



DELNOR-COMMUNITY HOSPITAL Provider CCN: 14-0211	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/27/2015 Run Time: 13:15 Version: 2014.10
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

**WORKSHEET S
PARTS I, II & III**

PART I - COST REPORT STATUS

PROVIDER USE ONLY	1. <input checked="" type="checkbox"/> ELECTRONICALLY FILED COST REPORT	DATE: 01/27/2015	TIME: 13:15
	2. <input type="checkbox"/> MANUALLY SUBMITTED COST REPORT		
	3. <input type="checkbox"/> IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THE COST REPORT		
	4. <input checked="" type="checkbox"/> MEDICARE UTILIZATION. ENTER 'F' FOR FULL OR 'L' FOR LOW.		
CONTRACTOR USE ONLY	5. <input type="checkbox"/> COST REPORT STATUS	6. DATE RECEIVED: _____	10. NPR DATE: _____
	1 -AS SUBMITTED	7. CONTRACTOR NO: _____	11. CONTRACTOR'S VENDOR CODE: _____
	2 -SETTLED WITHOUT AUDIT	8. <input type="checkbox"/> INITIAL REPORT FOR THIS PROVIDER CCN	12. <input type="checkbox"/> IF LINE 5, COLUMN 1 IS 4: ENTER NUMBER OF TIMES REOPENED = 0-9.
	3 -SETTLED WITH AUDIT	9. <input type="checkbox"/> FINAL REPORT FOR THIS PROVIDER CCN	
	4 -REOPENED		
	5 -AMENDED		

PART II - CERTIFICATION

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 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 DELNOR-COMMUNITY HOSPITAL (14-0211) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 07/01/2014 AND ENDING 08/31/2014, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT 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.

(SIGNED) _____
OFFICER OR ADMINISTRATOR OF PROVIDER(S)

TITLE

DATE

PART III - SETTLEMENT SUMMARY

		TITLE XVIII					
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		-5,549	-43			1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC						10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		-5,549	-43			200

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 THIS INFORMATION COLLECTION IS ESTIMATED 673 HOURS PER RESPONSE, INCLUDING THE TIME TO REVIEW INSTRUCTIONS, SEARCH EXISTING RESOURCES, GATHER



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**WORKSHEET S
PARTS I, II & III**

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 THIS FORM, PLEASE WRITE TO: CMS, 7500 SECURITY BOULEVARD, ATTN: PRA REPORT CLEARANCE OFFICER, MAIL STOP C4-26-05, BALTIMORE, MARYLAND 21244-1850.



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Hospital and Hospital Health Care Complex Address:										
1	Street: 300 RANDALL ROAD	P.O. Box:								1
2	City: GENEVA	State: IL	ZIP Code: 60134	County: KANE						2
Hospital and Hospital-Based Component Identification:										
										Payment System (P, T, O, or N)
	Component	Component Name	CCN Number	CBSA Number	Prov-ider Type	Date Certified	V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	DELNOR-COMMUNITY HOSPITAL	14-0211	16974	1	07/01/1966	N	P	O	3
4	Subprovider - IPF									4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF									7
8	Swing Beds - NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA									12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC									15
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19
20	Cost Reporting Period (mm/dd/yyyy)	From: 07 / 01 / 2014	To: 08 / 31 / 2014							20
21	Type of control (see instructions)	2								21
Inpatient PPS Information								1	2	
22	Does this facility qualify for and receive disproportionate share hospital payments 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 §412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.							N	N	22
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting 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)							N	N	22.01
23	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 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.							1	N	23
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days			
		1	2	3	4	5	6			
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.									24
25	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.									25
26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.				1					26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.				1					27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.									35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.				Beginning:	Ending:			36	
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.									37
38	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				Beginning:	Ending:			38	
								1	2	



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

**WORKSHEET S-2
PART I**

39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

**WORKSHEET S-2
PART I**

Prospective Payment System (PPS)-Capital		V 1	XVIII 2	XIX 3	
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	Y	N	45
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N	48
Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	N			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Worksheet E-4. If column 2 is 'N', complete Worksheet D, Part III & IV and D-2, Part II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub 15-1, section 2148? If yes, complete Worksheet D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59
60	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter 'Y' for yes or 'N' for no. (see instructions)	N			60
		Y/N	IME	Direct GME	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1. (see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				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)				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)				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)				61.06
Of the FTEs in line 61.05, specify each new program 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.					
	Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1	2	3	4	
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.					
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)					
62	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				62
62.01	Enter the number of FTE residents that rotated from a teaching health center (THC) into your hospital in this cost reporting period of HRSA THC program. (see instructions)				62.01
Teaching Hospitals that Claim Residents in Non-Provider Settings					
63	Has your facility trained residents in non-provider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64-67. (see instructions)	N			63



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**WORKSHEET S-2
PART I**

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.				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	RATIO (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						64
Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)							
	Program Name	Program Code		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
	1	2		3	4	5	
65							65
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings-Effective for cost reporting periods beginning on or after July 1, 2010				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	RATIO (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						66
Enter in lines 67-67.49, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)							
	Program Name	Program Code		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
	1	2		3	4	5	
67							67
Inpatient Psychiatric Facility PPS				1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.			N			70
71	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, enter 1, 2, or 3 respectively in column 3. If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5.						71
Inpatient Rehabilitation Facility PPS				1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.			N			75
76	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, enter 1, 2, or 3 respectively in column 3. If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5.						76
Long Term Care Hospital PPS							
80	Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no.				N		80
TEFRA Providers							
85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA? Enter 'Y' for yes or 'N' for no.				N		85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter 'Y' for yes, or 'N' for no.						86

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WORKSHEET S-2
PART I

Title V and XIX Services		V	XIX					
		1	2					
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	N	Y	90				
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.	N	N	91				
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column.		N	92				
93	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	93				
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94				
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.			95				
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96				
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.			97				
Rural Providers		1	2					
105	Does this hospital qualify as a Critical Access Hospital (CAH)?	N		105				
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106				
107	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes, complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter 'Y' for yes or 'N' for no in column 2.			107				
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.	N		108				
109	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 each therapy.	Physical	Occupational	Speech	Respiratory	N	N	109
Miscellaneous Cost Reporting Information								
115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98'	N						115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.	N						116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.	N						117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1						118
		Premiums	Paid Losses	Self Insurance				
118.01	List amounts of malpractice premiums and paid losses:	17,185						118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N						118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.	N		N				120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.	Y						121
Transplant Center Information								
125	Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification date(s)(mm/dd/yyyy) below.	N						125
126	If this is a Medicare certified kidney transplant center enter the certification date in column 1 and termination date, if applicable in column 2.							126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date, if applicable in column 2.							127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date, if applicable in column 2.							128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date, if applicable in column 2.							129
130	If this is a Medicare certified pancreas transplant center enter the certification date in column 1 and termination date, if applicable in column 2.							130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date, if applicable in column 2.							131
132	If this is a Medicare certified islet transplant center enter the certification date in column 1 and termination date, if applicable in column 2.							132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date, if applicable in column 2.							133
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable in column 2.							134



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WORKSHEET S-2
PART I

All Providers					
			1	2	
140	Are there any related organization or home office costs as defined in CMS Pub 15-1, Chapter 10? Enter 'Y' for yes, or 'N' for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number (see instructions)			Y	140
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141	Name: CADENCE HEALTH	Contractor's Name: NGS			141
142	Street: 25 NORTH WINFIELD ROAD	Contractor's Number: 00131			142
143	City: WINFIELD	P.O. Box:	State: IL	ZIP Code: 60190	143
144	Are provider based physicians' costs included in Worksheet A?			Y	144
145	If costs for renal services are claimed on Worksheet A, line 74 are they costs for inpatient services only? Enter 'Y' for yes, or 'N' for no.			Y	145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, section 4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.			N	146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.			N	147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.			N	148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.			N	149
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter 'Y' for yes or 'N' for no for each component for Part A and Part B. See 42 CFR §413.13)					
		Title XVIII		Title V	Title XIX
		Part A	Part B	2	3
155	Hospital	N	N	N	N
156	Subprovider - IPF	N	N		
157	Subprovider - IRF	N	N		
158	Subprovider - Other				
159	SNF	N	N		
160	HHA	N	N		
161	CMHC		N		
161.10	CORF				
Multicampus					
165	Is this hospital part of a multicampus hospital that has one or more campuses in different CBSAs? Enter 'Y' for yes or 'N' for no.		N		165
166	If line 165 is yes, for each campus, enter the name in column 0, county in column 1, state in column 2, ZIP in column 3, CBSA in column 4, FTE/campus in column 5.				
	Name	County	State	ZIP Code	CBSA
	0	1	2	3	4
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act					
167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.			N	167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)				168
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transitional factor. (see instructions)				169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)				



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

GENERAL INSTRUCTION: ENTER Y FOR ALL YES RESPONSES. ENTER N FOR ALL NO RESPONSES.
ENTER ALL DATES IN THE MM/DD/YYYY FORMAT.

COMPLETED BY ALL HOSPITALS

		Y/N	DATE		
PROVIDER ORGANIZATION AND OPERATION		1	2		
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (see instructions)	N			1
		Y/N	DATE	V/I	
		1	2	3	
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	N			2
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (e.g., chain home offices, drug or medical supply companies) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (see instructions)	Y			3
		Y/N	TYPE	DATE	
FINANCIAL DATA AND REPORTS		1	2	3	
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (see instructions). IF NO, SEE INSTRUCTIONS.	Y	A	11/25/2014	4
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N			5
		Y/N	Y/N		
APPROVED EDUCATIONAL ACTIVITIES		1	2		
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	N			6
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	N			7
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N			8
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N			9
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N			10
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N			11
				Y/N	
BAD DEBTS				Y/N	
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.			Y	12
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.			N	13
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.			N	14
BED COMPLEMENT					
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			N	15
		PART A		PART B	
		Y/N	DATE	Y/N	DATE
PS&R REPORT DATA		1	2	3	4
16	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 instructions)	N		N	16
17	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 YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (see instructions)	Y	12/19/2014	Y	12/19/2014
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N	18
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N	19
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N	20



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

**WORKSHEET S-2
PART II**

21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N		21
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

GENERAL INSTRUCTION: ENTER Y FOR ALL YES RESPONSES. ENTER N FOR ALL NO RESPONSES.
ENTER ALL DATES IN THE MM/DD/YYYY FORMAT.

COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)

CAPITAL RELATED COSTS			
22	HAVE ASSETS BEEN RELIEFED FOR MEDICARE PURPOSES? IF YES, SEE INSTRUCTIONS.		22
23	HAVE CHANGES OCCURRED IN THE MEDICARE DEPRECIATION EXPENSE DUE TO APPRAISALS MADE DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		23
24	WERE NEW LEASES AND/OR AMENDMENTS TO EXISTING LEASES ENTERED INTO DURING THIS COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		24
25	HAVE THERE BEEN NEW CAPITALIZED LEASES ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		25
26	WERE ASSETS SUBJECT TO SEC. 2314 OF DEFRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		26
27	HAS THE PROVIDER'S CAPITALIZED POLICY CHANGED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		27
INTEREST EXPENSE			
28	WERE NEW LOANS, MORTGAGE AGREEMENTS OR LETTERS OF CREDIT ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		28
29	DID THE PROVIDER HAVE A FUNDED DEPRECIATION ACCOUNT AND/OR BOND FUNDS (debt service reserve fund) TREATED AS A FUNDED DEPRECIATION ACCOUNT? IF YES, SEE INSTRUCTIONS.		29
30	HAS EXISTING DEBT BEEN REPLACED PRIOR TO ITS SCHEDULED MATURITY WITH NEW DEBT? IF YES, SEE INSTRUCTIONS.		30
31	HAS DEBT BEEN RECALLED BEFORE SCHEDULED MATURITY WITHOUT ISSUANCE OF NEW DEBT? IF YES, SEE INSTRUCTIONS.		31
PURCHASED SERVICES			
32	HAVE CHANGES OR NEW AGREEMENTS OCCURRED IN PATIENT CARE SERVICES FURNISHED THROUGH CONTRACTUAL ARRANGEMENTS WITH SUPPLIERS OF SERVICES? IF YES, SEE INSTRUCTIONS.		32
33	IF LINE 32 IS YES, WERE THE REQUIREMENTS OF SEC. 2135.2 APPLIED PERTAINING TO COMPETITIVE BIDDING? IF NO, SEE INSTRUCTIONS.		33
PROVIDER-BASED PHYSICIANS			
34	ARE SERVICES FURNISHED AT THE PROVIDER FACILITY UNDER AN ARRANGEMENT WITH PROVIDER-BASED PHYSICIANS? IF YES, SEE INSTRUCTIONS.		34
35	IF LINE 34 IS YES, WERE THERE NEW AGREEMENTS OR AMENDED EXISTING AGREEMENTS WITH THE PROVIDER-BASED PHYSICIANS DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		35
		Y/N	DATE
HOME OFFICE COSTS		1	2
36	WERE HOME OFFICE COSTS CLAIMED ON THE COST REPORT?		
37	IF LINE 36 IS YES, HAS A HOME OFFICE COST STATEMENT BEEN PREPARED BY THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.		
38	IF LINE 36 IS YES, WAS THE FISCAL YEAR END OF THE HOME OFFICE DIFFERENT FROM THAT OF THE PROVIDER? IF YES, ENTER IN COLUMN 2 THE FISCAL YEAR END OF THE HOME OFFICE.		
39	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO OTHER CHAIN COMPONENTS? IF YES, SEE INSTRUCTIONS.		
40	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.		
COST REORT PREPARER INFORMATION			
41	FIRST NAME: JENNIFER	LAST NAME: STOSENTIN	TITLE: DIRECTOR OF CORPORATE FINA
42	EMPLOYER: CADENCE HEALTH		
43	PHONE NUMBER: 630-933-6340	E-MAIL ADDRESS: JENNIFER.STOSENTIN@CADENCEHEALTH.ORG	



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

	COMPONENT	WKST A LINE NO.	NO. OF BEDS	BED DAYS AVAILABL E	CAH HOURS	INPATIENT DAYS/OUTPATIENT VISITS/TRIPS				
						TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		1	2	3	4	5	6	7	8	
1	HOSPITAL ADULTS & PEDS. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	139	8,618			2,013	303	4,336	1
2	HMO AND OTHER (see instructions)						367			2
3	HMO IPF SUBPROVIDER									3
4	HMO IRF SUBPROVIDER									4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF									5
6	HOSPITAL ADULTS & PEDS. SWING BED NF									6
7	TOTAL ADULTS & PEDS. (exclude observation beds)(see instructions)		139	8,618			2,013	303	4,336	7
8	INTENSIVE CARE UNIT	31	20	1,240			333	33	749	8
9	CORONARY CARE UNIT	32								9
10	BURN INTENSIVE CARE UNIT	33								10
11	SURGICAL INTENSIVE CARE UNIT	34								11
12	OTHER SPECIAL CARE (SPECIFY)	35								12
13	NURSERY	43						130	461	13
14	TOTAL (see instructions)		159	9,858			2,346	466	5,546	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40								16
17	SUBPROVIDER - IRF	41								17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44								19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101								22
23	ASC (Distinct Part)	115								23
24	HOSPICE (Distinct Part)	116								24
24.10	HOSPICE (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88								26
27	TOTAL (sum of lines 14-26)		159							27
28	OBSERVATION BED DAYS								754	28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (see instructions)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (see instructions)								141	32
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)									32.01
33	LTCH NON-COVERED DAYS									33



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

	COMPONENT	FULL TIME EQUIVALENTS			DISCHARGES				
		TOTAL INTERNS & RESIDENTS	EMPLOYEE S ON PAYROLL	NONPAID WORKERS	TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		9	10	11	12	13	14	15	
1	HOSPITAL ADULTS & PEDS. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					503	93	1,219	1
2	HMO AND OTHER (see instructions)					75			2
3	HMO IPF SUBPROVIDER								3
4	HMO IRF SUBPROVIDER								4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF								5
6	HOSPITAL ADULTS & PEDS. SWING BED NF								6
7	TOTAL ADULTS & PEDS. (exclude observation beds)(see instructions)								7
8	INTENSIVE CARE UNIT								8
9	CORONARY CARE UNIT								9
10	BURN INTENSIVE CARE UNIT								10
11	SURGICAL INTENSIVE CARE UNIT								11
12	OTHER SPECIAL CARE (SPECIFY)								12
13	NURSERY								13
14	TOTAL (see instructions)		948.53			503	93	1,219	14
15	CAH VISITS								15
16	SUBPROVIDER - IPF								16
17	SUBPROVIDER - IRF								17
18	SUBPROVIDER I								18
19	SKILLED NURSING FACILITY								19
20	NURSING FACILITY								20
21	OTHER LONG TERM CARE								21
22	HOME HEALTH AGENCY								22
23	ASC (Distinct Part)								23
24	HOSPICE (Distinct Part)								24
24.10	HOSPICE (non-distinct part)								24.10
25	CMHC								25
26	RHC								26
27	TOTAL (sum of lines 14-26)		948.53						27
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)								32

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HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

PART II - WAGE DATA

	WKST A LINE NO.	AMOUNT REPORTED	RECLASSIF- ICATION OF SALARIES (from Worksheet A-6)	ADJUSTED SALARIES (column 2 ± column 3)	PAID HOURS RELATED TO SALARIES IN COLUMN 4	AVERAGE HOURLY WAGE (column 4 ± column 5)		
	1	2	3	4	5	6		
SALARIES								
1	TOTAL SALARIES (see instructions)	200	10,797,336		10,797,336	336,042.60	32.13	1
2	NON-PHYSICIAN ANESTHETIST PART A							2
3	NON-PHYSICIAN ANESTHETIST PART B							3
4	PHYSICIAN-PART A - ADMINISTRATIVE							4
4.01	PHYSICIAN-PART A - TEACHING							4.01
5	PHYSICIAN-PART B							5
6	NON-PHYSICIAN-PART B							6
7	INTERNS & RESIDENTS (in an approved program)	21						7
7.01	CONTRACTED INTERNS & RESIDENTS (in an approved program)							7.01
8	HOME OFFICE PERSONNEL							8
9	SNF	44						9
10	EXCLUDED AREA SALARIES (see instructions)		14,848	869	15,717	708.55	22.18	10
OTHER WAGES & RELATED COSTS								
11	CONTRACT LABOR (see instructions)		94,112		94,112	1,692.55	55.60	11
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES							12
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE		50,957		50,957	432.00	117.96	13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS		3,255,162		3,255,162	49,346.00	65.97	14
15	HOME OFFICE: PHYSICIAN PART A - ADMINISTRATIVE							15
16	HOME OFFICE & CONTRACT PHYSICIANS PART A - TEACHING							16
WAGE-RELATED COSTS								
17	WAGE-RELATED COSTS (core)(see instructions)		2,384,827		2,384,827			17
18	WAGE-RELATED COSTS (other)(see instructions)							18
19	EXCLUDED AREAS		4,692		4,692			19
20	NON-PHYSICIAN ANESTHETIST PART A							20
21	NON-PHYSICIAN ANESTHETIST PART B							21
22	PHYSICIAN PART A - ADMINISTRATIVE							22
22.01	PHYSICIAN PART A - TEACHING							22.01
23	PHYSICIAN PART B							23
24	WAGE-RELATED COSTS (RHC/FQHC)							24
25	INTERNS & RESIDENTS (in an approved program)							25
OVERHEAD COSTS - DIRECT SALARIES								
26	EMPLOYEE BENEFITS DEPARTMENT		559,682	-557,960	1,722	1,127.92	1.53	26
27	ADMINISTRATIVE & GENERAL		1,330,846	62,616	1,393,462	38,999.09	35.73	27
28	ADMINISTRATIVE & GENERAL UNDER CONTRACT (see instructions)							28
29	MAINTENANCE & REPAIRS							29
30	OPERATION OF PLANT		218,250	14,051	232,301	7,992.12	29.07	30
31	LAUNDRY & LINEN SERVICE		3,790	223	4,013	347.64	11.54	31
32	HOUSEKEEPING		230,949	11,535	242,484	16,136.99	15.03	32
33	HOUSEKEEPING UNDER CONTRACT (see instructions)							33
34	DIETARY		182,226	-98,676	83,550	12,438.36	6.72	34
35	DIETARY UNDER CONTRACT (see instructions)							35
36	CAFETERIA			108,338	108,338	7,394.93	14.65	36
37	MAINTENANCE OF PERSONNEL							37
38	NURSING ADMINISTRATION		239,586	33,303	272,889	7,462.25	36.57	38
39	CENTRAL SERVICES AND SUPPLY							39
40	PHARMACY		397,533	24,621	422,154	9,307.30	45.36	40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY							41
42	SOCIAL SERVICE							42
43	OTHER GENERAL SERVICE							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (see instructions)		10,797,336		10,797,336	336,042.60	32.13	1
2	EXCLUDED AREA SALARIES (see instructions)		14,848	869	15,717	708.55	22.18	2
3	SUBTOTAL SALARIES (line 1 minus line 2)		10,782,488	-869	10,781,619	335,334.05	32.15	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (see instructions)		3,400,231		3,400,231	51,470.55	66.06	4
5	SUBTOTAL WAGE-RELATED COSTS (see instructions)		2,384,827		2,384,827		22.12%	5



COMPU-MAX

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HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

6	TOTAL (sum of lines 3 through 5)		16,567,546	-869	16,566,677	386,804.60	42.83	6
7	TOTAL OVERHEAD COST (see instructions)		3,162,862	-401,949	2,760,913	101,206.60	27.28	7



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HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
PART IV

PART IV - WAGE RELATED COST

PART A - CORE LIST

		AMOUNT REPORTED	
	RETIREMENT COST		
1	401K EMPLOYER CONTRIBUTIONS	171,601	1
2	TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3	NONQUALIFIED DEFINED BENEFIT PLAN COST (see instructions)		3
4	QUALIFIED DEFINED BENEFIT PLAN COST (see instructions)	1,119,804	4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA PLAN ADMINISTRATION FEES		5
6	LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN		6
7	EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES		7
	HEALTH AND INSURANCE COST		
8	HEALTH INSURANCE (Purchased or Self Funded)	1,077,698	8
9	PRESCRIPTION DRUG PLAN		9
10	DENTAL, HEARING AND VISION PLAN	61,064	10
11	LIFE INSURANCE (If employee is owner or beneficiary)	10,722	11
12	ACCIDENTAL INSURANCE (If employee is owner or beneficiary)	85,253	12
13	DISABILITY INSURANCE (If employee is owner or beneficiary)	19,918	13
14	LONG-TERM CARE INSURANCE (If employee is owner or beneficiary)		14
15	WORKERS' COMPENSATION INSURANCE	113,366	15
16	RETIREMENT HEALTH CARE COST (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	TAXES		
17	FICA-EMPLOYERS PORTION ONLY	730,817	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19	UNEMPLOYMENT INSURANCE	20,033	19
20	STATE OR FEDERAL UNEMPLOYMENT TAXES		20
	OTHER		
21	EXECUTIVE DEFERRED COMPENSATION (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21
22	DAY CARE COSTS AND ALLOWANCES		22
23	TUITION REIMBURSEMENT	99,048	23
24	TOTAL WAGE RELATED COST (Sum of lines 1-23)	3,509,324	24

PART B - OTHER THAN CORE RELATED COST

25	OTHER WAGE RELATED (OTHER WAGE REL		25
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WAGE INDEX PENSION COST SCHEDULE (For Worksheet S-3, Part IV, Line 4)

EXHIBIT 3

STEP 2: DETERMINE THE 3-YEAR AVERAGING PERIOD				
1	WAGE INDEX FISCAL YEAR ENDING DATE	09/30/2018		1
2	PROVIDER'S COST REPORTING PERIOD USED FOR WAGE INDEX YEAR ON LINE 1 (FYB in Col. 1, FYE in Col. 2)	07/01/2013	06/30/2014	2
3	MIDPOINT OF PROVIDER'S COST REPORTING PERIOD SHOWN ON LINE 2, ADJUSTED TO FIRST OF MONTH	1/01/2014		3
4	DATE BEGINNING THE 3-YEAR AVERAGING PERIOD (subtract 18 months from midpoint shown on Line 3)	7/01/2012		4
5	DATE ENDING THE 3-YEAR AVERAGING PERIOD (add 18 months to midpoint shown on Line 3)	7/01/2015		5
STEP 2 (OPTIONAL): ADJUST AVERAGING PERIOD FOR A NEW PLAN (see instructions)				
6	EFFECTIVE DATE OF PENSION PLAN			6
7	FIRST DAY OF THE PROVIDER COST REPORTING PERIOD CONTAINING THE PENSION PLAN EFFECTIVE DATE			7
8	STARTING DATE OF THE ADJUSTED AVERAGING PERIOD (date on Line 7, adjusted to first of month)			8

IF THIS DATE OCCURS AFTER THE PERIOD SHOWN ON LINE 2, STOP HERE AND SEE INSTRUCTIONS

STEP 3: AVERAGE PENSION CONTRIBUTIONS DURING THE AVERAGING PERIOD				
9	BEGINNING DATE OF AVERAGING PERIOD FROM LINE 4 OR LINE 8, AS APPLICABLE	7/01/2012		9
10	ENDING DATE OF AVERAGING PERIOD FROM LINE 5	7/01/2015		10
11	ENTER PROVIDER CONTRIBUTIONS MADE DURING AVERAGING PERIOD ON LINES 9 & 10	DEPOSIT DATE(S)	CONTRIB-UTION(S)	11
11.01		06/30/2013	1,119,801	11.01
11.02		06/30/2014	1,119,801	11.02
11.03		06/30/2015	1,119,801	11.03
12	TOTAL CALENDAR MONTHS INCLUDED IN AVERAGING PERIOD (36 unless Step 2 completed)	36		12
13	TOTAL CONTRIBUTIONS MADE DURING AVERAGING PERIOD	3,359,403		13
14	AVERAGE MONTHLY CONTRIBUTION (Line 13 divided by Line 12)	93,317		14
15	NUMBER OF MONTHS IN PROVIDER COST REPORTING PERIOD ON LINE 2	12		15
16	AVERAGE PENSION CONTRIBUTIONS (Line 14 times Line 15)	1,119,804		16
STEP 4: TOTAL PENSION COST FOR WAGE INDEX				
17	ANNUAL PREFUNDING INSTALLMENT (see instructions)			17
18	REPORTABLE PREFUNDING INSTALLMENT ((Line 17 times Line 15) divided by 12)			18
19	TOTAL PENSION COST FOR WAGE INDEX (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)	1,119,804		19



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HOSPITAL CONTRACT LABOR AND BENEFIT COST

**WORKSHEET S-3
PART V**

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

	COMPONENT	CONTRACT LABOR 1	BENEFIT COST 2	
	0			
1	TOTAL FACILITY CONTRACT LABOR AND BENEFIT COST	1,254,940	15,115,983	1
2	HOSPITAL	1,254,940	15,115,983	2
3	SUBPROVIDER - IPF			3
4	SUBPROVIDER - IRF			4
5	SUBPROVIDER - (OTHER)			5
6	SWING BEDS - SNF			6
7	SWING BEDS - NF			7
8	HOSPITAL-BASED SNF			8
9	HOSPITAL-BASED NF			9
10	HOSPITAL-BASED OLTC			10
11	HOSPITAL-BASED HHA			11
12	SEPARATELY CERTIFIED ASC			12
13	HOSPITAL-BASED HOSPICE			13
14	HOSPITAL-BASED HEALTH CLINIC - RHC			14
15	HOSPITAL-BASED HEALTH CLINIC - FQHC			15
16	HOSPITAL-BASED (CMHC)			16
17	RENAL DIALYSIS			17
18	OTHER			18



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HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

WORKSHEET S-10

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

1	COST TO CHARGE RATIO (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)	0.229088	1
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MEDICAID (see instructions for each line)

2	NET REVENUE FROM MEDICAID	1,697,321	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	N	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?		4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID		5
6	MEDICAID CHARGES	13,050,125	6
7	MEDICAID COST (line 1 times line 6)	2,989,627	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (line 7 minus the sum of lines 2 and 5) IF LINE 7 IS LESS THAN THE SUM OF LINES 2 AND 5, THEN ENTER ZERO.	1,292,306	8

STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)(see instructions for each line)

9	NET REVENUE FROM STAND-ALONE SCHIP		9
10	STAND-ALONE SCHIP CHARGES		10
11	STAND-ALONE SCHIP COST (line 1 times line 10)		11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (line 11 minus line 9) IF LINE 11 IS LESS THAN LINE 9, THEN ENTER ZERO.		12

OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (see instructions for each line)

13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (not included on lines 2, 5, or 9)		13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (not included in lines 6 or 10)		14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (line 1 times line 14)		15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (line 15 minus line 13) IF LINE 15 IS LESS THAN LINE 13, THEN ENTER ZERO.		16

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE		17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS		18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (sum of lines 8, 12 and 16)	1,292,306	19

		UNINSURED PATIENTS	INSURED PATIENTS	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (at full charges excluding non-reimbursable cost centers) FOR THE ENTIRE FACILITY	1,208,365	6,990,110	8,198,475	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (line 1 times line 20)	276,822	1,601,350	1,878,172	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	3,112	7,196	10,308	22
23	COST OF CHARITY CARE (line 21 minus line 22)	273,710	1,594,154	1,867,864	23

24	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?	N	24
25	IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (see instructions)		25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)	3,717,901	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)		27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 26 minus line 27)	3,717,901	28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 1 times line 28)	851,727	29
30	COST OF UNCOMPENSATED CARE (line 23, column 3 plus line 29)	2,719,591	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (line 19 plus line 30)	4,011,897	31



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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATION S	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	CAP REL COSTS-BLDG & FIXT				2,802,953	2,802,953		2,802,953	1
2	00200	CAP REL COSTS-MVBLE EQUIP				946,738	946,738		946,738	2
3	00300	OTHER CAP REL COSTS							-0-	3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	559,682	21,161	580,843	-565,901	14,942		14,942	4
5.01	00510	NONPATIENT TELEPHONES				60,128	60,128	-1,755	58,373	5.01
5.02	00511	IS		140,146	140,146	-140,146		1,955,264	1,955,264	5.02
5.03	00512	PURCHASING	81,030	26,579	107,609	1,389	108,998	137,031	246,029	5.03
5.04	00513	PT REG	234,217	71,061	305,278	12,016	317,294		317,294	5.04
5.05	00514	PT ACCTS						238,721	238,721	5.05
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL	1,015,599	10,468,478	11,484,077	-1,833,440	9,650,637	-2,042,950	7,607,687	5.06
6	00600	MAINTENANCE & REPAIRS								6
7	00700	OPERATION OF PLANT	218,250	1,722,819	1,941,069	-517,336	1,423,733	-43,207	1,380,526	7
8	00800	LAUNDRY & LINEN SERVICE	3,790	97,697	101,487	-113	101,374		101,374	8
9	00900	HOUSEKEEPING	230,949	118,287	349,236	9,536	358,772		358,772	9
10	01000	DIETARY	182,226	256,526	438,752	-264,325	174,427	-332	174,095	10
11	01100	CAFETERIA				241,585	241,585	-164,734	76,851	11
12	01200	MAINTENANCE OF PERSONNEL								12
13	01300	NURSING ADMINISTRATION	239,586	116,130	355,716	5,498	361,214	-23,268	337,946	13
14	01400	CENTRAL SERVICES & SUPPLY								14
15	01500	PHARMACY	397,533	3,511,213	3,908,746	-3,362,449	546,297	-4,848	541,449	15
16	01600	MEDICAL RECORDS & LIBRARY		9,515	9,515		9,515	170,692	180,207	16
17	01700	SOCIAL SERVICE								17
19	01900	NONPHYSICIAN ANESTHETISTS								19
20	02000	NURSING SCHOOL								20
21	02100	I&R SERVICES-SALARY & FRINGES APPRVD								21
22	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD								22
23	02300	PARAMED ED PRGM-(SPECIFY)								23
		INPATIENT ROUTINE SERV COST CENTERS								
30	03000	ADULTS & PEDIATRICS	1,932,716	870,916	2,803,632	-248,571	2,555,061	-61,476	2,493,585	30
31	03100	INTENSIVE CARE UNIT	530,958	308,244	839,202	-55,628	783,574	-58,195	725,379	31
43	04300	NURSERY	176,351	52,467	228,818	6,711	235,529		235,529	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	OPERATING ROOM	427,651	2,189,280	2,616,931	-1,660,165	956,766		956,766	50
51	05100	RECOVERY ROOM	99,351	62,582	161,933	-7,981	153,952		153,952	51
52	05200	DELIVERY ROOM & LABOR ROOM	334,629	194,288	528,917	-33,434	495,483	-58,392	437,091	52
53	05300	ANESTHESIOLOGY	14,466	78,283	92,749	-14,256	78,493		78,493	53
54	05400	RADIOLOGY-DIAGNOSTIC	432,707	251,488	684,195	-157,903	526,292	-809	525,483	54
54.01	03630	ULTRA SOUND	136,233	44,173	180,406	22,596	203,002		203,002	54.01
54.02	03480	NUCLEAR ONCOLOGY	103,531	186,011	289,542	-123,347	166,195		166,195	54.02
55	05500	RADIOLOGY-THERAPEUTIC	211,009	323,534	534,543	-105,312	429,231	-29,706	399,525	55
56	05600	RADIOISOTOPE	46,445	93,188	139,633	15,707	155,340		155,340	56
57	05700	CT SCAN	135,376	85,922	221,298	26,383	247,681		247,681	57
58	05800	MRI	97,808	71,395	169,203	7,823	177,026		177,026	58
59	05900	CARDIAC CATHETERIZATION	230,405	630,377	860,782	-460,153	400,629		400,629	59
60	06000	LABORATORY	423,644	1,192,385	1,616,029	-102,087	1,513,942	-79,331	1,434,611	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	06400	INTRAVENOUS THERAPY	221,816	153,561	375,377	-70,807	304,570	-8,459	296,111	64
65	06500	RESPIRATORY THERAPY	178,812	68,902	247,714	-6,236	241,478		241,478	65
66	06600	PHYSICAL THERAPY	466,055	243,465	709,520	13,432	722,952	-8,661	714,291	66
69	06900	ELECTROCARDIOLOGY	144,558	305,914	450,472	-33,982	416,490	-223,759	192,731	69
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS				1,410,157	1,410,157		1,410,157	71
72	07200	IMPL. DEV. CHARGED TO PATIENTS				952,786	952,786		952,786	72
73	07300	DRUGS CHARGED TO PATIENTS				3,333,544	3,333,544		3,333,544	73
74	07400	RENAL DIALYSIS				79,501	79,501		79,501	74
75	07500	ASC (NON-DISTINCT PART)	235,379	153,532	388,911	-98,929	289,982		289,982	75
75.01	07501	LITHOTRIPSY								75.01
75.02	07502	PSYCH	41,668	48,770	90,438	-6,010	84,428		84,428	75.02
75.03	07503	NEURODIAGNOSTICS	19,046	7,534	26,580	-2,011	24,569		24,569	75.03
76.97	07697	CARDIAC REHABILITATION	47,307	53,730	101,037	-640	100,397		100,397	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99



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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATION S	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		OUTPATIENT SERVICE COST CENTERS								
90.03	09003	GENETIC TESTING	15,439	7,248	22,687	-206	22,481	-5,630	16,851	90.03
90.04	09004	CHRONIC PAIN CLINIC	26,696	30,518	57,214	-2,772	54,442		54,442	90.04
90.05	09005	DIABETES EDUCATION	49,852	20,047	69,899	3,209	73,108	-831	72,277	90.05
90.06	09006	WOUND CARE	58,304	41,444	99,748	-11,327	88,421		88,421	90.06
90.07	09007	SLEEP LAB	51,043	-41,192	9,851	73	9,924	-3,392	6,532	90.07
91	09100	EMERGENCY	730,371	494,256	1,224,627	-66,930	1,157,697	-206,516	951,181	91
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)								92
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	10,782,488	24,781,874	35,564,362	-632	35,563,730	-524,543	35,039,187	118
		NONREIMBURSABLE COST CENTERS								
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	14,848	14,859	29,707	869	30,576		30,576	190
192	19200	PHYSICIANS' PRIVATE OFFICES		505	505	-10	495		495	192
192.0 1	19201	HOME HEALTH AGENCY		227	227	-227				192.0 1
200		TOTAL (sum of lines 118-199)	10,797,336	24,797,465	35,594,801		35,594,801	-524,543	35,070,258	200



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RECLASSIFICATIONS

WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				
			COST CENTER	LINE #	SALARY		OTHER
		1	2	3	4	5	
1	SHARED DIETARY COSTS	A	CAFETERIA	11	108,338	133,247	1
500	TOTAL RECLASSIFICATIONS				108,338	133,247	500
	CODE LETTER - A						
1	SPACE RENTAL ALLOCATION	C	OTHER ADMINISTRATIVE AND GENE	5.06		526	1
2	SPACE RENTAL ALLOCATION	C					2
3	SPACE RENTAL ALLOCATION	C					3
4	SPACE RENTAL ALLOCATION	C					4
5	SPACE RENTAL ALLOCATION	C					5
6	SPACE RENTAL ALLOCATION	C					6
7	SPACE RENTAL ALLOCATION	C					7
8							8
500	TOTAL RECLASSIFICATIONS					526	500
	CODE LETTER - C						
1	CHARGEABLE DRUG	D	DRUGS CHARGED TO PATIENTS	73		3,333,544	1
500	TOTAL RECLASSIFICATIONS					3,333,544	500
	CODE LETTER - D						
1	DEPRECIATION	E	CAP REL COSTS-BLDG & FIXT	1		1,656,046	1
2			CAP REL COSTS-MVBLE EQUIP	2		930,346	2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
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31							31
32							32
33							33
34							34
35							35
36							36
37							37
38							38
39							39
40							40
500	TOTAL RECLASSIFICATIONS					2,586,392	500
	CODE LETTER - E						
1	CHARGEABLE MED SUPPLIES	F	MEDICAL SUPPLIES CHARGED TO P	71		1,410,157	1
2			IMPL. DEV. CHARGED TO PATIENT	72		952,786	2
3							3
4							4
5							5
6							6
7							7
8							8
9							9



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RECLASSIFICATIONS

WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				
			COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
500	TOTAL RECLASSIFICATIONS					2,362,943	500
	CODE LETTER - F						
1	RENAL DIALYSIS	H	RENAL DIALYSIS	74		79,501	1
500	TOTAL RECLASSIFICATIONS					79,501	500
	CODE LETTER - H						
1	CONTROLLER'S ADJ-INCENTIVE PYMT	I	PURCHASING	5.03	4,889		1
2			PT REG	5.04	12,745		2
3			OTHER ADMINISTRATIVE AND GENE	5.06	44,982		3
4			OPERATION OF PLANT	7	14,051		4
5			LAUNDRY & LINEN SERVICE	8	223		5
6			HOUSEKEEPING	9	11,535		6
7			DIETARY	10	9,662		7
8			NURSING ADMINISTRATION	13	33,303		8
9			PHARMACY	15	24,621		9
10			ADULTS & PEDIATRICS	30	79,870		10
11			INTENSIVE CARE UNIT	31	28,480		11
12			NURSERY	43	10,856		12
13			OPERATING ROOM	50	20,982		13
14			RECOVERY ROOM	51	6,503		14
15			DELIVERY ROOM & LABOR ROOM	52	20,929		15
16			ANESTHESIOLOGY	53	916		16
17			RADIOLOGY-DIAGNOSTIC	54	25,422		17
18			ULTRA SOUND	54.01	7,621		18
19			NUCLEAR ONCOLOGY	54.02	9,908		19
20			RADIOLOGY-THERAPEUTIC	55	12,505		20
21			RADIOISOTOPE	56	2,840		21
22			CT SCAN	57	8,405		22
23			MRI	58	5,679		23
24			CARDIAC CATHETERIZATION	59	11,950		24
25			LABORATORY	60	23,237		25
26			INTRAVENOUS THERAPY	64	11,243		26
27			RESPIRATORY THERAPY	65	10,097		27
28			PHYSICAL THERAPY	66	26,491		28
29			ELECTROCARDIOLOGY	69	8,103		29
30			ASC (NON-DISTINCT PART)	75	13,352		30
31			PSYCH	75.02	2,036		31
32			CARDIAC REHABILITATION	76.97	3,518		32
33			GENETIC TESTING	90.03	594		33
34			CHRONIC PAIN CLINIC	90.04	1,509		34
35			DIABETES EDUCATION	90.05	3,277		35
36			WOUND CARE	90.06	3,905		36
37			SLEEP LAB	90.07	2,624		37
38			EMERGENCY	91	38,228		38
39			GIFT, FLOWER, COFFEE SHOP & C	190	869		39
500	TOTAL RECLASSIFICATIONS				557,960		500
	CODE LETTER - I						
1	RADIOLOGY ADMINISTRATIVE	J	ULTRA SOUND	54.01	14,611	3,889	1
2			RADIOISOTOPE	56	11,380	3,029	2
3			CT SCAN	57	15,893	4,230	3
4			MRI	58	11,472	3,053	4
5			CARDIAC CATHETERIZATION	59	29,066	7,737	5
500	TOTAL RECLASSIFICATIONS				82,422	21,938	500
	CODE LETTER - J						
1	INTEREST EXPENSE	K	CAP REL COSTS-BLDG & FIXT	1		1,112,032	1
500	TOTAL RECLASSIFICATIONS					1,112,032	500



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RECLASSIFICATIONS

WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				
			COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
	CODE LETTER - K						
1	CAPITAL INSURANCE	L	CAP REL COSTS-BLDG & FIXT	1		34,875	1
2			CAP REL COSTS-MVBLE EQUIP	2		16,392	2
500	TOTAL RECLASSIFICATIONS					51,267	500
	CODE LETTER - L						
1	SURGERY ADMINISTRATION	M	RECOVERY ROOM	51	8,457	726	1
2			ANESTHESIOLOGY	53	1,231	917	2
3			ASC (NON-DISTINCT PART)	75	15,604	1,445	3
500	TOTAL RECLASSIFICATIONS				25,292	3,088	500
	CODE LETTER - M						
1	PRE ADMISSION TESTING	N	OPERATING ROOM	50	28,911	10,908	1
2			RECOVERY ROOM	51	7,746	690	2
3			ANESTHESIOLOGY	53	1,128	869	3
500	TOTAL RECLASSIFICATIONS				37,785	12,467	500
	CODE LETTER - N						
1	TELEPHONE EXPENSE	O	NONPATIENT TELEPHONES	5.01		60,128	1
500	TOTAL RECLASSIFICATIONS					60,128	500
	CODE LETTER - O						
	GRAND TOTAL (INCREASES)				811,797	9,757,073	

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.



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RECLASSIFICATIONS

WORKSHEET A-6

		DECREASES						
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
1	SHARED DIETARY COSTS	A	DIETARY	10	108,338	133,247		
500	TOTAL RECLASSIFICATIONS				108,338	133,247	500	
	CODE LETTER - A							
1	SPACE RENTAL ALLOCATION	C	RADIOLOGY-DIAGNOSTIC	54		98	1	
2	SPACE RENTAL ALLOCATION	C	LABORATORY	60		31	2	
3	SPACE RENTAL ALLOCATION	C	PHYSICAL THERAPY	66		212	3	
4	SPACE RENTAL ALLOCATION	C	PSYCH	75.02		58	4	
5	SPACE RENTAL ALLOCATION	C	CARDIAC REHABILITATION	76.97		73	5	
6	SPACE RENTAL ALLOCATION	C	CHRONIC PAIN CLINIC	90.04		32	6	
7	SPACE RENTAL ALLOCATION	C	DIABETES EDUCATION	90.05		13	7	
8			WOUND CARE	90.06		9	8	
500	TOTAL RECLASSIFICATIONS					526	500	
	CODE LETTER - C							
1	CHARGEABLE DRUG	D	PHARMACY	15		3,333,544	1	
500	TOTAL RECLASSIFICATIONS					3,333,544	500	
	CODE LETTER - D							
1	DEPRECIATION	E	IS	5.02		80,018	9	
2			PURCHASING	5.03		3,500	9	
3			PT REG	5.04		729	3	
4			OTHER ADMINISTRATIVE AND GENE	5.06		723,590	4	
5			OPERATION OF PLANT	7		531,387	5	
6			LAUNDRY & LINEN SERVICE	8		336	6	
7			HOUSEKEEPING	9		1,999	7	
8			DIETARY	10		32,402	8	
9			NURSING ADMINISTRATION	13		27,805	9	
10			PHARMACY	15		28,498	10	
11			ADULTS & PEDIATRICS	30		166,982	11	
12			INTENSIVE CARE UNIT	31		40,176	12	
13			OPERATING ROOM	50		238,640	13	
14			RECOVERY ROOM	51		17,438	14	
15			DELIVERY ROOM & LABOR ROOM	52		20,502	15	
16			RADIOLOGY-DIAGNOSTIC	54		74,090	16	
17			ULTRA SOUND	54.01		2,464	17	
18			NUCLEAR ONCOLOGY	54.02		81,044	18	
19			RADIOLOGY-THERAPEUTIC	55		117,817	19	
20			RADIOISOTOPE	56		1,542	20	
21			CT SCAN	57		866	21	
22			MRI	58		11,922	22	
23			CARDIAC CATHETERIZATION	59		85,527	23	
24			LABORATORY	60		125,293	24	
25			INTRAVENOUS THERAPY	64		37,054	25	
26			RESPIRATORY THERAPY	65		5,123	26	
27			PHYSICAL THERAPY	66		10,555	27	
28			ELECTROCARDIOLOGY	69		42,085	28	
29			ASC (NON-DISTINCT PART)	75		20,754	29	
30			PSYCH	75.02		7,988	30	
31			NEURODIAGNOSTICS	75.03		2,011	31	
32			CARDIAC REHABILITATION	76.97		4,085	32	
33			GENETIC TESTING	90.03		800	33	
34			CHRONIC PAIN CLINIC	90.04		1,758	34	
35			DIABETES EDUCATION	90.05		55	35	
36			WOUND CARE	90.06		431	36	
37			SLEEP LAB	90.07		2,551	37	
38			EMERGENCY	91		36,338	38	
39			HOME HEALTH AGENCY	192.01		227	39	
40			PHYSICIANS' PRIVATE OFFICES	192		10	40	
500	TOTAL RECLASSIFICATIONS					2,586,392	500	
	CODE LETTER - E							
1	CHARGEABLE MED SUPPLIES	F	PHARMACY	15		25,028	1	
2			ADULTS & PEDIATRICS	30		81,958	2	
3			INTENSIVE CARE UNIT	31		43,932	3	
4			NURSERY	43		4,145	4	
5			OPERATING ROOM	50		1,453,946	5	
6			RECOVERY ROOM	51		14,665	6	
7			DELIVERY ROOM & LABOR ROOM	52		33,861	7	
8			ANESTHESIOLOGY	53		19,317	8	



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RECLASSIFICATIONS

WORKSHEET A-6

		DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	WKST A-7 REF.
		1	6	7	8	9	10
9			RADIOLOGY-DIAGNOSTIC	54		4,777	9
10			ULTRA SOUND	54.01		1,061	10
11			NUCLEAR ONCOLOGY	54.02		52,211	11
12			CT SCAN	57		1,279	12
13			MRI	58		459	13
14			CARDIAC CATHETERIZATION	59		423,379	14
15			INTRAVENOUS THERAPY	64		44,996	15
16			RESPIRATORY THERAPY	65		11,210	16
17			PHYSICAL THERAPY	66		2,292	17
18			ASC (NON-DISTINCT PART)	75		58,324	18
19			CHRONIC PAIN CLINIC	90.04		2,491	19
20			WOUND CARE	90.06		14,792	20
21			EMERGENCY	91		68,820	21
500	TOTAL RECLASSIFICATIONS CODE LETTER - F					2,362,943	500
1	RENAL DIALYSIS	H	ADULTS & PEDIATRICS	30		79,501	1
500	TOTAL RECLASSIFICATIONS CODE LETTER - H					79,501	500
1	CONTROLLER'S ADJ-INCENTIVE PYMT	I	EMPLOYEE BENEFITS DEPARTMENT	4	557,960		1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
23							23
24							24
25							25
26							26
27							27
28							28
29							29
30							30
31							31
32							32
33							33
34							34
35							35
36							36
37							37
38							38
39							39
500	TOTAL RECLASSIFICATIONS CODE LETTER - I				557,960		500
1	RADIOLOGY ADMINISTRATIVE	J	RADIOLOGY-DIAGNOSTIC	54	82,422	21,938	1
2							2
3							3
4							4
5							5
500	TOTAL RECLASSIFICATIONS CODE LETTER - J				82,422	21,938	500



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RECLASSIFICATIONS

WORKSHEET A-6

		DECREASES						
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
1	INTEREST EXPENSE	K	OTHER ADMINISTRATIVE AND GENE	5.06		1,112,032	10	1
500	TOTAL RECLASSIFICATIONS					1,112,032		500
	CODE LETTER - K							
1	CAPITAL INSURANCE	L	EMPLOYEE BENEFITS DEPARTMENT	4		7,941	11	1
2			OTHER ADMINISTRATIVE AND GENE	5.06		43,326	11	2
500	TOTAL RECLASSIFICATIONS					51,267		500
	CODE LETTER - L							
1	SURGERY ADMINISTRATION	M	OPERATING ROOM	50	25,292	3,088		1
2								2
3								3
500	TOTAL RECLASSIFICATIONS				25,292	3,088		500
	CODE LETTER - M							
1	PRE ADMISSION TESTING	N	ASC (NON-DISTINCT PART)	75	37,785	12,467		1
2								2
3								3
500	TOTAL RECLASSIFICATIONS				37,785	12,467		500
	CODE LETTER - N							
1	TELEPHONE EXPENSE	O	IS	5.02		60,128		1
500	TOTAL RECLASSIFICATIONS					60,128		500
	CODE LETTER - O							
	GRAND TOTAL (DECREASES)				811,797	9,757,073		

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry. Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

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RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

	DESCRIPTION	BEGINNING BALANCES	ACQUISITIONS			DISPOSALS AND RETIREMENTS	ENDING BALANCE	FULLY DEPRECIATED ASSETS	
			PURCHASES	DONATION	TOTAL				
		1	2	3	4	5	6	7	
1	LAND	1,584,576					1,584,576		1
2	LAND IMPROVEMENTS	12,475,438	310,192		310,192		12,785,630		2
3	BUILDINGS AND FIXTURES	182,015,868	698,603		698,603		182,714,471		3
4	BUILDING IMPROVEMENTS	37,057,509	21,592		21,592		37,079,101		4
5	FIXED EQUIPMENT	2,189,193					2,189,193		5
6	MOVABLE EQUIPMENT	78,611,279	171,704		171,704		78,782,983		6
7	HIT DESIGNATED ASSETS								7
8	SUBTOTAL (sum of lines 1-7)	313,933,863	1,202,091		1,202,091		315,135,954		8
9	RECONCILING ITEMS								9
10	TOTAL (line 7 minus line 9)	313,933,863	1,202,091		1,202,091		315,135,954		10

PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 AND 2

	DESCRIPTION	SUMMARY OF CAPITAL							TOTAL(1) (Sum of (cols. 9 through 14)	
		DEPRECIATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)			
*		9	10	11	12	13	14	15		
1	CAP REL COSTS-BLDG & FIXT								1	
2	CAP REL COSTS-MVBLE EQUIP								2	
3	TOTAL (sum of lines 1-2)								3	

(1) The amount in columns 9 through 14 must equal the amount on Worksheet A, column 2, lines 1 and 2. Enter in each column the appropriate amounts including any directly assigned cost that may

have been included in Worksheet A, column 2, lines 1 and 2.

* All lines numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	DESCRIPTION	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		GROSS ASSETS	CAPITAL-IZED LEASES	GROSS ASSETS FOR RATIO (col. 1 - col. 2)	RATIO (see instr.)	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL (sum of (cols. 5 through 7)	
*		9	10	11	12	13	14	15	16	
1	CAP REL COSTS-BLDG & FI				0.000000					1
2	CAP REL COSTS-MVBLE EQU				0.000000					2
3	TOTAL (sum of lines 1-2)				0.000000					3

	DESCRIPTION	SUMMARY OF CAPITAL							TOTAL(2) (sum of (cols. 9 through 14)	
		DEPRECIATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)			
*		9	10	11	12	13	14	15		
1	CAP REL COSTS-BLDG & FIXT	1,656,046	1,112,032	34,875				2,802,953	1	
2	CAP REL COSTS-MVBLE EQUIP	930,346		16,392				946,738	2	
3	TOTAL (sum of lines 1-2)	2,586,392	1,112,032	51,267				3,749,691	3	

(2) The amounts on lines 1 and 2 must equal the corresponding amounts on Worksheet A, column 7, lines 1 and 2. Columns 9 through 14 should include related Worksheet A-6 reclassifications,

Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs. (See instructions.)

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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION(1)	BASIS / CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF.
				COST CENTER	LINE#	
		1	2	3	4	5
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (chapter 2)			CAP REL COSTS-BLDG & FIXT	1	1
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (chapter 2)			CAP REL COSTS-MVBLE EQUIP	2	2
3	INVESTMENT INCOME-OTHER (chapter 2)					3
4	TRADE, QUANTITY, AND TIME DISCOUNTS (chapter 8)					4
5	REFUNDS AND REBATES OF EXPENSES (chapter 8)	B	-7,000	OPERATION OF PLANT	7	5
6	RENTAL OF PROVIDER SPACE BY SUPPLIERS (chapter 8)	B	-29,706	RADIOLOGY-THERAPEUTIC	55	6
7	TELEPHONE SERVICES (PAY STATIONS EXCL) (chapter 21)	A	-1,755	NONPATIENT TELEPHONES	5.01	7
8	TELEVISION AND RADIO SERVICE (chapter 21)					8
9	PARKING LOT (chapter 21)					9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-965,285			10
11	SALE OF SCRAP, WASTE, ETC. (chapter 23)	B	-809	RADIOLOGY-DIAGNOSTIC	54	11
12	RELATED ORGANIZATION TRANSACTIONS (chapter 10)	WKST A-8-1	751,320			12
13	LAUNDRY AND LINEN SERVICE					13
14	CAFETERIA - EMPLOYEES AND GUESTS	B	-153,840	CAFETERIA	11	14
15	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					15
16	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS	B	-1,604	ADULTS & PEDIATRICS	30	16
17	SALE OF DRUGS TO OTHER THAN PATIENTS	B	-288	PHARMACY	15	17
18	SALE OF MEDICAL RECORDS AND ABSTRACTS					18
19	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)	B	-3,743	ADULTS & PEDIATRICS	30	19
20	VENDING MACHINES					20
21	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (chapter 21)					21
22	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENTS					22
23	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		RESPIRATORY THERAPY	65	23
24	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		PHYSICAL THERAPY	66	24
25	UTIL REVIEW-PHYSICIANS' COMPENSATION (chapter 21)			UTILIZATION REVIEW-SNF	114	25
26	DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1	26
27	DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2	27
28	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19	28
29	PHYSICIANS' ASSISTANT					29
30	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67	30
31	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		SPEECH PATHOLOGY	68	31
32	CAH HIT ADJ FOR DEPRECIATION AND					32
33						33
33.02	OTHER INCOME	B	-9,276	OTHER ADMINISTRATIVE AND GENERAL	5.06	33.02
33.03	OTHER INCOME	B	-23,907	OPERATION OF PLANT	7	33.03
33.05	MISC INCOME	B	-332	DIETARY	10	33.05
33.06	EHR PHYSICIAN EXPENSES	A	-9,515	MEDICAL RECORDS & LIBRARY	16	33.06
33.07	MISC INCOME	B	-890	ADULTS & PEDIATRICS	30	33.07
33.08	OTHER INCOME	B	-5,630	GENETIC TESTING	90.03	33.08
33.10	MEALS REV	B	-10,894	CAFETERIA	11	33.10
33.12	OTHER SERVICE REV	B	-45,675	EMERGENCY	91	33.12
33.13	OTHER SERVICE REV	B	-6,398	ADULTS & PEDIATRICS	30	33.13
33.15	WORK ORDER REVENUE	B	84	OPERATION OF PLANT	7	33.15
33.17	BARATRIC REVENUE	B	-11,763	ADULTS & PEDIATRICS	30	33.17
34						34
35						35
36						36
37						37
37.01	MEALS AND ENTERTAINMENT	A	-475	OTHER ADMINISTRATIVE AND GENERAL	5.06	37.01
37.02	MEALS AND ENTERTAINMENT	A	-43	OPERATION OF PLANT	7	37.02
37.04	PROMOTIONS	A	-528	OTHER ADMINISTRATIVE AND GENERAL	5.06	37.04
37.07	ADVERTISING AND PROMOTION	A	-431	ADULTS & PEDIATRICS	30	37.07
37.08	MEALS AND ENTERTAINMENT	A	-136	PHYSICAL THERAPY	66	37.08
37.09	MEALS AND ENTERTAINMENT	A	-103	ELECTROCARDIOLOGY	69	37.09
37.10	MARKETING	A	-80	LABORATORY	60	37.10
38						38
39	INVESTMENT FEES	A	31,468	OTHER ADMINISTRATIVE AND GENERAL	5.06	39



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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION(1)	BASIS / CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
				COST CENTER	LINE#	WKST A-7 REF.	
		1	2	3	4	5	
40							40
41	VALET SERVICES	A	-12,341	OPERATION OF PLANT	7		41
42							42
43	MISC	B	-4,968	OTHER ADMINISTRATIVE AND GENERAL	5.06		43
44							44
45							45
46							46
47							47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-524,543				50

- (1) Description - all chapter references in this column pertain to CMS Pub. 15-1
- (2) Basis for adjustment (see instructions)
 - A. Costs - if cost, including applicable overhead, can be determined
 - B. Amount Received - if cost cannot be determined
- (3) Additional adjustments may be made on lines 33 thru 49 and subscripents thereof.

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



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STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

WORKSHEET A-8-1

A: COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT INCLUDED IN WKST. A COLUMN 5	NET ADJUSTMENTS (col. 4 minus col. 5)*	WKST A-7 REF.	
1	2	3	4	5	6	7	
1	66	PHYSICAL THERAPY	RENTAL SPACE	58,865	67,390	-8,525	1
2	90.05	DIABETES EDUCATION	RENTAL SPACE	5,737	6,568	-831	2
3							3
3.02	5.02	IS	INFORMATION TECHNOLOGY	1,591,498		1,591,498	3.02
3.03	5.06	OTHER ADMINISTRATIVE AND GENERAL	PATIENT SATISFACTION	77,437		77,437	3.03
3.04	5.03	PURCHASING	HOME OFFICE COST	137,031		137,031	3.04
3.05	5.06	OTHER ADMINISTRATIVE AND GENERAL	PHYSICIAN RELATIONS	23,637		23,637	3.05
3.06	5.05	PT ACCTS	REVENUE CYCLE	238,721		238,721	3.06
3.07	16	MEDICAL RECORDS & LIBRARY	HOME OFFICE COST	180,207		180,207	3.07
3.08	5.02	IS	EPIC	363,766		363,766	3.08
3.09	5.06	OTHER ADMINISTRATIVE AND GENERAL	HOME OFFICE COSTS	4,616,259	6,467,880	-1,851,621	3.09
4							4
5	TOTALS (SUM OF LINES 1-4) TRANSFER COLUMN 6, LINE 5 TO WORKSHEET A-8, COLUMN 2, LINE 12			7,293,158	6,541,838	751,320	5

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

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

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

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

SYMBOL (1)	NAME	PERCENTAGE OF OWNERSHIP	RELATED ORGANIZATION(S) AND/OR HOME OFFICE				
			NAME	PERCENTAGE OF OWNERSHIP	TYPE OF BUSINESS		
1	2	3	4	5	6		
6	B	DELCOM	100.00	SYSTEM	100.00	SYSTEM	6
7	B	CADENCE HEALTH	100.00	CADENCE HEALTH	100.00	HOME OFFICE	7
8							8
9							9
10							10

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

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



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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN- ERATION	PROFESS- IONAL COMPON- ENT	PROVIDER COMPON- ENT	RCE AMOUNT	PHYSICIAN / PROVIDER COMPON- ENT HOURS	UNADJ- USTED RCE LIMIT	5 PERCENT OF UNADJ- USTED RCE LIMIT	
	1	2	3	4	5	6	7	8	9	
1	5.06	OTHER ADMINISTRATIVE AGGREGATE	333,756	227,488	106,268	177,200	295	25,132	1,257	1
2										2
3	13	NURSING ADMINISTRATI AGGREGATE	23,353		23,353	177,200	1	85	4	3
4										4
5	15	PHARMACY AGGREGATE	4,645		4,645	177,200	1	85	4	5
6										6
7	30	ADULTS & PEDIATRICS AGGREGATE	36,647	36,647						7
8										8
9	31	INTENSIVE CARE UNIT AGGREGATE	58,195	58,195						9
10										10
11	52	DELIVERY ROOM & LABO AGGREGATE	58,392	58,392						11
12										12
13	60	LABORATORY AGGREGATE	79,251	79,251						13
14										14
15	69	ELECTROCARDIOLOGY AGGREGATE	223,656	223,656						15
16										16
17	64	INTRAVENOUS THERAPY AGGREGATE	8,459	8,459						17
18										18
19	90.07	SLEEP LAB AGGREGATE	4,500		4,500	177,200	13	1,108	55	19
20										20
21	91	EMERGENCY AGGREGATE	171,490	158,538	12,952	177,200	125	10,649	532	21
200		TOTAL	1,002,344	850,626	151,718		435	37,059	1,852	200



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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBER- SHIPS & CONTIN- UING EDUCATIO N	PROVIDER COMPON- ENT SHARE OF COL. 12	PHYSICIAN COST OF MALPRAC T- ICE INSURANC E	PROVIDER COMPON- ENT SHARE OF COL. 14	ADJUSTED RCE LIMIT	RCE DISALLOW - ANCE	ADJUST- MENT	
	10	11	12	13	14	15	16	17	18	
1	5.06	OTHER ADMINISTRATIVE AGGREGATE					25,132	81,136	308,624	1
2										2
3	13	NURSING ADMINISTRATI AGGREGATE					85	23,268	23,268	3
4										4
5	15	PHARMACY AGGREGATE					85	4,560	4,560	5
6										6
7	30	ADULTS & PEDIATRICS AGGREGATE							36,647	7
8										8
9	31	INTENSIVE CARE UNIT AGGREGATE							58,195	9
10										10
11	52	DELIVERY ROOM & LABO AGGREGATE							58,392	11
12										12
13	60	LABORATORY AGGREGATE							79,251	13
14										14
15	69	ELECTROCARDIOLOGY AGGREGATE							223,656	15
16										16
17	64	INTRAVENOUS THERAPY AGGREGATE							8,459	17
18										18
19	90.07	SLEEP LAB AGGREGATE					1,108	3,392	3,392	19
20										20
21	91	EMERGENCY AGGREGATE					10,649	2,303	160,841	21
200		TOTAL					37,059	114,659	965,285	200

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	ALLOCATION (from Wkst A, col.7)	CAP BLDGs & FIXTURES	CAP MOVEABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMEN T	NONPATIENT TELEPHONE S	IS	
		0	1	2	4	5.01	5.02	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	2,802,953	2,802,953					1
2	CAP REL COSTS-MVBLE EQUIP	946,738		946,738				2
4	EMPLOYEE BENEFITS DEPARTMENT	14,942			14,942			4
5.01	NONPATIENT TELEPHONES	58,373	1,747			60,120		5.01
5.02	IS	1,955,264	61,780	57,617		2,824	2,077,485	5.02
5.03	PURCHASING	246,029	57,822	2,231	119	689		5.03
5.04	PT REG	317,294	37,856	417	342	1,687		5.04
5.05	PT ACCTS	238,721						5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	7,607,687	87,961		1,468	4,752		5.06
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	1,380,526	78,452	34,644	322	2,548		7
8	LAUNDRY & LINEN SERVICE	101,374	17,991	322	6	34		8
9	HOUSEKEEPING	358,772	28,046	1,916	336	482		9
10	DIETARY	174,095	58,959	13,083	116	172		10
11	CAFETERIA	76,851	78,206	17,354	150	241		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	337,946	12,012	23,339	378	723		13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY	541,449	32,806	20,679	584	999		15
16	MEDICAL RECORDS & LIBRARY	180,207				275		16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	2,493,585	772,168	124,643	2,785	10,261	182,775	30
31	INTENSIVE CARE UNIT	725,379	120,803	16,101	774	1,584	40,763	31
43	NURSERY	235,529	23,032		259	1,308	20,771	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	956,766	235,600	157,054	626	2,479	117,762	50
51	RECOVERY ROOM	153,952	16,371	16,718	169	344	19,866	51
52	DELIVERY ROOM & LABOR ROOM	437,091	112,304		492	1,928	38,963	52
53	ANESTHESIOLOGY	78,493	8,982	19,655	25	448	16,829	53
54	RADIOLOGY-DIAGNOSTIC	525,483	102,239	55,352	520	3,753	63,032	54
54.01	ULTRA SOUND	203,002	2,421	2,362	219	138	50,584	54.01
54.02	NUCLEAR ONCOLOGY	166,195	78,452	77,697	157	689	26,493	54.02
55	RADIOLOGY-THERAPEUTIC	399,525	79,471	30,960	309	758	17,059	55
56	RADIOISOTOPE	155,340	7,699	529	84	310	17,960	56
57	CT SCAN	247,681	11,675	373	221	138	163,987	57
58	MRI	177,026	16,380	6,313	159	241	53,085	58
59	CARDIAC CATHETERIZATION	400,629	149,077	60,865	376	1,549	45,365	59
60	LABORATORY	1,434,611	107,235	94,093	618	2,858	186,479	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY	296,111	57,876	32,309	323	1,102	14,127	64
65	RESPIRATORY THERAPY	241,478	10,956	4,837	261	826	29,372	65
66	PHYSICAL THERAPY	714,291	10,683	5,449	682	2,204	44,338	66
69	ELECTROCARDIOLOGY	192,731	30,130	33,519	211	1,584	69,920	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,410,157					149,307	71
72	IMPL. DEV. CHARGED TO PATIENTS	952,786					66,590	72
73	DRUGS CHARGED TO PATIENTS	3,333,544					379,743	73
74	RENAL DIALYSIS	79,501					5,372	74
75	ASC (NON-DISTINCT PART)	289,982	71,354	10,616	314	2,617	27,109	75
75.01	LITHOTRIPSY					69		75.01
75.02	PSYCH	84,428		7,658	60		3,219	75.02
75.03	NEURODIAGNOSTICS	24,569	4,805	1,928	26	34	2,246	75.03
76.97	CARDIAC REHABILITATION	100,397		3,319	70	999	4,165	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.03	GENETIC TESTING	16,851		767	22	69	198	90.03
90.04	CHRONIC PAIN CLINIC	54,442		1,674	39	1,033	6,186	90.04
90.05	DIABETES EDUCATION	72,277		51	74	241	2,143	90.05
90.06	WOUND CARE	88,421	13,459	413	86	344	4,627	90.06
90.07	SLEEP LAB	6,532	11,866	2,012	74	69	8,381	90.07
91	EMERGENCY	951,181	186,415	7,869	1,064	4,545	198,669	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92



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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVEABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMEN T	NONPATIENT TELEPHONE S	IS	
		0	1	2	4	5.01	5.02	
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	35,039,187	2,795,091	946,738	14,920	59,948	2,077,485	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	30,576	7,862		22	172		190
192	PHYSICIANS' PRIVATE OFFICES	495						192
192.0	HOME HEALTH AGENCY							192.0
1								1
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	35,070,258	2,802,953	946,738	14,942	60,120	2,077,485	202

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	PURCHASING 5.03	PT REG 5.04	PT ACCTS 5.05	SUBTOTAL (cols.0-4) 4A	OTHER ADMI NISTRATIVE AND GENER 5.06	OPERATION OF PLANT 7	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	NONPATIENT TELEPHONES							5.01
5.02	IS							5.02
5.03	PURCHASING	306,890						5.03
5.04	PT REG	203	357,799					5.04
5.05	PT ACCTS			238,721				5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	1,355			7,703,223	7,703,223		5.06
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	232			1,496,724	421,295	1,918,019	7
8	LAUNDRY & LINEN SERVICE	149			119,876	33,742	13,929	8
9	HOUSEKEEPING	1,639			391,191	110,112	21,714	9
10	DIETARY				246,425	69,363	45,648	10
11	CAFETERIA				172,802	48,640	60,549	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	17			374,415	105,390	9,300	13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY	248			596,765	167,976	25,399	15
16	MEDICAL RECORDS & LIBRARY				180,482	50,802		16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	489	31,475	21,002	3,639,183	1,024,350	597,836	30
31	INTENSIVE CARE UNIT	746	7,020	4,684	917,854	258,356	93,529	31
43	NURSERY	21	3,577	2,387	286,884	80,752	17,832	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	83,897	20,280	13,531	1,587,995	446,986	182,408	50
51	RECOVERY ROOM	69	3,421	2,283	213,193	60,009	12,675	51
52	DELIVERY ROOM & LABOR ROOM	69	6,710	4,477	602,034	169,459	86,949	52
53	ANESTHESIOLOGY	14	2,898	1,934	129,278	36,389	6,954	53
54	RADIOLOGY-DIAGNOSTIC	182	10,855	7,243	768,659	216,361	79,156	54
54.01	ULTRA SOUND	144	8,711	5,812	273,393	76,954	1,874	54.01
54.02	NUCLEAR ONCOLOGY	57	4,562	3,044	357,346	100,585	60,739	54.02
55	RADIOLOGY-THERAPEUTIC	288	2,938	1,960	533,268	150,103	61,528	55
56	RADIOISOTOPE	6,151	3,093	2,064	193,230	54,390	5,960	56
57	CT SCAN	5	28,240	18,843	471,163	132,622	9,039	57
58	MRI	4	9,142	6,100	268,450	75,563	12,682	58
59	CARDIAC CATHETERIZATION	15,424	7,812	5,213	686,310	193,181	115,419	59
60	LABORATORY	6,797	32,113	21,427	1,886,231	530,933	83,024	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY	23	2,433	1,623	405,927	114,260	44,809	64
65	RESPIRATORY THERAPY	8	5,058	3,375	296,171	83,366	8,483	65
66	PHYSICAL THERAPY	75	7,635	5,095	790,452	222,495	8,271	66
69	ELECTROCARDIOLOGY	127	12,041	8,034	348,297	98,038	23,328	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	111,606	25,712	17,156	1,713,938	482,436		71
72	IMPL. DEV. CHARGED TO PATIENTS	75,407	11,467	7,651	1,113,901	313,539		72
73	DRUGS CHARGED TO PATIENTS		65,435	43,641	3,822,363	1,075,913		73
74	RENAL DIALYSIS		925	617	86,415	24,324		74
75	ASC (NON-DISTINCT PART)	292	4,668	3,115	410,067	115,425	55,244	75
75.01	LITHOTRIPSY				69	19		75.01
75.02	PSYCH	52	554	370	96,341	27,118		75.02
75.03	NEURODIAGNOSTICS	1	387	258	34,254	9,642	3,720	75.03
76.97	CARDIAC REHABILITATION	17	717	479	110,163	31,008		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.03	GENETIC TESTING	72	34	23	18,036	5,077		90.03
90.04	CHRONIC PAIN CLINIC	24	1,065	711	65,174	18,345		90.04
90.05	DIABETES EDUCATION	20	369	246	75,421	21,229		90.05
90.06	WOUND CARE		797	532	108,679	30,591	10,420	90.06
90.07	SLEEP LAB	45	1,443	963	31,385	8,834	9,187	90.07
91	EMERGENCY	116	34,212	22,828	1,406,899	396,011	144,327	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							



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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	PURCHASING	PT REG	PT ACCTS	SUBTOTAL (cols.0-4)	OTHER ADMI NISTRATIVE AND GENER	OPERATION OF PLANT	
		5.03	5.04	5.05	4A	5.06	7	
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	306,085	357,799	238,721	35,030,326	7,691,983	1,911,932	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	766			39,398	11,090	6,087	190
192	PHYSICIANS' PRIVATE OFFICES	39			534	150		192
192.0 1	HOME HEALTH AGENCY							192.0 1
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	306,890	357,799	238,721	35,070,258	7,703,223	1,918,019	202



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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	
		8	9	10	11	13	15	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	NONPATIENT TELEPHONES							5.01
5.02	IS							5.02
5.03	PURCHASING							5.03
5.04	PT REG							5.04
5.05	PT ACCTS							5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL							5.06
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE	167,547						8
9	HOUSEKEEPING		523,017					9
10	DIETARY		12,683	374,119				10
11	CAFETERIA		16,824		298,815			11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		2,584			500,644		13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY		7,057		11,171		808,368	15
16	MEDICAL RECORDS & LIBRARY							16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	77,250	166,106	316,792	78,145	183,887		30
31	INTENSIVE CARE UNIT	10,849	25,987	57,327	17,336	40,787		31
43	NURSERY	1,885	4,955		5,005	11,769		43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	536	50,682		17,749	41,759		50
51	RECOVERY ROOM	7,699	3,522		3,283	7,730		51
52	DELIVERY ROOM & LABOR ROOM	9,197	24,159		11,196	26,343		52
53	ANESTHESIOLOGY		1,932		1,093	2,579	2,006	53
54	RADIOLOGY-DIAGNOSTIC	10,144	21,994		12,387	29,145	49	54
54.01	ULTRA SOUND	4,514	521		4,669	10,993	17	54.01
54.02	NUCLEAR ONCOLOGY		16,876		3,704	8,713		54.02
55	RADIOLOGY-THERAPEUTIC		17,096		10,405	24,488	150	55
56	RADIOISOTOPE	938	1,656		1,731	4,078	2	56
57	CT SCAN	5,323	2,512		4,809	11,315	350	57
58	MRI	2,108	3,524		3,253	7,651	1,952	58
59	CARDIAC CATHETERIZATION		32,069		7,207	16,969		59
60	LABORATORY		23,068		19,539			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY		12,450		7,437	17,506		64
65	RESPIRATORY THERAPY		2,357		6,872	16,170	434	65
66	PHYSICAL THERAPY		2,298		15,397		2	66
69	ELECTROCARDIOLOGY	4,722	6,482		4,818	11,337		69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS						802,790	73
74	RENAL DIALYSIS							74
75	ASC (NON-DISTINCT PART)	13,641	15,349		7,267	17,107		75
75.01	LITHOTRIPSY							75.01
75.02	PSYCH							75.02
75.03	NEURODIAGNOSTICS		1,034		1,807			75.03
76.97	CARDIAC REHABILITATION				1,692			76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.03	GENETIC TESTING				685			90.03
90.04	CHRONIC PAIN CLINIC				1,038	2,443	347	90.04
90.05	DIABETES EDUCATION				1,480			90.05
90.06	WOUND CARE		2,895		187	3,477	151	90.06
90.07	SLEEP LAB		2,553		2,215			90.07
91	EMERGENCY	18,741	40,101		26,274	4,398	118	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							



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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	
		8	9	10	11	13	15	
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	167,547	521,326	374,119	298,806	500,644	808,368	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		1,691		9			190
192	PHYSICIANS' PRIVATE OFFICES							192
192.0	HOME HEALTH AGENCY							192.0
1								1
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	167,547	523,017	374,119	298,815	500,644	808,368	202

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		16	24	25	26		
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5.01	NONPATIENT TELEPHONES						5.01
5.02	IS						5.02
5.03	PURCHASING						5.03
5.04	PT REG						5.04
5.05	PT ACCTS						5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL						5.06
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY	231,284					16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	20,343	6,103,892		6,103,892		30
31	INTENSIVE CARE UNIT	4,537	1,426,562		1,426,562		31
43	NURSERY	2,312	411,394		411,394		43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	13,107	2,341,222		2,341,222		50
51	RECOVERY ROOM	2,211	310,322		310,322		51
52	DELIVERY ROOM & LABOR ROOM	4,337	933,674		933,674		52
53	ANESTHESIOLOGY	1,873	182,104		182,104		53
54	RADIOLOGY-DIAGNOSTIC	7,015	1,144,910		1,144,910		54
54.01	ULTRA SOUND	5,630	378,565		378,565		54.01
54.02	NUCLEAR ONCOLOGY	2,949	550,912		550,912		54.02
55	RADIOLOGY-THERAPEUTIC	1,899	798,937		798,937		55
56	RADIOISOTOPE	1,999	263,984		263,984		56
57	CT SCAN	18,252	655,385		655,385		57
58	MRI	5,908	381,091		381,091		58
59	CARDIAC CATHETERIZATION	5,049	1,056,204		1,056,204		59
60	LABORATORY	20,755	2,563,550		2,563,550		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	INTRAVENOUS THERAPY	1,572	603,961		603,961		64
65	RESPIRATORY THERAPY	3,269	417,122		417,122		65
66	PHYSICAL THERAPY	4,935	1,043,850		1,043,850		66
69	ELECTROCARDIOLOGY	7,782	504,804		504,804		69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,618	2,212,992		2,212,992		71
72	IMPL. DEV. CHARGED TO PATIENTS	7,411	1,434,851		1,434,851		72
73	DRUGS CHARGED TO PATIENTS	42,325	5,743,391		5,743,391		73
74	RENAL DIALYSIS	598	111,337		111,337		74
75	ASC (NON-DISTINCT PART)	3,017	637,117		637,117		75
75.01	LITHOTRIPSY		88		88		75.01
75.02	PSYCH	358	123,817		123,817		75.02
75.03	NEURODIAGNOSTICS	250	50,707		50,707		75.03
76.97	CARDIAC REHABILITATION	464	143,327		143,327		76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.03	GENETIC TESTING	22	23,820		23,820		90.03
90.04	CHRONIC PAIN CLINIC	689	88,036		88,036		90.04
90.05	DIABETES EDUCATION	238	98,368		98,368		90.05
90.06	WOUND CARE	515	156,915		156,915		90.06
90.07	SLEEP LAB	933	55,107		55,107		90.07
91	EMERGENCY	22,112	2,058,981		2,058,981		91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						



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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		16	24	25	26		
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)	231,284	35,011,299		35,011,299		118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		58,275		58,275		190
192	PHYSICIANS' PRIVATE OFFICES		684		684		192
192.0	HOME HEALTH AGENCY						192.0
1							1
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (sum of lines 118-201)	231,284	35,070,258		35,070,258		202

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVEABLE EQUIPMENT	SUBTOTAL	NONPATIENT TELEPHONE S	IS	
		0	1	2	2A	5.01	5.02	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	NONPATIENT TELEPHONES		1,747		1,747	1,747		5.01
5.02	IS		61,780	57,617	119,397	82	119,479	5.02
5.03	PURCHASING		57,822	2,231	60,053	20		5.03
5.04	PT REG		37,856	417	38,273	49		5.04
5.05	PT ACCTS							5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	9,610	87,961		97,571	138		5.06
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT		78,452	34,644	113,096	74		7
8	LAUNDRY & LINEN SERVICE		17,991	322	18,313	1		8
9	HOUSEKEEPING		28,046	1,916	29,962	14		9
10	DIETARY		58,959	13,083	72,042	5		10
11	CAFETERIA		78,206	17,354	95,560	7		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		12,012	23,339	35,351	21		13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY	1,920	32,806	20,679	55,405	29		15
16	MEDICAL RECORDS & LIBRARY					8		16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	4,721	772,168	124,643	901,532	299	10,514	30
31	INTENSIVE CARE UNIT	2,564	120,803	16,101	139,468	46	2,345	31
43	NURSERY		23,032		23,032	38	1,195	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	48,453	235,600	157,054	441,107	72	6,774	50
51	RECOVERY ROOM		16,371	16,718	33,089	10	1,143	51
52	DELIVERY ROOM & LABOR ROOM		112,304		112,304	56	2,241	52
53	ANESTHESIOLOGY		8,982	19,655	28,637	13	968	53
54	RADIOLOGY-DIAGNOSTIC	48,522	102,239	55,352	206,113	109	3,626	54
54.01	ULTRA SOUND		2,421	2,362	4,783	4	2,910	54.01
54.02	NUCLEAR ONCOLOGY		78,452	77,697	156,149	20	1,524	54.02
55	RADIOLOGY-THERAPEUTIC		79,471	30,960	110,431	22	981	55
56	RADIOISOTOPE		7,699	529	8,228	9	1,033	56
57	CT SCAN		11,675	373	12,048	4	9,433	57
58	MRI		16,380	6,313	22,693	7	3,054	58
59	CARDIAC CATHETERIZATION		149,077	60,865	209,942	45	2,610	59
60	LABORATORY	15,187	107,235	94,093	216,515	83	10,727	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY	33	57,876	32,309	90,218	32	813	64
65	RESPIRATORY THERAPY	78	10,956	4,837	15,871	24	1,690	65
66	PHYSICAL THERAPY	104,522	10,683	5,449	120,654	64	2,551	66
69	ELECTROCARDIOLOGY		30,130	33,519	63,649	46	4,022	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						8,589	71
72	IMPL. DEV. CHARGED TO PATIENTS						3,831	72
73	DRUGS CHARGED TO PATIENTS						21,816	73
74	RENAL DIALYSIS						309	74
75	ASC (NON-DISTINCT PART)		71,354	10,616	81,970	76	1,559	75
75.01	LITHOTRIPSY					2		75.01
75.02	PSYCH	28,742		7,658	36,400		185	75.02
75.03	NEURODIAGNOSTICS		4,805	1,928	6,733	1	129	75.03
76.97	CARDIAC REHABILITATION	35,940		3,319	39,259	29	240	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.03	GENETIC TESTING			767	767	2	11	90.03
90.04	CHRONIC PAIN CLINIC	15,805		1,674	17,479	30	356	90.04
90.05	DIABETES EDUCATION	6,555		51	6,606	7	123	90.05
90.06	WOUND CARE	4,646	13,459	413	18,518	10	266	90.06
90.07	SLEEP LAB		11,866	2,012	13,878	2	482	90.07
91	EMERGENCY		186,415	7,869	194,284	132	11,429	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							



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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVEABLE EQUIPMENT	SUBTOTAL	NONPATIENT TELEPHONE S	IS	
		0	1	2	2A	5.01	5.02	
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	327,298	2,795,091	946,738	4,069,127	1,742	119,479	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		7,862		7,862	5		190
192	PHYSICIANS' PRIVATE OFFICES							192
192.0	HOME HEALTH AGENCY							192.0
1								1
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	327,298	2,802,953	946,738	4,076,989	1,747	119,479	202



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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	PURCHASING 5.03	PT REG 5.04	OTHER ADMI NISTRATIVE AND GENER 5.06	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	NONPATIENT TELEPHONES							5.01
5.02	IS							5.02
5.03	PURCHASING	60,073						5.03
5.04	PT REG	40	38,362					5.04
5.05	PT ACCTS							5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	265		97,974				5.06
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	45		5,358	118,573			7
8	LAUNDRY & LINEN SERVICE	29		429	861	19,633		8
9	HOUSEKEEPING	321		1,400	1,342		33,039	9
10	DIETARY			882	2,822		801	10
11	CAFETERIA			619	3,743		1,063	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	3		1,340	575		163	13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY	49		2,136	1,570		446	15
16	MEDICAL RECORDS & LIBRARY			646				16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	96	3,375	13,028	36,961	9,052	10,493	30
31	INTENSIVE CARE UNIT	146	753	3,286	5,782	1,271	1,642	31
43	NURSERY	4	384	1,027	1,102	221	313	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	16,423	2,174	5,685	11,277	63	3,202	50
51	RECOVERY ROOM	13	367	763	784	902	222	51
52	DELIVERY ROOM & LABOR ROOM	13	719	2,155	5,375	1,078	1,526	52
53	ANESTHESIOLOGY	3	311	463	430		122	53
54	RADIOLOGY-DIAGNOSTIC	36	1,164	2,752	4,893	1,189	1,389	54
54.01	ULTRA SOUND	28	934	979	116	529	33	54.01
54.02	NUCLEAR ONCOLOGY	11	489	1,279	3,755		1,066	54.02
55	RADIOLOGY-THERAPEUTIC	56	315	1,909	3,804		1,080	55
56	RADIOISOTOPE	1,204	332	692	368	110	105	56
57	CT SCAN	1	3,028	1,687	559	624	159	57
58	MRI	1	980	961	784	247	223	58
59	CARDIAC CATHETERIZATION	3,019	838	2,457	7,135		2,026	59
60	LABORATORY	1,330	3,443	6,753	5,133		1,457	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY	5	261	1,453	2,770		786	64
65	RESPIRATORY THERAPY	2	542	1,060	524		149	65
66	PHYSICAL THERAPY	15	819	2,830	511		145	66
69	ELECTROCARDIOLOGY	25	1,291	1,247	1,442	553	409	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	21,846	2,757	6,136				71
72	IMPL. DEV. CHARGED TO PATIENTS	14,761	1,230	3,988				72
73	DRUGS CHARGED TO PATIENTS		7,013	13,686				73
74	RENAL DIALYSIS		99	309				74
75	ASC (NON-DISTINCT PART)	57	501	1,468	3,415	1,598	970	75
75.01	LITHOTRIPSY							75.01
75.02	PSYCH	10	59	345				75.02
75.03	NEURODIAGNOSTICS		41	123	230		65	75.03
76.97	CARDIAC REHABILITATION	3	77	394				76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.03	GENETIC TESTING	14	4	65				90.03
90.04	CHRONIC PAIN CLINIC	5	114	233				90.04
90.05	DIABETES EDUCATION	4	40	270				90.05
90.06	WOUND CARE		85	389	644		183	90.06
90.07	SLEEP LAB	9	155	112	568		161	90.07
91	EMERGENCY	23	3,668	5,037	8,922	2,196	2,533	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							



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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	PURCHASING	PT REG	OTHER ADMI NISTRATIVE AND GENER	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	
		5.03	5.04	5.06	7	8	9	
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	59,915	38,362	97,831	118,197	19,633	32,932	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	150		141	376		107	190
192	PHYSICIANS' PRIVATE OFFICES	8		2				192
192.0 1	HOME HEALTH AGENCY							192.0 1
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	60,073	38,362	97,974	118,573	19,633	33,039	202

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	SUBTOTAL	
		10	11	13	15	16	24	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	NONPATIENT TELEPHONES							5.01
5.02	IS							5.02
5.03	PURCHASING							5.03
5.04	PT REG							5.04
5.05	PT ACCTS							5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL							5.06
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY	76,552						10
11	CAFETERIA		100,992					11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		3,027	40,480				13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY		3,775		63,410			15
16	MEDICAL RECORDS & LIBRARY					654		16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	64,822	26,412	14,866		54	1,091,504	30
31	INTENSIVE CARE UNIT	11,730	5,859	3,298		12	175,638	31
43	NURSERY		1,692	952		6	29,966	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		5,999	3,376		35	496,187	50
51	RECOVERY ROOM		1,109	625		6	39,033	51
52	DELIVERY ROOM & LABOR ROOM		3,784	2,130		11	131,392	52
53	ANESTHESIOLOGY		369	209	157	5	31,687	53
54	RADIOLOGY-DIAGNOSTIC		4,186	2,357	4	19	227,837	54
54.01	ULTRA SOUND		1,578	889	1	15	12,799	54.01
54.02	NUCLEAR ONCOLOGY		1,252	705		8	166,258	54.02
55	RADIOLOGY-THERAPEUTIC		3,517	1,980	12	5	124,112	55
56	RADIOISOTOPE		585	330		5	13,001	56
57	CT SCAN		1,625	915	27	48	30,158	57
58	MRI		1,099	619	153	16	30,837	58
59	CARDIAC CATHETERIZATION		2,436	1,372		13	231,893	59
60	LABORATORY		6,604			55	252,100	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY		2,514	1,415		4	100,271	64
65	RESPIRATORY THERAPY		2,322	1,307	34	9	23,534	65
66	PHYSICAL THERAPY		5,204			13	132,806	66
69	ELECTROCARDIOLOGY		1,628	917		21	75,250	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS					44	39,372	71
72	IMPL. DEV. CHARGED TO PATIENTS					20	23,830	72
73	DRUGS CHARGED TO PATIENTS				62,974	153	105,642	73
74	RENAL DIALYSIS					2	719	74
75	ASC (NON-DISTINCT PART)		2,456	1,383		8	95,461	75
75.01	LITHOTRIPSY						2	75.01
75.02	PSYCH					1	37,000	75.02
75.03	NEURODIAGNOSTICS		611			1	7,934	75.03
76.97	CARDIAC REHABILITATION		572			1	40,575	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.03	GENETIC TESTING		231				1,094	90.03
90.04	CHRONIC PAIN CLINIC		351	198	27	2	18,795	90.04
90.05	DIABETES EDUCATION		500			1	7,551	90.05
90.06	WOUND CARE		63	281	12	1	20,452	90.06
90.07	SLEEP LAB		749			2	16,118	90.07
91	EMERGENCY		8,880	356	9	58	237,527	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							



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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	SUBTOTAL	
		10	11	13	15	16	24	
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	76,552	100,989	40,480	63,410	654	4,068,335	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		3				8,644	190
192	PHYSICIANS' PRIVATE OFFICES						10	192
192.0 1	HOME HEALTH AGENCY							192.0 1
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	76,552	100,992	40,480	63,410	654	4,076,989	202



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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP-DOWN ADJS	TOTAL				
		25	26				
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5.01	NONPATIENT TELEPHONES						5.01
5.02	IS						5.02
5.03	PURCHASING						5.03
5.04	PT REG						5.04
5.05	PT ACCTS						5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL						5.06
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY						16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS		1,091,504				30
31	INTENSIVE CARE UNIT		175,638				31
43	NURSERY		29,966				43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM		496,187				50
51	RECOVERY ROOM		39,033				51
52	DELIVERY ROOM & LABOR ROOM		131,392				52
53	ANESTHESIOLOGY		31,687				53
54	RADIOLOGY-DIAGNOSTIC		227,837				54
54.01	ULTRA SOUND		12,799				54.01
54.02	NUCLEAR ONCOLOGY		166,258				54.02
55	RADIOLOGY-THERAPEUTIC		124,112				55
56	RADIOISOTOPE		13,001				56
57	CT SCAN		30,158				57
58	MRI		30,837				58
59	CARDIAC CATHETERIZATION		231,893				59
60	LABORATORY		252,100				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	INTRAVENOUS THERAPY		100,271				64
65	RESPIRATORY THERAPY		23,534				65
66	PHYSICAL THERAPY		132,806				66
69	ELECTROCARDIOLOGY		75,250				69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		39,372				71
72	IMPL. DEV. CHARGED TO PATIENTS		23,830				72
73	DRUGS CHARGED TO PATIENTS		105,642				73
74	RENAL DIALYSIS		719				74
75	ASC (NON-DISTINCT PART)		95,461				75
75.01	LITHOTRIPSY		2				75.01
75.02	PSYCH		37,000				75.02
75.03	NEURODIAGNOSTICS		7,934				75.03
76.97	CARDIAC REHABILITATION		40,575				76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.03	GENETIC TESTING		1,094				90.03
90.04	CHRONIC PAIN CLINIC		18,795				90.04
90.05	DIABETES EDUCATION		7,551				90.05
90.06	WOUND CARE		20,452				90.06
90.07	SLEEP LAB		16,118				90.07
91	EMERGENCY		237,527				91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						



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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP-DOWN ADJS	TOTAL				
		25	26				
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)		4,068,335				118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		8,644				190
192	PHYSICIANS' PRIVATE OFFICES		10				192
192.0	HOME HEALTH AGENCY						192.0
1							1
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (sum of lines 118-201)		4,076,989				202

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVEABLE EQUIPMENT NEW MME DE PT	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	NONPATIENT TELEPHONE S NON PATIENT	IS GROSS REVENUE	PURCHASING PURCHASING	
		1	2	4	5.01	5.02	5.03	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	308,015						1
2	CAP REL COSTS-MVBLE EQUIP		987,519					2
4	EMPLOYEE BENEFITS DEPARTMENT			10,795,614				4
5.01	NONPATIENT TELEPHONES	192			1,746			5.01
5.02	IS	6,789	60,099		82	152,828,821		5.02
5.03	PURCHASING	6,354	2,327	85,919	20		3,877,645	5.03
5.04	PT REG	4,160	435	246,962	49		2,561	5.04
5.05	PT ACCTS							5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL MAINTENANCE & REPAIRS	9,666		1,060,581	138		17,123	5.06
6	OPERATION OF PLANT	8,621	36,136	232,301	74		2,931	6
8	LAUNDRY & LINEN SERVICE	1,977	336	4,013	1		1,886	7
9	HOUSEKEEPING	3,082	1,999	242,484	14		20,707	8
10	DIETARY	6,479	13,647	83,550	5			9
11	CAFETERIA	8,594	18,102	108,338	7			10
12	MAINTENANCE OF PERSONNEL							11
13	NURSING ADMINISTRATION	1,320	24,344	272,889	21		214	12
14	CENTRAL SERVICES & SUPPLY							13
15	PHARMACY	3,605	21,570	422,154	29		3,132	14
16	MEDICAL RECORDS & LIBRARY				8			15
17	SOCIAL SERVICE							16
19	NONPHYSICIAN ANESTHETISTS							17
20	NURSING SCHOOL							19
21	I&R SERVICES-SALARY & FRINGES APPRVD							20
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							21
23	PARAMED ED PRGM-(SPECIFY)							22
	INPATIENT ROUTINE SERV COST CENTERS							23
30	ADULTS & PEDIATRICS	84,853	130,012	2,012,586	298	13,445,263	6,181	30
31	INTENSIVE CARE UNIT	13,275	16,795	559,438	46	2,998,594	9,432	31
43	NURSERY	2,531		187,207	38	1,527,965	264	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	25,890	163,816	452,252	72	8,662,795	1,060,068	50
51	RECOVERY ROOM	1,799	17,438	122,057	10	1,461,369	868	51
52	DELIVERY ROOM & LABOR ROOM	12,341		355,558	56	2,866,200	869	52
53	ANESTHESIOLOGY	987	20,502	17,741	13	1,237,998	174	53
54	RADIOLOGY-DIAGNOSTIC	11,235	57,736	375,707	109	4,636,779	2,299	54
54.01	ULTRA SOUND	266	2,464	158,465	4	3,721,075	1,825	54.01
54.02	NUCLEAR ONCOLOGY	8,621	81,044	113,439	20	1,948,879	714	54.02
55	RADIOLOGY-THERAPEUTIC	8,733	32,294	223,514	22	1,254,890	3,641	55
56	RADIOISOTOPE	846	552	60,665	9	1,321,161	77,716	56
57	CT SCAN	1,283	389	159,674	4	12,063,221	63	57
58	MRI	1,800	6,585	114,959	7	3,905,057	50	58
59	CARDIAC CATHETERIZATION	16,382	63,487	271,421	45	3,337,161	194,884	59
60	LABORATORY	11,784	98,146	446,881	83	13,717,744	85,879	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY	6,360	33,701	233,059	32	1,039,213	295	64
65	RESPIRATORY THERAPY	1,204	5,045	188,909	24	2,160,623	105	65
66	PHYSICAL THERAPY	1,174	5,684	492,546	64	3,261,591	946	66
69	ELECTROCARDIOLOGY	3,311	34,963	152,661	46	5,143,434	1,609	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS					10,983,320	1,410,151	71
72	IMPL. DEV. CHARGED TO PATIENTS					4,898,488	952,791	72
73	DRUGS CHARGED TO PATIENTS					27,939,530		73
74	RENAL DIALYSIS					395,178		74
75	ASC (NON-DISTINCT PART)	7,841	11,073	226,550	76	1,994,187	3,692	75
75.01	LITHOTRIPSY				2			75.01
75.02	PSYCH		7,988	43,704		236,828	659	75.02
75.03	NEURODIAGNOSTICS	528	2,011	19,046	1	165,250	11	75.03
76.97	CARDIAC REHABILITATION		3,462	50,825	29	306,410	220	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.03	GENETIC TESTING		800	16,033	2	14,588	913	90.03
90.04	CHRONIC PAIN CLINIC		1,746	28,205	30	455,071	307	90.04
90.05	DIABETES EDUCATION		53	53,129	7	157,625	255	90.05
90.06	WOUND CARE	1,479	431	62,209	10	340,359	4	90.06
90.07	SLEEP LAB	1,304	2,099	53,667	2	616,505	572	90.07
91	EMERGENCY	20,485	8,208	768,599	132	14,614,470	1,463	91



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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVEABLE EQUIPMENT NEW MME DE PT	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	NONPATIENT TELEPHONE S NON PATIENT	IS GROSS REVENUE	PURCHASING PURCHASING	
		1	2	4	5.01	5.02	5.03	
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	307,151	987,519	10,779,897	1,741	152,828,821	3,867,474	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	864		15,717	5		9,676	190
192	PHYSICIANS' PRIVATE OFFICES						495	192
192.01	HOME HEALTH AGENCY							192.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	2,802,953	946,738	14,942	60,120	2,077,485	306,890	202
203	UNIT COST MULT-WS B PT I	9.100054	0.958704	0.001384	34.432990	0.013594	0.079143	203
204	COST TO BE ALLOC PER B PT II				1,747	119,479	60,073	204
205	UNIT COST MULT-WS B PT II				1.000573	0.000782	0.015492	205



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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	PT REG	PT ACCTS	RECON- CILIATION	OTHER ADMI NISTRATIVE AND GENER ACCUM COST	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	
		GROSS REVENUE	GROSS REVENUE					
		5.04	5.05	5A.06	5.06	7	8	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	NONPATIENT TELEPHONES							5.01
5.02	IS							5.02
5.03	PURCHASING							5.03
5.04	PT REG	152,828,821						5.04
5.05	PT ACCTS		152,828,821					5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL			-7,703,223	27,367,035			5.06
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT				1,496,724	272,233		7
8	LAUNDRY & LINEN SERVICE				119,876	1,977	33,776	8
9	HOUSEKEEPING				391,191	3,082		9
10	DIETARY				246,425	6,479		10
11	CAFETERIA				172,802	8,594		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION				374,415	1,320		13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY				596,765	3,605		15
16	MEDICAL RECORDS & LIBRARY				180,482			16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	13,445,263	13,445,263		3,639,183	84,853	15,573	30
31	INTENSIVE CARE UNIT	2,998,594	2,998,594		917,854	13,275	2,187	31
43	NURSERY	1,527,965	1,527,965		286,884	2,531	380	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	8,662,795	8,662,795		1,587,995	25,890	108	50
51	RECOVERY ROOM	1,461,369	1,461,369		213,193	1,799	1,552	51
52	DELIVERY ROOM & LABOR ROOM	2,866,200	2,866,200		602,034	12,341	1,854	52
53	ANESTHESIOLOGY	1,237,998	1,237,998		129,278	987		53
54	RADIOLOGY-DIAGNOSTIC	4,636,779	4,636,779		768,659	11,235	2,045	54
54.01	ULTRA SOUND	3,721,075	3,721,075		273,393	266	910	54.01
54.02	NUCLEAR ONCOLOGY	1,948,879	1,948,879		357,346	8,621		54.02
55	RADIOLOGY-THERAPEUTIC	1,254,890	1,254,890		533,268	8,733		55
56	RADIOISOTOPE	1,321,161	1,321,161		193,230	846	189	56
57	CT SCAN	12,063,221	12,063,221		471,163	1,283	1,073	57
58	MRI	3,905,057	3,905,057		268,450	1,800	425	58
59	CARDIAC CATHETERIZATION	3,337,161	3,337,161		686,310	16,382		59
60	LABORATORY	13,717,744	13,717,744		1,886,231	11,784		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY	1,039,213	1,039,213		405,927	6,360		64
65	RESPIRATORY THERAPY	2,160,623	2,160,623		296,171	1,204		65
66	PHYSICAL THERAPY	3,261,591	3,261,591		790,452	1,174		66
69	ELECTROCARDIOLOGY	5,143,434	5,143,434		348,297	3,311	952	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,983,320	10,983,320		1,713,938			71
72	IMPL. DEV. CHARGED TO PATIENTS	4,898,488	4,898,488		1,113,901			72
73	DRUGS CHARGED TO PATIENTS	27,939,530	27,939,530		3,822,363			73
74	RENAL DIALYSIS	395,178	395,178		86,415			74
75	ASC (NON-DISTINCT PART)	1,994,187	1,994,187		410,067	7,841	2,750	75
75.01	LITHOTRIPSY				69			75.01
75.02	PSYCH	236,828	236,828		96,341			75.02
75.03	NEURODIAGNOSTICS	165,250	165,250		34,254	528		75.03
76.97	CARDIAC REHABILITATION	306,410	306,410		110,163			76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.03	GENETIC TESTING	14,588	14,588		18,036			90.03
90.04	CHRONIC PAIN CLINIC	455,071	455,071		65,174			90.04
90.05	DIABETES EDUCATION	157,625	157,625		75,421			90.05
90.06	WOUND CARE	340,359	340,359		108,679	1,479		90.06
90.07	SLEEP LAB	616,505	616,505		31,385	1,304		90.07
91	EMERGENCY	14,614,470	14,614,470		1,406,899	20,485	3,778	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92



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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	PT REG GROSS REVENUE	PT ACCTS GROSS REVENUE	RECON- CILIATION	OTHER ADMI NISTRATIVE AND GENER ACCUM COST	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	
		5.04	5.05	5A.06	5.06	7	8	
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	152,828,821	152,828,821	-7,703,223	27,327,103	271,369	33,776	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN				39,398	864		190
192	PHYSICIANS' PRIVATE OFFICES				534			192
192.0 1	HOME HEALTH AGENCY							192.0 1
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	357,799	238,721		7,703,223	1,918,019	167,547	202
203	UNIT COST MULT-WS B PT I	0.002341	0.001562		0.281478	7.045505	4.960534	203
204	COST TO BE ALLOC PER B PT II	38,362			97,974	118,573	19,633	204
205	UNIT COST MULT-WS B PT II	0.000251			0.003580	0.435557	0.581271	205



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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA NUMBER OF FTE	NURSING ADMINISTRATION HOURS OF SERV	PHARMACY PHARMACY STAT	MEDICAL RECORDS & LIBRARY GROSS REVENUE	
		9	10	11	13	15	16	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	NONPATIENT TELEPHONES							5.01
5.02	IS							5.02
5.03	PURCHASING							5.03
5.04	PT REG							5.04
5.05	PT ACCTS							5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL							5.06
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING	267,174						9
10	DIETARY	6,479	4,888					10
11	CAFETERIA	8,594		70,273				11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	1,320		2,106	177,256			13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY	3,605		2,627		3,358,544		15
16	MEDICAL RECORDS & LIBRARY						152,828.821	16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	84,853	4,139	18,378	65,106		13,445,263	30
31	INTENSIVE CARE UNIT	13,275	749	4,077	14,441		2,998,594	31
43	NURSERY	2,531		1,177	4,167		1,527,965	43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	25,890		4,174	14,785		8,662,795	50
51	RECOVERY ROOM	1,799		772	2,737		1,461,369	51
52	DELIVERY ROOM & LABOR ROOM	12,341		2,633	9,327		2,866,200	52
53	ANESTHESIOLOGY	987		257	913	8,336	1,237,998	53
54	RADIOLOGY-DIAGNOSTIC	11,235		2,913	10,319	203	4,636,779	54
54.01	ULTRA SOUND	266		1,098	3,892	69	3,721,075	54.01
54.02	NUCLEAR ONCOLOGY	8,621		871	3,085		1,948,879	54.02
55	RADIOLOGY-THERAPEUTIC	8,733		2,447	8,670	625	1,254,890	55
56	RADIOISOTOPE	846		407	1,444	10	1,321,161	56
57	CT SCAN	1,283		1,131	4,006	1,454	12,063,221	57
58	MRI	1,800		765	2,709	8,112	3,905,057	58
59	CARDIAC CATHETERIZATION	16,382		1,695	6,008		3,337,161	59
60	LABORATORY	11,784		4,595			13,717,744	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY	6,360		1,749	6,198		1,039,213	64
65	RESPIRATORY THERAPY	1,204		1,616	5,725	1,802	2,160,623	65
66	PHYSICAL THERAPY	1,174		3,621		8	3,261,591	66
69	ELECTROCARDIOLOGY	3,311		1,133	4,014		5,143,434	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						10,983,320	71
72	IMPL. DEV. CHARGED TO PATIENTS						4,898,488	72
73	DRUGS CHARGED TO PATIENTS					3,335,368	27,939,530	73
74	RENAL DIALYSIS						395,178	74
75	ASC (NON-DISTINCT PART)	7,841		1,709	6,057		1,994,187	75
75.01	LITHOTRIPSY							75.01
75.02	PSYCH						236,828	75.02
75.03	NEURODIAGNOSTICS	528		425			165,250	75.03
76.97	CARDIAC REHABILITATION			398			306,410	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.03	GENETIC TESTING			161			14,588	90.03
90.04	CHRONIC PAIN CLINIC			244	865	1,441	455,071	90.04
90.05	DIABETES EDUCATION			348			157,625	90.05
90.06	WOUND CARE	1,479		44	1,231	627	340,359	90.06
90.07	SLEEP LAB	1,304		521			616,505	90.07
91	EMERGENCY	20,485		6,179	1,557	489	14,614,470	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92



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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA NUMBER OF FTE	NURSING ADMINISTRATION HOURS OF SERVICE	PHARMACY PHARMACY STAT	MEDICAL RECORDS & LIBRARY GROSS REVENUE	
		9	10	11	13	15	16	
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	266,310	4,888	70,271	177,256	3,358,544	152,828,821	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	864		2				190
192	PHYSICIANS' PRIVATE OFFICES							192
192.01	HOME HEALTH AGENCY							192.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	523,017	374,119	298,815	500,644	808,368	231,284	202
203	UNIT COST MULT-WS B PT I	1.957589	76.538257	4.252202	2.824412	0.240690	0.001513	203
204	COST TO BE ALLOC PER B PT II	33.039	76.552	100.992	40.480	63.410	654	204
205	UNIT COST MULT-WS B PT II	0.123661	15.661211	1.437138	0.228370	0.018880	0.000004	205



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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS							
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	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	NONPATIENT TELEPHONES							5.01
5.02	IS							5.02
5.03	PURCHASING							5.03
5.04	PT REG							5.04
5.05	PT ACCTS							5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL							5.06
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY							16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS							30
31	INTENSIVE CARE UNIT							31
43	NURSERY							43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
51	RECOVERY ROOM							51
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
54.01	ULTRA SOUND							54.01
54.02	NUCLEAR ONCOLOGY							54.02
55	RADIOLOGY-THERAPEUTIC							55
56	RADIOISOTOPE							56
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY							64
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
75	ASC (NON-DISTINCT PART)							75
75.01	LITHOTRIPSY							75.01
75.02	PSYCH							75.02
75.03	NEURODIAGNOSTICS							75.03
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.03	GENETIC TESTING							90.03
90.04	CHRONIC PAIN CLINIC							90.04
90.05	DIABETES EDUCATION							90.05
90.06	WOUND CARE							90.06
90.07	SLEEP LAB							90.07



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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS							
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN							190
192	PHYSICIANS' PRIVATE OFFICES							192
192.0	HOME HEALTH AGENCY							192.0
1								1
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I							202
203	UNIT COST MULT-WS B PT I							203
204	COST TO BE ALLOC PER B PT II							204
205	UNIT COST MULT-WS B PT II							205



COMPU-MAX

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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		
		PART	LINE NO.	AMOUNT
	1	2	3	4

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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	COSTS					
		TOTAL COST (from Wkst. B, Part I, col. 26)	THERAPY LIMIT ADJ.	TOTAL COSTS	RCE DISALLOW- ANCE	TOTAL COSTS	
		1	2	3	4	5	
INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	6,103,892		6,103,892		6,103,892	30
31	INTENSIVE CARE UNIT	1,426,562		1,426,562		1,426,562	31
43	NURSERY	411,394		411,394		411,394	43
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	2,341,222		2,341,222		2,341,222	50
51	RECOVERY ROOM	310,322		310,322		310,322	51
52	DELIVERY ROOM & LABOR ROOM	933,674		933,674		933,674	52
53	ANESTHESIOLOGY	182,104		182,104		182,104	53
54	RADIOLOGY-DIAGNOSTIC	1,144,910		1,144,910		1,144,910	54
54.01	ULTRA SOUND	378,565		378,565		378,565	54.01
54.02	NUCLEAR ONCOLOGY	550,912		550,912		550,912	54.02
55	RADIOLOGY-THERAPEUTIC	798,937		798,937		798,937	55
56	RADIOISOTOPE	263,984		263,984		263,984	56
57	CT SCAN	655,385		655,385		655,385	57
58	MRI	381,091		381,091		381,091	58
59	CARDIAC CATHETERIZATION	1,056,204		1,056,204		1,056,204	59
60	LABORATORY	2,563,550		2,563,550		2,563,550	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	INTRAVENOUS THERAPY	603,961		603,961		603,961	64
65	RESPIRATORY THERAPY	417,122		417,122		417,122	65
66	PHYSICAL THERAPY	1,043,850		1,043,850		1,043,850	66
69	ELECTROCARDIOLOGY	504,804		504,804		504,804	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,212,992		2,212,992		2,212,992	71
72	IMPL. DEV. CHARGED TO PATIENTS	1,434,851		1,434,851		1,434,851	72
73	DRUGS CHARGED TO PATIENTS	5,743,391		5,743,391		5,743,391	73
74	RENAL DIALYSIS	111,337		111,337		111,337	74
75	ASC (NON-DISTINCT PART)	637,117		637,117		637,117	75
75.01	LITHOTRIPSY	88		88		88	75.01
75.02	PSYCH	123,817		123,817		123,817	75.02
75.03	NEURODIAGNOSTICS	50,707		50,707		50,707	75.03
76.97	CARDIAC REHABILITATION	143,327		143,327		143,327	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
90.03	GENETIC TESTING	23,820		23,820		23,820	90.03
90.04	CHRONIC PAIN CLINIC	88,036		88,036		88,036	90.04
90.05	DIABETES EDUCATION	98,368		98,368		98,368	90.05
90.06	WOUND CARE	156,915		156,915		156,915	90.06
90.07	SLEEP LAB	55,107		55,107	3,392	58,499	90.07
91	EMERGENCY	2,058,981		2,058,981	2,303	2,061,284	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	904,189		904,189		904,189	92
OTHER REIMBURSABLE COST CENTERS							
200	SUBTOTAL (SEE INSTRUCTIONS)	35,915,488		35,915,488	5,695	35,921,183	200
201	LESS OBSERVATION BEDS	904,189		904,189		904,189	201
202	TOTAL (SEE INSTRUCTIONS)	35,011,299		35,011,299		35,016,994	202

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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	CHARGES			COST OR OTHER RATIO	TEFRA INPATIENT RATIO	PPS INPATIENT RATIO	
		INPATIENT	OUTPATIENT	TOTAL (column 6 + column 7)				
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	11,813,584		11,813,584				30
31	INTENSIVE CARE UNIT	2,998,594		2,998,594				31
43	NURSERY	1,527,965		1,527,965				43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	3,833,341	4,829,454	8,662,795	0.270262	0.270262	0.270262	50
51	RECOVERY ROOM	653,891	807,478	1,461,369	0.212350	0.212350	0.212350	51
52	DELIVERY ROOM & LABOR ROOM	2,593,316	272,884	2,866,200	0.325753	0.325753	0.325753	52
53	ANESTHESIOLOGY	563,877	674,121	1,237,998	0.147096	0.147096	0.147096	53
54	RADIOLOGY-DIAGNOSTIC	896,038	3,740,741	4,636,779	0.246919	0.246919	0.246919	54
54.01	ULTRA SOUND	544,641	3,176,434	3,721,075	0.101735	0.101735	0.101735	54.01
54.02	NUCLEAR ONCOLOGY	74,586	1,874,293	1,948,879	0.282681	0.282681	0.282681	54.02
55	RADIOLOGY-THERAPEUTIC	2,236	1,252,654	1,254,890	0.636659	0.636659	0.636659	55
56	RADIOISOTOPE	261,118	1,060,043	1,321,161	0.199812	0.199812	0.199812	56
57	CT SCAN	2,669,914	9,393,307	12,063,221	0.054329	0.054329	0.054329	57
58	MRI	504,147	3,400,910	3,905,057	0.097589	0.097589	0.097589	58
59	CARDIAC CATHETERIZATION	1,406,939	1,930,222	3,337,161	0.316498	0.316498	0.316498	59
60	LABORATORY	5,294,456	8,423,288	13,717,744	0.186878	0.186878	0.186878	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY	142,564	896,649	1,039,213	0.581172	0.581172	0.581172	64
65	RESPIRATORY THERAPY	1,912,050	248,573	2,160,623	0.193056	0.193056	0.193056	65
66	PHYSICAL THERAPY	1,023,730	2,237,861	3,261,591	0.320043	0.320043	0.320043	66
69	ELECTROCARDIOLOGY	1,476,860	3,666,574	5,143,434	0.098145	0.098145	0.098145	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,822,158	4,161,162	10,983,320	0.201487	0.201487	0.201487	71
72	IMPL. DEV. CHARGED TO PATIENTS	3,567,350	1,331,138	4,898,488	0.292917	0.292917	0.292917	72
73	DRUGS CHARGED TO PATIENTS	6,259,754	21,679,776	27,939,530	0.205565	0.205565	0.205565	73
74	RENAL DIALYSIS	383,529	11,649	395,178	0.281739	0.281739	0.281739	74
75	ASC (NON-DISTINCT PART)	297,349	1,696,838	1,994,187	0.319487	0.319487	0.319487	75
75.01	LITHOTRIPSY							75.01
75.02	PSYCH		236,828	236,828	0.522814	0.522814	0.522814	75.02
75.03	NEURODIAGNOSTICS	93,327	71,923	165,250	0.306850	0.306850	0.306850	75.03
76.97	CARDIAC REHABILITATION	4,079	302,331	306,410	0.467762	0.467762	0.467762	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.03	GENETIC TESTING		14,588	14,588	1.632849	1.632849	1.632849	90.03
90.04	CHRONIC PAIN CLINIC	10,802	444,269	455,071	0.193456	0.193456	0.193456	90.04
90.05	DIABETES EDUCATION	5,285	152,340	157,625	0.624063	0.624063	0.624063	90.05
90.06	WOUND CARE	913	339,446	340,359	0.461028	0.461028	0.461028	90.06
90.07	SLEEP LAB		616,505	616,505	0.089386	0.089386	0.089386	90.07
91	EMERGENCY	3,180,443	11,434,027	14,614,470	0.140886	0.140886	0.141044	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	334,394	1,297,285	1,631,679	0.554146	0.554146	0.554146	92
	OTHER REIMBURSABLE COST CENTERS							
200	SUBTOTAL (SEE INSTRUCTIONS)	61,153,230	91,675,591	152,828,821				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)	61,153,230	91,675,591	152,828,821				202



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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

CHECK TITLE V PPS
 APPLICABLE TITLE XVIII, PART A TEFRA
 BOXES: TITLE XIX

		CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26))	SWING BED ADJUSTMENT	REDUCED CAPITAL RELATED COST (col. 1 minus col. 2)	TOTAL PATIENT DAYS	PER DIEM (col. 3 ÷ col. 4)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM CAPITAL COST (col. 5 x col. 6)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	1,091,504		1,091,504	5,090	214.44	2,013	431,668	30
31	INTENSIVE CARE UNIT	175,638		175,638	749	234.50	333	78,089	31
32	CORONARY CARE UNIT								32
33	BURN INTENSIVE CARE UNIT								33
34	SURGICAL INTENSIVE CARE UNIT								34
35	OTHER SPECIAL CARE (SPECIFY)								35
40	SUBPROVIDER - IPF								40
41	SUBPROVIDER - IRF								41
42	SUBPROVIDER I								42
43	NURSERY	29,966		29,966	461	65.00			43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	1,297,108		1,297,108	6,300		2,346	509,757	200

(A) Worksheet A line numbers



DELNOR-COMMUNITY HOSPITAL Provider CCN: 14-0211	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/27/2015 Run Time: 13:15 Version: 2014.10
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-0211

WORKSHEET D
PART II

CHECK [] TITLE V [XX] HOSPITAL [] SUB (OTHER) [XX] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [] IPF [] TEFRA
 BOXES: [] TITLE XIX [] IRF

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II (col. 26))	TOTAL CHARGES (from Wkst. C, Part I, (col. 8))	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	496,187	8,662,795	0.057278	2,170,795	124,339	50
51	RECOVERY ROOM	39,033	1,461,369	0.026710	353,710	9,448	51
52	DELIVERY ROOM & LABOR ROOM	131,392	2,866,200	0.045842	9,796	449	52
53	ANESTHESIOLOGY	31,687	1,237,998	0.025595	237,279	6,073	53
54	RADIOLOGY-DIAGNOSTIC	227,837	4,636,779	0.049137	527,790	25,934	54
54.01	ULTRA SOUND	12,799	3,721,075	0.003440	298,254	1,026	54.01
54.02	NUCLEAR ONCOLOGY	166,258	1,948,879	0.085310	69,536	5,932	54.02
55	RADIOLOGY-THERAPEUTIC	124,112	1,254,890	0.098903	1,574	156	55
56	RADIOISOTOPE	13,001	1,321,161	0.009841	181,491	1,786	56
57	CT SCAN	30,158	12,063,221	0.002500	1,315,632	3,289	57
58	MRI	30,837	3,905,057	0.007897	164,740	1,301	58
59	CARDIAC CATHETERIZATION	231,893	3,337,161	0.069488	776,431	53,953	59
60	LABORATORY	252,100	13,717,744	0.018378	2,520,635	46,324	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	INTRAVENOUS THERAPY	100,271	1,039,213	0.096487	72,718	7,016	64
65	RESPIRATORY THERAPY	23,534	2,160,623	0.010892	1,082,415	11,790	65
66	PHYSICAL THERAPY	132,806	3,261,591	0.040718	662,065	26,958	66
69	ELECTROCARDIOLOGY	75,250	5,143,434	0.014630	876,791	12,827	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	39,372	10,983,320	0.003585	3,710,536	13,302	71
72	IMPL. DEV. CHARGED TO PATIENTS	23,830	4,898,488	0.004865	2,288,463	11,133	72
73	DRUGS CHARGED TO PATIENTS	105,642	27,939,530	0.003781	3,183,892	12,038	73
74	RENAL DIALYSIS	719	395,178	0.001819	270,983	493	74
75	ASC (NON-DISTINCT PART)	95,461	1,994,187	0.047870	172,619	8,263	75
75.01	LITHOTRIPSY	2					75.01
75.02	PSYCH	37,000	236,828	0.156232			75.02
75.03	NEURODIAGNOSTICS	7,934	165,250	0.048012	45,293	2,175	75.03
76.97	CARDIAC REHABILITATION	40,575	306,410	0.132421	1,943	257	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.03	GENETIC TESTING	1,094	14,588	0.074993			90.03
90.04	CHRONIC PAIN CLINIC	18,795	455,071	0.041301			90.04
90.05	DIABETES EDUCATION	7,551	157,625	0.047905	1,240	59	90.05
90.06	WOUND CARE	20,452	340,359	0.060089			90.06
90.07	SLEEP LAB	16,118	616,505	0.026144			90.07
91	EMERGENCY	237,527	14,614,470	0.016253	1,663,250	27,033	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	161,688	1,631,679	0.099093	233,489	23,137	92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	2,932,915	136,488,678		22,893,360	436,491	200

(A) Worksheet A line numbers



DELNOR-COMMUNITY HOSPITAL Provider CCN: 14-0211	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/27/2015 Run Time: 13:15 Version: 2014.10
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK [] TITLE V [XX] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [] TEFRA
 BOXES: [] TITLE XIX

(A)	COST CENTER DESCRIPTION	NURSING SCHOOL	ALLIED HEALTH COST	ALL OTHER MEDICAL EDUCATION COST	SWING-BED ADJUSTMENT AMOUNT (see instructions)	TOTAL COSTS (sum of cols. 1 through 3 minus col 4.)
		1	2	3	4	5
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)					30
31	INTENSIVE CARE UNIT					31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT					34
35	OTHER SPECIAL CARE (SPECIFY)					35
40	SUBPROVIDER - IPF					40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY					43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)					200

(A) Worksheet A line numbers



DELNOR-COMMUNITY HOSPITAL Provider CCN: 14-0211	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/27/2015 Run Time: 13:15 Version: 2014.10
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK TITLE V PPS
 APPLICABLE TITLE XVIII, PART A TEFRA
 BOXES: TITLE XIX

(A)	COST CENTER DESCRIPTION	TOTAL PATIENT DAYS	PER DIEM (col. 5÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	5,090		2,013		30
31	INTENSIVE CARE UNIT	749		333		31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT					34
35	OTHER SPECIAL CARE (SPECIFY)					35
40	SUBPROVIDER - IPF					40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY	461				43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	6,300		2,346		200

(A) Worksheet A line numbers



DELNOR-COMMUNITY HOSPITAL Provider CCN: 14-0211	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/27/2015 Run Time: 13:15 Version: 2014.10
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-0211

**WORKSHEET D
PART IV**

CHECK TITLE V HOSPITAL SUB (OTHER) ICF/MR PPS
 APPLICABLE TITLE XVIII, PART A IPF SNF TEFRA
 BOXES: TITLE XIX IRF NF

(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
51	RECOVERY ROOM							51
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
54.01	ULTRA SOUND							54.01
54.02	NUCLEAR ONCOLOGY							54.02
55	RADIOLOGY-THERAPEUTIC							55
56	RADIOISOTOPE							56
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY							64
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
75	ASC (NON-DISTINCT PART)							75
75.01	LITHOTRIPSY							75.01
75.02	PSYCH							75.02
75.03	NEURODIAGNOSTICS							75.03
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.03	GENETIC TESTING							90.03
90.04	CHRONIC PAIN CLINIC							90.04
90.05	DIABETES EDUCATION							90.05
90.06	WOUND CARE							90.06
90.07	SLEEP LAB							90.07
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers



DELNOR-COMMUNITY HOSPITAL Provider CCN: 14-0211	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/27/2015 Run Time: 13:15 Version: 2014.10
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-0211

**WORKSHEET D
PART IV**

CHECK [] TITLE V [XX] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [] IPF [] SNF [] TEFRA
 BOXES: [] TITLE XIX [] IRF [] NF

(A)	COST CENTER DESCRIPTION	TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5 ÷ col. 7)	OUTPAT-IENT RATIO OF COST TO CHARGES (col. 6 ÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPAT-IENT PROGRAM CHARGES	OUTPAT-IENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)
7	8	9	10	11	12	13		
ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	8,662,795			2,170,795		774,331	50
51	RECOVERY ROOM	1,461,369			353,710		143,495	51
52	DELIVERY ROOM & LABOR ROOM	2,866,200			9,796		1,328	52
53	ANESTHESIOLOGY	1,237,998			237,279		128,219	53
54	RADIOLOGY-DIAGNOSTIC	4,636,779			527,790		654,207	54
54.01	ULTRA SOUND	3,721,075			298,254		657,914	54.01
54.02	NUCLEAR ONCOLOGY	1,948,879			69,536		1,014,591	54.02
55	RADIOLOGY-THERAPEUTIC	1,254,890			1,574		477,626	55
56	RADIOISOTOPE	1,321,161			181,491		416,740	56
57	CT SCAN	12,063,221			1,315,632		2,824,316	57
58	MRI	3,905,057			164,740		645,707	58
59	CARDIAC CATHETERIZATION	3,337,161			776,431		931,943	59
60	LABORATORY	13,717,744			2,520,635		1,247,327	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY	1,039,213			72,718		456,298	64
65	RESPIRATORY THERAPY	2,160,623			1,082,415		72,234	65
66	PHYSICAL THERAPY	3,261,591			662,065			66
69	ELECTROCARDIOLOGY	5,143,434			876,791		1,236,360	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,983,320			3,710,536		962,705	71
72	IMPL. DEV. CHARGED TO PATIENTS	4,898,488			2,288,463		445,295	72
73	DRUGS CHARGED TO PATIENTS	27,939,530			3,183,892		8,877,970	73
74	RENAL DIALYSIS	395,178			270,983		3,883	74
75	ASC (NON-DISTINCT PART)	1,994,187			172,619		412,023	75
75.01	LITHOTRIPSY							75.01
75.02	PSYCH	236,828						75.02
75.03	NEURODIAGNOSTICS	165,250			45,293		16,230	75.03
76.97	CARDIAC REHABILITATION	306,410			1,943		156,977	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS								
90.03	GENETIC TESTING	14,588						90.03
90.04	CHRONIC PAIN CLINIC	455,071					197,849	90.04
90.05	DIABETES EDUCATION	157,625			1,240			90.05
90.06	WOUND CARE	340,359					212,537	90.06
90.07	SLEEP LAB	616,505					214,773	90.07
91	EMERGENCY	14,614,470			1,663,250		2,260,160	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1,631,679			233,489		728,916	92
OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	136,488,678			22,893,360		26,171,954	200

(A) Worksheet A line numbers



DELNOR-COMMUNITY HOSPITAL Provider CCN: 14-0211	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/27/2015 Run Time: 13:15 Version: 2014.10
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-0211

WORKSHEET D
PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL [] SUB (OTHER) [] SWING BED SNF
 APPLICABLE [XX] TITLE XVIII, PART B [] IPF [] SNF [] SWING BED NF
 BOXES: [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

(A)	COST CENTER DESCRIPTION	COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PROGRAM CHARGES			PROGRAM COST			
			PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
1	2	3	4	5	6	7			
ANCILLARY SERVICE COST CENTERS									
50	OPERATING ROOM	0.270262	774,331			209,272		50	
51	RECOVERY ROOM	0.212350	143,495			30,471		51	
52	DELIVERY ROOM & LABOR ROOM	0.325753	1,328			433		52	
53	ANESTHESIOLOGY	0.147096	128,219			18,861		53	
54	RADIOLOGY-DIAGNOSTIC	0.246919	654,207			161,536		54	
54.01	ULTRA SOUND	0.101735	657,914			66,933		54.01	
54.02	NUCLEAR ONCOLOGY	0.282681	1,014,591			286,806		54.02	
55	RADIOLOGY-THERAPEUTIC	0.636659	477,626			304,085		55	
56	RADIOISOTOPE	0.199812	416,740			83,270		56	
57	CT SCAN	0.054329	2,824,316			153,442		57	
58	MRI	0.097589	645,707			63,014		58	
59	CARDIAC CATHETERIZATION	0.316498	931,943			294,958		59	
60	LABORATORY	0.186878	1,247,327			233,098		60	
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30	
64	INTRAVENOUS THERAPY	0.581172	456,298			265,188		64	
65	RESPIRATORY THERAPY	0.193056	72,234			13,945		65	
66	PHYSICAL THERAPY	0.320043						66	
69	ELECTROCARDIOLOGY	0.098145	1,236,360			121,343		69	
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.201487	962,705			193,973		71	
72	IMPL. DEV. CHARGED TO PATIENTS	0.292917	445,295			130,434		72	
73	DRUGS CHARGED TO PATIENTS	0.205565	8,877,970		816	1,825,000		168 73	
74	RENAL DIALYSIS	0.281739	3,883			1,094		74	
75	ASC (NON-DISTINCT PART)	0.319487	412,023			131,636		75	
75.01	LITHOTRIPSY							75.01	
75.02	PSYCH	0.522814						75.02	
75.03	NEURODIAGNOSTICS	0.306850	16,230			4,980		75.03	
76.97	CARDIAC REHABILITATION	0.467762	156,977			73,428		76.97	
76.98	HYPERBARIC OXYGEN THERAPY							76.98	
76.99	LITHOTRIPSY							76.99	
OUTPATIENT SERVICE COST CENTERS									
90.03	GENETIC TESTING	1.632849						90.03	
90.04	CHRONIC PAIN CLINIC	0.193456	197,849			38,275		90.04	
90.05	DIABETES EDUCATION	0.624063						90.05	
90.06	WOUND CARE	0.461028	212,537			97,986		90.06	
90.07	SLEEP LAB	0.089386	214,773			19,198		90.07	
91	EMERGENCY	0.140886	2,260,160			318,425		91	
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.554146	728,916			403,926		92	
OTHER REIMBURSABLE COST CENTERS									
200	SUBTOTAL (see instructions)		26,171,954		816	5,545,010		168 200	
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES							201	
202	NET CHARGES (line 200 - line 201)		26,171,954		816	5,545,010		168 202	

(A) Worksheet A line numbers



DELNOR-COMMUNITY HOSPITAL Provider CCN: 14-0211	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/27/2015 Run Time: 13:15 Version: 2014.10
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

CHECK TITLE V
 APPLICABLE TITLE XVIII, PART A
 BOXES: TITLE XIX

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26))	SWING BED ADJUSTMENT	REDUCED CAPITAL RELATED COST (col. 1 minus col. 2)	TOTAL PATIENT DAYS	PER DIEM (col. 3 ÷ col. 4)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM CAPITAL COST (col. 5 x col. 6)	
	INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	1,091,504		1,091,504	5,090	214.44	303	64,975	30
31	INTENSIVE CARE UNIT	175,638		175,638	749	234.50	33	7,739	31
32	CORONARY CARE UNIT								32
33	BURN INTENSIVE CARE UNIT								33
34	SURGICAL INTENSIVE CARE UNIT								34
35	OTHER SPECIAL CARE (SPECIFY)								35
40	SUBPROVIDER - IPF								40
41	SUBPROVIDER - IRF								41
42	SUBPROVIDER I								42
43	NURSERY	29,966		29,966	461	65.00	130	8,450	43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	1,297,108		1,297,108	6,300		466	81,164	200

(A) Worksheet A line numbers



DELNOR-COMMUNITY HOSPITAL Provider CCN: 14-0211	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/27/2015 Run Time: 13:15 Version: 2014.10
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-0211

WORKSHEET D
PART II

CHECK [] TITLE V [XX] HOSPITAL [] SUB (OTHER)
 APPLICABLE [] TITLE XVIII, PART A [] IPF
 BOXES: [XX] TITLE XIX [] IRF

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II (col. 26))	TOTAL CHARGES (from Wkst. C, Part I, (col. 8))	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)
		1	2	3	4	5
	ANCILLARY SERVICE COST CENTERS					
50	OPERATING ROOM	496,187	8,662,795	0.057278		50
51	RECOVERY ROOM	39,033	1,461,369	0.026710		51
52	DELIVERY ROOM & LABOR ROOM	131,392	2,866,200	0.045842		52
53	ANESTHESIOLOGY	31,687	1,237,998	0.025595		53
54	RADIOLOGY-DIAGNOSTIC	227,837	4,636,779	0.049137		54
54.01	ULTRA SOUND	12,799	3,721,075	0.003440		54.01
54.02	NUCLEAR ONCOLOGY	166,258	1,948,879	0.085310		54.02
55	RADIOLOGY-THERAPEUTIC	124,112	1,254,890	0.098903		55
56	RADIOISOTOPE	13,001	1,321,161	0.009841		56
57	CT SCAN	30,158	12,063,221	0.002500		57
58	MRI	30,837	3,905,057	0.007897		58
59	CARDIAC CATHETERIZATION	231,893	3,337,161	0.069488		59
60	LABORATORY	252,100	13,717,744	0.018378		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
64	INTRAVENOUS THERAPY	100,271	1,039,213	0.096487		64
65	RESPIRATORY THERAPY	23,534	2,160,623	0.010892		65
66	PHYSICAL THERAPY	132,806	3,261,591	0.040718		66
69	ELECTROCARDIOLOGY	75,250	5,143,434	0.014630		69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	39,372	10,983,320	0.003585		71
72	IMPL. DEV. CHARGED TO PATIENTS	23,830	4,898,488	0.004865		72
73	DRUGS CHARGED TO PATIENTS	105,642	27,939,530	0.003781		73
74	RENAL DIALYSIS	719	395,178	0.001819		74
75	ASC (NON-DISTINCT PART)	95,461	1,994,187	0.047870		75
75.01	LITHOTRIPSY	2				75.01
75.02	PSYCH	37,000	236,828	0.156232		75.02
75.03	NEURODIAGNOSTICS	7,934	165,250	0.048012		75.03
76.97	CARDIAC REHABILITATION	40,575	306,410	0.132421		76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
90.03	GENETIC TESTING	1,094	14,588	0.074993		90.03
90.04	CHRONIC PAIN CLINIC	18,795	455,071	0.041301		90.04
90.05	DIABETES EDUCATION	7,551	157,625	0.047905		90.05
90.06	WOUND CARE	20,452	340,359	0.060089		90.06
90.07	SLEEP LAB	16,118	616,505	0.026144		90.07
91	EMERGENCY	237,527	14,614,470	0.016253		91
92	OBSERVATION BEDS (NON-DISTINCT PART)	161,688	1,631,679	0.099093		92
	OTHER REIMBURSABLE COST CENTERS					
200	TOTAL (sum of lines 50-199)	2,932,915	136,488,678			200

(A) Worksheet A line numbers



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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK [] TITLE V
 APPLICABLE [] TITLE XVIII, PART A
 BOXES: [XX] TITLE XIX

(A)	COST CENTER DESCRIPTION	NURSING SCHOOL	ALLIED HEALTH COST	ALL OTHER MEDICAL EDUCATION COST	SWING-BED ADJUSTMENT AMOUNT (see instructions)	TOTAL COSTS (sum of cols. 1 through 3 minus col 4.)
		1	2	3	4	5
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)					30
31	INTENSIVE CARE UNIT					31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT					34
35	OTHER SPECIAL CARE (SPECIFY)					35
40	SUBPROVIDER - IPF					40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY					43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)					200

(A) Worksheet A line numbers



DELNOR-COMMUNITY HOSPITAL Provider CCN: 14-0211	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/27/2015 Run Time: 13:15 Version: 2014.10
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK TITLE V
 APPLICABLE TITLE XVIII, PART A
 BOXES: TITLE XIX

(A)	COST CENTER DESCRIPTION	TOTAL PATIENT DAYS	PER DIEM (col. 5÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	5,090		303		30
31	INTENSIVE CARE UNIT	749		33		31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT					34
35	OTHER SPECIAL CARE (SPECIFY)					35
40	SUBPROVIDER - IPF					40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY	461		130		43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	6,300		466		200

(A) Worksheet A line numbers



DELNOR-COMMUNITY HOSPITAL Provider CCN: 14-0211	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/27/2015 Run Time: 13:15 Version: 2014.10
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-0211

**WORKSHEET D
PART IV**

CHECK TITLE V HOSPITAL SUB (OTHER) ICF/MR
 APPLICABLE TITLE XVIII, PART A IPF SNF
 BOXES: TITLE XIX IRF NF

(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
51	RECOVERY ROOM							51
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
54.01	ULTRA SOUND							54.01
54.02	NUCLEAR ONCOLOGY							54.02
55	RADIOLOGY-THERAPEUTIC							55
56	RADIOISOTOPE							56
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY							64
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
75	ASC (NON-DISTINCT PART)							75
75.01	LITHOTRIPSY							75.01
75.02	PSYCH							75.02
75.03	NEURODIAGNOSTICS							75.03
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.03	GENETIC TESTING							90.03
90.04	CHRONIC PAIN CLINIC							90.04
90.05	DIABETES EDUCATION							90.05
90.06	WOUND CARE							90.06
90.07	SLEEP LAB							90.07
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers



DELNOR-COMMUNITY HOSPITAL Provider CCN: 14-0211	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/27/2015 Run Time: 13:15 Version: 2014.10
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-0211

**WORKSHEET D
PART IV**

CHECK TITLE V HOSPITAL SUB (OTHER) ICF/MR
 APPLICABLE TITLE XVIII, PART A IPF SNF
 BOXES: TITLE XIX IRF NF

(A)	COST CENTER DESCRIPTION	TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5 ÷ col. 7)	OUTPAT-IENT RATIO OF COST TO CHARGES (col. 6 ÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPAT-IENT PROGRAM CHARGES	OUTPAT-IENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)	
7	8	9	10	11	12	13			
ANCILLARY SERVICE COST CENTERS									
50	OPERATING ROOM	8,662,795							50
51	RECOVERY ROOM	1,461,369							51
52	DELIVERY ROOM & LABOR ROOM	2,866,200							52
53	ANESTHESIOLOGY	1,237,998							53
54	RADIOLOGY-DIAGNOSTIC	4,636,779							54
54.01	ULTRA SOUND	3,721,075							54.01
54.02	NUCLEAR ONCOLOGY	1,948,879							54.02
55	RADIOLOGY-THERAPEUTIC	1,254,890							55
56	RADIOISOTOPE	1,321,161							56
57	CT SCAN	12,063,221							57
58	MRI	3,905,057							58
59	CARDIAC CATHETERIZATION	3,337,161							59
60	LABORATORY	13,717,744							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	INTRAVENOUS THERAPY	1,039,213							64
65	RESPIRATORY THERAPY	2,160,623							65
66	PHYSICAL THERAPY	3,261,591							66
69	ELECTROCARDIOLOGY	5,143,434							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,983,320							71
72	IMPL. DEV. CHARGED TO PATIENTS	4,898,488							72
73	DRUGS CHARGED TO PATIENTS	27,939,530							73
74	RENAL DIALYSIS	395,178							74
75	ASC (NON-DISTINCT PART)	1,994,187							75
75.01	LITHOTRIPSY								75.01
75.02	PSYCH	236,828							75.02
75.03	NEURODIAGNOSTICS	165,250							75.03
76.97	CARDIAC REHABILITATION	306,410							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
OUTPATIENT SERVICE COST CENTERS									
90.03	GENETIC TESTING	14,588							90.03
90.04	CHRONIC PAIN CLINIC	455,071							90.04
90.05	DIABETES EDUCATION	157,625							90.05
90.06	WOUND CARE	340,359							90.06
90.07	SLEEP LAB	616,505							90.07
91	EMERGENCY	14,614,470							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1,631,679							92
OTHER REIMBURSABLE COST CENTERS									
200	TOTAL (sum of lines 50-199)	136,488,678							200

(A) Worksheet A line numbers



DELNOR-COMMUNITY HOSPITAL Provider CCN: 14-0211	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/27/2015 Run Time: 13:15 Version: 2014.10
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-0211

WORKSHEET D
PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL [] SUB (OTHER) [] SWING BED SNF
 APPLICABLE [] TITLE XVIII, PART B [] IPF [] SNF [] SWING BED NF
 BOXES: [XX] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

(A)	COST CENTER DESCRIPTION	COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PROGRAM CHARGES			PROGRAM COST			
			PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
1	2	3	4	5	6	7			
ANCILLARY SERVICE COST CENTERS									
50	OPERATING ROOM	0.270262						50	
51	RECOVERY ROOM	0.212350						51	
52	DELIVERY ROOM & LABOR ROOM	0.325753						52	
53	ANESTHESIOLOGY	0.147096						53	
54	RADIOLOGY-DIAGNOSTIC	0.246919						54	
54.01	ULTRA SOUND	0.101735						54.01	
54.02	NUCLEAR ONCOLOGY	0.282681						54.02	
55	RADIOLOGY-THERAPEUTIC	0.636659						55	
56	RADIOISOTOPE	0.199812						56	
57	CT SCAN	0.054329						57	
58	MRI	0.097589						58	
59	CARDIAC CATHETERIZATION	0.316498						59	
60	LABORATORY	0.186878						60	
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30	
64	INTRAVENOUS THERAPY	0.581172						64	
65	RESPIRATORY THERAPY	0.193056						65	
66	PHYSICAL THERAPY	0.320043						66	
69	ELECTROCARDIOLOGY	0.098145						69	
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.201487						71	
72	IMPL. DEV. CHARGED TO PATIENTS	0.292917						72	
73	DRUGS CHARGED TO PATIENTS	0.205565						73	
74	RENAL DIALYSIS	0.281739						74	
75	ASC (NON-DISTINCT PART)	0.319487						75	
75.01	LITHOTRIPSY							75.01	
75.02	PSYCH	0.522814						75.02	
75.03	NEURODIAGNOSTICS	0.306850						75.03	
76.97	CARDIAC REHABILITATION	0.467762						76.97	
76.98	HYPERBARIC OXYGEN THERAPY							76.98	
76.99	LITHOTRIPSY							76.99	
OUTPATIENT SERVICE COST CENTERS									
90.03	GENETIC TESTING	1.632849						90.03	
90.04	CHRONIC PAIN CLINIC	0.193456						90.04	
90.05	DIABETES EDUCATION	0.624063						90.05	
90.06	WOUND CARE	0.461028						90.06	
90.07	SLEEP LAB	0.089386						90.07	
91	EMERGENCY	0.140886						91	
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.554146						92	
OTHER REIMBURSABLE COST CENTERS									
200	SUBTOTAL (see instructions)							200	
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES							201	
202	NET CHARGES (line 200 - line 201)							202	

(A) Worksheet A line numbers



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0211

WORKSHEET D-1
PART I

CHECK [] TITLE V - I/P [XX] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [] IPF [] SNF [] TEFRA
 BOXES: [] TITLE XIX - I/P [] IRF [] NF [] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	5,090	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	5,090	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	4,336	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	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)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	2,013	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions)		10
11	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)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)		16

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	6,103,892	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 5 x line 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 6 x line 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 7 x line 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 8 x line 20)		25
26	TOTAL SWING-BED COST (see instructions)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	6,103,892	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	6,103,892	37



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0211

WORKSHEET D-1
PART II

CHECK [] TITLE V - I/P [XX] HOSPITAL [] SUB (OTHER) [XX] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [] IPF [] TEFRA
 BOXES: [] TITLE XIX - I/P [] IRF [] OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

							1	
		TOTAL INPATIENT COST	TOTAL INPATIENT DAYS	AVERAGE PER DIEM (col. 1 ÷ col. 2)	PROGRAM DAYS	PROGRAM COST (col. 3 x col. 4)		
		1	2	3	4	5		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)					1,199.19	38	
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					2,413,969	39	
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (line 14 x line 35)						40	
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40)					2,413,969	41	
42	NURSERY (Titles V and XIX only)						42	
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS							
43	INTENSIVE CARE UNIT	1,426,562	749	1,904.62	333	634,238	43	
44	CORONARY CARE UNIT						44	
45	BURN INTENSIVE CARE UNIT						45	
46	SURGICAL INTENSIVE CARE UNIT						46	
47	OTHER SPECIAL CARE (SPECIFY)						47	

							1	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)					4,854,496	48	
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					7,902,703	49	

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)					509,757	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)					436,491	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)					946,248	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)					6,956,455	53

TARGET AMOUNT AND LIMIT COMPUTATION

54	PROGRAM DISCHARGES						54
55	TARGET AMOUNT PER DISCHARGE						55
56	TARGET AMOUNT (line 54 x line 55)						56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)						57
58	BONUS PAYMENT (see instructions)						58
59	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET						59
60	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET						60
61	IF LINE 53 ÷ 54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (line 53) ARE LESS THAN EXPECTED COSTS (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE ENTER ZERO (see instructions)						61
62	RELIEF PAYMENT (see instructions)						62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)						63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)						64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)						65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)						66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)						67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)						68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)						69



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0211

WORKSHEET D-1
PARTS III & IV

CHECK TITLE V - I/P HOSPITAL SUB (OTHER) ICF/MR PPS
 APPLICABLE TITLE XVIII, PART A IPF SNF TEFRA
 BOXES: TITLE XIX - I/P IRF NF OTHER

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					754	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)					1,199.19	88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)					904,189	89
		COST	ROUTINE COST (from line 27)	column 1 ÷ column 2	TOTAL OBSERVATION BED COST (from line 89)	OBSERVATION BED PASS-THROUGH COST col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	CAPITAL-RELATED COST	1,091,504	6,103,892	0.178821	904,189	161,688	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0211

WORKSHEET D-1
PART I

CHECK TITLE V - I/P HOSPITAL SUB (OTHER) ICF/MR PPS
 APPLICABLE TITLE XVIII, PART A IPF SNF TEFRA
 BOXES: TITLE XIX - I/P IRF NF OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	5,090	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	5,090	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	4,336	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	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)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	303	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions)		10
11	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)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)	461	15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)	130	16

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	6,103,892	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 5 x line 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 6 x line 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 7 x line 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 8 x line 20)		25
26	TOTAL SWING-BED COST (see instructions)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	6,103,892	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	6,103,892	37



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0211

WORKSHEET D-1
PART II

CHECK [] TITLE V - I/P [XX] HOSPITAL [] SUB (OTHER) [] PPS
 APPLICABLE [] TITLE XVIII, PART A [] IPF [] TEFRA
 BOXES: [XX] TITLE XIX - I/P [] IRF [XX] OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

							1	
		TOTAL INPATIENT COST	TOTAL INPATIENT DAYS	AVERAGE PER DIEM (col. 1 ÷ col. 2)	PROGRAM DAYS	PROGRAM COST (col. 3 x col. 4)		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)					1,199.19	38	
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					363,355	39	
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (line 14 x line 35)						40	
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40)					363,355	41	
42	NURSERY (Titles V and XIX only)	411,394	461	892.39	130	116,011	42	
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS								
43	INTENSIVE CARE UNIT	1,426,562	749	1,904.62	33	62,852	43	
44	CORONARY CARE UNIT						44	
45	BURN INTENSIVE CARE UNIT						45	
46	SURGICAL INTENSIVE CARE UNIT						46	
47	OTHER SPECIAL CARE (SPECIFY)						47	

							1	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)						48	
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					542,218	49	

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)					81,164	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)						51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)					81,164	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)						53

TARGET AMOUNT AND LIMIT COMPUTATION

54	PROGRAM DISCHARGES						54
55	TARGET AMOUNT PER DISCHARGE						55
56	TARGET AMOUNT (line 54 x line 55)						56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)						57
58	BONUS PAYMENT (see instructions)						58
59	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET						59
60	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET						60
61	IF LINE 53 ÷ 54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (line 53) ARE LESS THAN EXPECTED COSTS (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE ENTER ZERO (see instructions)						61
62	RELIEF PAYMENT (see instructions)						62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)						63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)						64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)						65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)						66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)						67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)						68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)						69



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0211

WORKSHEET D-1
PARTS III & IV

CHECK TITLE V - I/P HOSPITAL SUB (OTHER) ICF/MR PPS
 APPLICABLE TITLE XVIII, PART A IPF SNF TEFRA
 BOXES: TITLE XIX - I/P IRF NF OTHER

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					754	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)						88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)						89
		COST	ROUTINE COST (from line 27)	column 1 ÷ column 2	TOTAL OBSERVATION BED COST (from line 89)	OBSERVATION BED PASS-THROUGH COST col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	CAPITAL-RELATED COST						90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93



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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-0211

WORKSHEET D-3

CHECK [] TITLE V [XX] HOSPITAL [] SUB (OTHER) [] SWING BED SNF [XX] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [] IPF [] SNF [] SWING BED NF [] TEFRA
 BOXES: [] TITLE XIX [] IRF [] NF [] ICF/MR [] OTHER

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS		4,705,607		30
31	INTENSIVE CARE UNIT		1,537,607		31
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.270262	2,170,795	586,683	50
51	RECOVERY ROOM	0.212350	353,710	75,110	51
52	DELIVERY ROOM & LABOR ROOM	0.325753	9,796	3,191	52
53	ANESTHESIOLOGY	0.147096	237,279	34,903	53
54	RADIOLOGY-DIAGNOSTIC	0.246919	527,790	130,321	54
54.01	ULTRA SOUND	0.101735	298,254	30,343	54.01
54.02	NUCLEAR ONCOLOGY	0.282681	69,536	19,657	54.02
55	RADIOLOGY-THERAPEUTIC	0.636659	1,574	1,002	55
56	RADIOISOTOPE	0.199812	181,491	36,264	56
57	CT SCAN	0.054329	1,315,632	71,477	57
58	MRI	0.097589	164,740	16,077	58
59	CARDIAC CATHETERIZATION	0.316498	776,431	245,739	59
60	LABORATORY	0.186878	2,520,635	471,051	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	INTRAVENOUS THERAPY	0.581172	72,718	42,262	64
65	RESPIRATORY THERAPY	0.193056	1,082,415	208,967	65
66	PHYSICAL THERAPY	0.320043	662,065	211,889	66
69	ELECTROCARDIOLOGY	0.098145	876,791	86,053	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.201487	3,710,536	747,625	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.292917	2,288,463	670,330	72
73	DRUGS CHARGED TO PATIENTS	0.205565	3,183,892	654,497	73
74	RENAL DIALYSIS	0.281739	270,983	76,346	74
75	ASC (NON-DISTINCT PART)	0.319487	172,619	55,150	75
75.01	LITHOTRIPSY				75.01
75.02	PSYCH	0.522814			75.02
75.03	NEURODIAGNOSTICS	0.306850	45,293	13,898	75.03
76.97	CARDIAC REHABILITATION	0.467762	1,943	909	76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90.03	GENETIC TESTING	1.632849			90.03
90.04	CHRONIC PAIN CLINIC	0.193456			90.04
90.05	DIABETES EDUCATION	0.624063	1,240	774	90.05
90.06	WOUND CARE	0.461028			90.06
90.07	SLEEP LAB	0.094888			90.07
91	EMERGENCY	0.141044	1,663,250	234,591	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.554146	233,489	129,387	92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		22,893,360	4,854,496	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		22,893,360		202

(A) Worksheet A line numbers



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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-0211

WORKSHEET D-3

CHECK TITLE V HOSPITAL SUB (OTHER) SWING BED SNF PPS
 APPLICABLE TITLE XVIII, PART A IPF SNF SWING BED NF TEFRA
 BOXES: TITLE XIX IRF NF ICF/MR OTHER

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
31	INTENSIVE CARE UNIT				31
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.270262			50
51	RECOVERY ROOM	0.212350			51
52	DELIVERY ROOM & LABOR ROOM	0.325753			52
53	ANESTHESIOLOGY	0.147096			53
54	RADIOLOGY-DIAGNOSTIC	0.246919			54
54.01	ULTRA SOUND	0.101735			54.01
54.02	NUCLEAR ONCOLOGY	0.282681			54.02
55	RADIOLOGY-THERAPEUTIC	0.636659			55
56	RADIOISOTOPE	0.199812			56
57	CT SCAN	0.054329			57
58	MRI	0.097589			58
59	CARDIAC CATHETERIZATION	0.316498			59
60	LABORATORY	0.186878			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	INTRAVENOUS THERAPY	0.581172			64
65	RESPIRATORY THERAPY	0.193056			65
66	PHYSICAL THERAPY	0.320043			66
69	ELECTROCARDIOLOGY	0.098145			69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.201487			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.292917			72
73	DRUGS CHARGED TO PATIENTS	0.205565			73
74	RENAL DIALYSIS	0.281739			74
75	ASC (NON-DISTINCT PART)	0.319487			75
75.01	LITHOTRIPSY				75.01
75.02	PSYCH	0.522814			75.02
75.03	NEURODIAGNOSTICS	0.306850			75.03
76.97	CARDIAC REHABILITATION	0.467762			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90.03	GENETIC TESTING	1.632849			90.03
90.04	CHRONIC PAIN CLINIC	0.193456			90.04
90.05	DIABETES EDUCATION	0.624063			90.05
90.06	WOUND CARE	0.461028			90.06
90.07	SLEEP LAB	0.089386			90.07
91	EMERGENCY	0.140886			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.554146			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)				200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)				202

(A) Worksheet A line numbers



DELNOR-COMMUNITY HOSPITAL Provider CCN: 14-0211	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/27/2015 Run Time: 13:15 Version: 2014.10
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CALCULATION OF REIMBURSEMENT SETTLEMENT

**WORKSHEET E
PART A**

**CHECK
APPLICABLE BOX:**

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS	4,119,743			1
1.01	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES OCCURRING PRIOR TO OCTOBER 1, 2013 (see instructions)				1.01
1.02	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2013 (see instructions)				1.02
1.03	DRG FOR FEDERAL SPECIFIC OPERATING PAYMENT FOR MODEL 4 BPCI (see instructions)				1.03
2	OUTLIER PAYMENTS FOR DISCHARGES (see instructions)	347,533			2
2.01	OUTLIER RECONCILIATION AMOUNT				2.01
2.02	OUTLIER PAYMENT FOR MODEL 4 BPCI (see instructions)				
3	MANAGED CARE SIMULATED PAYMENTS	611,947			3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)	146.84			4
	INDIRECT MEDICAL EDUCATION ADJUSTMENT CALCULATION FOR HOSPITALS				
5	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE 12/31/1996 (see instructions)				5
6	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH 42 CFR 413.79(e)				6
7	MMA SECTION 422 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105(f)(1)(iv)(B)(1)				7
7.01	ACA SECTION 5503 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105(f)(1)(iv)(B)(2). IF THE COST REPORT STRADDLES JULY 1, 2011 THEN SEE INSTRUCTIONS				7.01
8	ADJUSTMENT (INCREASE OR DECREASE) TO THE FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH 42 CFR §413.75(b), §413.79(c)(2)(iv) AND VOL. 64 FEDERAL REGISTER, MAY 12, 1998, PAGE 26340 AND VOL. 67 FEDERAL REGISTER, PAGE 50069, AUGUST 1, 2002				8
8.01	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS UNDER SECTION 5503 OF THE ACA. IF THE COST REPORT STRADDLES JULY 1, 2011, SEE INSTRUCTIONS				8.01
8.02	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS FROM A CLOSED TEACHING HOSPITAL UNDER SECTION 5506 OF ACA. (see instructions)				8.02
9	SUM OF LINES 5 PLUS 6 MINUS LINES (7 AND 7.01) PLUS/MINUS LINES (8, 8.01 AND 8.02) (see instructions)				9
10	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS				10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS				11
12	CURRENT YEAR ALLOWABLE FTE (see instructions)				12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR				13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO				14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3				15
16	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF THE PROGRAM				16
17	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE				17
18	ADJUSTED ROLLING AVERAGE FTE COUNT				18
19	CURRENT YEAR RESIDENT TO BED RATIO (line 18 divided by line 4)				19
20	PRIOR YEAR RESIDENT TO BED RATIO (see instructions)				20
21	ENTER THE LESSER OF LINES 19 OR 20 (see instructions)				21
22	IME PAYMENT ADJUSTMENT (see instructions)				22
	INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON				
23	NUMBER OF ADDITIONAL ALLOPATHIC AND OSTEOPATHIC IME FTE RESIDENT CAP SLOTS UNDER 42 SEC. 412.105(f)(1)(iv)(C)				23
24	IME FTE RESIDENT COUNT OVER CAP (see instructions)				24
25	IF THE AMOUNT ON LINE 24 IS GREATER THAN -0-, THEN ENTER THE LOWER OF LINE 23 OR LINE 24 (see instructions)				25
26	RESIDENT TO BED RATIO (divide line 25 by line 4)				26
27	IME PAYMENTS ADJUSTMENT (see instructions)				27
28	IME ADJUSTMENT (see instructions)				28
29	TOTAL IME PAYMENT (sum of lines 22 and 28)				29
	DISPROPORTIONATE SHARE ADJUSTMENT				
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (see instructions)	0.0062			30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL (see instructions)				31
32	SUM OF LINES 30 AND 31				32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)				33
34	DISPROPORTIONATE SHARE ADJUSTMENT (see instructions)				34
		PRIOR TO	ON OR AFTER		



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CALCULATION OF REIMBURSEMENT SETTLEMENT

**WORKSHEET E
PART A**

**CHECK
APPLICABLE BOX:**

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
	UNCOMPENSATED CARE ADJUSTMENT	OCTOBER 1	OCTOBER 1		
35	TOTAL UNCOMPENSATED CARE AMOUNT (see instructions)				35
35.01	FACTOR 3 (see instructions)				35.01
35.02	HOSPITAL UNCOMPENSATED CARE PAYMENT (if line 34 is zero, enter zero on this line) (see instructions)				35.02
35.03	PRO RATA SHARE OF THE HOSPITAL UNCOMPENSATED CARE PAYMENT AMOUNT (see instructions)				35.03
36	TOTAL UNCOMPENSATED CARE (sum of columns 1 and 2 on line 35.03)				36
	ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES				
40	TOTAL MEDICARE DISCHARGES ON WORKSHEET S-3, PART I EXCLUDING DISCHARGES FOR MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				40
41	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				41
41.01	TOTAL ESRD MEDICARE COVERED AND PAID DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				41.01
42	DIVIDE LINE 41 BY LINE 40 (if less than 10%, you do not qualify for adjustment)				42
43	TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				43
44	RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK (line 43 divided by line 41.01 divided by 7 days)				44
45	AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS (see instructions)				45
46	TOTAL ADDITIONAL PAYMENT (line 45 times line 44 times line 41.01)				46
47	SUBTOTAL (see instructions)	4,467,276			47
48	HOSPITAL SPECIFIC PAYMENTS (to be completed by SCH and MDH, small rural hospitals only (see instructions)				48
49	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS SCH AND MDH ONLY (see instructions)	4,467,276			49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (from Wkst L, Parts I, II, as applicable)	432,361			50
51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (Wkst L, Part III) (see instructions)				51
52	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT (from Wkst E-4, line 49) (see instructions)				52
53	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT				53
54	SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES	1,588			54
55	NET ORGAN ACQUISITION COST (Wkst D-4, Part III, col. 1, line 69)				55
56	COST OF TEACHING PHYSICIANS (Wkst D-5, Part II, col. 3, line 20)				56
57	ROUTINE SERVICE OTHER PASS THROUGH COSTS				57
58	ANCILLARY SERVICE OTHER PASS THROUGH COSTS (Wkst D, Part IV, col. 11, line 200)				58
59	TOTAL (sum of amounts on lines 49 through 58)	4,901,225			59
60	PRIMARY PAYER PAYMENTS				60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (line 59 minus line 60)	4,901,225			61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	459,648			62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	7,600			63
64	ALLOWABLE BAD DEBTS (see instructions)				64
65	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)				65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)				66
67	SUBTOTAL (line 61 plus line 65 minus lines 62 and 63)	4,433,977			67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (see instructions)				68
69	OUTLIER PAYMENTS RECONCILIATION				69
70	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				70
70.93	HVBP PAYMENT ADJUSTMENT (see instructions)	-1,050			70.93
70.94	HOSPITAL READMISSIONS REDUCTION ADJUSTMENT (see instructions)	-13,188			70.94
71	AMOUNT DUE PROVIDER (see instructions)	4,419,739			71
71.01	SEQUESTRATION ADJUSTMENT (see instructions)	88,395			71.01
72	INTERIM PAYMENTS	4,336,893			72
73	TENTATIVE SETTLEMENT (for contractor use only)				73
74	BALANCE DUE PROVIDER/PROGRAM (line 71 minus lines 71.01, 72 and 73)	-5,549			74
75	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-2, SECTION 115.2				75

TO BE COMPLETED BY CONTRACTOR

90	OPERATING OUTLIER AMOUNT FROM WORKSHEET E, PART A, LINE 2				90
91	CAPITAL OUTLIER FROM WORKSHEET L, PART I, LINE 2				91
92	OPERATING OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (see instructions)				92
93	CAPITAL OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (see instructions)				93
94	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (see instructions)				94
95	TIME VALUE OF MONEY FOR OPERATING EXPENSES (see instructions)				95



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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK
APPLICABLE BOX:

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

96	TIME VALUE OF MONEY FOR CAPITAL RELATED EXPENSES (see instructions)	1	1.01	1.02	96
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-0211

**WORKSHEET E
PART B**

CHECK APPLICABLE BOX: HOSPITAL IPF IRF SUB (OTHER) SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	MEDICAL AND OTHER SERVICES (see instructions)	168			1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPTS (see instructions)	5,545,010			2
3	PPS PAYMENTS	3,543,366			3
4	OUTLIER PAYMENT (see instructions)	1,477			4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)	0.765			5
6	LINE 2 TIMES LINE 5	4,241,933			6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6	0.8357			7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)				8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200				9
10	ORGAN ACQUISITION				10
11	TOTAL COST (sum of lines 1 and 10) (see instructions)	168			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	ANCILLARY SERVICE CHARGES	816			12
13	ORGAN ACQUISITION CHARGES (from Wkst D-4, Part III, line 69, col. 4)				13
14	TOTAL REASONABLE CHARGES (sum of lines 12 and 13)	816			14
	CUSTOMARY CHARGES				
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS				15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)				16
17	RATIO OF LINE 15 TO LINE 16 (not to exceed 1.000000)	1.000000			17
18	TOTAL CUSTOMARY CHARGES (see instructions)	816			18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions))	648			19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 11 exceeds line 18 (see instructions))				20
21	LESSER OF COST OR CHARGES (line 11 minus line 20) (for CAH, see instructions)	168			21
22	INTERNS AND RESIDENTS (see instructions)				22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)				23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)	3,544,843			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)				25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)	731,716			26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)	2,813,295			27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Wkst E-4, line 50)				28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (from Wkst E-4, line 36)				29
30	SUBTOTAL (sum of lines 27 through 29)	2,813,295			30
31	PRIMARY PAYER PAYMENTS	99			31
32	SUBTOTAL (line 30 minus line 31)	2,813,196			32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	COMPOSITE RATE ESRD (from Wkst I-5, line 11)				33
34	ALLOWABLE BAD DEBTS (see instructions)				34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)				35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)				36
37	SUBTOTAL (see instructions)	2,813,196			37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				39
40	SUBTOTAL (see instructions)	2,813,196			40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	56,264			40.01
41	INTERIM PAYMENTS	2,756,975			41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)	-43			43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2				44

TO BE COMPLETED BY CONTRACTOR

90	ORIGINAL OUTLIER AMOUNT (see instructions)				90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (see instructions)				91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY				92
93	TIME VALUE OF MONEY (see instructions)				93
94	TOTAL (sum of lines 91 and 93)				94



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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-0211

WORKSHEET E-1
PART I

CHECK HOSPITAL SUB (OTHER)
 APPLICABLE IPF SNF
 BOXES: IRF SWING BED SNF

	DESCRIPTION	INPATIENT PART A		PART B		
		mm/dd/yyyy 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER		4,336,893		2,756,975	1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO					2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT					3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM					3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM				3.03
	EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	TO				3.04
		PROVIDER				3.05
						3.06
						3.07
						3.08
						3.09
						3.10
						3.50
						3.51
		PROVIDER				3.52
		TO				3.53
		PROGRAM				3.54
						3.55
						3.56
						3.57
						3.58
						3.59
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99				3.99
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4,336,893		2,756,975	4
TO BE COMPLETED BY CONTRACTOR						
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT					5.01
	AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT.					5.02
	IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	PROGRAM				5.03
		TO				5.04
		PROVIDER				5.05
						5.06
						5.07
						5.08
						5.09
						5.10
						5.50
						5.51
		PROVIDER				5.52
		TO				5.53
		PROGRAM				5.54
						5.55
						5.56
						5.57
						5.58
						5.59
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99				5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due) BASED ON THE COST REPORT (1)	.01	82,846		56,221	6.01
		.02				6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)		4,419,739		2,813,196	7
8	NAME OF CONTRACTOR	CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)		8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.



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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK [XX] HOSPITAL [] CAH
APPLICABLE BOX:

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	1,219	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	2,346	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	367	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	5,085	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	152,828,821	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	8,198,475	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168		7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (see instructions)		8
9	SEQUESTRATION ADJUSTMENT AMOUNT (see instructions)		9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (see instructions)		10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)		30
31	OTHER ADJUSTMENTS ()		31
32	BALANCE DUE PROVIDER (line 8 (or line 10) minus line 30 and line 31) (see instructions)		32



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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-0211

WORKSHEET E-3
PART VII

CHECK TITLE V HOSPITAL NF PPS
 APPLICABLE TITLE XIX SUB (OTHER) ICF/MR TEFRA
 BOXES: SNF OTHER

PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR TITLE XIX SERVICES

	INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
COMPUTATION OF NET COST OF COVERED SERVICES			
1	542,218		1
2			2
3			3
4	542,218		4
5			5
6			6
7	542,218		7
COMPUTATION OF LESSER OF COST OR CHARGES			
REASONABLE CHARGES			
8			8
9			9
10			10
11			11
12			12
CUSTOMARY CHARGES			
13			13
14			14
15	1	1	15
16			16
17			17
18	542,218		18
19			19
20			20
21			21
PROSPECTIVE PAYMENT AMOUNT			
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	542,218		30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43



DELNOR-COMMUNITY HOSPITAL Provider CCN: 14-0211	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 08/31/2014	Run Date: 01/27/2015 Run Time: 13:15 Version: 2014.10
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BALANCE SHEET

WORKSHEET G

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

	ASSETS (Omit Cents)	GENERAL FUND 1	SPECIFIC PURPOSE FUND 2	ENDOWMENT FUND 3	PLANT FUND 4	
CURRENT ASSETS						
1	CASH ON HAND AND IN BANKS	5,838,545				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE	2,581,403				3
4	ACCOUNTS RECEIVABLE	85,610,219				4
5	OTHER RECEIVABLES	5,538,874				5
6	ALLOWANCES FOR UNCOLLECTIBLE NOTES AND ACCOUNTS RECEIVABLE	-57,570,835				6
7	INVENTORY	4,326,705				7
8	PREPAID EXPENSES	295,406				8
9	OTHER CURRENT ASSETS					9
10	DUE FROM OTHER FUNDS	1,362,687				10
11	TOTAL CURRENT ASSETS (sum of lines 1-10)	47,983,004				11
FIXED ASSETS						
12	LAND	1,584,576				12
13	LAND IMPROVEMENTS	12,785,630				13
14	ACCUMULATED DEPRECIATION	-9,262,449				14
15	BUILDINGS	182,714,471				15
16	ACCUMULATED DEPRECIATION	-52,580,303				16
17	LEASEHOLD IMPROVEMENTS	2,189,193				17
18	ACCUMULATED AMORTIZATION	-1,560,763				18
19	FIXED EQUIPMENT	37,079,101				19
20	ACCUMULATED DEPRECIATION	-21,412,750				20
21	AUTOMOBILES AND TRUCKS					21
22	ACCUMULATED DEPRECIATION					22
23	MAJOR MOVABLE EQUIPMENT	78,782,983				23
24	ACCUMULATED DEPRECIATION	-54,649,573				24
25	MINOR EQUIPMENT DEPRECIABLE					25
26	ACCUMULATED DEPRECIATION					26
27	HIT DESIGNATED ASSETS					27
28	ACCUMULATED DEPRECIATION					28
29	MINOR EQUIPMENT-NONDEPRECIABLE	3,400,282				29
30	TOTAL FIXED ASSETS (sum of lines 12-29)	179,070,398				30
OTHER ASSETS						
31	INVESTMENTS	195,978,502				31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	20,684,429				34
35	TOTAL OTHER ASSETS (sum of lines 31-34)	216,662,931				35
36	TOTAL ASSETS (sum of lines 11, 30 and 35)	443,716,333				36
	LIABILITIES AND FUND BALANCES (Omit Cents)	GENERAL FUND 1	SPECIFIC PURPOSE FUND 2	ENDOWMENT FUND 3	PLANT FUND 4	
CURRENT LIABILITIES						
37	ACCOUNTS PAYABLE	4,754,187				37
38	SALARIES, WAGES & FEES PAYABLE	190,509				38
39	PAYROLL TAXES PAYABLE	295,000				39
40	NOTES & LOANS PAYABLE (short term)	3,894,258				40
41	DEFERRED INCOME					41
42	ACCELERATED PAYMENTS					42
43	DUE TO OTHER FUNDS	28,459,543				43
44	OTHER CURRENT LIABILITIES	164,408				44
45	TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44)	37,757,905				45
LONG TERM LIABILITIES						
46	MORTGAGE PAYABLE					46
47	NOTES PAYABLE	132,437,979				47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES	11,221,794				49
50	TOTAL LONG TERM LIABILITIES (sum of lines 46 thru 49)	143,659,773				50
51	TOTAL LIABILITIES (sum of lines 45 and 50)	181,417,678				51
CAPITAL ACCOUNTS						
52	GENERAL FUND BALANCE	262,298,655				52
53	SPECIFIC PURPOSE FUND BALANCE					53
54	DONOR CREATED - ENDOWMENT FUND BALANCE - RESTRICTED					54
55	DONOR CREATED - ENDOWMENT FUND BALANCE - UNRESTRICTED					55
56	GOVERNING BODY CREATED - ENDOWMENT FUND BALANCE					56
57	PLANT FUND BALANCE - INVESTED IN PLANT					57



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BALANCE SHEET

WORKSHEET G

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

		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
	ASSETS (Omit Cents)	1	2	3	4	
58	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT, AND EXPANSION					58
59	TOTAL FUND BALANCES (sum of lines 52-58)	262,298,655				59
60	TOTAL LIABILITIES AND FUND BALANCES (sum of lines 51 and 59)	443,716,333				60



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STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	FUND BALANCES AT BEGINNING OF PERIOD		257,148,079			1
2	NET INCOME (loss) (from Worksheet G-3, line 29)		5,158,651			2
3	TOTAL (sum of line 1 and line 2)		262,306,730			3
4	ADDITIONS (credit adjustments)					4
5	TRNA CAPITAL TRANSFER	36,495				5
6		15,043				6
7						7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)		51,538			10
11	SUBTOTAL (line 3 plus line 10)		262,358,268			11
12	DEDUCTIONS (debit adjustments)					12
13	PRIOR PERIOD CORRECTION FY12	59,613				13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)		59,613			18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)		262,298,655			19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	FUND BALANCES AT BEGINNING OF PERIOD					1
2	NET INCOME (loss) (from Worksheet G-3, line 29)					2
3	TOTAL (sum of line 1 and line 2)					3
4	ADDITIONS (credit adjustments)					4
5	TRNA CAPITAL TRANSFER					5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)					10
11	SUBTOTAL (line 3 plus line 10)					11
12	DEDUCTIONS (debit adjustments)					12
13	PRIOR PERIOD CORRECTION FY12					13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)					18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)					19



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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	HOSPITAL	13,153,078		13,153,078	1
2	SUBPROVIDER IPF				2
3	SUBPROVIDER IRF				3
5	SWING BED - SNF				5
6	SWING BED - NF				6
7	SKILLED NURSING FACILITY				7
8	NURSING FACILITY				8
9	OTHER LONG TERM CARE				9
10	TOTAL GENERAL INPATIENT CARE SERVICES (sum of lines 1-9)	13,153,078		13,153,078	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	INTENSIVE CARE UNIT	3,417,046		3,417,046	11
12	CORONARY CARE UNIT				12
13	BURN INTENSIVE CARE UNIT				13
14	SURGICAL INTENSIVE CARE UNIT				14
15	OTHER SPECIAL CARE (SPECIFY)				15
16	TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (sum of lines 11-15)	3,417,046		3,417,046	16
17	TOTAL INPATIENT ROUTINE CARE SERVICES (sum of lines 10 and 16)	16,570,124		16,570,124	17
18	ANCILLARY SERVICES	43,182,721	93,317,350	136,500,071	18
19	OUTPATIENT SERVICES	27,135	168,075	195,210	19
20	RHC				20
21	FQHC				21
22	HOME HEALTH AGENCY				22
23	AMBULANCE				23
25	ASC				25
26	HOSPICE				26
27	OTHER (SPECIFY)				27
28	TOTAL PATIENT REVENUES (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	59,779,980	93,485,425	153,265,405	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (per Worksheet A, column 3, line 200)		35,594,801	29
30	ADD (SPECIFY)			30
31	BAD DEBTS	3,717,901		31
32				32
33				33
34				34
35				35
36	TOTAL ADDITIONS (sum of lines 30-35)		3,717,901	36
37	DEDUCT (SPECIFY)			37
38				38
39				39
40				40
41				41
42	TOTAL DEDUCTIONS (sum of lines 37-41)			42
43	TOTAL OPERATING EXPENSES (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		39,312,702	43



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STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (from Worksheet G-2, Part I, column 3, line 28)	153,265,405	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	110,426,624	2
3	NET PATIENT REVENUES (line 1 minus line 2)	42,838,781	3
4	LESS - TOTAL OPERATING EXPENSES (from Worksheet G-2, Part II, line 43)	39,312,702	4
5	NET INCOME FROM SERVICE TO PATIENTS (line 3 minus line 4)	3,526,079	5

OTHER INCOME

6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	34,875	6
7	INCOME FROM INVESTMENTS		7
8	REVENUES FROM TELEPHONE AND OTHER MISCELLANEOUS COMMUNICATION SERVICES		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS	809	10
11	REBATES AND REFUNDS OF EXPENSES	23,907	11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	153,840	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS	1,604	16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS		18
19	TUITION (fees, sale of textbooks, uniforms, etc.)	3,743	19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE	29,706	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (THRIFT SHOP INCOME)		24
24.0	OTHER (BARIATRICS SUPPLY INCOME)	11,763	24.0
1			1
24.0	OTHER (EHR PHYSICIAN INCOME)		24.0
2			2
24.0	OTHER (PUBLIC SAFETY INCOME)	7,000	24.0
3			3
24.0	OTHER (EMS REVENUE)	32,756	24.0
4			4
24.0	OTHER (MISCELLANEOUS ACTIVITY INCOME)	9,276	24.0
5			5
24.0	OTHER (NLMC REVENUE)		24.0
6			6
24.0	OTHER (FOOD SERVICES INCOME)	332	24.0
7			7
24.0	OTHER (MEDICAL STAFF INCOME)		24.0
8			8
24.0	OTHER (BARIATRIC INCOME)	890	24.0
9			9
24.1	OTHER (ADMINISTRATION INCOME)	49,491	24.1
0			0
24.1	OTHER (PHARMACY INCOME)		24.1
1			1
24.1	OTHER (REHAB AURORA)		24.1
2			2
24.1	OTHER (MEAL REVENUE)	10,894	24.1
3			3
24.1	OTHER (MEANINGFUL USE INCOME)	193,046	24.1
4			4
24.1	OTHER (BARIATRIC INCOME)	6,398	24.1
5			5
24.1	OTHER (TRAUMA SERVICES)	45,675	24.1
6			6
24.1	OTHER (WORK ORDER REVENUE)	-84	24.1
7			7
24.1	OTHER (INTEREST RATE SWAP)	9,515	24.1
8			8
24.1	OTHER (BDF INTEREST INCOME)		24.1
9			9
24.2	OTHER (BDF DIVIDENT INCOME)		24.2
0			0
24.2	OTHER (BDF INVESTMENT GAINS)		24.2
1			1
24.2	OTHER (BDF UNREALIZED GAINS)		24.2
2			2



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STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

	DESCRIPTION		
24.2 3	OTHER (SF INTEREST INCOME)		24.2 3
24.2 4	OTHER (SF DIVIDEND INCOME)		24.2 4
24.2 5	OTHER (SF INVESTMENT GAINS)		24.2 5
24.2 6	OTHER (SF UNREALIZED GAINS)	1,007,136	24.2 6
25	TOTAL OTHER INCOME (sum of lines 6-24)	1,632,572	25
26	TOTAL (line 5 plus line 25)	5,158,651	26
27.0 1	OTHER EXPENSES (LOAN FORGIVENESS EXPENSE)		27.0 1
27.0 2	OTHER EXPENSES (FEDERAL INCOME TAX EXPENSE)		27.0 2
27.0 3	OTHER EXPENSES (STATE INCOME TAX EXPENSE)		27.0 3
27.0 4	OTHER EXPENSES (BOND FEES)		27.0 4
27.0 5	OTHER EXPENSES (INVESTMENT FEES)		27.0 5
29	NET INCOME (or loss) FOR THE PERIOD (line 26 minus line 28)	5,158,651	29



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CALCULATION OF CAPITAL PAYMENT

COMPONENT CCN: 14-0211

WORKSHEET L

CHECK [] TITLE V [XX] HOSPITAL [XX] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [] SUB (OTHER) [] COST METHOD
 BOXES: [] TITLE XIX

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	CAPITAL DRG OTHER THAN OUTLIER	329,219	1
1.01	MODEL 4 BPCI CAPITAL DRG OTHER THAN OUTLIER		1.01
2	CAPITAL DRG OUTLIER PAYMENTS	102,714	2
2.01	MODEL 4 BPCI CAPITAL DRG OUTLIER PAYMENTS		2.01
3	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)	82.02	3
4	NUMBER OF INTERNS & RESIDENTS (see instructions)		4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (see instructions)		5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (multiply line 5 by the sum of lines 1 and 1.01)		6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (Worksheet E, Part A line 30) (see instructions)	0.0062	7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS (see instructions)		8
9	SUM OF LINES 7 AND 8	0.0062	9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)	0.0013	10
11	DISPROPORTIONATE SHARE ADJUSTMENT (line 10 times the sum of lines 1 and 1.01)	428	11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of lines 1, 1.01, 2, 2.01, 6 and 11)	432,361	12

PART II - PAYMENT UNDER REASONABLE COST

1	PROGRAM INPATIENT ROUTINE CAPITAL COST (see instructions)		1
2	PROGRAM INPATIENT ANCILLARY CAPITAL COST (see instructions)		2
3	TOTAL INPATIENT PROGRAM CAPITAL COST (line 1 plus line 2)		3
4	CAPITAL COST PAYMENT FACTOR (see instructions)		4
5	TOTAL INPATIENT PROGRAM CAPITAL COST (line 3 times line 4)		5

PART III - COMPUTATION OF EXCEPTION PAYMENTS

1	PROGRAM INPATIENT CAPITAL COSTS (see instructions)		1
2	PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES (see instructions)		2
3	NET PROGRAM INPATIENT CAPITAL COSTS (line 1 minus line 2)		3
4	APPLICABLE EXCEPTION PERCENTAGE (see instructions)		4
5	CAPITAL COST FOR COMPARISON TO PAYMENTS (line 3 x line 4)		5
6	PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY CIRCUMSTANCES (see instructions)		6
7	ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (line 2 x line 6)		7
8	CAPITAL MINIMUM PAYMENT LEVEL (line 5 plus line 7)		8
9	CURRENT YEAR CAPITAL PAYMENTS (from Part I, line 12 as applicable)		9
10	CURRENT YEAR COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (line 8 less line 9)		10
11	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT (from prior year Worksheet L, Part III, line 14)		11
12	NET COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (line 10 plus line 11)		12
13	CURRENT YEAR EXCEPTION PAYMENT (if line 12 is positive, enter the amount on this line)		13
14	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR THE FOLLOWING PERIOD (if line 12 is negative, enter the amount on this line)		14
15	CURRENT YEAR ALLOWABLE OPERATING AND CAPITAL PAYMENT (see instructions)		15
16	CURRENT YEAR OPERATING AND CAPITAL COSTS (see instructions)		16
17	CURRENT YEAR EXCEPTION OFFSET AMOUNT (see instructions)		17



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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDINARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		0	2A	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	NONPATIENT TELEPHONES							5.01
5.02	IS							5.02
5.03	PURCHASING							5.03
5.04	PT REG							5.04
5.05	PT ACCTS							5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL							5.06
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY							16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS							30
31	INTENSIVE CARE UNIT							31
43	NURSERY							43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
51	RECOVERY ROOM							51
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
54.01	ULTRA SOUND							54.01
54.02	NUCLEAR ONCOLOGY							54.02
55	RADIOLOGY-THERAPEUTIC							55
56	RADIOISOTOPE							56
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY							64
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
75	ASC (NON-DISTINCT PART)							75
75.01	LITHOTRIPSY							75.01
75.02	PSYCH							75.02
75.03	NEURODIAGNOSTICS							75.03
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.03	GENETIC TESTING							90.03
90.04	CHRONIC PAIN CLINIC							90.04
90.05	DIABETES EDUCATION							90.05
90.06	WOUND CARE							90.06
90.07	SLEEP LAB							90.07
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							



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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL		
		0	2A	24	25	26		
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN							190
192	PHYSICIANS' PRIVATE OFFICES							192
192.0 1	HOME HEALTH AGENCY							192.0 1
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)							202