17.00	Total inpatient routine care services (sum of lines 10 and 16)	18, 715, 649		18, 715, 649	17.00
18. 00	Ancillary services	22, 369, 596		80, 919, 823	
19. 00	Outpatient services	] ==, ==, ==	821, 354	821, 354	19.00
20. 00	DCHMC			1, 474, 714	20.00
20. 01	NDMC/ODON			1, 326, 840	20. 01
20. 02	QUI CK CARE			1, 465, 431	
20. 04	PEDI ATRI CS		.,,	1, 240, 873	
20. 05	DAVI ESS MARTI N		., =,	1, 066, 618	
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		1, 000, 010	0	21.00
22. 00	HOME HEALTH AGENCY		162, 582	162, 582	22.00
23. 00	AMBULANCE SERVICES		102, 302	102, 302	23.00
24. 00	CMHC				24.00
24. 10	CORF	0	0	0	24. 10
25. 00	AMBULATORY SURGICAL CENTER (D. P. )		l	U	25.00
26. 00	HOSPI CE	0	846, 110	846, 110	26.00
27. 00	OTHER REVENUE		5, 504, 569	5, 504, 569	27.00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to	Wkst. 41, 085, 245		113, 544, 563	28.00
20.00	G-3, line 1)	WKS1. 41, 065, 245	12, 439, 310	113, 344, 303	20.00
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		56, 358, 806		29. 00
30.00	IGT CONSULTING AND MISC EXPENSES	168, 675			30.00
31. 00	TOT CONSOLITING AND WITSC EXITENSES	100, 073			31.00
32. 00					32.00
33. 00					33.00
34. 00					34.00
35. 00					35.00
36. 00	Total additions (sum of lines 20.25)	1	168, 675		36.00
37. 00	Total additions (sum of lines 30-35) DEDUCT (SPECIFY)	0	100, 073		37.00
38. 00	DEDUCT (SPECIFF)				38.00
		1			
39.00		0			39.00
40.00		1			40.00
41.00	Total deductions (sum of Lines 27 41)	0			41.00
42.00	Total deductions (sum of lines 37-41)		[ 0		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(t	r anster	56, 527, 481		43. 00
	to Wkst. G-3, line 4)	I	ı l		I

Health Financial Systems DAVIESS COMMUNITY HOSPITAL	In Lie	u of Form CMS-2	2552-10			
STATEMENT OF REVENUES AND EXPENSES Provi der CCN: 150061	Peri od:	Worksheet G-3				
	From 01/01/2014 To 12/31/2014	Date/Time Pre 5/21/2015 12:				
		1. 00				
1.00 Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)		113, 544, 563	1.00			
2.00 Less contractual allowances and discounts on patients' accounts		61, 069, 625	2. 00			
3.00 Net patient revenues (line 1 minus line 2)		52, 474, 938	3.00			
4.00 Less total operating expenses (from Wkst. G-2, Part II, line 43)		56, 527, 481				
5.00 Net income from service to patients (line 3 minus line 4)		-4, 052, 543	5. 00			
OTHER I NCOME		7.447				
6.00 Contributions, donations, bequests, etc		7, 416				
7.00 Income from investments		34, 952				
8.00 Revenues from telephone and other miscellaneous communication services	0	8.00				
9.00 Revenue from television and radio service 10.00 Purchase discounts	0 4. 009	9. 00 10. 00				
	74, 316					
11.00 Rebates and refunds of expenses 12.00 Parking Lot receipts		74, 310				
13.00 Revenue from Laundry and Linen service		0	13.00			
14.00 Revenue from meals sold to employees and guests		276, 048				
15.00 Revenue from rental of living quarters		· ·	15.00			
16.00 Revenue from sale of medical and surgical supplies to other than patients		0				
17.00 Revenue from sale of drugs to other than patients			17. 00			
18.00 Revenue from sale of medical records and abstracts		25, 475				
19.00 Tuition (fees, sale of textbooks, uniforms, etc.)		· ·	19.00			
20.00 Revenue from gifts, flowers, coffee shops, and canteen		0				
21.00 Rental of vending machines		0	21.00			
22.00 Rental of hospital space		163, 862				
23.00 Governmental appropriations		0	23. 00			
24.00 OTHER INCOME		1, 618, 239				
25.00 Total other income (sum of lines 6-24)		2, 207, 084				
26.00   Total (line 5 plus line 25)		-1, 845, 459				
27.00 OTHER EXPENSES (SPECIFY)		0	27. 00			
28.00   Total other expenses (sum of line 27 and subscripts)		0	28. 00			
29.00 Net income (or loss) for the period (line 26 minus line 28) -1,845,459 29.						

llool +b	Financial Cyatama		DAVIECE COMMUNI	TV HOSDITAL		la li o	u of Form CMC (	DEED 10
	<u>Financial Systems</u> LLOCATION - HHA GENERAL SERVICE		DAVIESS COMMUNI		CCN: 150061	Peri od:	u of Form CMS-2 Worksheet H-1	
				HHA CCN:	157189	From 01/01/2014 To 12/31/2014	Part I	
				HHA CCN.	137109	10 12/31/2014	5/21/2015 12:	
						Home Health	PPS	
			Capital Rel	ated Costs		Agency I		
		Net Expenses	Bl dgs &	Movabl e	Plant	Transportati o	Subtotal	
		for Cost Allocation	Fi xtures	Equi pment	Operation & Maintenance		(col s. 0-4)	
		(from Wkst.			Marritonanoc			
		H, col . 10)						
	GENERAL SERVICE COST CENTERS	0	1. 00	2. 00	3. 00	4. 00	4A. 00	
1. 00	Capital Related - Bldg. &	0	0				0	1.00
	Fixtures							
2. 00	Capital Related - Movable Equipment	0		0			0	2.00
3. 00	Plant Operation & Maintenance	0	0	0		0	0	3. 00
4.00	Transportati on	0	0	0		0 0		4. 00
5. 00	Administrative and General	128, 780	0	0		0 0	128, 780	5. 00
6. 00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	54, 752	ol	0		0 0	54, 752	6. 00
7. 00	Physical Therapy	0	o	0	1	0 0	0	7. 00
8. 00	Occupational Therapy	0	0	0		0 0	0	8.00
9. 00 10. 00	Speech Pathology Medical Social Services	0	0	0		0 0	0	9. 00 10. 00
11. 00	Home Heal th Aide	14, 461	o	0		0 0	14, 461	
12.00	Supplies (see instructions)	0	0	0		0 0	0	
13.00	Drugs	0	0	0	1	0 0	0	
14. 00	DME HHA NONREI MBURSABLE SERVI CES	0	U	0		0 0	0	14. 00
15.00	Home Dialysis Aide Services	0	0	0		0 0	0	15.00
16. 00	Respiratory Therapy	0	0	0		0 0	0	16. 00
17. 00 18. 00	Private Duty Nursing Clinic	0	0	0		0 0	0	17. 00 18. 00
19. 00	Health Promotion Activities	0	0	0		0 0	0	
20.00	Day Care Program	0	0	0		0 0	0	20. 00
21.00	9	0	0	0		0 0	0	21.00
22.00	Homemaker Service All Others (specify)	0	0	0		0 0	0	22. 00 23. 00
	Total (sum of lines 1-23)	198, 000	o	0	1	0 0	198, 000	
		Administrativ	Total (col s.					
		e & General 5.00	4A + 5) 6.00					
	GENERAL SERVICE COST CENTERS	3.00	0.00					
1.00	Capital Related - Bldg. &							1.00
2. 00	Fixtures Capital Related - Movable							2. 00
2.00	Equi pment							2.00
3.00	Plant Operation & Maintenance							3. 00
4. 00 5. 00	Transportation Administrative and General	128, 780						4. 00 5. 00
5.00	HHA REIMBURSABLE SERVICES	120, 700	l					3.00
6.00	Skilled Nursing Care	101, 863	156, 615					6.00
7.00	Physical Therapy Occupational Therapy	0	0					7. 00 8. 00
8. 00 9. 00	Speech Pathology	0	0					9.00
10.00	Medical Social Services	13	20					10.00
11.00	Home Heal th Ai de	26, 904	41, 365					11.00
12. 00 13. 00	Supplies (see instructions) Drugs	0	0					12. 00 13. 00
14. 00			0					14. 00
	HHA NONREIMBURSABLE SERVICES							
15. 00 16. 00	Home Dialysis Aide Services Respiratory Therapy	0	0					15. 00 16. 00
17. 00		0	0					17. 00
18. 00	Clinic	0	0					18. 00
	Health Promotion Activities	0	0					19.00
	Day Care Program Home Delivered Meals Program	0	0					20. 00 21. 00
	Homemaker Service	0	o					22.00
	All Others (specify)	0	0					23.00
24. 00	Total (sum of lines 1-23)	1	198, 000					24.00

	<u>Financial Systems</u> LLOCATION - HHA STATISTICAL BAS		DAVIESS COMMUN				Peri od:	u of Form CMS-: Worksheet H-1	
				HHA C	CN:		From 01/01/2014 To 12/31/2014		pared: 29 pm
							Home Health Agency I	PPS	
	·	Capital Rel	ated Costs						
		Bl dgs &	Movabl e	Plant			Reconciliatio		_
		Fixtures (SQUARE FEET)	Equi pment (DOLLAR VALUE)	Operation Maintenan (SQUARE FE	се	n (MILEAGE)	n	e & General (ACCUM. COST)	
		1. 00	2. 00	3.00	/	4. 00	5A. 00	5. 00	
	GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. &	0					0		1.00
	Fixtures								
2.00	Capital Related - Movable		0				0		2.00
	Equi pment								
3.00	Plant Operation & Maintenance	0	0		0		0		3.00
4. 00	Transportation (see	0	0		O		0		4.00
5. 00	instructions) Administrative and General	0	0		0		0 -128, 780	69, 220	5.00
5.00	HHA REIMBURSABLE SERVICES	J O	U		U		0  -120,700	09, 220	3.00
6. 00	Skilled Nursing Care	1 0	0		ol		0 0	54, 752	6.00
7. 00	Physical Therapy		0		0		0 0	34,732	7.00
8. 00	Occupational Therapy		0		0		0 0		8.00
9. 00	Speech Pathology		Ô		ol		0 0	l	9.00
	Medical Social Services	l o	0		o		0 0	1 7	10.00
11 00	Hama Haaliba Atala	ا ما	-		~			14 4/1	

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16.00

17.00

18.00

19.00

20.00

21.00 22.00

23.00

24.00

14, 461

69, 220

128, 780 25. 00

1. 860445 26. 00

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16.00

17.00

18.00

19.00

20.00

21.00

22.00

23.00

24.00

25.00

Home Health Aide

Respiratory Therapy

Day Care Program

Homemaker Service

26.00 Unit Cost Multiplier

All Others (specify)

Private Duty Nursing

Drugs

Clinic

Supplies (see instructions)

HHA NONREIMBURSABLE SERVICES

Home Dialysis Aide Services

Health Promotion Activities

Home Delivered Meals Program

Total (sum of lines 1-23)

Cost To Be Allocated (per Worksheet H-1, Part I)

HHA CCN: 157189 Home Health PPS

						Agency I	FF3	
			CAPITAL REL	ATED COSTS		Algority !		
	Cost Center Description	HHA Trial Balance (1)	NEW BLDG & FLXT	NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIV E & GENERAL	
		0	1. 00	2. 00	4. 00	4A	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00	Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) (2)	0 156, 615 0 0 20 41, 365 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	12, 869		22, 800 11, 853 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	35, 669 168, 468 0 0 0 20 44, 085 0 0 0 0 0 0 0	11, 840	1. 00 2. 00 3. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00
	6 decimal places.  Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		REPAI RS 6. 00	PLANT 7. 00	LINEN SERVICE 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 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 20. 00 21. 00	Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify)	11, 880 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	7, 647 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	8. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	8, 139 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 976	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 20. 00 21. 00

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

Peri od: Worksheet H-2
From 01/01/2014 Part I
To 12/31/2014 Date/Time Prepared: 5/21/2015 12: 29 pm
Home Heal th PPS Provi der CCN: 150061 Peri od: HHA CCN: 157189

						Home Health	PPS	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	Agency I SOCIAL	Subtotal	
	cost center bescription	ADMI NI STRATI O	SERVICES &	THANWACT	RECORDS &	SERVI CE	Subtotal	
		N	SUPPLY		LI BRARY	02.00		
		13. 00	14. 00	15. 00	16.00	17. 00	24.00	
1.00	Administrative and General	11, 290	95	0	2, 221	36, 718	138, 475	1.00
2.00	Skilled Nursing Care	5, 056	0	0	0	0	230, 776	1
3. 00	Physi cal Therapy	0	0	0	0	0	0	
4. 00	Occupational Therapy	0	0	0	0	0	0	
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6. 00 7. 00	Medical Social Services Home Health Aide	0 3, 495	0		0	-	27 63, 135	•
8. 00	Supplies (see instructions)	3, 493	0	1	0	-	03, 133	1
9. 00	Drugs		0		0		0	•
10.00	DME	l ő	0	1	0		0	
11. 00	Home Dialysis Aide Services	0	0	0	0	0	0	1
12.00	Respi ratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	1	0	0	0	
15. 00	Health Promotion Activities	0	0		0	0	0	
16.00	Day Care Program	0	0	-	0	0	0	
17. 00	Home Delivered Meals Program	0	0		0	0	0	
18. 00 19. 00	Homemaker Service All Others (specify)	0	0	0	0	0	0	
20. 00	Total (sum of lines 1-19) (2)	19, 841	95	0	2, 221	36, 718	432, 413	1
21. 00	Unit Cost Multiplier: column	17,041	73		2, 221	30, 710	432, 413	21.00
200	26, line 1 divided by the sum							21.00
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.	1 . 1 0	6 1 1 1 1	A11	T. I. I. IIIIA			
	Cost Center Description	Intern & Residents	Subtotal	Allocated HHA A&G (see Part	Total HHA Costs			
		Cost & Post		II)	COSTS			
		Stepdown		,				
		Adjustments						
		25. 00	26. 00	27. 00	28. 00			
1. 00	Administrative and General	0	138, 475					1.00
2.00	Skilled Nursing Care	0	230, 776		339, 495			2.00
3.00	Physical Therapy	0	0	0	0			3.00
4. 00 5. 00	Occupational Therapy Speech Pathology	0	0	0	0			4. 00 5. 00
6. 00	Medical Social Services	0	27	13	40			6.00
7. 00	Home Heal th Aide		63, 135		92, 878			7.00
8. 00	Supplies (see instructions)	O	0	0	0			8.00
9.00	Drugs	0	0	0	0			9.00
10.00	DME	0	0	0	0			10.00
11. 00	Home Dialysis Aide Services	0	0	0	0			11.00
12.00	Respiratory Therapy	0	0	1	0			12.00
13. 00 14. 00	Private Duty Nursing	0	0	0	0			13. 00 14. 00
15. 00	Health Promotion Activities		0	0	0			15.00
16. 00	Day Care Program		0	0	0			16.00
17. 00	Home Delivered Meals Program	O	0	O	0			17.00
18.00	Homemaker Service	0	0	0	0			18. 00
19. 00	All Others (specify)	0	0	0	0			19.00
20.00	, , , ,	0	432, 413		432, 413			20.00
21. 00	Unit Cost Multiplier: column			0. 471103				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.

Health Financial Systems	DAVIESS COMMUNITY F	S COMMUNITY HOSPITAL			Lieu of Form CMS-2552-10	
ALLOCATION OF GENERAL SERVICE COSTS TO HI	HA COST CENTERS STATISTICAL	Provi der CCN:		Peri od:	Worksheet H-2	
BASIS				From 01/01/2014		
		HHA CCN:	157189	To 12/31/2014	Date/Time Prepared:	
					5/21/2015 12:29 pm	
				Home Health	PPS	

						Home Health Agency I	PPS	
		CAPI TAL REL	ATED COSTS			Agency I		
	Cost Center Description	NEW BLDG & FIXT (SOUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	MAI NTENANCE & REPAI RS (SQUARE FEET)	
		1. 00	2. 00	4. 00	5A	5. 00	6. 00	
2. 00 Sk 3. 00 Pr 4. 00 Oc 5. 00 Sc 6. 00 Mc 8. 00 Sc 9. 00 Dr 10. 00 DM 11. 00 Hc 12. 00 Rc 13. 00 Pr 14. 00 Cl 15. 00 Hc 16. 00 Da 17. 00 Hc 18. 00 Hc 19. 00 Al 20. 00 Tc 21. 00 Tc	dministrative and General killed Nursing Care hysical Therapy ccupational Therapy peech Pathology edical Social Services ome Health Aide upplies (see instructions) rugs ME ome Dialysis Aide Services espiratory Therapy rivate Duty Nursing linic ealth Promotion Activities ay Care Program ome Delivered Meals Program omemaker Service II Others (specify) otal (sum of lines 1-19) otal cost to be allocated nit cost multiplier Cost Center Description	1. 00  1, 365  0  0  0  0  0  0  0  0  0  0  0  0  0	2.00 0 0 0 0 0 0 0 0 0 0 0 0	4. 00 94, 359 49, 054 0 0 0 11, 259 0 0 0 0 0 0 0 0 0 0 0 0 0		35, 669 168, 468 0 0 20 44, 085 0 0 0 0 0	1, 365 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	21.00
		(SQUARE FEET)	(POUNDS OF LAUNDRY)	FEET)	SERVED)	PAID)	N (DIRECT NRSING HRS)	
T.		7. 00	8. 00	9. 00	10.00	11.00	13. 00	
2. 00 Sk 3. 00 Pr 4. 00 Oc 5. 00 Sk 6. 00 Me 7. 00 Hc 8. 00 Dr 10. 00 DM 11. 00 Hc 12. 00 Re 13. 00 Pr 14. 00 Cl 15. 00 He 16. 00 Da 17. 00 Hc 19. 00 Al 20. 00 Tc 21. 00 Tc	dministrative and General killed Nursing Care hysical Therapy ccupational Therapy peech Pathology edical Social Services ome Health Aide upplies (see instructions) rugs ME ome Dialysis Aide Services espiratory Therapy rivate Duty Nursing linic ealth Promotion Activities and Care Program ome Delivered Meals Pr	1, 365 0 0 0 0 0 0 0 0 0 0 0 0 0 1, 365 17, 647 12. 928205	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 365 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1, 762 0 0 0 0 1, 218 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0	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 20.00 21.00

Health Financial Systems	DAVIESS COMMUNITY	HOSPI TAL	u of Form CMS-2552-10	
ALLOCATION OF GENERAL SERVICE COSTS TO BASIS	O HHA COST CENTERS STATISTICAL	Provi der CCN: 150061 HHA CCN: 157189	Peri od: From 01/01/2014 To 12/31/2014	Worksheet H-2 Part II Date/Time Prepared: 5/21/2015 12:29 pm
•				

						Home Health	PPS	27 p
		OFNEDAL	DUIA DAMA OV	11501.041	000141	Agency I		
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCI AL			
		SERVICES &	(COSTED	RECORDS &	SERVI CE			
		SUPPLY	REQUIS.)	LI BRARY	(TIME			
		(COSTED		(GROSS	SPENT)			
		REQUIS.)	15.00	CHARGES)	17.00	_		-
1 00	TA lot of a local to a control of the control of th	14. 00	15. 00	16.00	17.00			1 00
1.00	Administrative and General	373	0	162, 582	1, 962	2		1.00
2.00	Skilled Nursing Care	0	0	(				2.00
3. 00	Physi cal Therapy	0	0	(		2		3. 00
4.00	Occupational Therapy	0	0	(		)		4.00
5. 00	Speech Pathology	0	0	(		)		5.00
6.00	Medical Social Services	0	0	(				6.00
7. 00	Home Health Aide	0	0	(				7. 00
8.00	Supplies (see instructions)	0	0	(				8. 00
9.00	Drugs	0	0	(	) (			9. 00
10.00	DME	0	0	(	) (			10.00
11. 00	Home Dialysis Aide Services	0	0	(	) (			11.00
12.00	Respiratory Therapy	0	0	(	) (			12.00
13.00	Private Duty Nursing	0	0	(	) (			13.00
14.00	Clinic	0	0	(	) (			14.00
15.00	Health Promotion Activities	0	0	(	) (			15.00
16.00	Day Care Program	0	0	(				16.00
17.00	Home Delivered Meals Program	0	0	(	) (			17.00
18.00	Homemaker Service	o	0	(				18.00
19.00	All Others (specify)	o	0	(				19.00
20.00	Total (sum of lines 1-19)	373	0	162, 582	1, 962	2		20.00
21.00	Total cost to be allocated	95	0	2, 22				21.00
22. 00	Unit cost multiplier	0. 254692	0. 000000			7		22. 00

Haal th	Financial Systems		DAVIESS COMMUN	ILT HUSDITAL		Inlia	u of Form CMS-2	2552_10
	FIONMENT OF PATIENT SERVICE COS	īS.	DAVIESS COMMON		CCN: 150061	Peri od:	Worksheet H-3	2332-10
7.1.1 01(1	TOTAL SERVICE GOS			HHA CCN:		From 01/01/2014 To 12/31/2014	Part I Date/Time Pre	
				Ti tl	e XVIII	Home Health Agency I	5/21/2015 12: 2 PPS	29 pm
	Cost Center Description	From, Wkst. H-2, Part I,	Facility Costs (from	Shared Ancillary	Total HHA Costs (cols.	Total Visits	Average Cost Per Visit	
		col. 28, line	Wkst. H-2, Part I)	Costs (from Part II)	1 + 2)		(col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5. 00	
	PART I - COMPUTATION OF LESSER COST LIMITATION	OF AGGREGATE				MITATION COST, C		
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	339, 495		339, 49	95 901	376. 80	1.00
2.00	Physi cal Therapy	3.00		l			48. 37	2.00
3.00	Occupational Therapy	4.00	0	3, 889	3, 88	154	25. 25	3.00
4.00	Speech Pathology	5.00	0	3, 332	3, 33	53	62. 87	4.00
5.00	Medical Social Services	6. 00	40		4	10 1	40. 00	5.00
6.00	Home Health Aide	7. 00	92, 878		92, 87		194. 71	6.00
7. 00	Total (sum of lines 1-6)		432, 413	30, 485				7.00
					Program Visit	ts		
					Pa	art B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject			
					to Deductibles	Deductibles		
					Coi nsurance			
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
	Limitation Cost Computation							
8. 00	Skilled Nursing Care		99915	0				8. 00
9. 00	Physi cal Therapy		99915	0				9.00
10.00	Occupational Therapy		99915	0		77		10.00
11.00	Speech Pathology		99915	0		27		11.00
12.00	Medical Social Services		99915	0		1		12.00
13.00	Home Heal th Ai de		99915	0	2. 1, 25			13.00
14. 00	Total (sum of lines 8-13)  Cost Center Description	From Wkst.	Facility	Shared	Total HHA		Ratio (col. 3	14. 00
	cost center bescription	H-2 Part I,	Costs (from	Ancillary	Costs (cols.	(from HHĀ	÷ col . 4)	
		col. 28, line	Wkst. H-2, Part I)	Costs (from Part II)	1 + 2)	Record)		
		0						
			1. 00	2.00	3. 00	4. 00	5. 00	
15 00	Supplies and Drugs Cost Comput	ati ons		2.00				15.00
	Supplies and Drugs Cost Comput Cost of Medical Supplies Cost of Drugs	ations 8.00 9.00	0	2. 00 0 921	92	0 0	0. 000000	
	Cost of Medical Supplies	ations 8.00 9.00	0	2. 00 0 921	92 Cost of	0 0	0. 000000	
	Cost of Medical Supplies	ations 8.00 9.00	0	2. 00 0 921	92	0 0 21 1,873	0. 000000	
	Cost of Medical Supplies	ations 8.00 9.00	0 0 Program Visits	2. 00 0 921	92 Cost of	0 0	0. 000000	
	Cost of Medical Supplies Cost of Drugs	ati ons 8.00 9.00	0 0 Program Visits Par Not Subject to	2.00  0 921  t B Subject to Deductibles &	92 Cost of Services	0 0 21 1,873 Part B Not Subject	0.000000 0.491725 Subject to Deductibles &	
	Cost of Medical Supplies Cost of Drugs	ati ons 8.00 9.00	Program Visits Par Not Subject to Deductibles &	2.00  0 921  t B Subject to Deductibles &	92 Cost of Services	O 0 1,873  Part B Not Subject to Deductibles &	0.000000 0.491725 Subject to Deductibles &	
	Cost of Medical Supplies Cost of Drugs	ations 8.00 9.00 Part A	0 0 Program Visits Par Not Subject to Deductibles & Coinsurance	2.00  0 921  t B Subject to Deducti bl es & Coi nsurance	Cost of Services Part A	0 0 1,873  Part B  Not Subject to  Deductibles & Coinsurance	0. 000000 0. 491725 Subj ect to Deducti bl es & Coi nsurance	
	Cost of Medical Supplies Cost of Drugs  Cost Center Description	ations 8.00 9.00 Part A	Program Visits  Par Not Subject to Deductibles & Coinsurance 7.00	2.00  0 921  t B  Subject to Deductibles & Coinsurance  8.00	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance 10.00	0.000000 0.491725 Subject to Deductibles & Coinsurance	
	Cost of Medical Supplies Cost of Drugs  Cost Center Description  PART I - COMPUTATION OF LESSER COST LIMITATION	ations 8.00 9.00 Part A	Program Visits  Par Not Subject to Deductibles & Coinsurance 7.00	2.00  0 921  t B  Subject to Deductibles & Coinsurance  8.00	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance 10.00	0.000000 0.491725 Subject to Deductibles & Coinsurance	
16.00	Cost of Medical Supplies Cost of Drugs  Cost Center Description  PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation	ations  8.00 9.00  Part A  6.00  OF AGGREGATE	Program Visits  Par Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, A	2.00  0 921  t B Subject to Deductibles & Coinsurance  8.00 AGGREGATE OF TI	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance 10.00 MITATION COST, C	0.000000 0.491725 Subject to Deductibles & Coinsurance	16.00
1. 00	Cost of Medical Supplies Cost of Drugs  Cost Center Description  PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation Skilled Nursing Care	ations 8.00 9.00 Part A	Program Visits  Par Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, A	t B Subject to Deductibles & Coinsurance  8.00 AGGREGATE OF TI	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance 10.00 MITATION COST, C	0.000000 0.491725 Subject to Deductibles & Coinsurance 11.00 DR BENEFICIARY	1. 00
1. 00 2. 00	Cost of Medical Supplies Cost of Drugs  Cost Center Description  PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy	ations  8.00 9.00  Part A  6.00  OF AGGREGATE	Program Visits  Par Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, A	t B Subject to Deductibles & Coinsurance 8.00 AGGREGATE OF TI	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance 10.00 MITATION COST, C	0.000000 0.491725 Subject to Deductibles & Coinsurance 11.00 DR BENEFICIARY	1. 00 2. 00
1. 00 2. 00 3. 00	Cost of Medical Supplies Cost of Drugs  Cost Center Description  PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy	ations  8.00 9.00  Part A  6.00  OF AGGREGATE	Program Visits  Par Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, A	2.00  0 921  t B  Subject to Deductibles & Coinsurance  8.00  AGGREGATE OF TI	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance 10.00 MITATION COST, CO 0 203,095 0 16,688 0 1,944	0.000000 0.491725 Subject to Deductibles & Coinsurance	1. 00 2. 00 3. 00
1. 00 2. 00 3. 00 4. 00	Cost of Medical Supplies Cost of Drugs  Cost Center Description  PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	ations  8.00 9.00  Part A  6.00  OF AGGREGATE	Program Visits  Par Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, A	2.00  0 921  t B  Subject to Deductibles & Coinsurance  8.00  AGGREGATE OF TI	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance 10.00 MITATION COST, CO  203,095 0 16,688 0 1,944 0 1,697	0.000000 0.491725 Subject to Deductibles & Coinsurance	1. 00 2. 00 3. 00 4. 00
1. 00 2. 00 3. 00 4. 00 5. 00	Cost of Medical Supplies Cost of Drugs  Cost Center Description  PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	ations  8.00 9.00  Part A  6.00  OF AGGREGATE	Program Visits  Par Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, A  539 345 77 27	2.00  0 921  t B  Subject to Deductibles & Coinsurance  8.00  AGGREGATE OF TH	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance 10.00 MITATION COST, CO 0 203,095 0 16,688 0 1,944 0 1,697 0 40	0.000000 0.491725 Subject to Deductibles & Coinsurance	1. 00 2. 00 3. 00 4. 00 5. 00
1. 00 2. 00 3. 00 4. 00	Cost of Medical Supplies Cost of Drugs  Cost Center Description  PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	ations  8.00 9.00  Part A  6.00  OF AGGREGATE	Program Visits  Par Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, A  539 345 77 277 1 270	2.00  0 921  t B  Subject to Deductibles & Coinsurance  8.00  AGGREGATE OF Ti	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance 10.00 MITATION COST, CO  203,095 0 16,688 0 1,944 0 1,697	0.000000 0.491725 Subject to Deductibles & Coinsurance 11.00 R BENEFICIARY	1. 00 2. 00 3. 00 4. 00

	Financial Systems		DAVIESS COMMUN				u of Form CMS-2	
APP0R1	TIONMENT OF PATIENT SERVICE COST	ΓS		Provi der	CCN: 150061	Period: From 01/01/2014	Worksheet H-3 Part I	
				HHA CCN:	157189			
				Ti tl	e XVIII	Home Health	PPS	
			1			Agency I		
	Cost Center Description							
		6. 00	7. 00	8. 00	9. 00	10. 00	11. 00	
0.00	Limitation Cost Computation				1			0.00
8. 00	Skilled Nursing Care							8.00
9. 00 10. 00	Physical Therapy Occupational Therapy							9.00
11. 00	Speech Pathology			}				11.00
12. 00	Medical Social Services							12.00
13. 00	Home Health Aide		•					13.00
	Total (sum of lines 8-13)		•					14.00
14.00	Total (Suil of Titles 0-15)	Prog	ram Covered Ch	l arnes	Cost of			14.00
		1109	rain covered on	ui ges	Servi ces			
					Jei vi ces			
			Par	rt B		Part B		
	Cost Center Description	Part A	Not Subject	Subject to	Part A	Not Subject	Subject to	
	•		to	Deductibles &		to	Deductibles &	
			Deductibles &	Coi nsurance		Deductibles &	Coi nsurance	
			Coi nsurance			Coi nsurance		
		6. 00	7. 00	8. 00	9. 00	10. 00	11. 00	
	Supplies and Drugs Cost Comput							ļ
15.00		0						15.00
16. 00	Cost of Drugs		С	0		0	0	16.00
	Cost Center Description	Total Program						
		Cost (sum of						
		col s. 9-10) 12.00						-
	PART I - COMPUTATION OF LESSER		PROGRAM COST	AGGREGATE OF T	HE PROGRAM LI	MITATION COST C	R BENEFICIΔRY	
	COST LIMITATION	OI MOOKEOMIE	TROOMAIN COST,	AGGREGATE OF T	TIE TROOKAW EI	WII TATTON COST, C	N DENETTOTAKI	
	Cost Per Visit Computation							1
1.00	Skilled Nursing Care	203, 095						1.00
2.00	Physi cal Therapy	16, 688						2.00
3.00	Occupational Therapy	1, 944						3.00
4.00	Speech Pathology	1, 697						4.00
5.00	Medical Social Services	40						5.00
6.00	Home Health Aide	52, 572						6.00
7.00	Total (sum of lines 1-6)	276, 036						7.00
	Cost Center Description							
	1	12. 00						
	Limitation Cost Computation	1	T					
8.00	Skilled Nursing Care							8.00
	Physical Therapy							9.00
9.00	Occupational Therapy							10.00
10.00	C I. B. III. I.							l 11.00
10. 00 11. 00	Speech Pathology							
10. 00 11. 00 12. 00	Medical Social Services							12.00
10. 00 11. 00 12. 00 13. 00								

Heal th	Financial Systems		DAVIESS COMMUN	ITY H	IOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORT	IONMENT OF PATIENT SERVICE COS	TS			Provi der	CCN: 150061	Peri od:	Worksheet H-3	
							From 01/01/2014		
					HHA CCN:	157189	To 12/31/2014		
								5/21/2015 12:	29 pm_
					Ti tl	e XVIII	Home Health	PPS	
						Agency I			
	Cost Center Description	From Wkst. C,	Cost to	Tot	tal HHA	HHA Shared	Transfer to		
		Part I, col.	Charge Ratio	Char	ge (from	Ancillary	Part I as		
		9, line		pr	ovi der	Costs (col.	1 Indicated		
				re	cords)	x col. 2)			
		0	1. 00		2.00	3. 00	4. 00		
	PART II - APPORTIONMENT OF COS	T OF HHA SERVI	CES FURNISHED E	BY SHA	ARED HOSPI	TAL DEPARTME	ENTS		
1.00	Physi cal Therapy	66.00	0. 498199		46, 697	23, 20	64 col. 2, line 2	. 00	1.00
2.00	Occupational Therapy	67.00	0. 368803		10, 544	3, 8	89 col. 2, line 3	. 00	2.00
3.00	Speech Pathology	68.00	0. 672368		4, 955	3, 3	32 col. 2, line 4	. 00	3.00
4.00	Cost of Medical Supplies	71.00	0. 588257		0		0 col. 2, line 1	5. 00	4.00
5.00	Cost of Drugs	73.00	0. 491530		1, 873	9:	21 col. 2, line 1	6. 00	5.00

T CHI	Financial Systems DAVIESS COMMUNITY ATION OF HHA REIMBURSEMENT SETTLEMENT		CCN: 150061	Peri od:	eu of Form CMS-2 Worksheet H-4	
LCUL	ATTON OF THA REIMBURSEMENT SETTLEMENT			From 01/01/2014	Part I-II	
		HHA CCN:	157189	To 12/31/2014	Date/Time Pre 5/21/2015 12:	
		Titl	e XVIII	Home Health	PPS	27
				Agency I		
			Dont A		rt B	
			Part A	Not Subject to	Subject to Deductibles &	
				Deductibles &		
				Coi nsurance		
	DADT I COMPUTATION OF THE LECEP OF DEACONABLE COST OF CHECK	MADY CHADCE	1.00	2. 00	3. 00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOR Reasonable Cost of Part A & Part B Services	JWART CHARGE				1
0	Reasonable cost of services (see instructions)			0 0	0	1
0	Total charges			0 0	0	2
	Customary Charges	<del> </del>				١.
00	Amount actually collected from patients liable for payment for	servi ces		0 0	0	3
00	on a charge basis (from your records) Amount that would have been realized from patients liable for	pavment		0 0	0	4
	for services on a charge basis had such payment been made in a					]
_	with 42 CFR §413.13(b)		2 22	00 000000		_
0 0	Ratio of line 3 to line 4 (not to exceed 1.000000) Total customary charges (see instructions)		0. 0000	0.000000	0.000000	1
0	Excess of total customary charges over total reasonable cost	(complete			1	
-	only if line 6 exceeds line 1)	(				
00	Excess of reasonable cost over customary charges (complete onl 1 exceeds line 6)	yifline		0	0	8
0	Primary payer amounts			0 0		9
				Part A Services	Part B Services	
				1. 00	2. 00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT					
00	Total reasonable cost (see instructions)			(	1	
	Talal BBC Batal account Ell Establish the LO III account					
00	Total PPS Reimbursement - Full Episodes without Outliers				.00,000	
00 00	Total PPS Reimbursement - Full Episodes with Outliers			(	0	12
00 00 00					0 3, 269	12 13
00 00 00 00 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers			(	0 0 3, 269 0 2, 121 0	12 13 14 15
00 00 00 00 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes			(	0 0 3, 269 2, 121 0 0	12 13 14 15 16
00 00 00 00 00 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments			(	0 3, 269 2, 121 0 0 0	12 13 14 15 16
00 00 00 00 00 00 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments			(	0 0 3, 269 2, 121 0 0	12 13 14 15 16 17
00 00 00 00 00 00 00 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments			(	0 3, 269 0 2, 121 0 0 0 0 0 0 0	12 13 14 15 16 17 18
00 00 00 00 00 00 00 00 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinse	urance)			0 0 3, 269 0 2, 121 0 0 0 0 0 0 0 0 0 0 0 0	12 13 14 15 16 17 18 19 20 21
00 00 00 00 00 00 00 00 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsus Subtotal (sum of lines 10 thru 20 minus line 21)	urance)			0 0 3, 269 0 2, 121 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	12 13 14 15 16 17 18 19 20 21
00 00 00 00 00 00 00 00 00 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinst Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8)	urance)			0 0 3, 269 2, 121 0 0 0 0 0 0	12 13 14 15 16 17 18 19 20 21 22 23
00 00 00 00 00 00 00 00 00 00 00 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsusubtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23)	urance)			0 0 3, 269 0 2, 121 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 166, 228	122 133 144 155 166 177 188 199 20 21 22 23 24
00 00 00 00 00 00 00 00 00 00 00 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinst Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8)	urance)			0 0 3, 269 2, 121 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	12 13 14 15 16 17 18 19 20 21 22 23 24 25
00 00 00 00 00 00 00 00 00 00 00 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsus Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records)	urance)			0 0 3, 269 2, 121 0	12 13 14 15 16 17 18 19 20 21 22 23 24 25 26
00 00 00 00 00 00 00 00 00 00 00 00 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments Total Other Payments  DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinst Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see in	nstructi ons)	)		0 0 3, 269 2, 121 0 0 0 0 0 0 0 0 0 0 0 0 0 0 166, 228 0 166, 228	12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28
00 00 00 00 00 00 00 00 00 00 00 00 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinst Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see in Total costs - current cost reporting period (line 26 plus line	nstructi ons)	)		0 0 3, 269 2, 121 0 0 0 0 0 0 0 0 0 0 0 0 0 0 166, 228 0 166, 228	122 133 144 155 166 177 188 199 200 211 222 233 244 255 267 277 288 299
00 00 00 00 00 00 00 00 00 00 00 00 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsusubtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see in Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	nstructions) e 27)	)		0	122 133 144 155 166 177 188 199 200 211 222 233 244 255 262 277 288 299 300
00 00 00 00 00 00 00 00 00 00 00 00 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsus Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see in Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)	nstructions) e 27)	)		0 0 3, 269 2, 121 0 166, 228 0 166, 228	122 133 144 155 166 177 188 199 200 211 222 233 244 255 267 277 288 299 300 300 300 300 300 300 300 300 300 3
00 00 00 00 00 00 00 00 00 00 00 00 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsusubtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see in Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	nstructions) e 27)	)		0 0 3, 269 2, 121 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 166, 228 0 166, 228 0 166, 228	122 133 144 155 166 177 188 199 200 211 222 233 244 255 266 277 288 299 300 31
00 00 00 00 00 00 00 00 00 00 00 00 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinst Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see in Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions Subtotal (see instructions)	nstructions) e 27)	)		0 0 3, 269 2, 121 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 166, 228 0 166, 228 0 166, 228 0 0 166, 228	122 133 144 155 166 177 188 199 200 21 22 23 24 25 25 26 27 30 30 31 31
00 00 00 00 00 00 00 00 00 00 00 00 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinse Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see in Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions Subtotal (see instructions) Sequestration adjustment (see instructions) Interim payments (see instructions) Tentative settlement (for contractor use only)	nstructions; e 27) s)	)		0	122 133 144 155 166 177 188 199 200 211 222 233 244 255 266 277 288 299 300 311 311 322 333
00 00 00 00 00 00 00 00 00 00 00 00 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinst Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see in Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) Sequestration adjustment (see instructions)	nstructions) e 27) s) and 33)			0 0 3, 269 2, 121 0 166, 228 0 166, 228 0 0 166, 228 0 0 166, 228 0 0 0 0 166, 228 0 0 0 0 166, 290 0	122 133 144 155 166 177 188 199 200 211 222 233 244 255 266 277 288 299 300 311 313 313 323 334

Health Financial Systems	DAVIESS COMMUNITY I	In Lie	u of Form CMS-2552-10	
ANALYSIS OF PAYMENTS TO PROVIDER-BASED PROGRAM BENEFICIARIES	HHAS FOR SERVICES RENDERED TO	Provi der CCN: 150061 HHA CCN: 157189	Peri od: From 01/01/2014 To 12/31/2014	Worksheet H-5 Date/Time Prepared: 5/21/2015 12:29 pm

Home Health Agency I Inpatient Part A Part B mm/dd/yyyy mm/dd/yyyy Amount Amount 1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 162, 904 1.00 2.00 Interim payments payable on individual bills, either 0 2.00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. 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 3.01 3. 02 0 0 3.02 3.03 0 3.03 3.04 0 0 3.04 0 3.05 3.05 Provider to Program 3.50 0 0 3.50 3. 51 0 0 3.51 0 3.52 0 3.52 3.53 0 3.53 3.54 0 0 3.54 0 3. 99 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3. 50-3. 98) Total interim payments (sum of lines 1, 2, and 3.99) 4.00 0 162, 904 4.00 (transfer to Wkst. H-4, Part II, column as appropriate, line 32) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after 5.00 desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 0 n 5.01 0 0 5.02 5.02 5.03 0 0 5.03 Provider to Program 5.50 0 5.50 n 5. 51 0 0 5.51 5.52 0 0 5.52 0 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 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 6.01 0 0 6.02 SETTLEMENT TO PROGRAM 6.02 0 Total Medicare program liability (see instructions) n 162, 904 7.00 7.00 NPR Date Contractor Number (Mo/Day/Yr) 0 1.00 2.00

8. 00

8.00 Name of Contractor

Heal th	Financial Systems	DAVIESS COMMUNI	IAT IDSOH VT		Inlie	u of Form CMS-:	2552_10
	IS OF PROVIDER-BASED HOSPICE COSTS	DAVIESS COMMON		CCN: 150061	Peri od:	Worksheet K	2332 10
AWALIS	NO OF TROUTDER BASED HOST FOE GOSTO			CCN: 151553	From 01/01/2014 To 12/31/2014	Date/Time Pre	epared:
						5/21/2015 12:	29 pm
		Sal ari es	Employee	Transportati	Hospi ce I o Contracted	Other	
		(from Wkst.	Benefits	n (see inst.		other	
		K-1)	(from Wkst.	ii (see mst.	(from Wkst.		
		K 1)	K-2)		K-3)		
		1. 00	2.00	3.00	4.00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.				0	0	1.00
2.00	Capital Related Costs-Movable Equip.				0	0	2.00
3.00	Plant Operation and Maintenance	0	(		0 0	0	3.00
4.00	Transportation - Staff	0	(	22, 2	74 0	0	4.00
5.00	Volunteer Service Coordination	0	(		0 0	0	5.00
6.00	Administrative and General	118, 132	(		0 0	63, 490	6.00
	I NPATI ENT CARE SERVI CE						
7. 00	Inpatient - General Care	64, 180	(		0 156, 344	0	
8. 00	Inpatient - Respite Care	0	(	)	0 0	0	8.00
	VI SI TI NG SERVI CES			_1	_1		
9.00	Physi ci an Servi ces	0	(	-	0 0	0	
10.00	Nursing Care	0	(	-	0 0	0	
11.00	Nursing Care-Continuous Home Care	0	(		0	0	
12.00	Physical Therapy	0	(		0 0	0	
13. 00 14. 00	Occupational Therapy Speech/ Language Pathology	0	(		0 0	0	
15. 00	Medical Social Services		(	-		0	
16. 00	Spiritual Counseling		(	1		0	
17. 00	Dietary Counseling		(		0 0	0	
18. 00	Counseling - Other	0	(		0 0	0	
19. 00	Home Health Aide and Homemaker	36, 737	(	ő	0 0	0	
20.00	HH Aide & Homemaker - Cont. Home Care	0	(		0 0	Ö	
21. 00	Other	l ol	(		0 0		
	OTHER HOSPICE SERVICE COSTS	· · · · · · · · · · · · · · · · · · ·					
22.00	Drugs, Biological and Infusion Therapy	0	(		0 0	0	22. 00
23.00	Anal gesi cs	o	(		0 0	0	23.00
24.00	Sedatives / Hypnotics	0	(		0 0	0	24.00
25.00	Other - Specify	0	(		0 0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	(		0 0	0	26.00
27.00	Patient Transportation	0	(	)	0 0	0	27. 00
28. 00	I maging Services	0	(	이	0 0	0	
29. 00	Labs and Diagnostics	0	(		0 0	0	
30.00	Medical Supplies	0	(		0	0	
31.00	Outpatient Services (including E/R Dept.)	0	(		0 0	0	
32.00	Radiation Therapy	0	(		0 0	0	
33.00	Chemotherapy	0	(		0 0	0	
34.00	Other	U U		ــــــــــــــــــــــــــــــــــــــ	0 0	0	34.00

0 0 0

219, 049

0 0 0

0 0 0

22, 274

0 0 0

156, 344

35.00

36.00

0

0

0 37. 00 38. 00

63, 490 39. 00

35.00 Bereavement Program Costs

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

36.00 Volunteer Program Costs

HOSPICE NONREIMBURSABLE SERVICE

Heal th	Financial Systems	DAVIESS COMMUN	JITV HOSDITAI		In lie	u of Form CMS-	2552_10
	SIS OF PROVIDER-BASED HOSPICE COSTS	DAVI E33 COMMO		CCN: 150061	Peri od:	Worksheet K	2332 10
			Hospi ce (	CCN: 151553	From 01/01/2014 To 12/31/2014	Date/Time Pre 5/21/2015 12:	epared:
					Hospi ce I	3/21/2013 12.	27 μπ
		Total (cols. 1-5)	Recl assi fi cat i on	Subtotal (col. 6 ± col. 7)	Adjustments	Total (col. 8 ± col. 9)	
		6. 00	7. 00	8.00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS	9. 22					
1.00	Capital Related Costs-Bldg and Fixt.	C	0		0 0	0	1.00
2.00	Capital Related Costs-Movable Equip.	C	0		0 0	0	2.00
3.00	Plant Operation and Maintenance	C	0		0 0	0	3.00
4.00	Transportation - Staff	22, 274	0	22, 2	74 0	22, 274	4.00
5.00	Volunteer Service Coordination	C	0	)	0 0	0	5.00
6.00	Administrative and General	181, 622	2 0	181, 63	22 0	181, 622	6. 00
	INPATIENT CARE SERVICE	_					
7. 00	Inpatient - General Care	220, 524					
8. 00	Inpatient - Respite Care	C	0		0 0	0	8. 00
	VISITING SERVICES	1					
9. 00	Physician Services	C	1	1	0 0	1	
10.00	Nursing Care		0	1	0 0	ľ	10.00
11.00	Nursing Care-Continuous Home Care				0 0	1	
12.00	Physical Therapy				0	0	12.00
13.00	Occupational Therapy				0	0	
14. 00 15. 00	Speech/ Language Pathology Medical Social Services				0	0	14. 00 15. 00
16. 00	Spiritual Counseling				0		16.00
17. 00	Dietary Counseling				0		1
18. 00	Counseling - Other				0	0	18.00
19. 00	Home Health Aide and Homemaker	36, 737		36, 7	37 0	36, 737	
20. 00	HH Ai de & Homemaker - Cont. Home Care	30, 737	l l	30, 7.	0 0		20.00
21. 00	Other		1		0 0		
21.00	OTHER HOSPICE SERVICE COSTS		,	1	<u> </u>		21.00
22. 00	Drugs, Biological and Infusion Therapy	C	) 0		0 0	0	22. 00
23. 00	Anal gesi cs	C			0 0	0	23.00
24.00	Sedatives / Hypnotics	C			0 0	0	
25.00	Other - Specify		0		0 0	0	25.00
26.00	Durable Medical Equipment/Oxygen	C	0		0 0	0	26.00
27.00	Patient Transportation	C	0		0 0	0	27.00
28. 00	I maging Services	C	) 0		0 0	0	28. 00
29. 00	Labs and Diagnostics	C	0	)	0 0	0	29. 00
30.00	Medical Supplies	C	0	)	0 0	0	30. 00
31.00	Outpatient Services (including E/R Dept.)	0	0	)	0	0	31.00
32.00	Radiation Therapy	C	0	1	0	0	32.00
33. 00	Chemotherapy	C	) 0	1	0 0	0	33.00
34.00	Other	C	) 0		0 0	0	34.00

0 0 0

461, 157

0 35.00 0 36.00 0 37.00 0 38.00 461,157 39.00

HOSPICE NONREIMBURSABLE SERVICE

35.00 Bereavement Program Costs

Volunteer Program Costs

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

Health Financial Systems	DAVIESS COMMUNITY HOSPITAL		In Lie	u of Form CMS-2552-10
HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES	Provi der CC	N: 150061		Worksheet K-1
	Hospi ca CCN	151553	From 01/01/2014	Nate/Time Prepared:

			Hospi ce CCN:	151553	To 12/31/2014	Date/Time Pre	pared:
					Hospi ce I	5/21/2015 12:	29 pm_
		Admi ni otrotor	Director	Cool of		Nuncoo	
		Admi ni strator	Di rector	Soci al Servi ces	Supervi sors	Nurses	
		1. 00	2.00	3. 00	4.00	5. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2. 00	Capital Related Costs-Brug and Trxt.						2.00
3. 00	Plant Operation and Maintenance	0	0			0	3.00
4. 00	Transportation - Staff		0			0	4.00
5. 00	Volunteer Service Coordination		o			0	5.00
6. 00	Administrative and General	98, 817	o			0	6.00
0.00	I NPATI ENT CARE SERVI CE	70,017	<u> </u>		9		0.00
7. 00	Inpatient - General Care	0	0		0 0	64, 180	7.00
8. 00	Inpati ent - Respi te Care	0	ol		ol ol	0 1, 100	
0.00	VI SI TI NG SERVI CES	9	<u> </u>		31 31		0.00
9.00	Physician Services	0	O		0 0	0	9.00
10.00	Nursing Care	o	ol		ol ol	0	10.00
	Nursing Care-Continuous Home Care	o	o		o o	0	11.00
	Physical Therapy	o	o		o o	0	12.00
	Occupational Therapy	0	o		0 0	0	13.00
	Speech/ Language Pathology	0	o		0 0	0	14.00
	Medi cal Soci al Servi ces	O	o		0 0	0	15.00
	Spiritual Counseling	O	O		0 0	0	16.00
	Di etary Counsel i ng	0	О		0 0	0	17. 00
18.00	Counseling - Other	0	0		0 0	0	18.00
19.00	Home Health Aide and Homemaker	0	0		0 0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		0 0	0	20.00
21.00	Other	0	0		0 0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Anal gesi cs						23.00
24.00	Sedatives / Hypnotics						24.00
	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26. 00
27.00	Patient Transportation	0	0		0	0	27. 00
28. 00	I maging Services	0	0		0	0	28. 00
29. 00	Labs and Diagnostics	0	0		0	0	29. 00
	Medical Supplies	0	0		0 0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0		0	0	31.00
32.00	Radiation Therapy	0	0		0 0	0	32.00
33. 00	Chemotherapy	0	0		0 0	0	33.00
34.00	Other	0	0		0 0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35. 00	Bereavement Program Costs	0	0		0 0	0	35.00
36.00	Volunteer Program Costs	0	0		0 0	0	36.00
37. 00	Fundrai si ng	0	0		0 0	0	37.00
38. 00	Other Program Costs	0	0		0 0	0	38.00
39.00	Total (sum of lines 1 thru 38)	98, 817	0		0 0	64, 180	39.00

Heal th	Financial Systems	DAVIESS COMMUN	IITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPI (	E COMPENSATION ANALYSIS SALARIES AND WAGES		Provi der	CCN: 150061	Peri od:	Worksheet K-1	
			Hospi ce (	CCN: 151553			pared: 29 pm
					Hospi ce I		
		Total Therapi sts	Ai des	All-Other	Total (1)		
		6. 00	7. 00	8. 00	9. 00		
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance		0	1	0		3.00
4.00	Transportation - Staff		0	1	0		4.00
5.00	Volunteer Service Coordination		0	1	0		5.00
6.00	Administrative and General		0	19, 3	15 118, 132		6.00
	I NPATI ENT CARE SERVI CE						
7.00	Inpatient - General Care		0	1	0 64, 180		7.00
8.00	Inpatient - Respite Care		0		0 0		8. 00
	VISITING SERVICES						
9.00	Physician Services		0		0 0		9. 00
	Nursing Care		0		0		10.00
11. 00	Nursing Care-Continuous Home Care		0		0		11.00
	Physi cal Therapy	0	0	1	0 0		12.00
	Occupational Therapy	0	0	1	0 0		13.00
14. 00	Speech/ Language Pathology	0	0	l	0 0		14.00

15.00

16.00

17.00

18.00

19.00

20.00 21.00

22.00

23.00

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19, 315

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36, 737

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36, 737

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219, 049

36, 737

Anal gesi cs

Spiritual Counseling

Dietary Counseling

Speech/ Language Pathology Medical Social Services

Counseling - Other Home Health Aide and Homemaker

Durable Medical Equipment/Oxygen

HOSPICE NONREIMBURSABLE SERVICE

Bereavement Program Costs

Volunteer Program Costs

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

OTHER HOSPICE SERVICE COSTS

Sedatives / Hypnotics Other - Specify

Pati ent Transportation

Labs and Diagnostics

I maging Services

Medical Supplies

Radiation Therapy

 ${\tt Chemotherapy}$ 

Fundrai si ng

0ther

HH Aide & Homemaker - Cont. Home Care

Drugs, Biological and Infusion Therapy

Outpatient Services (including E/R Dept.)

15.00

16.00

17.00

18.00

19.00

20.00

22. 00

23.00

24.00

25.00

26.00

27.00

28.00

29.00

30.00

31.00

32.00 33.00

34.00

35.00

36.00

Heal th Financial Systems DAVIESS COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10 HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES Provider CCN: 150061 Hospice CCN: 151553 To 12/31/2014 Date/Time Prepared:

			nospi ce (	JON. 131333	10 12/31/2014	5/21/2015 12:	
					Hospi ce I		
		Admi ni strator	Di rector	Soci al Servi ces	Supervi sors	Nurses	
		1. 00	2.00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0		0 0	0	3.00
4.00	Transportation - Staff	0	0		0 0	0	4.00
5.00	Volunteer Service Coordination	0	0		0 0	0	5.00
6.00	Administrative and General	0	0		0 0	0	6. 00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	1	0	156, 344	7. 00
8.00	Inpatient - Respite Care	0	0		0 0	0	8. 00
	VISITING SERVICES						
9.00	Physi ci an Servi ces	0	0		0	0	9. 00
10.00	Nursi ng Care	0	0		0	0	10.00
11. 00	Nursing Care-Continuous Home Care	0	0		0	0	11. 00
12.00	Physi cal Therapy	0	0		0	0	12.00
13.00	Occupational Therapy	0	0		0	0	13.00
14.00	Speech/ Language Pathology	0	0		0	0	14.00
15. 00	Medical Social Services	0	0		0	0	15.00
16.00	Spiritual Counseling	0	0		0	0	16. 00
17. 00		0	0		0	0	17. 00
18. 00	Counseling - Other	0	0		0	0	18. 00
19. 00	Home Health Aide and Homemaker	0	0		0	0	19. 00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		0	0	20.00
21. 00	Other	0	0		0 0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
	Drugs, Biological and Infusion Therapy						22. 00
23. 00							23. 00
24. 00	1						24.00
25. 00	Other - Specify						25.00
26. 00	Durable Medical Equipment/Oxygen						26. 00
27. 00	Patient Transportation	0	0		0	0	27. 00
28. 00	I maging Services	0	0		0	0	28. 00
29. 00	Labs and Diagnostics	0	0		0	0	29. 00
30.00	Medical Supplies	0	0		0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0		0	0	31.00
32.00	Radiation Therapy	0	0		0	0	32.00
33. 00	Chemotherapy	0	0		0	0	33.00
34.00	Other	0	0		0 0	0	34.00
05 00	HOSPI CE NONREI MBURSABLE SERVI CE			ı			
	Bereavement Program Costs	0	0	•	0 0	0	35.00
36.00	Volunteer Program Costs	0	0		0 0	0	36.00
37. 00	Fundrai si ng	0	0		0	0	37.00
38.00	Other Program Costs	0	0		0 0	154 244	38.00
39.00	Total (sum of lines 1 thru 38)	١	0	1	0 0	156, 344	39.00

Health Financial Systems	DAVIESS COMMUNITY HOSPITAL	1	n Lieu of Form CMS-2552-10
HOSPICE COMPENSATION ANALYSIS CONTRA	ED SERVICES/PURCHASED SERVICES Provider	CCN: 150061 Peri od: From 01/01	Worksheet K-3
	Hospi ce C		/2014 Date/Time Prepared: 5/21/2015 12:29 pm
		Hospi ce	1

			Hospi ce (	CCN: 151553	To 12/31/2014	Date/Time Prepared:
					Hospi ce I	5/21/2015 12: 29 pm
		Total	Ai des	All-Other	Total (1)	
		Therapi sts	Ai des	Air-other	10(a) (1)	
		6. 00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS	0.00	7.00	0.00	7.00	
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance		0		o o	3.00
4.00	Transportation - Staff		0		o o	4.00
5.00	Volunteer Service Coordination		0		o o	5.00
6.00	Administrative and General		0		0 0	6.00
	INPATIENT CARE SERVICE	· · · · · · · · · · · · · · · · · · ·				
7.00	Inpatient - General Care		0		0 156, 344	7.00
8.00	Inpatient - Respite Care		0		0 0	8.00
	VISITING SERVICES					
9.00	Physi ci an Servi ces		0		0 0	9. 00
10.00	Nursi ng Care		0		0 0	10.00
11.00	Nursing Care-Continuous Home Care		0		0 0	11.00
12.00	Physi cal Therapy	0	0		0 0	12.00
13.00	Occupational Therapy	0	0		0 0	13.00
14.00	Speech/ Language Pathology	0	0		0 0	14.00
15.00	Medical Social Services		0		0 0	15.00
16.00	Spiritual Counseling		0		0 0	16.00
17.00	Di etary Counsel i ng		0		0 0	17.00
18.00	Counseling - Other		0		0 0	18.00
19.00	Home Health Aide and Homemaker		0		0 0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0		0 0	20.00
21.00	Other		0		0 0	21.00
	OTHER HOSPICE SERVICE COSTS					
22. 00	Drugs, Biological and Infusion Therapy					22. 00
	Anal gesi cs					23. 00
24.00	Sedatives / Hypnotics					24.00
	Other - Specify					25. 00
26. 00	Durable Medical Equipment/Oxygen					26. 00
27. 00	•		0		0	27. 00
28. 00	I maging Services		0		0	28. 00
29. 00			0		0	29. 00
30. 00	Medical Supplies		0		0	30.00
31. 00	, ,		0		0	31.00
32.00	Radiation Therapy		0		0	32.00
33.00	Chemotherapy		0		0	33.00
34.00	Other		0		0 0	34.00
05.65	HOSPI CE NONREI MBURSABLE SERVI CE	1	_	ı	al =1	05.55
35.00			0	l .	0 0	35.00
36.00			0		0 0	36.00
37.00	9		0		0 0	37.00
38.00	Other Program Costs		0		0 0	38.00
39.00	Total (sum of lines 1 thru 38)	0	0	1	0 156, 344	39.00

			nospi ce (	JON. 131333 1	0 12/31/2014	5/21/2015 12:	
					Hospi ce I	0,21,2010 121	<u> </u>
			CAPLTAL RE	LATED COST			
			0,11 1 1,12 112	.225 0001			
		NET EXPENSES	BUI LDI NGS &	MOVABLE	PLANT	TRANSPORTATIO	
		FOR COST	FIXTURES	EQUI PMENT	OPERATION &	N	
		ALLOCATI ON	1171101120		MAI NT.		
		0	1. 00	2.00	3. 00	4. 00	
	GENERAL SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·		•			
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1.00
2.00	Capital Related Costs-Movable Equip.	o		0			2.00
3.00	Plant Operation and Maintenance	o	0	0	0		3.00
4.00	Transportation - Staff	22, 274	0	0	0	22, 274	4.00
5.00	Volunteer Service Coordination	l ol	0	o o	0		5.00
6.00	Administrative and General	181, 622	0	o o	0	0	
	INPATIENT CARE SERVICE	1 121, 2==	-				1
7.00	Inpatient - General Care	220, 524	0	0	0	22, 274	7. 00
8. 00	Inpatient - Respite Care	o	0		0	·	1
	VI SI TI NG SERVI CES						
9.00	Physi ci an Servi ces	0	0	0	0	0	9.00
10.00	Nursing Care	o	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	o	0	0	0	0	11.00
12.00	Physical Therapy	ol	0	0	0	l 0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14. 00	Speech/ Language Pathology	o o	0	Ō	0	0	14. 00
15. 00	Medical Social Services		0		0	0	15. 00
16. 00	Spiritual Counseling		0	· ·	0	0	16. 00
17. 00	Di etary Counsel i ng		0	_	0	0	17. 00
18. 00	Counseling - Other		0		0	0	18.00
19. 00	Home Health Aide and Homemaker	36, 737	0	_	0	0	19.00
20. 00	HH Ai de & Homemaker - Cont. Home Care	30, 737	0	_	0	· -	20.00
21. 00	Other		0		0	1	
21.00	OTHER HOSPICE SERVICE COSTS	<u> </u>		1			21.00
22. 00	Drugs, Biological and Infusion Therapy	O	0	0	0	0	22.00
23. 00	Anal gesi cs		0		0	1	23. 00
24. 00	Sedatives / Hypnotics		0	1	0	0	24.00
25. 00	Other - Specify		0	0	0	0	25.00
26. 00	Durable Medical Equipment/Oxygen		0	_	0	0	26. 00
27. 00	Pati ent Transportation		0		0	0	27. 00
28. 00	I maging Services		0	_	0	· -	28.00
29. 00	Labs and Diagnostics		0		0	0	29.00
30. 00	Medical Supplies		0	0	0	0	30.00
31. 00	Outpatient Services (including E/R Dept.)		0	0	0	0	31.00
32.00	Radi ati on Therapy		0	_	0	0	32.00
	1 3	0	-	_	0		
33. 00 34. 00	Chemotherapy	0	0		0		33. 00 34. 00
34.00	Other HOSPICE NONREIMBURSABLE SERVICE	l ol	0	<u> </u>	0	0	34.00
35. 00	Bereavement Program Costs	O	0	0	0	0	35.00
36. 00	Volunteer Program Costs		0	1	0		36.00
37. 00	Fundrai si ng		0	0		0	37.00
38. 00	Other Program Costs		0	0		0	38.00
	Total (sum of lines 1 thru 38)	461, 157	0	1	0	1	
37.00	Tiotal (Suil of Filles I till a 30)	401, 137	0	1 0	1	1 22,274	J 57. UU

Health Financial Systems	DAVIESS COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION - HOSPICE GENERAL SERVICE COST	Provi der CCN: 150061	Peri od: Worksheet K-4 From 01/01/2014 Part I
		11011 0170172014 14111

			Hospi ce (		To 12/31/2014	Date/Time Prepared: 5/21/2015 12:29 pm
					Hospi ce I	5/21/2015 12: 29 piii
		VOLUNTEER	SUBTOTAL	ADMINI CEDATIA		
				ADMI NI STRATI V		
		SERVI CES	(col s. 0 - 5)	E & GENERAL	5A ± col. 6)	
		COORDI NATOR	ГА	/ 00	7.00	
	CENEDAL CEDVICE COCT CENTEDS	5. 00	5A	6. 00	7. 00	
1 00	GENERAL SERVICE COST CENTERS	I	I	T	T	1.00
1.00	Capital Related Costs-Bldg and Fixt.	•				1.00
2.00	Capital Related Costs-Movable Equip.					2.00
3. 00	Plant Operation and Maintenance					3.00
4. 00	Transportation - Staff					4.00
5.00	Volunteer Service Coordination	0				5. 00
6. 00	Administrative and General	0	181, 622	181, 62	2	6. 00
	INPATIENT CARE SERVICE					
7. 00	Inpatient - General Care	0				7.00
8. 00	Inpatient - Respite Care	0	0	)	0 0	8. 00
	VISITING SERVICES					
9. 00	Physi ci an Servi ces	0		l	0 0	9.00
10.00	Nursi ng Care	0	0	)	0 0	10.00
11. 00	Nursing Care-Continuous Home Care	0	0		0 0	11.00
12.00	Physical Therapy	0	0	)	o l	12.00
13.00	Occupational Therapy	0	0	)	ol o	13.00
14.00	Speech/ Language Pathology	0	0		ol ol	14.00
15. 00	Medical Social Services	0		)		15. 00
16. 00	Spiritual Counseling	0	0			16. 00
17. 00	Di etary Counsel i ng					17. 00
	Counseling - Other					18. 00
19. 00	Home Health Aide and Homemaker		_	1	9	19.00
20. 00	HH Ai de & Homemaker - Cont. Home Care		1	1	00,000	20.00
21. 00	Other					21.00
21.00	OTHER HOSPICE SERVICE COSTS			'	<u> </u>	21.00
22. 00	Drugs, Biological and Infusion Therapy	0	0	1	0	22.00
23. 00	Anal gesi cs		l .	•		23. 00
24. 00	Sedatives / Hypnotics			1		24.00
25. 00	Other - Specify					25.00
26. 00	, ,					26.00
	Durable Medical Equipment/Oxygen			1		
27. 00	Pati ent Transportation	0	_	1		27.00
28. 00	I maging Services	0	0	1	0	28.00
29. 00	Labs and Diagnostics	0	0	1	0	29.00
30. 00	Medical Supplies	0	0	1	0	30.00
31. 00	Outpatient Services (including E/R Dept.)	0	0	1	0	31.00
32. 00	Radiation Therapy	0	0	1	0	32.00
33. 00	Chemotherapy	0	_	l	0	33.00
34. 00	Other	0	0	)	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE					
35.00	Bereavement Program Costs	0	0	)	0 0	35.00
36.00	Volunteer Program Costs	0	0	)	0 0	36.00
37.00	Fundrai si ng	0	0	)	0 0	37.00
38.00	Other Program Costs	0	0	)	o	38.00
39.00	Total (sum of lines 1 thru 38)	0	461, 157	1	461, 157	39. 00
						*

To 5/21/2015 12:29 pm Hospi ce I CAPITAL RELATED COST BULLDINGS & MOVABLE PLANT TRANSPORTATI O VOLUNTEER FIXTURES (SQ. EQUIPMENT (\$ OPERATION & N (MI LEAGE) SERVI CES VALUE) MAINT. (SQ. COORDI NATOR FT.) FT.) (HOURS) 1. 00 3. 00 2.00 4.00 5. 00 GENERAL SERVICE COST CENTERS 1.00 Capital Related Costs-Bldg and Fixt. 0 1.00 Capital Related Costs-Movable Equip. 2.00 2.00 0 0 Plant Operation and Maintenance 0 0 3.00 3.00 0 4.00 Transportation - Staff 0 22, 274 4.00 5.00 Volunteer Service Coordination 0 0 0 0 5.00 Administrative and General 0 0 0 0 6.00 6.00 0 INPATIENT CARE SERVICE Inpatient - General Care Inpatient - Respite Care 7.00 0 0 0 22, 274 0 7.00 8.00 0 0 0 8.00 VISITING SERVICES 9.00 Physician Services 9 00 0 0 0 10.00 Nursing Care 0 0 0 0 0 10.00 Nursing Care-Continuous Home Care 0 0 11.00 0000000000 0 0 0 11.00 Physical Therapy 0 0 12.00 12 00 0 0 13.00 Occupational Therapy 0 0 13.00 14.00 Speech/ Language Pathology 0 0 0 14.00 0 0 0 0 Medical Social Services 0 15.00 0 0 15.00 Spiritual Counseling 0 0 16.00 16.00 0 0 17.00 Dietary Counseling 0 0 17.00 Counseling - Other 0 0 0 18.00 0 Home Health Aide and Homemaker 0 19.00 0 0 19.00 0 20 00 HH Aide & Homemaker - Cont. Home Care Ω 20.00 0 0 21.00 Other 0 0 0 21.00 OTHER HOSPICE SERVICE COSTS 0 Drugs, Biological and Infusion Therapy 0 0 0 22.00 22.00 23.00 0 0 0 0 23.00 Anal desi cs 0 0 24.00 Sedatives / Hypnotics 000000000 0 0 24.00 Other - Specify 25.00 0 0 0 0 0 0 0 0 0 25.00 26.00 Durable Medical Equipment/Oxygen 0 0 0 26.00 0 27.00 Patient Transportation 0 0 27.00 Imaging Services 0 28.00 28.00 29.00 Labs and Diagnostics 0 0 0 29.00 Medical Supplies 0 30.00 30.00 0 0 0 31.00 Outpatient Services (including E/R Dept.) 0 0 31.00 32.00 Radiation Therapy 0 0 0 0 32.00 0 0 Chemotherapy 0 0 33.00 33.00 0 0 0 34.00 0ther 0 34.00 HOSPICE NONREIMBURSABLE SERVICE 35.00 Bereavement Program Costs 0 0 35.00 Volunteer Program Costs 36.00 0 C 0 0 0 36.00 0 37.00 Fundrai si ng 0 0 0 0 37.00 38.00 Other Program Costs 0 0 0 38.00 39.00 Cost to be Allocated (per Wkst. K-4, Part I) 0 22, 274 0 39.00

0.000000

0.000000

0.000000

1.000000

0.000000

40.00

40.00 Unit Cost Multiplier

				•		5/	/21/2015 12	:29 pm
					Hospi ce	I		
		RECONCI LI ATI O	ADMI NI S	TRATI V				
		N	E & GEN	NERAL				
			(ACC. (	COST)				
		6A	6.0	00				
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.	0						1.00
2.00	Capital Related Costs-Movable Equip.	0						2.00
3.00	Plant Operation and Maintenance	0						3.00
4.00	Transportation - Staff	0						4.00
5.00	Volunteer Service Coordination							5. 00
6.00	Administrative and General	-181, 622	2	79, 535				6. 00
	I NPATI ENT CARE SERVI CE							
7. 00	Inpatient - General Care	0		42, 798				7. 00
8.00	Inpatient - Respite Care	0		0				8. 00
	VI SI TI NG SERVI CES							
9. 00	Physician Services	0	l .	0				9. 00
	Nursing Care	0		0				10.00
	Nursing Care-Continuous Home Care	0		0				11. 00
	Physi cal Therapy	0		0				12.00
	Occupational Therapy	0		0				13.00
	Speech/ Language Pathology	0		0				14.00
	Medical Social Services	0		0				15. 00
	Spiritual Counseling	0		0				16. 00
	Di etary Counseling	0		0				17. 00
	Counseling - Other	0		0				18. 00
	Home Health Aide and Homemaker	0		36, 737				19. 00
20.00	HH Aide & Homemaker - Cont. Home Care	0	l .	0				20.00
21. 00	Other	0		0				21. 00
	OTHER HOSPICE SERVICE COSTS	T						
	Drugs, Biological and Infusion Therapy	0	li .	0				22. 00
	Anal gesi cs	0	)	0				23.00
	Sedatives / Hypnotics	0	)	0				24.00
	Other - Specify	0	)	0				25.00
	Durable Medical Equipment/Oxygen	0	)	0				26. 00
	Pati ent Transportati on	0	)	0				27. 00
	I maging Services	0		0				28. 00
	Labs and Diagnostics	0	)	0				29. 00
	Medical Supplies	0		0				30.00
31.00	Outpatient Services (including E/R Dept.)	0	)	0				31.00
32.00	Radiation Therapy	0	)	0				32.00
33. 00	Chemotherapy	0	)	0				33.00
34.00	Other	0	9	0				34.00
05.00	HOSPI CE NONREI MBURSABLE SERVI CE							05.00
	Bereavement Program Costs	0		0				35.00
	Volunteer Program Costs	0		0				36.00
	Fundrai si ng	0		0				37.00
	Other Program Costs	0		0				38.00
39. 00	1 ''		1	81, 622				39.00
40. 00	Unit Cost Multiplier	l	0.	649729				40.00

Provi der CCN: 150061 | Peri od: From 01/01/2014 | Part I | Date/Ti me Prepared: 5/21/2015 12: 29 pm

						5/21/2015 12:	29 pm
					Hospi ce I		
			CAPI TAL REI	_ATED COSTS			
	Cost Center Description	Hospice Trial	NEW BLDG &	NEW MVBLE	EMPLOYEE	Subtotal	
		Bal ance (1)	FLXT	EQUI P	BENEFITS		
					DEPARTMENT		
		0	1.00	2.00	4. 00	4A	
1. 00	Administrative and General		0	0	28, 543	28, 543	1.00
2.00	Inpatient - General Care	400, 551	5, 515	0	15, 508	421, 574	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physi ci an Servi ces	O	0	0	0	0	4.00
5.00	Nursing Care	o	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	o	0	0	0	0	6.00
7.00	Physical Therapy	o	0	0	0	0	7.00
8.00	Occupational Therapy	o	0	l 0	0	0	8.00
9. 00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11. 00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Di etary Counsel i ng	0	0	0	0	0	12.00
13. 00	Counseling - Other	0	0	0	0	0	13.00
14. 00	Home Health Aide and Homemaker	60, 606	0	0	8, 877	69, 483	
15. 00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0,011	0	15.00
16. 00	Other	0	n	0	0	Ö	16.00
17. 00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18. 00	Anal gesi cs	0	0	0	0	0	18.00
19. 00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21. 00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22. 00	Pati ent Transportati on	0	0	0	0	Ö	22.00
23. 00	I maging Services	0	0	0	0	Ö	23. 00
24. 00	Labs and Diagnostics	0	0	0	0	Ö	24.00
25. 00	Medical Supplies	0	0	0	0	0	25.00
26. 00	Outpatient Services (including E/R Dept.)		0	0	0	0	26.00
27. 00	Radi ati on Therapy		0	0	0	0	27.00
28. 00	Chemotherapy		0	0	0	0	28.00
29. 00	Other	0	0		0	0	29.00
30.00	Bereavement Program Costs	0	0		0	0	30.00
31.00	Volunteer Program Costs		0			0	31.00
31.00	Fundrai si ng		0			0	32.00
32.00	Other Program Costs		0			0	32.00
34. 00	Total (sum of lines 1 thru 33) (2)	461, 157	U E E1E	0	52, 928	519, 600	
	Unit Cost Multiplier (see instructions)	401, 157	5, 515		52, 928	0.000000	
33.00	John Cost Martipiner (See Histractions)	1		I		0.000000	33.00

 Provi der CCN:
 150061
 Peri od: From 01/01/2014
 Worksheet K-5

 Hospi ce CCN:
 151553
 To
 12/31/2014
 Date/Ti me Prepared: 5/21/2015
 12: 29 pm

Note   Cost Center Description   ADMINISTRATIV   MAINTENANCE & OPERATION   LAUNDRY & LINEN SERVICE
Comparison   Com
1.00   Administrative and General   9,474   0   0   0   0   0   1.00
1.00         Administrative and General         9, 474         0         0         0         1.00           2.00         Inpatient - General Care         139, 933         5,091         7,563         0         3,488         2.00           3.00         Inpatient - Respite Care         0
2.00         Inpatient - General Care         139, 933         5,091         7,563         0         3,488         2.00           3.00         Inpatient - Respite Care         0         0         0         0         0         0         3.00           4.00         Physician Services         0         0         0         0         0         0         0         4.00           5.00         Nursing Care         0
3.00       Inpatient - Respite Care       0       0       0       0       0       3.00         4.00       Physician Services       0
4. 00       Physician Services       0       0       0       0       0       4. 00         5. 00       Nursing Care       0       0       0       0       0       0       5. 00         6. 00       Nursing Care-Continuous Home Care       0        0
5.00         Nursing Care         0         0         0         0         0         5.00           6.00         Nursing Care-Continuous Home Care         0
6.00         Nursing Care-Continuous Home Care         0
7. 00         Physical Therapy         0         0         0         0         7.00           8. 00         Occupational Therapy         0         0         0         0         0         0         0         8.00           9. 00         Speech/ Language Pathology         0         0         0         0         0         0         9.00           10. 00         Medical Social Services         0         <
8.00 Occupational Therapy 0 0 0 0 0 0 0 0 8.00 9.00 Speech/ Language Pathology 0 0 0 0 0 0 0 0 9.00 10.00 Medical Social Services 0 0 0 0 0 0 0 10.00 11.00 Spiritual Counseling 0 0 0 0 0 0 11.00 12.00 Dietary Counseling 0 0 0 0 0 0 12.00 13.00 Counseling - Other 0 0 0 0 0 0 13.00 14.00 Home Health Aide and Homemaker 23,063 0 0 0 0 14.00 15.00 HH Aide & Homemaker - Cont. Home Care 0 0 0 0 0 0 15.00 16.00 Other 0 0 0 0 0 0 0 16.00 17.00 Drugs, Biological and Infusion Therapy 0 0 0 0 0 0 18.00 19.00 Sedatives / Hypnotics 0 0 0 0 0 0 0 0 18.00 20.00 Other - Specify 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
9.00   Speech   Language Pathology   0   0   0   0   0   0   0   0   10.00   10.00   10.00   Medical Social Services   0   0   0   0   0   0   10.00   11.00   11.00   11.00   12.00   12.00   12.00   12.00   13.00   13.00   13.00   13.00   13.00   14.00   14.00   14.00   15.00   14.00   15.00   16.00   16.00   16.00   16.00   16.00   17.00   17.00   18.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.10   19.00   19.10
10.00       Medical Social Services       0       0       0       0       0       10.00         11.00       Spiritual Counseling       0       0       0       0       0       0       11.00         12.00       Dietary Counseling       0       0       0       0       0       0       0       0       12.00         13.00       Counseling - Other       0       0       0       0       0       0       0       0       13.00         14.00       Home Health Aide and Homemaker       23,063       0       0       0       0       14.00       0       0       0       14.00       0       0       0       14.00       0       0       0       0       0       14.00       0       0       0       0       0       14.00       0       0       0       0       14.00       0       0       0       0       0       14.00       0 <t< td=""></t<>
11. 00       Spiritual Counseling       0       0       0       0       0       11. 00         12. 00       Dietary Counseling       0       0       0       0       0       0       12. 00         13. 00       Counseling - Other       0       0       0       0       0       0       0       0       13. 00         14. 00       Home Health Aide and Homemaker       23, 063       0       0       0       0       0       14. 00         15. 00       HH Aide & Homemaker - Cont. Home Care       0       0       0       0       0       0       0       0       15. 00         16. 00       Other       0       0       0       0       0       0       0       0       0       16. 00         17. 00       Drugs, Biological and Infusion Therapy       0       0       0       0       0       0       0       0       17. 00         18. 00       Analgesics       0       0       0       0       0       0       0       0       0       18. 00         19. 00       Sedatives / Hypnotics       0       0       0       0       0       0       0       0       0 </td
12.00       Di etary Counseling       0       0       0       0       0       12.00         13.00       Counseling - Other       0       0       0       0       0       0       13.00         14.00       Home Health Aide and Homemaker       23,063       0       0       0       0       14.00         15.00       HH Aide & Homemaker - Cont. Home Care       0       0       0       0       0       0       0       15.00         16.00       Other       0       0       0       0       0       0       0       0       16.00         17.00       Drugs, Biological and Infusion Therapy       0       0       0       0       0       0       17.00         18.00       Anal gesics       0       0       0       0       0       18.00         19.00       Sedatives / Hypnotics       0       0       0       0       0       0       19.00         20.00       Other - Specify       0       0       0       0       0       0       0       20.00         21.00       Durable Medical Equipment/0xygen       0       0       0       0       0       0       0
12.00       Di etary Counseling       0       0       0       0       0       12.00         13.00       Counseling - Other       0       0       0       0       0       0       13.00         14.00       Home Health Aide and Homemaker       23,063       0       0       0       0       14.00         15.00       HH Aide & Homemaker - Cont. Home Care       0       0       0       0       0       0       0       15.00         16.00       Other       0       0       0       0       0       0       0       0       16.00         17.00       Drugs, Biological and Infusion Therapy       0       0       0       0       0       0       17.00         18.00       Anal gesics       0       0       0       0       0       18.00         19.00       Sedatives / Hypnotics       0       0       0       0       0       0       19.00         20.00       Other - Specify       0       0       0       0       0       0       0       20.00         21.00       Durable Medical Equipment/0xygen       0       0       0       0       0       0       0
14.00     Home Heal th Ai de and Homemaker     23,063     0     0     0     0     14.00       15.00     HH Ai de & Homemaker - Cont. Home Care     0     0     0     0     0     0     15.00       16.00     Other     0     0     0     0     0     0     16.00       17.00     Drugs, Biological and Infusion Therapy     0     0     0     0     0     0     17.00       18.00     Anal gesics     0     0     0     0     0     0     18.00       19.00     Sedatives / Hypnotics     0     0     0     0     0     0     19.00       20.00     Other - Specify     0     0     0     0     0     0     20.00       21.00     Durable Medical Equipment/Oxygen     0     0     0     0     0     21.00       22.00     Patient Transportation     0     0     0     0     0     0     22.00
15.00 HH Ai de & Homemaker - Cont. Home Care 0 0 0 0 0 0 15.00 16.00 Other 0 0 0 0 0 0 16.00 17.00 Drugs, Biological and Infusion Therapy 0 0 0 0 0 0 17.00 18.00 Analgesics 0 0 0 0 0 0 18.00 19.00 Sedatives / Hypnotics 0 0 0 0 0 0 19.00 20.00 Other - Specify 0 0 0 0 0 0 20.00 21.00 Durable Medical Equipment/Oxygen 0 0 0 0 0 22.00 22.00 Patient Transportation 0 0 0 0 0 0 22.00
16.00     Other     0     0     0     0     0     16.00       17.00     Drugs, Biological and Infusion Therapy     0     0     0     0     0     17.00       18.00     Anal gesics     0     0     0     0     0     18.00       19.00     Sedatives / Hypnotics     0     0     0     0     0     19.00       20.00     Other - Specify     0     0     0     0     0     20.00       21.00     Durable Medical Equipment/Oxygen     0     0     0     0     21.00       22.00     Patient Transportation     0     0     0     0     0     0
17. 00       Drugs, Biological and Infusion Therapy       0       0       0       0       17. 00         18. 00       Anal gesics       0       0       0       0       0       18. 00         19. 00       Sedatives / Hypnotics       0       0       0       0       0       19. 00         20. 00       Other - Specify       0       0       0       0       0       0       20. 00         21. 00       Durable Medical Equipment/0xygen       0       0       0       0       0       21. 00         22. 00       Patient Transportation       0       0       0       0       0       0       22. 00
18.00     Anal gesics     0     0     0     0     18.00       19.00     Sedatives / Hypnotics     0     0     0     0     0     19.00       20.00     Other - Specify     0     0     0     0     0     0     0     0     20.00       21.00     Durable Medical Equipment/Oxygen     0     0     0     0     0     0     21.00       22.00     Patient Transportation     0     0     0     0     0     0     22.00
19.00     Sedatives / Hypnotics     0     0     0     0     19.00       20.00     Other - Specify     0     0     0     0     0     0     20.00       21.00     Durable Medical Equipment/Oxygen     0     0     0     0     0     0     21.00       22.00     Patient Transportation     0     0     0     0     0     22.00
19.00     Sedatives / Hypnotics     0     0     0     0     19.00       20.00     Other - Specify     0     0     0     0     0     0     20.00       21.00     Durable Medical Equipment/Oxygen     0     0     0     0     0     0     21.00       22.00     Patient Transportation     0     0     0     0     0     0     22.00
20.00     Other - Specify     0     0     0     0     0     20.00       21.00     Durable Medical Equipment/Oxygen     0     0     0     0     0     21.00       22.00     Patient Transportation     0     0     0     0     0     0     22.00
22.00 Patient Transportation 0 0 0 0 22.00
22.00 Patient Transportation 0 0 0 0 22.00
24.00 Labs and Diagnostics 0 0 0 0 24.00
25.00 Medical Supplies 0 0 0 0 25.00
26.00 Outpatient Services (including E/R Dept.) 0 0 0 26.00
27.00 Radiation Therapy 0 0 0 0 27.00
28.00 Chemotherapy 0 0 0 0 28.00
29.00 Other 0 0 0 0 29.00
30.00 Bereavement Program Costs 0 0 0 0 0 30.00
31.00 Volunteer Program Costs 0 0 0 0 31.00
32.00 Fundraising 0 0 0 0 0 32.00
33.00 Other Program Costs 0 0 0 0 33.00
34.00 Total (sum of lines 1 thru 33) (2) 172,470 5,091 7,563 0 3,488 34.00
35.00 Unit Cost Multiplier (see instructions) 35.00

Health Financial Systems DAVIESS CALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS Provi der CCN: 150061 | Peri od: | Worksheet K-5 | Pori od: | From 01/01/2014 | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part |

						5/21/2015 12:	29 pm_
					Hospi ce I		
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
				ADMI NI STRATI O	SERVICES &		
				N	SUPPLY		
		10. 00	11. 00	13. 00	14.00	15. 00	
1.00	Administrative and General	0	0	0	0	0	1.00
2.00	Inpatient - General Care	0	7, 683	29, 142	14, 529	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physi ci an Servi ces	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5. 00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6. 00
7.00	Physi cal Therapy	0	0	0	0	0	7. 00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9. 00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Di etary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	0ther	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17. 00
18.00	Anal gesi cs	0	0	0	0	0	18. 00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19. 00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	I maging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medi cal Supplies	0	0	0	0	0	25. 00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radi ati on Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28. 00
29.00	0ther	0	0	0	0	0	29. 00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundrai si ng	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	7, 683	29, 142	14, 529	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35. 00

Provi der CCN: 150061 | Peri od: | Worksheet K-5 | Part | | Hospi ce CCN: 151553 | To 12/31/2014 | Date/Time Prepared: | Date/Time Prepared: | F/31/2015 | 13:30 | Provider CCN: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Part | Prepared: | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | P

			oop. oo o	70.11		5/21/2015 12:	29 pm
					Hospi ce I		
	Cost Center Description	MEDI CAL	SOCI AL	Subtotal	Intern &	Subtotal	
		RECORDS &	SERVI CE	(col s. 4A-23)	Resi dents	(col s. 24 ±	
		LI BRARY			Cost & Post	25)	
					Stepdown		
					Adjustments		
		16. 00	17. 00	24.00	25. 00	26.00	
1.00	Administrative and General	0	0	38, 017			1.00
2.00	Inpatient - General Care	11, 558	55, 077	695, 638	0	695, 638	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physi cal Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Di etary Counsel i ng	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	92, 546	0	92, 546	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Anal gesi cs	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	I maging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundrai si ng	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	11, 558	55, 077	826, 201	0	826, 201	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

In Lieu of Form CMS-2552-10 Health Financial Systems DAVIESS COMMUNITY HOSPITAL ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS Provi der CCN: 150061 Peri od: Worksheet K-5

From 01/01/2014 To 12/31/2014 Part I Date/Time Prepared: Hospi ce CCN: 151553 5/21/2015 12:29 pm

22.00

23.00

24.00

25.00

26.00

27.00

28.00

29.00

30.00

31.00

32.00

33.00

34.00

35.00

Hospi ce I Cost Center Description Allocated Total Hospice Costs (cols. Hospi ce A&G (See Part II) 26 ± 27) 27. 00 28.00 1.00 Administrative and General 1.00 2.00 Inpatient - General Care 33, 553 729, 191 2.00 3.00 Inpatient - Respite Care 3.00 0 4.00 Physician Services 0 0 4.00 5.00 Nursing Care 0 0 5.00 0 6.00 Nursing Care-Continuous Home Care 00000 6.00 Physical Therapy 7.00 0 7.00 8.00 Occupational Therapy 8.00 9.00 Speech/ Language Pathology 0 9.00 Medical Social Services 0 10.00 10.00 Spiritual Counseling 0 11.00 11.00 12.00 Dietary Counseling 0 0 12.00 13.00 Counseling - Other 0 13.00 Home Health Aide and Homemaker 14.00 4.464 97,010 14.00 15.00 HH Aide & Homemaker - Cont. Home Care 0 0 15.00 16.00 0 16.00 0ther 0 17.00 000000000000000000 0 Drugs, Biological and Infusion Therapy 17.00 18.00 Anal gesi cs 0 18.00 19.00 Sedatives / Hypnotics 19.00 0 20.00 Other - Specify 20.00 Durable Medical Equipment/Oxygen 0 21.00 21.00

0. 048234

0

0

0

0

0

0

0

0

0

0

0

826, 201

22.00

23.00

24.00

25.00

26.00

27.00

28.00

29.00

30.00

31.00

32 00

34.00

Pati ent Transportati on

Bereavement Program Costs

Total (sum of lines 1 thru 33) (2)

35.00 Unit Cost Multiplier (see instructions)

Volunteer Program Costs

Outpatient Services (including E/R Dept.)

Labs and Diagnostics

Imaging Services

Medical Supplies

Radiation Therapy

Chemotherapy

Fundrai si ng

33.00 Other Program Costs

Other

						5/21/2015 12:	29 pm
					Hospi ce I		
	·	CAPITAL RELA	TED COSTS				
	Cost Center Description	NEW BLDG &	NEW MVBLE	EMPLOYEE	Reconciliatio	ADMI NI STRATI V	
	, and the second	FLXT	EQUI P	BENEFITS	n	E & GENERAL	
		(SQUARE	(DOLLAR	DEPARTMENT		(ACCUM. COST)	
		FEET)	VALUE)	(GROSS		, , , , ,	
			***************************************	SALARI ES)			
		1, 00	2.00	4.00	5A	5. 00	
1. 00	Administrative and General	0	0	118, 132		28, 543	1.00
2. 00	Inpatient - General Care	585	0	64, 180		421, 574	2.00
3. 00	Inpatient - Respite Care	0	0	01,100		0	3.00
4. 00	Physician Services		0		0	Ö	4. 00
5. 00	Nursing Care		0		0		5. 00
6. 00	Nursing Care-Continuous Home Care	0	0		0	0	6. 00
7. 00	Physical Therapy	0	0		0		7. 00
8. 00		0	0		0		8. 00
	Occupational Therapy	0	0		0		
9.00	Speech/ Language Pathology	0	0		0	0	9.00
10.00	Medical Social Services	0	0		0	0	10.00
11.00	Spiritual Counseling	0	0		0	0	11.00
12.00	Di etary Counsel i ng	0	0	C	0	0	12.00
13. 00	Counseling - Other	0	0	C	0	0	13.00
14. 00	Home Health Aide and Homemaker	0	0	36, 737	0	69, 483	14.00
15. 00	HH Aide & Homemaker - Cont. Home Care	0	0	(	0	0	15.00
16.00	Other	0	0	C	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	C	0	0	17.00
18.00	Anal gesi cs	0	0	C	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	C	0	0	19.00
20.00	Other - Specify	0	0	C	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	C	0	0	21.00
22.00	Pati ent Transportation	o	0	l c	0	0	22.00
23.00	I maging Services	0	0	l c	0	0	23.00
24.00	Labs and Diagnostics	o	0		0	0	24.00
25.00	Medical Supplies	l ol	0	l c	0	O	25.00
26. 00	Outpatient Services (including E/R Dept.)	o	0		0	0	26.00
27. 00	Radiation Therapy	أم	0		0	o o	27. 00
28. 00	Chemotherapy		0	j .	0	o o	28. 00
29. 00	Other	o o	0		0	0	29. 00
30.00	Bereavement Program Costs		0		0	Ö	30.00
31. 00	Volunteer Program Costs		0		0		31.00
32. 00	Fundrai si ng		0				32.00
33. 00	Other Program Costs		0				33. 00
		[ [	0	210 040	0		34.00
34.00	Total (sum of lines 1 thru 33) (2)	585	0	219, 049		519, 600	
35.00	Total cost to be allocated	5, 515	0 000000	52, 928		172, 470	35.00
36.00	Unit Cost Multiplier (see instructions)	9. 427350	0. 000000	0. 241626	1	0. 331928	36.00

			ноѕрі се (	LCN: 151553   1	0 12/31/2014	5/21/2015 12:	
					Hospi ce I		
	Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		REPAI RS	PLANT	LINEN SERVICE	(SQUARE	(MEALS	
		(SQUARE	(SQUARE	(POUNDS OF	FEET)	SERVED)	
		FEET)	FEET)	LAUNDRY)			
		6. 00	7. 00	8. 00	9. 00	10.00	
1. 00	Administrative and General	0	-			0	
2.00	Inpatient - General Care	585	585		585	0	
3.00	Inpatient - Respite Care	0	0		0	0	
4.00	Physician Services	0	0	1	0	0	
5. 00	Nursing Care	0	0	·	0	0	
6.00	Nursing Care-Continuous Home Care	0	0	1	0	0	
7.00	Physi cal Therapy	0	0	1	0	0	
8.00	Occupational Therapy	0	0	1	0	0	
9.00	Speech/ Language Pathology	0	0	1	_	0	
10.00	Medical Social Services	0	0	1	_	0	
11. 00	Spiritual Counseling	0	0	·	_	0	1
	Di etary Counsel i ng	0	0		0	0	
13. 00	Counseling - Other	0	0	1	0	0	
14. 00	Home Health Aide and Homemaker	0	0	1		0	1
15. 00	HH Aide & Homemaker - Cont. Home Care	0	0	1	_	0	
16.00	Other	0	0	1	_	0	
17. 00	Drugs, Biological and Infusion Therapy	0	0	1	0	0	1
18. 00	Anal gesi cs	0	0		0	0	
	Sedatives / Hypnotics	0	0		· · · · · · · · · · · · · · · · · · ·	0	
	Other - Specify	0	0	_		0	1 -0.00
	Durable Medical Equipment/Oxygen	0	0	_	_	0	21.00
22. 00	Patient Transportation	0	0		· ·	0	
	I maging Services	0	0	_	_	0	
	Labs and Diagnostics	0	0		0	0	
25. 00	Medical Supplies	0	0	_	0	0	
	Outpatient Services (including E/R Dept.)	0	0	_	0	0	
27. 00	Radiation Therapy	0	0	_	0	0	1 -7.00
28. 00	Chemotherapy	0	0		0	0	28. 00
29. 00	Other	0	0	0	0	0	
30.00	Bereavement Program Costs	0	0	0	0	0	
31.00	Volunteer Program Costs	0	0	0	0	0	
32.00	Fundrai si ng	0	0	0	0	0	1 02.00
	Other Program Costs	0	0	_	0	0	
34.00	Total (sum of lines 1 thru 33) (2)	585	585	•	585	0	
35. 00	Total cost to be allocated	5, 091	7, 563	•	3, 488		1 00.00
36.00	Unit Cost Multiplier (see instructions)	8. 702564	12. 928205	0.000000	5. 962393	0. 000000	36.00

			nospi ce c	CIV. 131333 10	12/31/2014	5/21/2015 12:	
					Hospi ce I		
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		(HOURS	ADMINISTRATIO	SERVICES &	(COSTED	RECORDS &	
		PAI D)	N	SUPPLY	REQUIS.)	LI BRARY	
		·	(DI RECT	(COSTED		(GROSS	
			NRSING HRS)	REQUIS.)		CHARGES)	
		11. 00	13. 00	14. 00	15. 00	16.00	
1.00	Administrative and General	0	0	0	0	0	1.00
2.00	Inpatient - General Care	10, 155	10, 155	57, 296	0	846, 110	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursi ng Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physi cal Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Di etary Counsel i ng	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Anal gesi cs	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19. 00
20.00	Other - Specify	0	0	0	0	0	20.00
21. 00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22. 00	Patient Transportation	0	0	0	0	0	22. 00
23.00	I maging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25. 00	Medical Supplies	0	0	0	0	0	25. 00
26. 00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26. 00
27. 00	Radiation Therapy	0	0	0	0	0	27. 00
28. 00	Chemotherapy	0	0	0	0	0	28. 00
29. 00	Other	0	0	0	0	0	29. 00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundrai si ng	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	10, 155			0	846, 110	34.00
35.00	Total cost to be allocated	7, 683			0	11, 558	35.00
36.00	Unit Cost Multiplier (see instructions)	0. 756573	2. 869719	0. 253578	0. 000000	0. 013660	36.00

Health Financial Systems	DAVIESS COMMUNITY H	OSPI TAL	In Lieu	u of Form CMS-2552-10
ALLOCATION OF GENERAL SERVICE COSTS STATISTICAL BASIS		Provider CCN: Hospice CCN:	From 01/01/2014	Worksheet K-5 Part II Date/Time Prepared: 5/21/2015 12:29 pm

				5/21/2015 12:	29 pm_
			Hospi ce I		
	Cost Center Description	SOCI AL			
		SERVI CE			
		(TIME			
		SPENT)			
		17. 00			
1. 00	Administrative and General	0			1.00
2.00	Inpatient - General Care	2, 943			2.00
3.00	Inpatient - Respite Care	0			3.00
4.00	Physician Services	0			4.00
5.00	Nursi ng Care	0			5.00
6.00	Nursing Care-Continuous Home Care	0			6.00
7.00	Physi cal Therapy	0			7. 00
8.00	Occupational Therapy	0			8. 00
9.00	Speech/ Language Pathology	0			9. 00
10.00	Medical Social Services	0			10.00
11.00	Spiritual Counseling	0			11.00
12.00	Di etary Counsel i ng	0			12.00
13.00	Counseling - Other	0			13.00
14.00	Home Health Aide and Homemaker	0			14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0			15.00
16.00	Other	0			16.00
17.00	Drugs, Biological and Infusion Therapy	0			17.00
18. 00	Anal gesi cs	o			18.00
19.00	Sedatives / Hypnotics	o			19.00
20. 00	Other - Specify	0			20.00
21. 00	Durable Medical Equipment/Oxygen	0			21.00
	Pati ent Transportation	0			22.00
23. 00	I maging Services	0			23.00
24. 00	Labs and Diagnostics	0			24.00
25. 00	Medical Supplies	0			25. 00
26. 00	Outpatient Services (including E/R Dept.)	0			26. 00
27. 00	Radi ati on Therapy	0			27. 00
28. 00	Chemotherapy				28.00
29. 00	Other				29. 00
30.00	Bereavement Program Costs				30.00
31. 00	Volunteer Program Costs				31.00
32. 00	Fundrai si ng	0			32.00
33. 00	Other Program Costs	0			33.00
34. 00	Total (sum of lines 1 thru 33) (2)	2, 943			34.00
35. 00	Total cost to be allocated	55, 077			35.00
	Unit Cost Multiplier (see instructions)	18. 714577			36.00
30.00	John Coost Multiplier (see Thistructions)	10.714377		ļ	30.00

Heal th	Financial Systems DAVIESS (	COMMUNITY F	HOSPI TAL		In Lieu of Form CMS-2552-10			
COMPUT	TATION OF TOTAL HOSPICE SHARED COSTS		Provi der	CCN: 150061	Peri od:	Worksheet K-5		
					From 01/01/2014			
			Hospice (	CCN: 151553	To 12/31/2014	Date/Time Pre	pared:	
						5/21/2015 12:	29 pm	
					Hospi ce I			
	Cost Center Description		. C, Part		Total Hospi ce			
		L,	col . 11	Charge Rati		Shared		
			line		(Provi der	Ancillary		
					Records)	Costs (cols.		
						1 x 2)		
			0	1. 00	2. 00	3. 00		
	ANCILLARY SERVICE COST CENTERS							
1.00	PHYSI CAL THERAPY		66. 00	0. 4981	99 0	0	1.00	
2.00	OCCUPATI ONAL THERAPY		67.00	0. 36880	0	0	2.00	
3.00	SPEECH PATHOLOGY		68. 00	0. 6723	68 0	0	3.00	
4.00	DRUGS CHARGED TO PATIENTS		73. 00	0. 4915	30 0	0	4.00	
5.00	DURABLE MEDICAL EQUIP-RENTED		96. 00				5.00	
6. 00	LABORATORY	İ	60. 00		14 0	0	6.00	
6. 01	BLOOD LABORATORY		60. 01	0007		· ·	6. 01	
7. 00	MEDICAL SUPPLIES CHARGED TO PATIENTS		71. 00	0. 5882!	57 0	0	7. 00	
8. 00	OTHER OUTPATIENT SERVICE COST CENTER		93.00			0	8. 00	
9. 00	RADI OLOGY-THERAPEUTI C		55.00		0	O	9.00	
	CARDI AC REHAB				0	0		
10.00			76. 00	2. 1888	0		10.00	
11. 00	Totals (sum of lines 1-10)	l				0	11. 00	

Health Financial Systems DAVIESS COMM	JNITY HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
CALCULATION OF HOSPICE PER DIEM COST	F	Provi der CCN: 150061		Peri od:	Worksheet K-6	
			CN: 151553	From 01/01/2014 To 12/31/2014		
				Hospi ce I		
	Titl€	e XVIII	Title XIX	Other	Total	
	1	. 00	2.00	3. 00	4. 00	
1.00 Total cost (see instructions)					826, 201	1.00
2.00 Total Unduplicated Days (Worksheet S-9, column 6, line 5)					3, 380	2.00
3.00 Average cost per diem (line 1 divided by line 2)					244. 44	3.00
4.00 Upduplicated Medicare Days (Worksheet S-9, column 1, line 5)		2, 946				4. 00
5.00 Aggregate Medicare cost (line 3 time line 4)		720, 120				5.00
6.00 Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)				0		6. 00
7.00 Aggregate Medicaid cost (line 3 time line 60)				0		7.00
8.00 Upduplicated SNF Days (Worksheet S-9, column 3, line 5)		o				8.00
9.00 Aggregate SNF cost (line 3 time line 8)		o				9.00
10.00 Unduplicated NF Days (Worksheet S-9, column 4, line 5)				0		10.00
11.00 Aggregate NF cost (line 3 times line 10)				0		11.00
12.00 Other Unduplicated days (Worksheet S-9, column 5, line 5)				434		12.00
13.00 Aggregate cost for other days (line 3 times line 12)		l		106, 087		13.00

VI CIII	n Financial Systems DAVIESS COMMU LATION OF CAPITAL PAYMENT	NITY HOSPITAL  Provider CCN: 150061	Period:	u of Form CMS-2 Worksheet L	<u> </u>				
JALCUI	LATION OF CAPITAL PATMENT	Provider CCN. 150061	From 01/01/2014 To 12/31/2014	Parts I-III Date/Time Pre 5/21/2015 12:					
		Title XVIII	Hospi tal	PPS					
	DART I FILLY PROCRECTIVE METHOD			1. 00					
	PART I - FULLY PROSPECTIVE METHOD  CAPITAL FEDERAL AMOUNT								
1. 00	Capital DRG other than outlier			299, 268	1. C				
1. 00	Model 4 BPCI Capital DRG other than outlier			299, 200	1.0				
2. 00	Capital DRG outlier payments			0	2.0				
. 01	Model 4 BPCI Capital DRG outlier payments		Ö	2.0					
3. 00									
. 00									
5. 00	Indirect medical education percentage (see instructions)			0. 00 0. 00	4. C				
o. 00									
. 00	Percentage of SSI recipient patient days to Medicare Part 30) (see instructions)		0. 00	7. C					
3. 00	Percentage of Medicaid patient days to total days (see in	structions)		0. 00	8.0				
9. 00	Sum of lines 7 and 8		0. 00	9.0					
0.00	Allowable disproportionate share percentage (see instruct	0. 00	10. C						
1.00	Disproportionate share adjustment (line 10 times the sum		0	11. (					
2. 00	Total prospective capital payments (sum of lines 1, 1.01,	2, 2.01, 6 and 11)		299, 268	12. (				
	DADT LL DAVMENT LINDED DEACONABLE COCT			1. 00					
. 00	PART II - PAYMENT UNDER REASONABLE COST Program inpatient routine capital cost (see instructions)			0	1.0				
. 00	Program inpatient ancillary capital cost (see instruction)	2)		0	2. (				
. 00	Total inpatient program capital cost (see Histraction Total inpatient program capital cost (line 1 plus line 2)	3)		0	3. (				
. 00	Capital cost payment factor (see instructions)			0	4. (				
. 00	Total inpatient program capital cost (line 3 x line 4)			Ö					
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			1. 00					
. 00	Program inpatient capital costs (see instructions)			0	1. (				
. 00	Program inpatient capital costs (see instructions)  Program inpatient capital costs for extraordinary circums	tances (see instructions)		0	2.0				
00	Net program inpatient capital costs (line 1 minus line 2)	tances (see mistractions)		0	3. (				
00	Applicable exception percentage (see instructions)			0. 00					
00	Capital cost for comparison to payments (line 3 x line 4)			0.00					
00	Percentage adjustment for extraordinary circumstances (se	e instructions)		0. 00					
	Adjustment to capital minimum payment level for extraordi		x line 6)	0	7.				
00	Capital minimum payment level (line 5 plus line 7)	`	,	0	8.				
		opl i cabl e)		0	9. (				
. 00	Current year capital payments (from Part I, line 12, as a								
00		to capital payments (line 8	O Carryover of accumulated capital minimum payment level over capital payment (from prior year						
. 00 . 00 0. 00	Current year comparison of capital minimum payment level			0	11. (				
. 00 . 00 0. 00 1. 00	Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level ov Worksheet L, Part III, line 14)	er capital payment (from pr	ior year	- 1					
. 00 . 00 0. 00 1. 00 2. 00	Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level ov Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capita	er capital payment (from pr I payments (line 10 plus li	ior year ne 11)	0	12.				
. 00 . 00 0. 00 1. 00 2. 00 3. 00	Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level ov Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, e	er capital payment (from pr I payments (line 10 plus lin nter the amount on this line	ior year ne 11) e)	0	12. ( 13. (				
. 00 . 00 0. 00 1. 00 2. 00 3. 00 4. 00	Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level ov Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, e Carryover of accumulated capital minimum payment level ov (if line 12 is negative, enter the amount on this line)	er capital payment (from pr I payments (line 10 plus lin nter the amount on this lin er capital payment for the	ior year ne 11) e)	0					
. 00 . 00 . 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00	Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level ov Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, e Carryover of accumulated capital minimum payment level ov (if line 12 is negative, enter the amount on this line)	er capital payment (from property) I payments (line 10 plus line ter the amount on this line er capital payment for the instructions)	ior year ne 11) e)	0 0 0	12. 13. 14.				

	Financial Systems	DAVIESS COMMUN				eu of Form CMS-2	2552-10
	IS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDE	ERALLY QUALIFIE	D Provi der	CCN: 150061	Peri od:	Worksheet M-1	
HEALTH	CENTER COSTS		Component	t CCN: 158500	From 01/01/2014 To 12/31/2014		
					Rural Health	Cost	
					Clinic (RHC) I		
		Compensation	Other Costs		1 Reclassi fi cat		
				+ col. 2)	i ons	Trial Balance	
						(col. 3 +	
		1.00	0.00	0.00	4.00	col . 4)	
	FACILITY HEALTH CARE CTAFE COCTO	1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00	FACILITY HEALTH CARE STAFF COSTS  Physi ci an	21, 418	0	21, 41	18 0	21, 418	1.00
2.00	Physician Physician Assistant	21, 418	0		0 0	1	1
3. 00	Nurse Practitioner	197, 078	0	197, 07	9	197, 078	
4. 00	Visiting Nurse	197,070	0	197, 0	0	197,078	1
5. 00	Other Nurse	0	0		0		
6. 00	Clinical Psychologist	0	0				1
7. 00	Clinical Social Worker	0	0				
8. 00	Laboratory Techni ci an	0	0			Ö	
9. 00	Other Facility Health Care Staff Costs	131, 457	0	131, 45	57 0	131, 457	
	Subtotal (sum of lines 1 through 9)	349, 953	0	349, 95		349, 953	
	Physician Services Under Agreement	0	265, 700			1	
	Physician Supervision Under Agreement	0	0	,	0 0	0	1
13.00	Other Costs Under Agreement	0	0		0 0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	265, 700	265, 70	00 0	265, 700	14.00
15.00	Medical Supplies	0	31, 796	31, 79	96 0	31, 796	15.00
16.00	Transportation (Health Care Staff)	0	0		0 0	0	16.00
17.00	Depreciation-Medical Equipment	0	0		0 0	0	17.00
	Professional Liability Insurance	0	0		0	0	18. 00
	Other Health Care Costs	0	0		0	0	19. 00
	Allowable GME Costs	0	0		0	0	
	Subtotal (sum of lines 15 through 20)	0	31, 796			31, 796	1
22. 00	Total Cost of Health Care Services (sum of	349, 953	297, 496	647, 44	19 0	647, 449	22. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICS	1 _		T	_1		
	Pharmacy	0	0		0 0	1	
24.00	Dental	0	0		0	0	
25.00	Optometry	0	0		0	0	25.00
	All other nonreimbursable costs	0	0			0	
27. 00 28. 00	Nonallowable GME costs			1		0	27. 00 28. 00
∠8. 00	Total Nonreimbursable Costs (sum of lines 23	1					28.00

82, 376

82, 376

432, 329

68, 115

68, 115

365, 611

68, 115

82, 376

150, 491

797, 940

68, 115

82, 376

150, 491

797, 940

0

29.00

30.00

31.00

32.00

31.00

32.00

through 27) FACILITY OVERHEAD

30.00 Administrative Costs

29.00 Facility Costs

and 31)

Total Facility Overhead (sum of lines 29 and

Total facility costs (sum of lines 22, 28

Health Financial Systems	DAVIESS COMMUNITY I	HOSPI TAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF PROVIDER-BASED RURAL HEALTH CENTER COSTS	HEALTH CLINIC/FEDERALLY QUALIFIED		Period: From 01/01/2014 To 12/31/2014	Date/Time Prepared:
				5/21/2015 12: 29 pm
			Rural Health	Cost

					Rural Health Cost	
				_	Clinic (RHC) I	
		Adjustments	Net	Expenses		
				for		
				ocati on		
				ol. 5 +		
				ol. 6)		
		6. 00		7. 00		
	FACILITY HEALTH CARE STAFF COSTS					
1.00	Physi ci an	0		21, 418		1.00
2.00	Physician Assistant	0		0		2. 00
3.00	Nurse Practitioner	0		197, 078		3.00
4.00	Visiting Nurse	0		0		4. 00
5.00	Other Nurse	0	)	0		5.00
6.00	Clinical Psychologist	0	ol .	0		6.00
7.00	Clinical Social Worker	0	)	0		7. 00
8. 00	Laboratory Technician	0		0		8.00
9. 00	Other Facility Health Care Staff Costs	0		131, 457	i e	9. 00
10. 00	Subtotal (sum of lines 1 through 9)	0		349, 953		10.00
11. 00	Physician Services Under Agreement	0		265, 700	1	11.00
12. 00	Physician Supervision Under Agreement	0	()	203, 700	•	12.00
13. 00	Other Costs Under Agreement	0	1	0	1	13.00
	9	0	1	-	l .	
14.00		0	1	265, 700		14.00
15.00	Medical Supplies	0	1	31, 796	1	15.00
16. 00	1 ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '	0	1	0		16.00
17. 00		0	)	0		17. 00
18. 00	Professional Liability Insurance	0	)	0		18. 00
19. 00	Other Health Care Costs	0		0		19. 00
20.00	Allowable GME Costs	0		0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0		31, 796		21.00
22.00	Total Cost of Health Care Services (sum of	0		647, 449		22. 00
	lines 10, 14, and 21)					
	COSTS OTHER THAN RHC/FQHC SERVICS					
23.00	Pharmacy	0		0		23. 00
24.00	Dental	0		0		24.00
25.00	Optometry	0		0		25. 00
26. 00	All other nonreimbursable costs	0	l l	0		26.00
27. 00	Nonallowable GME costs	0		0		27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0		0	I .	28. 00
20.00	through 27)	Ü		Ü		20.00
	FACILITY OVERHEAD					
29 00	Facility Costs	0	ı	68, 115		29. 00
30.00		0		82, 376		30.00
31. 00	Total Facility Overhead (sum of lines 29 and	0		150, 491		31.00
31.00	30)	U	Ί	130, 491		31.00
22 00	1 '	^	J	707 040		32.00
32. 00	,	U	1	797, 940		32.00
	and 31)		I		I	1

Heal th	Financial Systems	DAVIESS COMMUN	ITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
	IS OF PROVIDER-BASED RURAL HEALTH CLINIC/FED	ERALLY QUALIFIE	D Provi der		eri od:	Worksheet M-1	
HEALTH	CENTER COSTS		Component		rom 01/01/2014 o 12/31/2014	Date/Time Pre	pared:
					Rural Health	5/21/2015 12: Cost	29 pm
					Clinic (RHC) II	COST	
		Compensation	Other Costs		Reclassi fi cat	Recl assi fi ed	
				+ col. 2)	i ons	Trial Balance	
				,		(col. 3 +	
						col. 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1. 00	Physi ci an	422, 609	0	422, 609	0	422, 609	1.00
2. 00	Physician Assistant	0	0	C	0	0	2.00
3. 00	Nurse Practitioner	76, 149	0	76, 149	0	76, 149	3.00
4.00	Visiting Nurse	0	0	C	0	0	4.00
5.00	Other Nurse	0	0	C	0	0	5.00
6. 00	Clinical Psychologist	0	0	C	0	0	6.00
7. 00	Clinical Social Worker	0	0	C	0	0	7.00
8. 00	Laboratory Techni ci an	0	0	C	0	0	8. 00
9. 00	Other Facility Health Care Staff Costs	182, 082	0	182, 082		182, 082	9.00
	Subtotal (sum of lines 1 through 9)	680, 840	0	680, 840		680, 840	
	Physician Services Under Agreement	0	51, 477	51, 477	0	51, 477	
	Physician Supervision Under Agreement	0	0	[ C	0	0	12.00
12 00	Other Costs Under Agreement		0	1		1	12 00

						col . 4)	
		1. 00	2. 00	3.00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	422, 609	0	422, 609	0	422, 609	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	76, 149	0	76, 149	0	76, 149	3.00
4.00	Visiting Nurse	0	0	0	0	0	4. 00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6. 00
7.00	Clinical Social Worker	0	0	0	0	0	7. 00
8.00	Laboratory Techni ci an	0	0	0	0	0	8. 00
9.00	Other Facility Health Care Staff Costs	182, 082	0	182, 082	0	182, 082	9. 00
10.00	Subtotal (sum of lines 1 through 9)	680, 840	0	680, 840	0	680, 840	10.00
11. 00	Physician Services Under Agreement	0	51, 477	51, 477	0	51, 477	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	
		0	51, 477	51, 477	0	51, 477	
	Medical Supplies	0	0	0	0	0	1
	Transportation (Health Care Staff)	0	0	0	0	0	16. 00
	Depreciation-Medical Equipment	0	0	0	0	0	
	Professional Liability Insurance	0	0	0	0	0	18. 00
	Other Health Care Costs	0	0	0	0	0	19. 00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
	Subtotal (sum of lines 15 through 20)	0	0	0	0	0	
22. 00	Total Cost of Health Care Services (sum of	680, 840	51, 477	732, 317	0	732, 317	22. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICS		al	- I	ام		
	Pharmacy	0	0	0	0	0	0.00
24. 00	Dental	0	0	0	0	0	24.00
25. 00	Optometry	0	0	0	0	0	25.00
	All other nonreimbursable costs	0	0	0	0	0	26.00
27. 00	Nonallowable GME costs	0	0	0	0	0	27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	U	O	Ü	U	0	28. 00
	through 27) FACILITY OVERHEAD						-
20.00	Facility Overhead Facility Costs	0	64, 788	64, 788	0	64, 788	29.00
30.00	Administrative Costs	67, 121	04, 766	67, 121	0	67, 121	30.00
31.00			64, 788	131, 909	0	131, 909	
31.00	30)	07, 121	04, 700	131, 909	U	131, 909	31.00
32 00	Total facility costs (sum of lines 22, 28	747, 961	116, 265	864, 226	0	864, 226	32.00
32.00	and 31)	747, 701	110, 200	004, 220	٥	004, 220	32.00
	land or	ı	'	l	'		1

Health Financial Systems	DAVIESS COMMUNITY	HOSPI TAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF PROVIDER-BASED RURAL HEAL HEALTH CENTER COSTS	LTH CLINIC/FEDERALLY QUALIFIED	Provi der CCN: 150061	Peri od: From 01/01/2014	Worksheet M-1
HEALTH CENTER COSTS		Component CCN: 153999		
			Rural Health	Cost

					Rural Health Cost	
					Clinic (RHC) II	
		Adjustments		xpenses		
				for		
			Allo	cati on		
			(col	I. 5 +		
			col	l. 6)		
		6. 00	7	'. 00		
	FACILITY HEALTH CARE STAFF COSTS					
1.00	Physi ci an	0		422, 609		1.00
2. 00	Physician Assistant	0		0		2.00
3.00	Nurse Practitioner	0		76, 149		3.00
4. 00	4	0	1			4.00
	Visiting Nurse	0	1	0		
5. 00	Other Nurse	0	1	0		5.00
6. 00	Clinical Psychologist	0	1	0		6. 00
7.00	Clinical Social Worker	0		0		7. 00
8.00	Laboratory Techni ci an	0		0		8. 00
9.00	Other Facility Health Care Staff Costs	0		182, 082		9.00
10.00	Subtotal (sum of lines 1 through 9)	0		680, 840		10.00
11.00	Physician Services Under Agreement	0	l l	51, 477		11.00
12.00	Physician Supervision Under Agreement	0		. 0		12.00
13. 00	Other Costs Under Agreement	0		0		13.00
14. 00	Subtotal (sum of lines 11 through 13)	0		51, 477		14.00
15. 00	Medical Supplies	0		51, 477		15.00
		0		0		16.00
16.00	Transportation (Health Care Staff)	0		0		1
17. 00	Depreciation-Medical Equipment	0	1	0		17. 00
18. 00	Professional Liability Insurance	0	1	0		18. 00
	Other Health Care Costs	0	1	0		19. 00
20.00	Allowable GME Costs	0		0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0		0		21.00
22.00	Total Cost of Health Care Services (sum of	0		732, 317		22.00
	lines 10, 14, and 21)					
	COSTS OTHER THAN RHC/FQHC SERVICS					
23.00	Pharmacy	0		0		23.00
24.00	Dental	0		0		24.00
25. 00	Optometry	0		0		25. 00
26. 00	All other nonreimbursable costs	0		0		26.00
27. 00	Nonal Lowable GME costs	0		0		27.00
28. 00	1	0		0		28.00
28.00	Total Nonreimbursable Costs (sum of lines 23	U	1	U		28.00
	through 27)					-
	FACILITY OVERHEAD		.1			
	Facility Costs	0	1	64, 788		29. 00
30. 00	Administrative Costs	0	1	67, 121		30.00
31.00	Total Facility Overhead (sum of lines 29 and	0	)	131, 909		31.00
	30)					
32.00	Total facility costs (sum of lines 22, 28	0		864, 226		32.00
	and 31)					

Heal th	Financial Systems	DAVIESS COMMUN	ITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
ANALYS	IS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDI	ERALLY QUALIFIE	D Provi der		Period: Worksheet M-		
HEALTH	CENTER COSTS		Componen-		From 01/01/2014 To 12/31/2014		
					Rural Health	Cost	
					<u>linic (RHC) III</u>		
		Compensation	Other Costs		Recl assi fi cat	Recl assi fi ed	
				+ col . 2)	i ons	Trial Balance	
						(col. 3 +	
		1.00	0.00	0.00	4.00	col . 4)	
	FACILITY HEALTH CARE CTAFE COCTO	1. 00	2. 00	3. 00	4. 00	5. 00	
1 00	FACILITY HEALTH CARE STAFF COSTS	( 000		1 ( 000		( 000	1 00
1.00	Physician	6, 000	0	1		6, 000 0	1.00
2. 00 3. 00	Physician Assistant Nurse Practitioner	275, 408	0	1	٥		2.00
4. 00		275, 408	0	275, 408	0	275, 408	ł
4. 00 5. 00	Visiting Nurse Other Nurse	0	0			0	5.00
6. 00	Clinical Psychologist	0	0			0	6.00
7. 00	Clinical Social Worker		0			0	7.00
8. 00	Laboratory Technician	0	0			0	8.00
9. 00	Other Facility Health Care Staff Costs	199, 840	0	199, 840		199, 840	
10.00	Subtotal (sum of lines 1 through 9)	481, 248	0	481, 248		481, 248	
11. 00	Physician Services Under Agreement	401, 240	0	401, 240		401, 240	11.00
12. 00	Physician Supervision Under Agreement		0			0	12.00
13. 00	Other Costs Under Agreement		0			0	13.00
	Subtotal (sum of lines 11 through 13)		0			0	14.00
	Medical Supplies		21, 417	21, 417	0	21, 417	
	Transportation (Health Care Staff)	o	,	(	0	0	16.00
17. 00	Depreciation-Medical Equipment	o	0		o o	0	17. 00
18. 00	Professional Liability Insurance	o	0		0	0	18.00
	Other Health Care Costs	o	0		0	0	19.00
20.00	Allowable GME Costs	o	0		o o	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	o	21, 417	21, 417	0	21, 417	21.00
22.00	Total Cost of Health Care Services (sum of	481, 248	21, 417	502, 665	0	502, 665	22.00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICS						
22 00	Dharmacy	0	0		0	0	1 23 00

43, 686

43, 686

524, 934

0

100, 247

100, 247

121, 664

100, 247

43, 686

143, 933

646, 598

0

23.00

26.00

28.00

29.00

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32.00

0

0 24.00

0 25.00

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0 27.00

0

100, 247

43, 686 143, 933

646, 598

23.00 Pharmacy

Optometry

through 27)
FACILITY OVERHEAD

30.00 Administrative Costs

29.00 Facility Costs

and 31)

30)

All other nonreimbursable costs

Total Nonreimbursable Costs (sum of lines 23

Total Facility Overhead (sum of lines 29 and

Total facility costs (sum of lines 22, 28

Nonallowable GME costs

24.00 Dental

25.00

26.00

27.00

28.00

31.00

32.00

Health Financial Systems	DAVIESS COMMUNITY	HOSPI TAL		In Lie	u of Form CMS-2	552-10
ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FED	DERALLY QUALIFIED	Provi der	CCN: 150061	Peri od: From 01/01/2014	Worksheet M-1	
HEALTH CENTER COSTS		Component	CCN: 158501	To 12/31/2014		
				Rural Health	Cost	<u> </u>
		<u> </u>		Clinic (RHC) III		

					Rural Health Cost	
				_	Clinic (RHC) III	
		Adjustments		Expenses		
				for		
				ocati on		
				ol. 5 +		
				ol. 6)		
		6. 00		7. 00		
	FACILITY HEALTH CARE STAFF COSTS					
1.00	Physi ci an	0	)	6, 000		1.00
2.00	Physician Assistant	0	)	0		2.00
3.00	Nurse Practitioner	0		275, 408		3.00
4.00	Visiting Nurse	0		0		4.00
5.00	Other Nurse	0	ol	0		5.00
6.00	Clinical Psychologist	0		0		6.00
7. 00	Clinical Social Worker	0		0		7.00
8. 00	Laboratory Technician	0		0	l .	8.00
9. 00	Other Facility Health Care Staff Costs	0		199, 840		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	()	481, 248	l .	10.00
11. 00	Physician Services Under Agreement	0	()	401, 240	l .	11.00
12. 00	Physician Supervision Under Agreement	0	()	0		12.00
		0	()	0		13.00
13.00	Other Costs Under Agreement	0	]	0		
14.00		0	]	0	l .	14.00
15. 00	Medical Supplies	0	2	21, 417	l .	15.00
16. 00	, ,	0	)	0		16.00
17. 00		0		0		17.00
18. 00	Professional Liability Insurance	0	)	0		18.00
19. 00	Other Health Care Costs	0		0		19.00
20.00	Allowable GME Costs	0		0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	)	21, 417		21.00
22. 00	Total Cost of Health Care Services (sum of	0	ol	502, 665		22.00
	lines 10, 14, and 21)					
	COSTS OTHER THAN RHC/FQHC SERVICS					
23.00	Pharmacy	0		0		23. 00
24.00	Dental	0	ol	0		24.00
25. 00	1	0	ol	0		25.00
26. 00	All other nonreimbursable costs	0		0		26.00
27. 00	Nonallowable GME costs	0		0		27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	()	0		28.00
20.00	through 27)	O	Ί	O		20.00
	FACILITY OVERHEAD		1			-
20 00	Facility Costs	0	VI	100, 247		29. 00
30.00		0	()	43, 686		30.00
		0	()			
31. 00	Total Facility Overhead (sum of lines 29 and	U	Ί	143, 933		31.00
22.00	30)	•	J	(4/ 500		22.00
32. 00	,	0	Ί	646, 598		32.00
	and 31)		I		I	I

Heal th	Financial Systems	DAVIESS COMMUN	ITY I	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	IS OF PROVIDER-BASED RURAL HEALTH CLINIC/FED	ERALLY QUALIFIE	D	Provi der		Peri od: From 01/01/2014	Worksheet M-1	
HEALIH	HEALTH CENTER COSTS			Component		To 12/31/2014		
						Rural Health Clinic (RHC) V	Cost	
	·	Compensation	0th	er Costs	Total (col.	1 Reclassi fi cat	Recl assi fi ed	
					+ col . 2)	i ons	Trial Balance	
							(col. 3 +	
							col . 4)	
		1. 00		2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS							
1. 00	Physi ci an	220, 622		0	220, 62	2 0	220, 622	1. 00
2.00	Physici an Assistant	0		0	1	0	0	2.00
3.00	Nurse Practitioner	94, 923		0	94, 92	3 0	94, 923	3.00
4.00	Visiting Nurse	0		0	)	0 0	0	4.00
5.00	Other Nurse	0		0		0 0	0	5.00
6.00	Clinical Psychologist	0		0		0	0	6.00
7.00	Clinical Social Worker	0		0		0	0	7.00

97, 519

413, 064

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37, 088

37, 088

450, 152

413,064

92.093

92, 093

92, 093

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31, 395

31, 395

123, 488

97, 519

92,093

92, 093

505, 157

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573, 640

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12.00

13.00

14.00

15 00

16.00

17.00

18.00

19 00

20.00

21.00

22.00

23.00

24.00

25.00

26.00

27.00

28.00

29.00

30.00

31.00

32.00

Laboratory Techni ci an

Medical Supplies

Other Facility Health Care Staff Costs

Physician Supervision Under Agreement

Subtotal (sum of lines 11 through 13)

Subtotal (sum of lines 15 through 20)

Total Cost of Health Care Services (sum of

Total Nonreimbursable Costs (sum of lines 23

Total Facility Overhead (sum of lines 29 and

Total facility costs (sum of lines 22, 28

Subtotal (sum of lines 1 through 9)

Physician Services Under Agreement

Transportation (Health Care Staff)

Depreciation-Medical Equipment

Other Health Care Costs

Nonallowable GME costs

Administrative Costs

Allowable GME Costs

Pharmacy

Optometry

through 27) FACILITY OVERHEAD

and 31)

Facility Costs

Dental

Professional Liability Insurance

lines 10, 14, and 21)
COSTS OTHER THAN RHC/FOHC SERVICS

All other nonreimbursable costs

Other Costs Under Agreement

Health Financial Systems	DAVIESS COMMUNITY F	HOSPI TAL	In Lieu of Form CMS-2552-10		
ANALYSIS OF PROVIDER-BASED RURAL HEALTH CENTER COSTS	ALTH CLINIC/FEDERALLY QUALIFIED		Peri od: From 01/01/2014	Worksheet M-1	
HEALTH GENTER GOSTS		Component CCN: 158503	To 12/31/2014	Date/Time Prepared: 5/21/2015 12:29 pm	
			Rural Health	Cost	

				Rural Health Cost	
				Clinic (RHC) V	
		Adjustments	Net Expenses	S	
			for		
			Allocation		
			(col. 5 +		
			col. 6)		
		6. 00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physi ci an	0	220, 62	22	1.00
2.00	Physician Assistant	0		o	2.00
3.00	Nurse Practitioner	0	94, 92	23	3.00
4.00	Visiting Nurse	0	•	o	4.00
5.00	Other Nurse	0		0	5.00
6. 00	Clinical Psychologist	0		0	6.00
7. 00	Clinical Social Worker	0		0	7.00
8. 00	Laboratory Techni ci an	0		0	8.00
9. 00	Other Facility Health Care Staff Costs	0	97, 51		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	413, 06	1	10.00
	Physician Services Under Agreement	0	413,00	0	11.00
11.00		0		7	
12.00		0		0	12.00
13.00	Other Costs Under Agreement	0		0	13.00
14.00		0		0	14.00
15.00		0	92, 09		15.00
16. 00	1 ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '	0		0	16. 00
17. 00		0		0	17.00
18.00	Professional Liability Insurance	0		0	18.00
19.00	Other Health Care Costs	0		0	19.00
20.00	Allowable GME Costs	0		0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	92, 09	93	21.00
22.00	Total Cost of Health Care Services (sum of	0	505, 15	57	22.00
	lines 10, 14, and 21)				
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00		0		0	23.00
24.00	Dental	0		o	24.00
25.00	Optometry	0		0	25.00
26.00	1'	0		0	26.00
27. 00	Nonallowable GME costs	0		0	27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0		0	28.00
20.00	through 27)	Ü			20.00
	FACILITY OVERHEAD				
29. 00		0	31, 39	05	29. 00
30.00	Administrative Costs	0	37, 08		30.00
31.00		0	68, 48	1	31.00
31.00	30)	U	00, 40	,,,	] 31.00
32. 00	Total facility costs (sum of lines 22, 28	0	573, 64		32.00
32.00	and 31)	U	373,04	.0	32.00
	una or)		I	I	1

		DAVIESS COMMUN				u of Form CMS-2	
	IS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDE	ERALLY QUALIFIE	D Provi der		Peri od:	Worksheet M-1	
HEALTH	CENTER COSTS		Componen		From 01/01/2014 To 12/31/2014	Date/Time Pre	pared.
						5/21/2015 12:	
					Rural Health	Cost	
					Clinic (RHC) VI		
		Compensation	Other Costs		1 Reclassi fi cat	Reclassi fied	
				+ col . 2)	i ons	Trial Balance	
						(col. 3 +	
		1.00	0.00			col . 4)	
	FACILITY HEALTH CARE CTAFE COCTO	1. 00	2. 00	3. 00	4. 00	5. 00	
1 00	FACILITY HEALTH CARE STAFF COSTS	124 500	0	124 50	20	124 500	1 00
1. 00 2. 00	Physi ci an Physi ci an Assi stant	134, 500	0	1,	00 0	134, 500 0	1.00 2.00
2. 00 3. 00	Nurse Practitioner	144 522	0	l .	-	_	3.00
		146, 522	0	146, 52		146, 522	
4. 00 5. 00	Visiting Nurse Other Nurse	0	0	1	0	0	
6. 00		0	0		0 0	0	
7. 00	Clinical Psychologist Clinical Social Worker	0	0		0 0	0	6. 00 7. 00
7. 00 8. 00	Laboratory Technician	0	0	1	0 0	0	
9. 00	Other Facility Health Care Staff Costs	133, 554	0	133, 55	0	133, 554	
10.00	Subtotal (sum of lines 1 through 9)	414, 576	0	414, 57		414, 576	
11. 00	Physician Services Under Agreement	414, 570	0	414,57	0 0	1 414, 370	11.00
12. 00	Physician Supervision Under Agreement	0	0		0 0	0	12.00
13. 00	Other Costs Under Agreement	0	0		0 0	0	13.00
14. 00	Subtotal (sum of lines 11 through 13)	0	0		0 0	0	14.00
15. 00	Medical Supplies	0	36, 655	36, 65	٥	36, 655	
16. 00	Transportation (Health Care Staff)	0	30, 033		0 0	0.000	16.00
17. 00	Depreciation-Medical Equipment	0	0		0 0	0	17. 00
18.00	Professional Liability Insurance	0	Ô		0 0	o o	18.00
19. 00	Other Health Care Costs	0	Ö		0 0	o o	19.00
20.00	Allowable GME Costs	0	Ö		0 0	o o	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	36, 655	36, 65	i5 0	36, 655	
22. 00	Total Cost of Health Care Services (sum of	414, 576	36, 655			451, 231	22. 00
	lines 10, 14, and 21)	,				,	
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0		0 0	0	23.00
24.00	Dental	0	0	)	0 0	0	24.00
25.00	Optometry	0	0	)	0 0	0	25. 00
26.00	All other nonreimbursable costs	0	0		0 0	0	26.00
27.00	Nonallowable GME costs	0	0		0 0	0	27. 00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0		0 0	0	28. 00
	1 1.073	1		I			I

43, 046

43, 046

457, 622

54, 432

54, 432

91, 087

54, 432

43, 046

97, 478

548, 709

54, 432

43, 046 97, 478

548, 709

0

29.00

30.00

31.00

32.00

through 27) FACILITY OVERHEAD

29.00 Facility Costs

and 31)

30.00 Administrative Costs

31.00 Total Facility Overhead (sum of lines 29 and

32.00 Total facility costs (sum of lines 22, 28

Health Financial Systems	DAVIESS COMMUNITY F	HOSPI TAL	In Lieu of Form CMS-2552-10			
ANALYSIS OF PROVIDER-BASED RURAL HEALTH CENTER COSTS	HEALTH CLINIC/FEDERALLY QUALIFIED	Provi der CCN: 150061 Component CCN: 158506	From 01/01/2014			
			Rural Health	Cost		

					Rural	Heal th	Cost	<del></del>
					Clinic	(RHC) VI		
		Adjustments	Net Expen	ses				
			for					
			Allocati					
			(col. 5					
			col. 6)					
		6. 00	7. 00					
	FACILITY HEALTH CARE STAFF COSTS							1
1. 00	Physi ci an	0	134	, 500				1.00
2.00	Physician Assistant	0	l .	0				2.00
3.00	Nurse Practitioner	0	146	, 522				3.00
4.00	Visiting Nurse	0		0				4.00
5.00	Other Nurse	0		0				5.00
6.00	Clinical Psychologist	0		0				6.00
7. 00	Clinical Social Worker	0		O				7.00
8. 00	Laboratory Techni ci an	0		o				8.00
9.00	Other Facility Health Care Staff Costs	0	133	, 554				9.00
10.00	Subtotal (sum of lines 1 through 9)	0	414	, 576				10.00
11. 00	Physician Services Under Agreement	0		ol				11.00
12. 00	Physician Supervision Under Agreement	0		0				12.00
13. 00	Other Costs Under Agreement	0		o				13.00
14. 00	Subtotal (sum of lines 11 through 13)	0		o				14.00
15. 00	Medical Supplies	0	36	, 655				15.00
16. 00	Transportation (Health Care Staff)	0		0				16.00
17. 00	Depreciation-Medical Equipment	0		o				17. 00
18. 00	Professional Liability Insurance	0		0				18.00
19. 00	Other Health Care Costs	0		0				19.00
20. 00	Allowable GME Costs	0		0				20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	36	, 655				21.00
22. 00	Total Cost of Health Care Services (sum of	0		, 231				22.00
22.00	lines 10, 14, and 21)	O	1	, 201				22.00
	COSTS OTHER THAN RHC/FQHC SERVICS		1					1
23. 00	Pharmacy	0		0				23.00
24. 00	Dental	0	l .	0				24.00
25. 00	Optometry	0		0				25.00
26. 00	All other nonreimbursable costs	0		0				26.00
27. 00	Nonal Lowable GME costs	0		ol				27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	ł	0				28.00
20.00	through 27)	O		٩				20.00
	FACILITY OVERHEAD		1					1
29. 00	Facility Costs	0	54	, 432				29.00
30.00	Administrative Costs	0		, 046				30.00
31. 00	Total Facility Overhead (sum of lines 29 and	0	l .	, 478				31.00
51.00	30)	O	1	, 1,0				] 31.00
32. 00	Total facility costs (sum of lines 22, 28	0	548	, 709				32.00
52.00	and 31)	O		,				52.00
	1=		1	1				1

	Financial Systems	DAVIESS COMMUN				u of Form CMS-2	
ALLOCA	TION OF OVERHEAD TO RHC/FQHC SERVICES		Provi der		Peri od:	Worksheet M-2	
			Componen	t CCN: 158500	From 01/01/2014 To 12/31/2014	Date/Time Pre 5/21/2015 12:	pared: 29 pm
					Rural Health	Cost	
					Clinic (RHC) I		
		Number of FTE	Total Visits			Greater of	
		Personnel		Standard (1)		col. 2 or	
					1 x col . 3)	col. 4	
	LUCITO AND DESCRIPTIVITY	1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						1
	Positions						
1.00	Physi ci an	0. 97					1.00
2.00	Physician Assistant	0.00		1 -,			2.00
3.00	Nurse Practitioner	1. 97	· ·			44 000	3.00
4.00	Subtotal (sum of lines 1 through 3)	2. 94		1	8, 211	11, 988	
5.00	Visiting Nurse	0.00		1		0	
6. 00	Clinical Psychologist	0.00		2		0	6.00
7.00	Clinical Social Worker	0.00		2		0	7.00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00		2		0	7. 01
7. 02	Diabetes Self Management Training (FQHC	0.00	(	)		0	7. 02
0.00	only)	2.04	11 000			11 000	0.00
8. 00	Total FTEs and Visits (sum of lines 4	2. 94	11, 988	3		11, 988	8. 00
9. 00	through 7) Physician Services Under Agreements		(			0	0 00
9.00	Physician services under Agreements			ή		U	9. 00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O RHC/FQHC SERV	/I CES				
10.00	Total costs of health care services (from Wk	st. M-1, col.	7, line 22)			647, 449	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line :	28)			0	11.00
12.00	Cost of all services (excluding overhead) (s		and 11)			647, 449	
13.00	Ratio of RHC/FQHC services (line 10 divided	by line 12)				1. 000000	13.00
14.00	Total facility overhead - (from Wkst. M-1, c					150, 491	
15.00	Parent provider overhead allocated to facili	ty (see instru	ctions)			635, 245	
16.00	Total overhead (sum of lines 14 and 15)					785, 736	
17.00	Allowable GME overhead (see instructions)					0	17. 00
18.00	Subtotal (see instructions)					785, 736	
19. 00	Overhead applicable to RHC/FQHC services (li					785, 736	
20.00	Total allowable cost of RHC/FQHC services (s	um of lines 10	and 19)			1, 433, 185	20.00

Heal th	Financial Systems	DAVIESS COMMUN	IITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO RHC/FQHC SERVICES		Provi der		Peri od:	Worksheet M-2	
			Componen-		From 01/01/2014 To 12/31/2014	Date/Time Pre 5/21/2015 12:	
					Rural Health	Cost	
			1 = 1 1 1 1 1 1 1		Clinic (RHC) II		
		Number of FTE	Total Visits			Greater of	
		Personnel		Standard (1)		col. 2 or	
		1. 00	2.00	2.00	1 x col . 3) 4.00	col . 4	
	VISITS AND PRODUCTIVITY	1.00	2.00	3. 00	4.00	5. 00	
	Positions						<u> </u>
1. 00	Physi ci an	2.05	8, 332	4, 20	8, 610		1.00
2. 00	Physician Assistant	0.00		1			2.00
3.00	Nurse Practitioner	0.00					3.00
4. 00	Subtotal (sum of lines 1 through 3)	2. 99			10, 584	10, 984	4.00
5. 00	Visiting Nurse	0.00		1	10,001	0	5.00
6. 00	Clinical Psychologist	0.00				0	6.00
7. 00	Clinical Social Worker	0.00				0	7.00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00		i		0	7. 01
7. 02	Diabetes Self Management Training (FQHC	0.00				0	7. 02
	only)						
8.00	Total FTEs and Visits (sum of lines 4	2. 99	10, 984			10, 984	8.00
	through 7)						
9.00	Physician Services Under Agreements		0			0	9. 00
		/==				1. 00	
10.00	DETERMINATION OF ALLOWABLE COST APPLICABLE T					700 047	1000
10.00	Total costs of health care services (from Wk					732, 317	
11. 00 12. 00	Total nonreimbursable costs (from Wkst. M-1, Cost of all services (excluding overhead) (s					0 732, 317	11. 00 12. 00
12.00	Ratio of RHC/FQHC services (line 10 divided		and ii)			1. 000000	
14. 00	Total facility overhead - (from Wkst. M-1, c		)			131, 909	
15. 00	Parent provider overhead allocated to facili					717, 410	
16. 00	Total overhead (sum of lines 14 and 15)	ty (See Institu	Cti ons)			849, 319	
17. 00	Allowable GME overhead (see instructions)					047, 317	17.00
18.00	Subtotal (see instructions)					849, 319	
19. 00	Overhead applicable to RHC/FQHC services (li	ne 13 x line 1	8)			849, 319	
	Total allowable cost of RHC/FQHC services (s					1, 581, 636	
			•				

	Financial Systems	DAVIESS COMMUN	IITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO RHC/FQHC SERVICES		Provi der	CCN: 150061	Peri od:	Worksheet M-2	
			Componen	t CCN: 158501	From 01/01/2014 To 12/31/2014	Date/Time Pre 5/21/2015 12:	
					Rural Health	Cost	
			1		Clinic (RHC) III		
		Number of FTE	Total Visits			Greater of	
		Personnel		Standard (1)		col. 2 or	
		4.00	0.00	2.00	1 x col. 3)	col . 4	
	WICHTO AND DEODUCTIVIETY	1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
1 00	Posi ti ons	0.00		1 20	20 0		1 00
1.00	Physician Assistant	0. 00 0. 00		4, 20 2, 10			1.00 2.00
2. 00 3. 00	Physician Assistant Nurse Practitioner	2. 96					3.00
4.00	Subtotal (sum of lines 1 through 3)	2. 96			6, 216	8, 411	4.00
5.00	Visiting Nurse	0.00			0, 210	0,411	5.00
6.00	Clinical Psychologist	0.00				0	6.00
7. 00	Clinical Social Worker	0.00				0	7.00
7. 00	Medical Nutrition Therapist (FQHC only)	0.00	l .			0	7.00
7. 02	Diabetes Self Management Training (FQHC	0.00	l .			0	7.02
7.02	only)	0.00		1			7.02
8.00	Total FTEs and Visits (sum of lines 4	2. 96	8, 411			8, 411	8.00
	through 7)					-,	
9.00	Physician Services Under Agreements		l c			0	9.00
	•						
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T						
10.00	Total costs of health care services (from Wk					502, 665	
11. 00	Total nonreimbursable costs (from Wkst. M-1,					0	11.00
12.00	Cost of all services (excluding overhead) (s		and 11)			502, 665	
13.00	Ratio of RHC/FQHC services (line 10 divided					1. 000000	
14.00	Total facility overhead - (from Wkst. M-1, c					143, 933	
15.00	Parent provider overhead allocated to facili		635, 660				
16.00	Total overhead (sum of lines 14 and 15)					779, 593	
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)	40 11 -	0)			779, 593	
19.00	Overhead applicable to RHC/FQHC services (Ii					779, 593	
20.00	Total allowable cost of RHC/FQHC services (s	sum of lines 10	and 19)			1, 282, 258	J 20.00

Heal th	Financial Systems	DAVIESS COMMUN	IITY HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO RHC/FQHC SERVICES		Provi der		Peri od:	Worksheet M-2	
			Componen-		From 01/01/2014 To 12/31/2014	Date/Time Pre 5/21/2015 12:	
					Rural Health	Cost	
					Clinic (RHC) V		
		Number of FTE	Total Visits			Greater of	
		Personnel		Standard (1)		col. 2 or	
					1 x col. 3)	col. 4	
		1. 00	2.00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Positions	T	T	T			
1. 00	Physi ci an	0. 93					1.00
2. 00	Physician Assistant	0.00		_,			2.00
3.00	Nurse Practitioner	0. 96					3.00
4.00	Subtotal (sum of lines 1 through 3)	1. 89		1	5, 922	9, 919	4.00
5.00	Visiting Nurse	0.00				0	5.00
6.00	Clinical Psychologist	0.00				0	6.00
7.00	Clinical Social Worker	0.00		)		0	7. 00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00		1		0	7. 01
7. 02	Diabetes Self Management Training (FQHC	0.00	0	1		0	7. 02
	onl y)						
8.00	Total FTEs and Visits (sum of lines 4	1. 89	9, 919	1		9, 919	8. 00
	through 7)						
9. 00	Physician Services Under Agreements		0			0	9. 00
	I	/				1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T						
10.00	Total costs of health care services (from Wk					505, 157	
11.00	Total nonreimbursable costs (from Wkst. M-1,					0	11.00
12.00	Cost of all services (excluding overhead) (s		and 11)			505, 157	
13.00	Ratio of RHC/FQHC services (line 10 divided					1. 000000	
14. 00	Total facility overhead - (from Wkst. M-1, c		68, 483				
15.00	Parent provider overhead allocated to facili	ty (see instru	ctions)			441, 787	
16.00	Total overhead (sum of lines 14 and 15)					510, 270	
17.00	Allowable GME overhead (see instructions)					0	17.00
18. 00	Subtotal (see instructions)					510, 270	
19. 00	Overhead applicable to RHC/FQHC services (Ii					510, 270	
20.00	Total allowable cost of RHC/FQHC services (s	um of lines 10	and 19)			1, 015, 427	20.00

	Financial Systems	DAVIESS COMMUN	IITY HOSPITAL		In Lie	u of Form CMS-2	
ALLOCA	TION OF OVERHEAD TO RHC/FQHC SERVICES		Provi der		Peri od:	Worksheet M-2	
			Componen-		From 01/01/2014 To 12/31/2014	Date/Time Pre 5/21/2015 12:	
					Rural Health	Cost	
					Clinic (RHC) VI		
		Number of FTE	Total Visits			Greater of	
		Personnel		Standard (1)		col. 2 or	
		4.00	0.00	0.00	1 x col. 3)	col . 4	
	WICHTO AND DEODUCTIVIETY	1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
1 00	Posi ti ons	0.75	1 704	1 4 20	2 150		1 00
1.00	Physician Assistant	0. 75 0. 00		i .			1. 00 2. 00
2. 00 3. 00	Physician Assistant Nurse Practitioner	1. 75					3.00
4. 00	Subtotal (sum of lines 1 through 3)	2. 50			6, 825		4.00
5. 00	Visiting Nurse	0.00		1	0, 023	7, 930	5.00
6. 00	Clinical Psychologist	0.00				0	6.00
7. 00	Clinical Social Worker	0.00				0	7.00
7. 00	Medical Nutrition Therapist (FQHC only)	0.00				0	7.00
7. 02	Diabetes Self Management Training (FQHC	0.00				0	7.02
7.02	only)	0.00					7.02
8.00	Total FTEs and Visits (sum of lines 4	2. 50	7, 956			7, 956	8.00
	through 7)		.,			.,	
9.00	Physician Services Under Agreements		0			0	9.00
	•						
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T						
10.00	Total costs of health care services (from Wk					451, 231	
11. 00	Total nonreimbursable costs (from Wkst. M-1,					0	11. 00
12.00	Cost of all services (excluding overhead) (s		and 11)			451, 231	
13.00	Ratio of RHC/FQHC services (line 10 divided					1. 000000	
14.00	Total facility overhead - (from Wkst. M-1, c					97, 478	
15.00	Parent provider overhead allocated to facili	ty (see instru	ctions)			488, 315	
16.00	Total overhead (sum of lines 14 and 15)					585, 793	
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)	40 11 -	0)			585, 793	
19.00	Overhead applicable to RHC/FQHC services (Ii					585, 793	
20.00	Total allowable cost of RHC/FQHC services (s	sum of lines 10	and 19)			1, 037, 024	J 20.00

Heal th	Financial Systems DAVIESS COMMUNITY	HOSPI TAI	In lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provi der CCN: 150061	Peri od:	Worksheet M-3	
0712002		Component CCN: 158500	From 01/01/2014	Date/Time Pre 5/21/2015 12:	pared:
		Title XVIII	Rural Health Clinic (RHC) I	Cost	<u> </u>
				1. 00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES				
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line			1, 433, 185	1. 00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line	e 15)		30, 685	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1, 402, 500	3.00
4. 00 5. 00	Total Visits (from Worksheet M-2, column 5, line 8) Physicians visits under agreement (from Wkst. M-2, column 5, li	20 (1)		11, 988 0	4. 00 5. 00
6. 00	Total adjusted visits (line 4 plus line 5)	Tie 9)		11, 988	6.00
7. 00	Adjusted cost per visit (line 3 divided by line 6)			116. 99	7.00
7.00	They do to do ot por visit (Time of divided by Time of		Cal cul ati on		7.00
				, ,	
			Prior to	On on After	
			January 1	January 1	
	D		1.00	2. 00	0.00
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6	or your contractor)	79. 80	79. 80	8.00
9. 00	Rate for Program covered visits (see instructions) CALCULATION OF SETTLEMENT		116. 99	116. 99	9. 00
10.00	Program covered visits excluding mental health services (from o	contractor records)	0	3, 463	10.00
11. 00	Program cost excluding costs for mental health services (line		o	405, 136	
12.00	Program covered visits for mental health services (from contract		o	0	12.00
13.00	Program covered cost from mental health services (line 9 x line	e 12)	o	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15. 00	Graduate Medical Education Pass Through Cost (see instructions)			0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 a			405, 136	
16. 01	Total program charges (see instructions) (from contractor's reco			575, 371	16. 01
16. 02 16. 03	Total program preventive charges (see instructions)(from provided Total program preventive costs ((line 16.02/line 16.01) times I			251 177	16. 02 16. 03
16. 03	Total Program non-preventive costs ((Time 16.02/Time 16.01) times 1 Total Program non-preventive costs ((Line 16 minus Lines 16.03)			290, 753	
10.04	(Titles V and XIX see instructions.)	and 10) trilles . 00)		270, 733	10.04
16. 05	Total program cost (see instructions)			290, 930	16. 05
17.00	Primary payer amounts			0	17. 00
18.00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		41, 518	18. 00
	records)				
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instructions records)	s) (from contractor		106, 727	19. 00
20. 00	Net Medicare cost excluding vaccines (see instructions)			290, 930	20.00
21. 00	Program cost of vaccines and their administration (from Wkst. M	M-4 line 16)		13, 844	21.00
22. 00	Total reimbursable Program cost (line 20 plus line 21)	. 1, 11116 10)		304, 774	
23.00	Allowable bad debts (see instructions)			0	23.00
23. 01	Adjusted reimbursable bad debts (see instructions)			0	23. 01
24.00	Allowable bad debts for dual eligible beneficiaries (see instru	ucti ons)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
25. 50	Pioneer ACO demonstration payment adjustment (see instructions)	)		0	25. 50
26. 00	Net reimbursable amount (see instructions)			304, 774	
26. 01	Sequestration adjustment (see instructions)			6, 095	
27. 00 28. 00	Interim payments Tentative settlement (for contractor use only)			311, 186 0	27. 00 28. 00
29. 00	Balance due component/program (line 26 minus lines 26.01, 27, a	and 28)		-12, 507	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance			0	30.00
	chapter I, §115.2				

	Financial Systems DAVIESS COMMUNITY ATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provi der CCN: 150061	Peri od:	u of Form CMS-2 Worksheet M-3	
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Component CCN: 153999	From 01/01/2014 To 12/31/2014	Date/Time Pre 5/21/2015 12:	pared:
		Title XVIII	Rural Health	Cost	2 / p
	<u> </u>		Clinic (RHC) II		
				1. 00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES				
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, li			1, 581, 636	1.0
2. 00	Cost of vaccines and their administration (from Wkst. M-4, li	ne 15)		57, 769	
. 00	Total allowable cost excluding vaccine (line 1 minus line 2)			1, 523, 867	
. 00	Total Visits (from Worksheet M-2, column 5, line 8)	Line O		10, 984	
5. 00 5. 00	Physicians visits under agreement (from Wkst. M-2, column 5, Total adjusted visits (line 4 plus line 5)	Tine 9)		0 10, 984	6.0
. 00	Adjusted cost per visit (line 3 divided by line 6)			138. 74	1
. 00	indjusted cost per visit (Time o divided by Time o)		Cal cul ati on		7.0
			Prior to	On on After	
			January 1	January 1	
			1.00	2.00	
. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	79. 80	79. 80	8.0
. 00	Rate for Program covered visits (see instructions)		138. 74	138. 74	9.0
	CALCULATION OF SETTLEMENT			2 244	
0.00	Program covered visits excluding mental health services (from Program cost excluding costs for mental health services (line		0	2, 811 389, 998	
1. 00 2. 00	Program covered visits for mental health services (from contr		0	389, 998	11. (
3. 00	Program covered cost from mental health services (line 9 x li		o	0	
4. 00	Limit adjustment for mental health services (see instructions		0	0	
5.00	Graduate Medical Education Pass Through Cost (see instruction			0	15. (
6. 00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2			389, 998	
6. 01	Total program charges (see instructions)(from contractor's re			462, 755	
6. 02	Total program preventive charges (see instructions) (from prov			2, 037	
6. 03 6. 04	Total program preventive costs ((line 16.02/line 16.01) times Total Program non-preventive costs ((line 16 minus lines 16.0			1, 717 280, 499	
0.04	(Titles V and XIX see instructions.)	s and roy trines . ooy		200, 477	10.
6. 05	Total program cost (see instructions)			282, 216	16. (
7. 00	Primary payer amounts			0	17.0
8. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		37, 657	18. (
9. 00	records) Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		84, 616	19.0
0. 00	records) Net Medicare cost excluding vaccines (see instructions)			282, 216	20.0
1. 00	Program cost of vaccines and their administration (from Wkst.	M-4. line 16)		19, 953	
2. 00	Total reimbursable Program cost (line 20 plus line 21)	,,		302, 169	
3. 00	Allowable bad debts (see instructions)			0	23. (
3. 01	Adjusted reimbursable bad debts (see instructions)			0	
4. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
5.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	->		0	
5. 50 6. 00	Pioneer ACO demonstration payment adjustment (see instruction Net reimbursable amount (see instructions)	5)		0 302, 169	
6. 00	Sequestration adjustment (see instructions)			6, 043	
7. 00	Interim payments			239, 506	
8. 00	Tentative settlement (for contractor use only)			0	28.0
9. 00	Balance due component/program (line 26 minus lines 26.01, 27,	and 28)		56, 620	
30.00	Protested amounts (nonallowable cost report items) in accorda	nco with CMS Dub 15 LL	1	0	30.0

Hoal +h	Financial Systems DAVIESS COMMUNITY I	HOSDI TAI	In Lie	u of Form CMS-2	DEE2 10
	ATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FOHC SERVICES	Provi der CCN: 150061	Peri od:	Worksheet M-3	
CALCUL	ATTOM OF RETWINDINGSEMENT SETTLEMENT FOR RIGOTUNG SERVICES	Component CCN: 158501	From 01/01/2014 To 12/31/2014	Date/Time Pre 5/21/2015 12:	pared:
		Title XVIII	Rural Health Clinic (RHC) III	Cost	27 piii
	·		CITILE (KIIC) III		
				1. 00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES				
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line	20)		1, 282, 258	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line	e 15)		0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1, 282, 258	3. 00
4. 00	Total Visits (from Worksheet M-2, column 5, line 8)	->		8, 411	4.00
5. 00	Physicians visits under agreement (from Wkst. M-2, column 5, li	ne 9)		0 411	5.00
6. 00 7. 00	Total adjusted visits (line 4 plus line 5) Adjusted cost per visit (line 3 divided by line 6)			8, 411 152. 45	6. 00 7. 00
7.00	Adjusted cost per visit (Time 3 divided by Time 6)		Cal cul ati on		7.00
			Carcuration	OI LIMIT (I)	
			Pri or to	On on After	
			January 1	January 1	
			1. 00	2. 00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6	or your contractor)	79. 80	79. 80	8. 00
9. 00	Rate for Program covered visits (see instructions)		152. 45	152. 45	9. 00
40.00	CALCULATION OF SETTLEMENT			700	10.00
10.00	Program covered visits excluding mental health services (from o		0	788	10.00
11. 00 12. 00	Program cost excluding costs for mental health services (line Sprogram covered visits for mental health services (from contractions)		0	120, 131 0	11. 00 12. 00
13. 00	Program covered cost from mental health services (line 9 x line		0	0	13.00
14. 00	Limit adjustment for mental health services (see instructions)	, 12)	Ö	0	14.00
15. 00	Graduate Medical Education Pass Through Cost (see instructions)	)		0	15. 00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 a			120, 131	16.00
16. 01	Total program charges (see instructions)(from contractor's reco	ords)		151, 266	16. 01
16. 02	Total program preventive charges (see instructions)(from provid			0	16. 02
16. 03	Total program preventive costs ((line 16.02/line 16.01) times I			0	16. 03
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.03	and 18) times .80)		85, 253	16. 04
14 05	(Titles V and XIX see instructions.)			05 252	1/ 05
16. 05 17. 00	Total program cost (see instructions) Primary payer amounts			85, 253 0	16. 05 17. 00
18. 00	Less: Beneficiary deductible for RHC only (see instructions) (	from contractor		13, 565	
10.00	records)	CITOM COITE ACTO		13, 303	10.00
19. 00	Beneficiary coinsurance for RHC/FOHC services (see instructions records)	s) (from contractor		27, 541	19. 00
20.00	Net Medicare cost excluding vaccines (see instructions)			85, 253	20. 00
21.00	Program cost of vaccines and their administration (from Wkst. M	N-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			85, 253	
23. 00	Allowable bad debts (see instructions)			0	23. 00
23. 01	Adjusted reimbursable bad debts (see instructions)			0	
24. 00	Allowable bad debts for dual eligible beneficiaries (see instru	ictions)		0	24. 00 25. 00
25. 00 25. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)			0	25.00
26. 00	Net reimbursable amount (see instructions)	,		85, 253	
26. 01	Sequestration adjustment (see instructions)			1, 705	
27. 00	, ,			66, 770	
28. 00	Tentative settlement (for contractor use only)			0	28. 00
29. 00	Balance due component/program (line 26 minus lines 26.01, 27, a	and 28)		16, 778	29. 00
30.00	Protested amounts (nonallowable cost report items) in accordance chapter I, §115.2	ce with CMS Pub. 15-II,		0	30.00
			ı I		'

Heal th	Financial Systems DAVIESS COMMINITY	HOSPI TAI	Inlie	u of Form CMS_1	2552_10
0712002			From 01/01/2014	Date/Time Pre	pared:
		Title XVIII	Rural Health Clinic (RHC) V	Cost	<u> F</u>
				1. 00	
					1.00
		9 15)		-	2.00
					3. 00 4. 00
		ne 0)			5.00
		116 7)			6.00
				·	7. 00
			Cal cul ati on		
Component CCN: 158503   To 12/31/2014   Date/Time Prepare   Title XVIII   Rural Health   Cost					
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6	or your contractor)	79. 80	79. 80	8. 00
9. 00			102. 37	102. 37	9. 00
10 00		contractor records)		0	10.00
					11.00
					12.00
				-	13. 00
		,	o		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)	)		0	15.00
	, , , , , , , , , , , , , , , , , , , ,				16.00
					16. 01
					16. 02
					16. 03 16. 04
10.04		and 16) trilles . 80)		U	10.04
16. 05				0	16. 05
	, ,			0	17. 00
18. 00		(from contractor		0	18. 00
19. 00	· · · · · /	s) (from contractor		0	19. 00
	records)				
		1 4 line 14)		-	20. 00 21. 00
		11-4, TTHE 16)			21.00
				-	23. 00
	· · · · · · · · · · · · · · · · · · ·			-	23. 01
24.00		uctions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
				-	25. 50
					26. 00
	, ,				26. 01
					27.00
28. 00 29. 00		and 20)		0	28. 00 29. 00
29. 00 30. 00	Balance due component/program (line 26 minus lines 26.01, 27, a Protested amounts (nonallowable cost report items) in accordance			0	30.00
30.00	chapter I, §115.2	SO WITTI ONO TUD. IJ-II,		O	30.00
			'		-

Heal th	Financial Systems DAVIESS COMMUNITY I	HOSPI TAI	In lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provi der CCN: 150061	Peri od:	Worksheet M-3	
0/12002	THIS OF RETHINGROCIMENT SETTEEMENT TOR MIST AND SERVICES	Component CCN: 158506	From 01/01/2014	Date/Time Pre 5/21/2015 12:	pared:
		Title XVIII	Rural Health Clinic (RHC) VI	Cost	<u></u>
			(1.1.1.)		
				1. 00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES				
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line	20)		1, 037, 024	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line	e 15)		35, 972	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1, 001, 052	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)			7, 956	4.00
5. 00	Physicians visits under agreement (from Wkst. M-2, column 5, li	ne 9)		0	5. 00
6. 00	Total adjusted visits (line 4 plus line 5)			7, 956	6.00
7. 00	Adjusted cost per visit (line 3 divided by line 6)			125. 82	7. 00
			Calculation	of Limit (1)	
			Prior to	On on After	
			January 1	January 1	
			1. 00	2. 00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6	or your contractor)	79. 80	79. 80	8.00
9. 00	Rate for Program covered visits (see instructions)		125. 82	125. 82	9. 00
10. 00	CALCULATION OF SETTLEMENT Program covered visits excluding mental health services (from c	contractor records)	ol	2, 522	10.00
11. 00	Program cost excluding costs for mental health services (line 9		0	317, 318	
12. 00	Program covered visits for mental health services (from contrac			317, 310	12.00
13. 00	Program covered cost from mental health services (line 9 x line			0	13.00
14. 00	Limit adjustment for mental health services (see instructions)	, 12)		0	14.00
15. 00	Graduate Medical Education Pass Through Cost (see instructions)	)		0	15. 00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 a			317, 318	16.00
16. 01	Total program charges (see instructions)(from contractor's reco	ords)		404, 594	16. 01
16. 02	Total program preventive charges (see instructions)(from provice	der's records)		6, 348	16. 02
16. 03	Total program preventive costs ((line 16.02/line 16.01) times I			4, 979	
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.03 (Titles V and XIX see instructions.)	and 18) times .80)		224, 931	16. 04
16. 05	Total program cost (see instructions)			229, 910	16. 05
17.00	Primary payer amounts			0	17. 00
18. 00	Less: Beneficiary deductible for RHC only (see instructions) (records)	(from contractor		31, 175	18. 00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instructions records)	s) (from contractor		73, 419	19. 00
20. 00	Net Medicare cost excluding vaccines (see instructions)			229, 910	20.00
21. 00	Program cost of vaccines and their administration (from Wkst. N	1-4 line 16)		20, 993	
22. 00	Total reimbursable Program cost (line 20 plus line 21)	,		250, 903	
23. 00	Allowable bad debts (see instructions)			0	23. 00
23. 01	Adjusted reimbursable bad debts (see instructions)			0	23. 01
24.00	Allowable bad debts for dual eligible beneficiaries (see instru	uctions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	•		0	25. 00
25. 50	Pioneer ACO demonstration payment adjustment (see instructions)	)		0	25. 50
26. 00	Net reimbursable amount (see instructions)			250, 903	
26. 01	Sequestration adjustment (see instructions)			5, 018	
27. 00	Interim payments			203, 537	27.00
28. 00	Tentative settlement (for contractor use only)			0	28. 00
29. 00	Balance due component/program (line 26 minus lines 26.01, 27, a			42, 348	
30. 00	Protested amounts (nonallowable cost report items) in accordance chapter I, §115.2	ce with CMS Pub. 15-II,		0	30. 00
	Chiapter   1, 3110.2		ı		l

Health Financial Systems	DAVIESS COMMUNITY	HOSPI TAL	In Lieu	u of Form CMS-2	552-10
COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCI	NE COST	Provi der CCN: 150061	Period: From 01/01/2014	Worksheet M-4	
		Component CCN: 158500			
		Title XVIII	Rural Health	Cost	<u> </u>
			Clinic (RHC) I		
			Pneumococcal	Influenza	

			man an moan em	0001	
			Clinic (RHC) I		
			Pneumococcal	I nfl uenza	
			1. 00	2. 00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		349, 953	349, 953	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total	health care staff tim	e 0. 000112	0.002300	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line	1 x line 2)	39	805	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (fro	m your records)	4, 171	8, 847	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus	line 4)	4, 210	9, 652	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line	22)	647, 449	647, 449	6.00
7.00	Total overhead (from Wkst. M-2, line 16)		785, 736	785, 736	7. 00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to tota	I direct cost (line 5	0. 006502	0. 014908	8. 00
	divided by line 6)				
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x li	ne 8)	5, 109	11, 714	9. 00
10.00	Total pneumococcal and influenza vaccine cost and its (their) a	dministration (sum of	9, 319	21, 366	10.00
	lines 5 and 9)				
11. 00	Total number of pneumococcal and influenza vaccine injections (	from your records)	61	317	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/	line 11)	152. 77	67. 40	12.00
13.00	Number of pneumococcal and influenza vaccine injections adminis	tered to Program	9	185	13.00
	benefi ci ari es				
14.00	Program cost of pneumococcal and influenza vaccine and its (the	ir) administration	1, 375	12, 469	14.00
	(line 12 x line 13)				
15.00	Total cost of pneumococcal and influenza vaccine and its (their			30, 685	15. 00
	of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3,	,			
16.00	Total Program cost of pneumococcal and influenza vaccine and it			13, 844	16.00
	administration (sum of cols. 1 and 2, line 14) (transfer this a	mount to Wkst. M-3,			
	line 21)				

Health Financial Systems	DAVIESS COMMUNITY H	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE	COST	Provi der CCN: 150061	Peri od: From 01/01/2014	Worksheet M-4	
		Component CCN: 153999		Date/Time Pre 5/21/2015 12:	
		Title XVIII	Rural Health	Cost	
			Clinic (RHC) II		
			Pneumococcal	I nfl uenza	
			1. 00	2. 00	

		i i i ii c (ittile) i i		
		Pneumococcal	I nfl uenza	
		1. 00	2. 00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	680, 840	680, 840	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0. 000206	0.002755	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	140	1, 876	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	8, 684	16, 048	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	8, 824	17, 924	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	732, 317	732, 317	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	849, 319	849, 319	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5	0. 012049	0. 024476	8. 00
	divided by line 6)			
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	10, 233	20, 788	9. 00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of	19, 057	38, 712	10.00
	lines 5 and 9)			
11. 00	Total number of pneumococcal and influenza vaccine injections (from your records)	127		
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	150. 06	67. 33	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program	19	254	13.00
	benefi ci ari es			
14. 00	Program cost of pneumococcal and influenza vaccine and its (their) administration	2, 851	17, 102	14. 00
	(line 12 x line 13)			
15. 00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum		57, 769	15. 00
	of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			
16. 00	Total Program cost of pneumococcal and influenza vaccine and its (their)		19, 953	16. 00
	administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3,			
	line 21)			

Heal th	Financial Systems DAVIESS COMMUNITY I	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provi der CCN: 150061	Peri od:		Worksheet M-4	
		Component CCN: 158506	From 01/0 To 12/3	1/2014 1/2014	Date/Time Pre 5/21/2015 12:	
		Title XVIII	Rural He	eal th	Cost	
			Clinic (R			
			Pneumoc		I nfl uenza	
			1.0		2. 00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)			14, 576	414, 576	
2.00	Ratio of pneumococcal and influenza vaccine staff time to total		ne 0.	000467	0. 002925	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line	,		194	1, 213	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (fro	,		4, 923	9, 322	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus			5, 117	·	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line	22)		51, 231	451, 231	6. 00
7. 00	Total overhead (from Wkst. M-2, line 16)		5	85, 793	585, 793	7. 00
8. 00	Ratio of pneumococcal and influenza vaccine direct cost to totadivided by line 6)	direct cost (line 5	0.	011340	0. 023347	8. 00
9. 00	Overhead cost - pneumococcal and influenza vaccine (line 7 x li	no 9)		6, 643	13, 677	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) a			11, 760	24, 212	
10.00	lines 5 and 9)	idili ili stratron (sull or		11, 700	24, 212	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (	from your records)		72	334	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/	Tine 11)		163. 33	72. 49	12.00
13.00	Number of pneumococcal and influenza vaccine injections adminis	stered to Program		34	213	13.00
	benefi ci ari es					
14. 00	Program cost of pneumococcal and influenza vaccine and its (the (line 12 x line 13)	eir) administration		5, 553	15, 440	14. 00
15. 00	Total cost of pneumococcal and influenza vaccine and its (their	administration (sum			35, 972	15. 00
	of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3,					
16. 00	Total Program cost of pneumococcal and influenza vaccine and it				20, 993	16. 00
	administration (sum of cols. 1 and 2, line 14) (transfer this a	mount to Wkst. M-3,				
	line 21)					

Health Financial Systems	DAVIESS COMMUNITY	HOSPI TAL				In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED	RHC/FQHC PROVIDER FOR SERVICES	Provi der	CCN:	150061	Perio	od: 01/01/2014	Worksheet M-5
RENDERED TO PROGRAM BENEFICIARIES		Component	CCN:	: 158500			Date/Time Prepared:
							5/21/2015 12:29 pm
					Rur	al Health	Cost
					Clin	ic (RHC) I	

			Rural Health	Cost	•
			Clinic (RHC) I		
				t B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
1. 00	Total interim payments paid to provider			311, 186	1. 00
2. 00	Interim payments payable on individual bills, either submi	tted or to be submitted to		0	2.00
	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 amoun				3.00
	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				0	3.0
3. 02				0	3.02
3. 03				0	3.03
3. 04				0	3.0
3. 05				0	3. 0
	Provider to Program				
3.50				0	3.50
3. 51				0	3.5
3. 52				0	3. 5
3. 53				0	3.5
3.54				0	3.5
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	. 98)		0	3. 9
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	sfer to Worksheet M-3, line	9	311, 186	4.00
	27)				
	TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after des	sk review. Also show date o	of		5.0
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
5. 01				0	5.0
5. 02				0	5.02
5. 03				0	5.0
	Provider to Program				
5. 50				0	5. 5
5. 51				0	5.5
5. 52				0	5. 5.
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.			0	5. 9
6. 00	Determined net settlement amount (balance due) based on the	e cost report. (1)			6.0
6. 01	SETTLEMENT TO PROVIDER			0	6.0
6. 02	SETTLEMENT TO PROGRAM			12, 507	6. 0
7. 00	Total Medicare program liability (see instructions)			298, 679	7.0
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
	T., 1 - 1 - 1	0	1. 00	2. 00	
8. 00	Name of Contractor				8.0

Health Financial Systems	DAVI ESS COMMUNI TY	HOSPI TAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RENDERED TO PROGRAM BENEFICIARIES	RHC/FQHC PROVI DER FOR SERVI CES	Provi der CCN: 150061	Period: From 01/01/2014	Worksheet M-5
REINDERED TO PROGRAW BENEFICIARIES		Component CCN: 153999		
			Rural Health	Cost

			Rural Health	Cost	
			Clinic (RHC) II		
				t B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
1. 00	Total interim payments paid to provider			239, 506	1.00
2.00	Interim payments payable on individual bills, either submitt		0	2.00	
	the contractor for services rendered in the cost reporting p	period. If none, write			
	"NONE" or enter a zero				
3.00	List separately each retroactive lump sum adjustment amount				3.00
	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				0	3.0
3. 02				0	3. 02
3. 03				0	3.00
3. 04				0	3.0
3. 05				0	3. 0!
0 50	Provider to Program				
3. 50				0	3.50
3. 51				0	3.5
3. 52				١ "	3. 5.
3. 53				0	3.5
3. 54	C. http://www.net.lines.com/and/and/and/and/and/and/and/and/and/and	202		0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.9			0	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transf 27)	er to worksneet M-3, line		239, 506	4.00
	TO BE COMPLETED BY CONTRACTOR				
5. 00	List separately each tentative settlement payment after desk	review Also show date of	F		5.00
3.00	each payment. If none, write "NONE" or enter a zero. (1)	c review. Arso snow date of	•		3.00
	Program to Provider				
5. 01	11 ogram to 11 ovraor			0	5.0°
5. 02				0	5.0
5. 03				0	5.0
	Provider to Program			_	
5. 50				0	5.50
5. 51				l ol	5.5
5. 52				l ol	5. 5.
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			l ol	5.99
6.00					6.00
6. 01	SETTLEMENT TO PROVIDER			56, 620	6.0
6. 02	SETTLEMENT TO PROGRAM			0	6. 0
7. 00	Total Medicare program liability (see instructions)			296, 126	
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1, 00	2.00	
		0	1.00	2.00	

Health Financial Systems	DAVIESS COMMUNITY	HOSPI TAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RENDERED TO PROGRAM BENEFICIARIES	RHC/FQHC PROVI DER FOR SERVI CES	Provi der CCN: 150061	Peri od: From 01/01/2014	Worksheet M-5
KENDERED TO TROOKING BENEFITOTIANTES		Component CCN: 158501	To 12/31/2014	Date/Time Prepared: 5/21/2015 12:29 pm
			Rural Health	Cost
			Clinic (RHC) III	

			Rural Health	Cost	•
			Clinic (RHC) III		
			Par	t B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
1.00	1.00 Total interim payments paid to provider			66, 770	1.00
2.00	Interim payments payable on individual bills, either submi		0	2.00	
	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 amoun			3.00	
	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				0	3.0
3. 02				0	3. 02
3.03				0	3. 0
3.04				0	3.0
3.05				0	3. 0
	Provider to Program				
3. 50				0	3. 5
3. 51				0	3.5
3. 52				0	3.5
3. 53				0	3.5
3.54				0	3.5
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.			0	3. 9
4.00				66, 770	4.00
	27)				
	TO BE COMPLETED BY CONTRACTOR				
5. 00	List separately each tentative settlement payment after des	sk review. Also show date o	f		5.0
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
5. 01				0	5.0
5. 02				0	5. 0.
5. 03				0	5.0
	Provi der to Program				
5. 50				0	5.5
5. 51				0	5.5
5. 52				0	5.5
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5.9
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			4, 770	6.0
6. 01	SETTLEMENT TO PROVIDER			16, 778	6.0
6. 02				0	6.0
7. 00	Total Medicare program liability (see instructions)			83, 548	7.0
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
0.00	N C. O I I	0	1.00	2. 00	0.0
8. 00	Name of Contractor		1		8.00

Health Financial Systems	DAVI ESS COMMUNI TY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RENDERED TO PROGRAM BENEFICIARIES	RHC/FQHC PROVI DER FOR SERVI CES	Provi der	CCN: 150061	Peri od: From 01/01/2014	Worksheet M-5	
RENDERED TO TROUBANT DENETTOTANTES		Component	CCN: 158506		Date/Time Pre	
				Rural Health	Cost	
				Clinic (RHC) VI		
	5/21/2015 12: 29 pm   Rural Health   Cost   Clinic (RHC) VI   Part B					
				mm/dd/\nnn/	Amount	

			Clinic (RHC) VI	COST	
				rt B	
			mm/dd/yyyy	Amount	
			1. 00	2.00	
00	Total interim payments paid to provider		1.00	203, 537	1.
	Interim payments payable on individual bills, either submitted	d or to be submitted to		203, 337	2
	the contractor for services rendered in the cost reporting per				_
	"NONE" or enter a zero	riod. It flotte, witte			
	List separately each retroactive lump sum adjustment amount ba	asad on subsequent			3
	revision of the interim rate for the cost reporting period. Al				3
	payment. If none, write "NONE" or enter a zero. (1)	130 Show date of each			
	Program to Provider				
1 ľ	Togiam to Trovider			0	3
2					3
3					3
4					3
5	Describer to Describe			0	3
	Provider to Program				_
0				0	3
1				0	3
2				0	3
3				0	3
4				0	3
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	3
	Total interim payments (sum of lines 1, 2, and 3.99) (transfer	r to Worksheet M-3, lin	е	203, 537	4
	27)				
	O BE COMPLETED BY CONTRACTOR				_
	List separately each tentative settlement payment after desk r	review. Also show date	OT		5
	each payment. If none, write "NONE" or enter a zero. (1)				
-	Program to Provider				
1				0	5
- 1				0	5
3	2 ! 1 1 D			0	. 5
-	Provider to Program				
)				0	5
1				0	5
2	2			0	5
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5
	Determined net settlement amount (balance due) based on the co	ost report. (1)			6
	SETTLEMENT TO PROVIDER			42, 348	6
	SETTLEMENT TO PROGRAM			0	6
0 .	Total Medicare program liability (see instructions)		_	245, 885	7
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		_			
0 [	Name of Contractor	0	1. 00	2. 00	8