Health Financi	al Syst	tems	MCDONOUGH DISTRICT	HOSPI TAL			In Lie	u of Form	CMS-25!	52-10
This report is	requi	red by I aw (42 USC 1395	g; 42 CFR 413.20(b)). Faili	ure to report	can resul	t in all	interim	FORM APPR	OVED	
payments made	si nce	the beginning of the co	st reporting period being (deemed overpay	ments (42	2 USC 1395	g).	OMB NO. C	938-00	50
HOSPITAL AND H	IOSPI TA	L HEALTH CARE COMPLEX C	OST REPORT CERTIFICATION	Provi der CCN	l: 140089	Peri od:		Worksheet		
AND SETTLEMENT	SUMMA	RY						Parts I-I		
						To 06/	30/2015	Date/Time		
								11/23/201	5 5: 22	pm
PART I - COST	REPORT	STATUS								
Provi der	1. [X] Electronically filed	cost report			Date:	11/23/2	015 Tim	e: 5:2	22 pm
use only	2. [] Manually submitted co	st report							
	3. [0] If this is an amended	report enter the number o	f times the pr	rovi der r	esubmitted	d this co	ost report		
	4. [F	Medicare Utilization.	Enter "F" for full or "L"	for low.				•		
Contractor	5. ſ 1	Cost Report Status	6. Date Received:		10. [NPR Date:				
use only		As Submitted			11. (Contractor	's Vendo	or Code:		4
uoo o j	(2)	Settled without Audit	8. [N] Initial Report for	this Provide	r CCN 12.	[0]If Ii	ne 5, cc	lumn 1 is	4: Ent	er
		Settled with Audit	9. N Final Report for t	his Provider (CCN			es reopene		
	()	Reopened						-		

PART II - CERTIFICATION

(5) Amended

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MCDONOUGH DISTRICT HOSPITAL (140089) for the cost reporting period beginning 07/01/2014 and ending 06/30/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Si gned)	
	Officer or Administrator of Provider(s)
Ti tl e	9
Date	

			Title XVIII				
	Cost Center Description		Part A	Part B	HIT	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-133, 293	185, 606	61, 908	2, 723, 100	1. 00
2.00	Subprovi der - I PF	0	0	0		0	2. 00
3.00	Subprovi der - I RF	0	0	0		0	3. 00
5.00	Swing bed - SNF	0	0	0		0	5. 00
6.00	Swing bed - NF	0				0	6. 00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7. 00
9.00	HOME HEALTH AGENCY I	0	0	-1		0	9. 00
10.00	RURAL HEALTH CLINIC I	0		81, 782		0	10.00
200.00	Total	0	-133, 293	267, 387	61, 908	2, 723, 100	200. 00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 140089 Peri od: Worksheet S-2 From 07/01/2014 Part I Date/Time Prepared: 06/30/2015 11/23/2015 5:05 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 525 E. GRANT 1.00 PO Box: 1.00 2.00 City: MACOMB State: IL Zip Code: 61455-County: MCDONOUGH 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Certi fi ed Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal MCDONOUGH DISTRICT 140089 99914 07/01/1966 Ν 0 3.00 HOSPI TAI Subprovider - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 1411089 Р 7 00 MDH SWING BEDS 99914 04/29/2015 N 7 00 N 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 Hospi tal -Based OLTC 11.00 11.00 12.00 Hospi tal -Based HHA MDH HOME HEALTH 147293 99914 12/14/1984 Ν Р 0 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 MDH HOSPICE 141524 99914 01/12/1989 14.00 O 15.00 Hospital-Based Health Clinic - RHC BUSHNELL FAMILY 148522 99914 01/31/2013 N 0 15.00 PRACTI CE Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18 00 19.00 Other 19.00 From: To: 1 00 2 00 20.00 Cost Reporting Period (mm/dd/yyyy) 07/01/2014 06/30/2015 20.00 21.00 Type of Control (see instructions) 21.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate 22.00 Υ N 22 00 share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting 22.01 period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires final uncompensated care payments to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result Ν Ν 22.03 of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 3 Ν 23.00 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method enter "Y" for yes or "N" for no. used in the prior cost reporting period? In column 2, Medi cai d Other In-State In-State Out-of Out-of Medi cai d Medi cai d State State HMO days Medi cai d paid days el i gi bl e Medi cai d Medi cai d days unpai d paid days el i gi bl e days unpai d 1.00 2. 00 3. 00 4. 00 5. 00 6.00 24.00 If this provider is an IPPS hospital, enter the 24.00 258 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state 0 0 0 0 25.00 0 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.

Heal th	Financial Systems MCDONOUG	H DISTE	RICT HOSPITAL		1	n Lieu	of For	m CMS-2	2552-10
	TAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provi der		eriod: rom 07/01/		Workshe Part I		
				To		/2015	Date/Ti 11/23/2		
					Urban/Rur	^al S	Date of	Geogr	OS PIII
26. 00	Enter your standard geographic classification (not wa	ge) sta	atus at the bed	inning of the	1.00	2	2. (00	26. 00
27. 00	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa	rural.		· · · ·		2			27. 00
27.00	reporting period. Enter in column 1, "1" for urban or	"2" fo	or rural. If ap			2			27.00
35. 00	enter the effective date of the geographic reclassifilf this is a sole community hospital (SCH), enter the			H status in		1			35. 00
	effect in the cost reporting period.			Status III	D!!	1	F!!		
					Begi nni 1. 00		Endi 2. (
36. 00	Enter applicable beginning and ending dates of SCH st of periods in excess of one and enter subsequent date		Subscript line	36 for number	07/01/2	014	06/30/	′2015	36. 00
37. 00	If this is a Medicare dependent hospital (MDH), enter		umber of period	s MDH status		0			37. 00
38. 00	is in effect in the cost reporting period. If line 37 is 1, enter the beginning and ending dates	of MDI	H status. If li	ne 37 is					38. 00
	greater than 1, subscript this line for the number of enter subsequent dates.								
	enter subsequent dates.				Y/N		Y/		
39. 00	Does this facility qualify for the inpatient hospital	paymer	nt adjustment f	for low volume	1. 00 Y	1	2. (Y		39. 00
	hospitals in accordance with 42 CFR §412.101(b)(2)(ii or "N" for no. Does the facility meet the mileage reg								
	CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes	or "N"	for no. (see i	nstructions)					
40. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob				N		N		40. 00
	no in column 2, for discharges on or after October 1.					l v	XVIII	XIX	
						1.00		3.00	
45. 00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymen	it for (di sproporti onat	e share in acc	ordance	N	N	N	45. 00
46. 00	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce	ntion 1	for extraordina	rv circumstano	es	N	N	l N	46. 00
40.00	pursuant to 42 CFR §412.348(f)? If yes, complete Wkst							"	40.00
47. 00	Pt. III. 47.00 Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.							N	47. 00
48. 00	48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. Teaching Hospitals							N	48. 00
56. 00	Is this a hospital involved in training residents in	approve	ed GME programs	? Enter "Y" f	or yes	N			56. 00
57. 00	or "N" for no. If line 56 is yes, is this the first cost reporting p	eriod (during which re	sidents in app	roved				57. 00
	GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont								
	for yes or "N" for no in column 2. If column 2 is "Y	", com	plete Worksheet						
58. 00	"N", complete Wkst. D, Parts III & IV and D-2, Pt. II If line 56 is yes, did this facility elect cost reimb	ursemei	nt for physicia	ns' services a	S				58. 00
59 00	defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes			Pt I		N			59. 00
	Are you claiming nursing school and/or allied health	costs 1	for a program t	hat meets the		Y			60.00
	provider-operated criteria under §413.85? Enter "Y"	Y/N	S OF "N" FOR NO	Direct GME	I ME		Di rect	GME	
		1. 00	2. 00	3. 00	4.00)	5. (00	
61. 00	Did your hospital receive FTE slots under ACA	N N	2.00	5. 55	1. 50	0.00	0. (61. 00
	section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)								
61. 01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports		0. 00	0.00					61. 01
	ending and submitted before March 23, 2010. (see								
61. 02	instructions) Enter the current year total unweighted primary care		0.00	0.00					61. 02
	FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of								
(4.00	ACA). (see instructions)		0.00	0.00					/4 00
61. 03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for		0.00	0.00					61. 03
	determining compliance with the 75% test. (see instructions)								
61. 04	Enter the number of unweighted primary care/or		0.00	0.00					61. 04
	surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).								
61. 05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's		0.00	0.00	1				61. 05
	primary care and/or general surgery FTE counts (line								
61. 06	61.04 minus line 61.03). (see instructions) Enter the amount of ACA §5503 award that is being		0.00	0.00					61. 06
	used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)								
		•	. '						

Health Financial Systems MCDONOUGH DISTRICT HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 140089 Peri od: Worksheet S-2 From 07/01/2014 Part I Date/Time Prepared: 06/30/2015 11/23/2015 5:05 pm Program Code Unweighted IME Program Name Unwei ghted Direct GME FTE FTE Count Count 1.00 2.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0.00 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column direct GME FTE unweighted count. 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 62 01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter Ν 63.00 for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions) Unwei ahted Ratio (col. 1/ Unwei ahted **FTES** FTEs in (col . 1 + col Nonprovi der Hospi tal 2)) Si te 1. 00 2.00 3.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. 64.00 Enter in column 1, if line 63 is yes, or your facility trained residents 0.000000 64.00 0.00 n the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Unwei ghted Program Name Program Code Unwei ghted Ratio (col. 3/ FTĔs FTEs in (col. 3 + col. Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 0.00 0.00 0.000000 65.00 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE

residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 + column 4)). (see instructions)

Health Financial Systems MCDONOUGH DISTR HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA			In Li Period: From 07/01/2017 To 06/30/201!		5-2 Prepared:
			1. 00	2.00	
 95.00 If line 94 is "Y", enter the reduction percentage in the apple. 00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column. 97.00 If line 96 is "Y", enter the reduction percentage in the apple. 	s or "N" for no	o in the	0. C N	N	00 95.00 96.00 00 97.00
Rural Providers 105.00 Does this hospital qualify as a critical access hospital (CA 106.00 of this facility qualifies as a CAH, has it elected the all-		hod of payment	N t N		105. 00 106. 00
for outpatient services? (see instructions) 107.00 If this facility qualifies as a CAH, is it eligible for cost training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, column reimbursed. If yes complete Wkst. D-2, Pt. II.	t reimbursemen n 1. (see insti	t for I&R ructions) If	N		107. 00
108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N		108. 00
	Physi cal 1.00	Occupati onal 2.00	Speech 3.00	Respiratory 4.00	У
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N N	N N	N N	109. 00
				1.00	-
110.00 Did this hospital participate in the Rural Community Hospita the current cost reporting period? Enter "Y" for yes or "N"		on project (41	10A Demo)for	N	110. 00
Miscellaneous Cost Reporting Information			1. (00 2.00 3.00	0
115.00 s this an all-inclusive rate provider? Enter "Y" for yes on is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals provided	. If column 2 int for long ter	is "E", enter rm care (inclu	in column udes	0	115. 00
Pub. 15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" 117.00 Is this facility legally-required to carry malpractice insurance.			"N" for N	1 1	116. 00 117. 00
118.00 s the mal practice insurance a claims-made or occurrence pol	licy? Enter 1 i	if the policy	is 1		118. 00
claim-made. Enter 2 if the policy is occurrence.		Premi ums	Losses	Insurance	
118.01 List amounts of malpractice premiums and paid losses:		1. 00 172, 10	2. 00 04 277, 28	3.00	0118.01
The english amounts of marphaetree premisans and para resses.		172,10	1.00	2.00	0110.01
118.02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scheol			N N	2.00	118. 02
and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendments.	n column 1, "Y' ualifies for th	" for yes or he Outpatient	N	N	119. 00 120. 00
Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implayments? Enter "Y" for yes or "N" for no.	antable devices	s charged to	Υ		121. 00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.	or yes and "N"	for no. If	N		125. 00
126.00 If this is a Medicare certified kidney transplant center, et in column 1 and termination date, if applicable, in column 2		fication date			126. 00
127.00 If this is a Medicare certified heart transplant center, en In column 1 and termination date, if applicable, in column 2	ter the certifi	ication date			127. 00
128.00 If this is a Medicare certified liver transplant center, en	ter the certifi	ication date			128. 00
in column 1 and termination date, if applicable, in column 2 129.00 If this is a Medicare certified lung transplant center, enter		cation date ir	n		129. 00
column 1 and termination date, if applicable, in column 2					
column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in column 1.	enter the cert	ti fi cati on			130. 00
130.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in column 131.00 If this is a Medicare certified intestinal transplant center	enter the ceri lumn 2. r, enter the ce				130. 00 131. 00
130.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in col 131.00 If this is a Medicare certified intestinal transplant center date in column 1 and termination date, if applicable, in col 132.00 If this is a Medicare certified islet transplant center, en	enter the cert lumn 2. r, enter the ce lumn 2. ter the certifi	erti fi cati on			
130.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in column 131.00 If this is a Medicare certified intestinal transplant center date in column 1 and termination date, if applicable, in column 1	enter the cert lumn 2. r, enter the co lumn 2. ter the certifi 2. ter the certifi	ertification			131. 00

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLE		STRI CT HOSPI TAL Provi der	CCN: 140089	Peri od:		u of Form CMS- Worksheet S-2	
				From O	7/01/2014 6/30/2015	Part I Date/Time Pro 11/23/2015 5	
					1. 00	2.00	-
All Providers							
[40.00] Are there any related organization chapter 10? Enter "Y" for yes or " are claimed, enter in column 2 the	N" for no in column 1. home office chain numbe	If yes, and home er. (see instruct	office cos	ts	N		140. 0
1.00 If this facility is part of a chai		2.00		namo ano	3. 00	of the	
home office and enter the home off			9	Halle and	a auui ess	or the	
41. 00 Name:	Contractor's Name:			ctor's Nu	mber:		141.0
42. 00 Street: 43. 00 Ci ty:	PO Box: State:		Zip Co	40.			142. 0 143. 0
43. 00 01 ty.	State.		ZI P CO	ue.			143. 0
						1.00	
44.00 Are provider based physicians' cos	ts included in Workshee	t A?				Y	144. C
					1. 00	2.00	\dashv
45.00 If costs for renal services are cl					N		145. 0
inpatient services only? Enter "Y" no, does the dialysis facility inc period? Enter "Y" for yes or "N"	clude Medicare utilization for no in column 2.	on for this cost	reporti ng				
46.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no ir yes, enter the approval date (mm/o	column 1. (See CMS Pub.			lf	N		146. 0
						1.00	_
47.00Was there a change in the statisti	cal basis? Enter "Y" fo	r ves or "N" for	no			1.00 N	147. (
48.00 Was there a change in the order of	allocation? Enter "Y"	for yes or "N" fo	or no.			N	148. (
49.00Was there a change to the simplifi	ed cost finding method?					N	149. (
		Part A 1.00	Part B 2.00	<u> </u>	itle V 3.00	Title XIX 4.00	-
Does this facility contain a provi	der that qualifies for			cation of			
or charges? Enter "Y" for yes or "	N" for no for each comp			. (See 42			
55.00 Hospi tal 56.00 Subprovi der - TPF		N N	N N		N N	N N	155. (156. (
57. 00 Subprovi der – TRF		N	N		N	N	157. (
58. 00 SUBPROVI DER							158. (
59.00 SNF 60.00 HOME HEALTH AGENCY		N N	N N		N N	N N	159. (160. (
61. 00 CMHC		.,	N		N	N	161. 0
Multicampus						1.00	
65.00 Is this hospital part of a Multica	mpus hospital that has	one or more campu	uses in dif	ferent CB	BSAs?	N	165. 0
Enter "Y" for yes or "N" for no.	N	0 1		7' 0 1	ODCA	ETE (0	
	Name 0	County 1.00	2. 00	Zip Code 3.00	4. 00	FTE/Campus 5.00	+
66.00 If line 165 is yes, for each		****					0 166. (
campus enter the name in column O, county in column 1, state in							
column 2, zip code in column 3,							
CBSA in column 4, FTE/Campus in							
column 5 (see instructions)							
						1.00	-
Health Information Technology (HI)				ent Act			
67.00 s this provider a meaningful user 68.00 f this provider is a CAH (line 10 reasonable cost incurred for the F	05 is "Y") and is a meani	ingful user (line		"), enter	the	Y	167. 0 0168. 0
68.01 If this provider is a CAH and is r	not a meaningful user, do	oes this provider			lshi p		168. (
lovcoption under \$412 70(a)(6)(ii)?	PEnter "Y" for yes or "I user (Line 167 is "Y") au				enter the	0.7	'5169. C
69.00 If this provider is a meaningful utransition factor. (see instruction							
69.00 If this provider is a meaningful υ					gi nni ng	Endi ng	
69.00 If this provider is a meaningful υ	ons)		oporti na		gi nni ng 1. 00 /01/2014	Endi ng 2. 00 06/30/2015	170. (

Health Financial Systems MCDONOUGH DISTRICT HOSPITAL In Lieu of the Company of th					
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provider CCN: 140089	From 07/01/2014	Worksheet S-2 Part I Date/Time Pre 11/23/2015 5:	pared:
				1172372013 3.	OS PIII
				1.00	
171.00 If line 167 is "Y", does this prov Medicare cost plans reported on WI (see instructions)	Y	171. 00			

	Financial Systems AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	MCDONOUGH DISTRICT HOSPITAL STIONNAIRE Provider		Peri od:	Worksheet S-:	-2552- 2
				From 07/01/2014 Fo 06/30/2015		epared
					11/23/2015 5	
				Y/N 1.00	2. 00	
	General Instruction: Enter Y for all YES resp	oonses. Enter N for all NO re	sponses. Enter			
	mm/dd/yyyy format.		<u> </u>			
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					
00	Has the provider changed ownership immediate	v prior to the beginning of	the cost	N		1.
	reporting period? If yes, enter the date of					
			Y/N	Date	V/I	
. 00	Has the provider terminated participation in	the Medicare Program? If	1. 00 N	2. 00	3. 00	2.
. 00	yes, enter in column 2 the date of termination		IN IN			2.
	voluntary or "I" for involuntary.					
. 00	Is the provider involved in business transaction		N			3.
	contracts, with individuals or entities (e.g. or medical supply companies) that are related					
	officers, medical staff, management personnel					
	of directors through ownership, control, or	family and other similar				
	relationships? (see instructions)		\/ /NI	T	D-+-	
			1. 00	7ype 2. 00	Date 3.00	+
	Financial Data and Reports		1.00	2.00	0.00	
. 00	Column 1: Were the financial statements pre		Y	A		4.0
	Accountant? Column 2: If yes, enter "A" for					
	or "R" for Reviewed. Submit complete copy or column 3. (see instructions) If no, see instr					
. 00	Are the cost report total expenses and total		N			5.0
	those on the filed financial statements? If	yes, submit reconciliation.		11.60		
				Y/N 1.00	Legal Oper. 2.00	
T	Approved Educational Activities			1.00	2.00	
. 00	Column 1: Are costs claimed for nursing scho	ool? Column 2: If yes, is th	ne provider is	N		6.
	the legal operator of the program?	2 . 6		.,		_
. 00	Are costs claimed for Allied Health Programs' Were nursing school and/or allied health pro		l during the	Y		7. 8.
. 00	cost reporting period? If yes, see instruction		i dui ing the	IN		0.
. 00	Are costs claimed for Interns and Residents i		al education	N		9. (
0.00	program in the current cost report? If yes,					100
0. 00	Was an approved Intern and Resident GME progress reporting period? If yes, see instruction		ne current	N		10.0
11. 00	Are GME cost directly assigned to cost center		roved	N		11. (
	Teaching Program on Worksheet A? If yes, see	instructions.				
					1. 00	
1	Bad Debts				1.00	
2.00	Is the provider seeking reimbursement for back				Y	12. (
3. 00	If line 12 is yes, did the provider's bad del	ot collection policy change o	luring this cos	st reporting	N	13.
4 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles a	and/or co-navments waived? If	ves see inst	ructions	N	14.
	Bed Complement	and/or co-payments warved: 11	yes, see misi	ir uctrons.	IN	14. \
5. 00	Did total beds available change from the price	or cost reporting period? If	yes, see instr	ructions.	Υ	15.
				rt A	Part B	
		Description 0	Y/N 1.00	2. 00	Y/N 3. 00	
	PS&R Data	· ·	1.00	2.00	3.00	
				10 (05 (0015	l v	
	Was the cost report prepared using the PS&R		Y	10/05/2015	Y	16.
	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes,		Y	10/05/2015	Ť	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		Y	10/05/2015	Y Y	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		Y	10/05/2015	Y	16.
6. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R		Y N	10/05/2015	N	
6. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records			10/05/2015		
6. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is			10/05/2015		
6. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns			10/05/2015		
7. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments			10/05/2015		17.
7. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4 (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional		N	10/05/2015	N	17.
7. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not		N	10/05/2015	N	17.
7. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file		N	10/05/2015	N	17.
6. 00 7. 00 8. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not		N	10/05/2015	N	17.
6. 007. 008. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of		N N	10/05/2015	N N	17. (
6. 007. 008. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see		N N	10/05/2015	N N	17. (
6. 00 7. 00 8. 00 9. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N N	10/05/2015	N N	16. (17. (18. (19. (
6. 00 7. 00 8. 00 9. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see		N N	10/05/2015	N N	17. 18.

	MCDONOUGH DISTRICT				u of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE	Provi der (CCN: 140089	Peri od: From 07/01/2014 To 06/30/2015	Worksheet S- Part II Date/Time Pr 11/23/2015 5	epared:
			F	art A	Part B	, 00 p
	Description	on [Y/N	Date	Y/N	
	0		1.00	2. 00	3. 00	
21.00 Was the cost report prepared only using the provider's records? If yes, see instructions.			N		N	21. 00
					1. 00	+
COMPLETED BY COST REIMBURSED AND TEFRA HOSPIT	TALS ONLY (EXCEPT C	HILDRENS HO	SPI TALS)			
Capital Related Cost						
Have assets been relifed for Medicare purposes? If yes, see instructions						22. 00
.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.						23. 00
	00 Were new leases and/or amendments to existing leases entered into during this cost reporting period?					24. 00
25.00 Have there been new capitalized leases entere	ed into during the	cost report	ing period?	If yes, see	N	25. 00
instructions. 26.00 Were assets subject to Sec. 2314 of DEFRA acq	uired during the co	st reportin	ng period? I	f yes, see		26. 00
instructions. 27.00 Has the provider's capitalization policy characteristics.	naed durina the cos	t renorting	neriod? If	ves submit	N	27. 00
copy.			, perrou. 11	yes, subiii t		
Interest Expense	£!!	al frame along	464		N	4 20 00
28.00 Were new loans, mortgage agreements or letter period? If yes, see instructions.	rs or credit entere	ea into auri	ng the cost	reporting	N	28. 00
29.00 Did the provider have a funded depreciation			t Service R	eserve Fund)	Υ	29. 00
treated as a funded depreciation account? If						
30.00 Has existing debt been replaced prior to its instructions.	scheduled maturity	with new d	lebt? If yes	, see	N	30.00
31.00 Has debt been recalled before scheduled matur	ritv without issuan	nce of new d	lebt? If ves	. see	N	31.00
instructions.				,		
Purchased Services						
32.00 Have changes or new agreements occurred in pa			l through co	ntractual	N	32.00
arrangements with suppliers of services? If						1 22 22
33.00 If line 32 is yes, were the requirements of no, see instructions.	Sec. 2135.2 applied	i pertaining	1 to competi	tive blading? If		33. 00

			1. 00	2. 00			
	Home Office Costs						
36.00	Were home office costs claimed on the cost report?		N		36. 00		
37.00	If line 36 is yes, has a home office cost statement been p	prepared by the home office?			37. 00		
	If yes, see instructions.						
38. 00					38. 00		
	the provider? If yes, enter in column 2 the fiscal year er						
39. 00	If line 36 is yes, did the provider render services to oth	ner chain components? If yes,			39. 00		
	see instructions.				40.00		
40. 00	40.00 fline 36 is yes, did the provider render services to the home office? f yes, see						
	instructions.						
		1. 00	2.	00			
	Cost Report Preparer Contact Information						
41. 00	Enter the first name, last name and the title/position	BRENDA	NEAL		41. 00		
	held by the cost report preparer in columns 1, 2, and 3,						
	respecti vel y.						
42. 00	Enter the employer/company name of the cost report	MCDONOUGH COUNTY HOSPITAL			42. 00		
	preparer.	DI STRI CT					
43.00	Enter the telephone number and email address of the cost	309/836-1521	BKNEAL@MDH. ORG		43.00		

Provider-Based Physicians

34.00 Are services furnished at the provider facility under an arrangement with provider-based physicians?

If yes, see instructions.

35.00 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.

34.00 35.00

Date

report preparer in columns 1 and 2, respectively.

From 07/01/2014 To 06/30/2015 Part II Date/Time Prepared: 11/23/2015 5:05 pm Part B Date 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R 10/05/2015 16.00 Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) 17.00 Was the cost report prepared using the PS&R 17.00 Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) 18.00 | If line 16 or 17 is yes, were adjustments 18.00 made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.

19.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of 19.00 other PS&R Report information? If yes, see i nstructi ons. If line 16 or 17 is yes, were adjustments 20.00 made to PS&R Report data for Other? Describe the other adjustments: Was the cost report prepared only using the provider's records? If yes, see 21.00 21.00 instructions. 3.00 Cost Report Preparer Contact Information Enter the first name, last name and the title/position ACCOUNTI NG/PAYROLL DEPT 41.00 held by the cost report preparer in columns 1, 2, and 3, respecti vel y.

42.00

43.00

Enter the employer/company name of the cost report

report preparer in columns 1 and 2, respectively.

Enter the telephone number and email address of the cost

42.00

43.00

preparer.

Health Financial Systems MCDONOUGHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 140089

						To 06/30/2015	Date/Time Pre 11/23/2015 5:	
							I/P Days / 0/P	
							Visits / Trips	
	Component	Worksheet A	No	of Beds	Bed Days	CAH Hours	Title V	
	35p31.0111	Line Number		o. Bous	Avai I abl e	57 H. 110 G. 5		
		1.00		2. 00	3.00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		31			0	1, 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2. 00
3.00	HMO IPF Subprovider							3. 00
4.00	HMO IRF Subprovider							4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						0	6.00
7.00	Total Adults and Peds. (exclude observation			31	11, 14	0.00	l .	
	beds) (see instructions)				•			
8.00	INTENSIVE CARE UNIT	31. 00		7	2, 55	0.00	0	8. 00
9.00	CORONARY CARE UNIT							9.00
10.00	BURN INTENSIVE CARE UNIT							10.00
11. 00	SURGICAL INTENSIVE CARE UNIT							11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)							12. 00
13. 00	NURSERY	43. 00					0	
14. 00	Total (see instructions)			38	13, 69	0.00		
15. 00	CAH visits			00	10,0,	0.00	0	
16. 00	SUBPROVIDER - I PF						_	16. 00
17. 00	SUBPROVI DER - I RF							17. 00
18. 00	SUBPROVI DER							18. 00
19. 00	SKILLED NURSING FACILITY	44. 00		0	,	o	0	
20. 00	NURSING FACILITY	00		ū			Ĭ	20.00
21. 00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY	101. 00					0	
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	101.00					J	23. 00
24. 00	HOSPI CE	116, 00		0	,	o		24. 00
24. 10	HOSPICE (non-distinct part)	30. 00		O	1			24. 10
25. 00	CMHC - CMHC	30.00						25. 00
26. 00	RURAL HEALTH CLINIC	88. 00					0	
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	00.00					0	26. 25
27. 00	Total (sum of lines 14-26)			38				27. 00
28. 00	Observation Bed Days			30			0	
29. 00	Ambul ance Tri ps						0	29.00
30.00	Employee discount days (see instruction)							30.00
31.00	Employee discount days (see l'istruction)							31.00
32.00	Labor & delivery days (see instructions)			3	1, 09!	=		32.00
32. 00	Total ancillary labor & delivery room			3	1, 09			32.00
32. UI	outpatient days (see instructions)							32.01
33. 00	LTCH non-covered days							33. 00
33.00	Eron non covered days				I	1	I	1 33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Peri od: Worksheet S-3 From 07/01/2014 Part I 06/30/2015 Date/Time Prepared:

11/23/2015 5:05 pm Full Time Equivalents I/P Days / O/P Visits / Trips Title XVIII Component Title XIX Total All Total Interns Employees On Pati ents & Residents Payrol I 6.00 7.00 8.00 9.00 10.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 2, 355 655 4, 776 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2 00 HMO and other (see instructions) 574 2 00 211 3.00 HMO IPF Subprovider 3.00 HMO IRF Subprovider 4.00 0 4.00 Hospital Adults & Peds. Swing Bed SNF 0 0 5.00 5.00 65 Hospital Adults & Peds. Swing Bed NF 6.00 C C 6.00 7.00 Total Adults and Peds. (exclude observation 2, 355 655 4, 841 7.00 beds) (see instructions) INTENSIVE CARE UNIT 74 8.00 446 691 8.00 CORONARY CARE UNIT 9.00 9.00 10.00 BURN INTENSIVE CARE UNIT 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 NURSERY 310 596 13.00 14.00 Total (see instructions) 2,801 1,039 6, 128 0.00 504.94 14.00 CAH visits 15.00 15.00 SUBPROVIDER - IPF 16.00 16.00 SUBPROVIDER - IRF 17.00 17.00 18.00 SUBPROVI DER 18.00 19.00 SKILLED NURSING FACILITY 0 0 0 0.00 0.00 19.00 20 00 NURSING FACILITY 20 00 21.00 OTHER LONG TERM CARE 21.00 22.00 HOME HEALTH AGENCY 3,824 476 6, 964 0.00 15.15 22.00 23.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 HOSPI CE 0 8.01 24 00 0 00 24.00 0 Ω 24. 10 HOSPICE (non-distinct part) 8 C 8 24.10 CMHC - CMHC 25.00 25.00 26, 00 RURAL HEALTH CLINIC 1.131 901 4, 402 0.00 5.89 26, 00 FEDERALLY QUALIFIED HEALTH CENTER 26.25 26.25 27.00 Total (sum of lines 14-26) 0.00 533.99 27.00 28.00 Observation Bed Days 256 918 28.00 1, 195 29.00 Ambul ance Trips 29.00 30.00 Employee discount days (see instruction) 0 30.00 31.00 Employee discount days - IRF 0 31.00 Labor & delivery days (see instructions) 10 27 32.00 32.00 0 Total ancillary labor & delivery room 32.01 0 32.01 outpatient days (see instructions) 33.00 LTCH non-covered days 0 33.00

 Heal th Financial
 Systems
 MCDONOUG

 HOSPITAL
 AND
 HOSPITAL
 HEALTH CARE COMPLEX
 STATISTICAL
 DATA
 Provider CCN: 140089

Full Time Discharges Equivalents Nonpaid Morkers Title V Title XVIII Title XIX Total All Patients Nonpaid Morkers Title V Title XVIII Title XIX Total All Patients Nonpaid					To	06/30/2015	Date/Time Prep 11/23/2015 5:0	
Component				<u>'</u>	Di sch	arges		
10.0 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) 1.00 12.00 13.00 14.00 15.00 1.0		Component	Nonpai d	Title V	Title XVIII	Title XIX		
1.00 Hospit tal Adult s & Peds. (col ums 5, 6, 7 and 8 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room avail able beds) 2.00 HMO and other (see instructions) 146 0 2.00 0.00 0.00 140 0.00 0.00 0.00 140 0.00				12 00	13.00	14 00		
8 exclude Swing Bed. Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 HM0 IPF Subprovi der 3.00 HM0 IPF Subprovi der 4.00 HM0 IPF Subprovi der 5.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults Adults & Peds. Swing Bed NF 8.00 INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 9.00 ORONARY CARE UNIT 1.00 SUBRICAL INTENSIVE CARE UNIT 1.00 SUBRICAL INTENSIVE CARE UNIT 1.00 OB URIN INTENSIVE CARE UNIT 1.00 SURGICAL INTENSIVE CARE UNIT 1.00 OWNSERY 1.00 CAR VISITS 1	1.00	Hospital Adults & Peds. (columns 5. 6. 7 and	11.00					1. 00
For the portion of LDP room available beds) 2.00 0.0		8 exclude Swing Bed, Observation Bed and		·		200	.,	00
MMO IPF Subprovider		1 3 / `						
4.00	2.00	HMO and other (see instructions)			146	0		2.00
5.00	3.00					0		3.00
6.00 Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) Total Adults and Peds. (exclude observation beds) (see instructions) See instructions See instructi						0		
7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 9.00 10 10.00	5.00							5. 00
Deds) (see instructions) NTENSIVE CARE UNIT	6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
8.00 INTENSIVE CARE UNIT 8.00 9.00 CORONARY CARE UNIT 10.00 9.00 11.00 SURN INTENSIVE CARE UNIT 11.00 11.0	7.00	Total Adults and Peds. (exclude observation						7. 00
9.00 CORONARY CARE UNIT 9.00 10.00 BURN INTENSIVE CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 1								
10.00 SURRI INTENSIVE CARE UNIT 10.00		1						
11. 00 OTHER SPECIAL CARE (SPECIFY) 12. 00 OTHER SPECIAL CARE (SPECIFY) 13. 00 NURSERY 14. 00 Total (see instructions) 15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 19. 00 SKILLED NURSING FACILITY 19. 00 NURSING FACILITY 19. 00 NURSING FACILITY 19. 00 NURSING FACILITY 19. 00 AMBULATORY SURGICAL CENTER (D.P.) 19. 00 AMBULATORY SURGICAL CENTER (D.P.) 10. 00 OMICA - CWHC 24. 00 HOSPICE (non-distinct part) 25. 00 CMHC - CWHC 26. 00 RURAL HEALTH CLINIC 27. 00 Total (sum of lines 14-26) 28. 00 Aboservation Bed Days 29. 00 Ambul ance Trips 29. 00 Employee discount days (see instruction) 20. 00 Employee discount days (see instructions) 20. 01 Total ancillary labor & delivery room outpatient days (see instructions) 20. 01 Total ancillary labor & delivery room outpatient days (see instructions)		4						
12. 00 13. 00 13. 00 14. 00 15. 00 15. 00 16. 00 15. 00 16. 00 18. 00 18. 00 19		1						
13. 00 NURSERY 13. 00 14. 00 15. 00 16. 00 15. 00 16. 00 15. 00 16. 00 15. 00 16. 00 15. 00 16. 00 15. 00 16. 00 15. 00 16. 00 15. 00 16. 00 15. 00 16. 00 15. 00 16. 00 16. 00 16. 00 17. 00 18. 00 18. 00 18. 00 19		4						
14. 00 Total (see instructions) 0. 00 0 698 253 1,610 14. 00 15. 00 CAH visits 15. 00 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 18. 00 19. 00	12.00	OTHER SPECIAL CARE (SPECIFY)						
15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER 19. 00 SKILLED NURSING FACILITY 20. 00 NURSING FACILITY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D. P.) 24. 00 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 32. 01	13.00	4						
16. 00 SUBPROVIDER - IPF 16. 00 17. 00 SUBPROVIDER - IRF 18. 00 18. 00 19. 00 SKILLED NURSING FACILITY 0. 00 19. 00			0. 00	(698	253	1, 610	
17. 00 SUBPROVI DER - IRF 17. 00 18. 00 SUBPROVI DER 18. 00 SKILLED NURSING FACILITY 0. 00 18. 00 19	15. 00	CAH visits						
18.00 SUBPROVI DER 18.00 19.00 19.00 19.00 20.00 19.00 20.00 19.00 20.00 19.00 20.00		4						
19.00 SKILLED NURSING FACILITY 0.00 19.00 20.0	17. 00	SUBPROVI DER - I RF						17. 00
20.00 NURSING FACILITY 20.00 21.00 21.00 22.00 21.00 22.00 40ME HEALTH AGENCY 0.00 22.00								
21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 24.00 HOSPICE 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions)		4	0. 00					
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23. 00 24. 00 HOSPI CE		4						
24.00 HOSPICE			0. 00					
24. 10 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL Graph HEALTH CENTER 26. 25 RURAL Graph HEALTH CENTER 27. 00 RURAL HEALTH CENTER 26. 25 RURAL Graph HEALTH CENTER 27. 00 RURAL HEALTH CENTER 28. 00 RURAL HEALTH CENTER 29. 00 RURAL HEALTH CENTER 29. 00 RURAL HEALTH CENTER 20. 25 RURAL HEALTH CLINIC 25. 00 26. 00 26. 25 RURAL HEALTH CLINIC 26. 00 26. 20 27. 00 28. 00 Particular Survival Survival Rural HEALTH CENTER 29. 00 RURAL HEALTH CLINIC 25. 00 26. 20 26. 00 26. 25 RURAL HEALTH CLINIC 26. 00 26. 20 27. 00 28. 00 Particular Survival Rural HEALTH CENTER 26. 25 RURAL HEALTH CLINIC 26. 00 26. 25 RURAL HEALTH CLINIC 26. 00 26. 20 27. 00 28. 00 Particular Survival Rural HEALTH CENTER 26. 25 RURAL HEALTH CLINIC 26. 00 26. 00 27. 00 28. 00 Particular Survival Rural HEALTH CENTER 29. 00 RURAL HEALTH CLINIC 29. 00 29. 00 29. 00 29. 00 29. 00 RURAL HEALTH CLINIC 25. 00 26. 00 26. 25 27. 00 29.								
25. 00 26. 00 RURAL HEALTH CLINIC 26. 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 30. 01 Total ancillary labor & delivery room outpatient days (see instructions)			0. 00					
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32.01 Total ancillary labor & delivery room outpatient days (see instructions) 32.01								
outpatient days (see instructions)								
	32. 01							32. 01
22.00 H ICH non-covered dave		, , , , , , , , , , , , , , , , , , , ,						
33. 00 Lion ilon-covered days	33. 00	LTCH non-covered days	l					33. 00

					To	06/30/2015	Date/Time Pre	
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	11/23/2015 5: Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es		Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col . 5)	
		1. 00	2.00	<u>Worksheet A-6)</u> 3.00	3) 4. 00	<u>col . 4</u> 5. 00	6. 00	
	PART II - WAGE DATA	1.00	2.00	0.00	1. 00	0.00	0.00	
	SALARI ES							
1. 00	Total salaries (see instructions)	200. 00	35, 048, 183	0	35, 048, 183	1, 105, 470. 00	31. 70	1. 00
2.00	Non-physician anesthetist Part		0	0	0	0. 00	0. 00	2. 00
	A							
3. 00	Non-physician anesthetist Part		1, 040, 308	0	1, 040, 308	8, 656. 00	120. 18	3. 00
4.00	Physician-Part A -		300, 383	0	300, 383	1, 944. 00	154. 52	4. 00
	Admi ni strati ve							
4. 01 5. 00	Physicians - Part A - Teaching Physician-Part B		0 1, 991, 866	0	0 1, 991, 866	0. 00 17, 030. 00	l e	
6. 00	Non-physician-Part B		105, 323	l e	105, 323	9, 185. 00		
7.00	Interns & residents (in an	21. 00	0	0	0	0.00	l e	7. 00
7 01	approved program)		0		0	0.00	0.00	7 01
7. 01	Contracted interns and residents (in an approved		0	0	U	0. 00	0. 00	7. 01
	programs)							
8.00	Home office personnel	44.00	0	0	0	0.00	l	
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	10, 220, 336	-368, 402	9, 851, 934	0. 00 252, 925. 00	1	
	instructions)		, ===, ===		1, 221, 121			
11 00	OTHER WAGES & RELATED COSTS	T	112 522	Ι	112 522	1 (05 00	l /7 07	11 00
11. 00	Contract Labor: Direct Patient Care		113, 523	0	113, 523	1, 685. 00	67.37	11. 00
12.00	Contract labor: Top level		147, 836	0	147, 836	3, 479. 00	42. 49	12. 00
	management and other							
	management and administrative services							
13.00	Contract Labor: Physician-Part		0	0	0	0.00	0. 00	13. 00
14 00	A - Administrative		0			0.00	0.00	14 00
14. 00	Home office salaries & wage-related costs		0	0	U	0. 00	0. 00	14. 00
15. 00	Home office: Physician Part A		0	0	0	0.00	0. 00	15. 00
1/ 00	- Administrative		0			0.00	0.00	17 00
16. 00	Home office and Contract Physicians Part A - Teaching		0	0	U	0. 00	0. 00	16. 00
	WAGE-RELATED COSTS							
17. 00	Wage-related costs (core) (see instructions)		10, 262, 988	0	10, 262, 988			17. 00
18. 00	Wage-related costs (other)		0	0	0			18. 00
	(see instructions)							
19. 00 20. 00	Excluded areas		2, 398, 739	0	2, 398, 739			19. 00 20. 00
20.00	Non-physician anesthetist Part		U	0	0			20.00
21. 00	Non-physician anesthetist Part		130, 179	0	130, 179			21. 00
22. 00	B Physician Part A -		41, 009	0	41, 009			22. 00
22.00	Administrative		41,007		41,007			22.00
22. 01	Physician Part A - Teaching		0	0	0			22. 01
23. 00 24. 00	Physician Part B Wage-related costs (RHC/FQHC)		224, 135 108, 788		224, 135 108, 788			23. 00 24. 00
25. 00	Interns & residents (in an		100, 700	0	0 100, 700			25. 00
	approved program)							
26 00	OVERHEAD COSTS - DIRECT SALARIE Employee Benefits Department	4.00	345, 270	0	345, 270	9, 362. 00	36. 88	26. 00
27. 00	Administrative & General	5. 00	4, 170, 874		4, 170, 874	·		
28. 00	Administrative & General under		147, 836	0	147, 836	3, 479. 00	42. 49	28. 00
29. 00	contract (see inst.) Maintenance & Repairs	6. 00	615, 140	0	615, 140	23, 861. 00	25. 78	29. 00
30. 00	Operation of Plant	7. 00	013, 140	ő	013, 140	0.00		
31. 00	Laundry & Linen Service	8. 00	117, 423		117, 423	9, 543. 00		
32. 00 33. 00	Housekeeping under contract	9. 00	275, 928	0	275, 928	23, 543. 00 0. 00		
33.00	(see instructions)		O	0	0	0.00	0.00	33.00
34.00	Di etary	10. 00	122, 517	67, 209	189, 726	10, 610. 00	l e	
35. 00	Di etary under contract (see instructions)		0	0	0	0.00	0. 00	35. 00
36. 00	Cafeteri a	11. 00	159, 864	-67, 209	92, 655	10, 202. 00	9. 08	36. 00
37. 00	Maintenance of Personnel	12. 00	0	0	0	0.00	0. 00	37. 00
38. 00 39. 00	Nursing Administration	13.00	519, 740	l	519, 740 293, 714			38.00
	Central Services and Supply Pharmacy	14. 00 15. 00	281, 229 576, 905	1			l	39. 00 40. 00
			2.0,700	'		,	, ,,,,	

HOSPITAL WAGE INDEX INFORMATION Provider CCN: 140089 Period: From 07/01/2014 To 06/30/2015 Part II Date/Time Prepared: 11/23/2015 5: 05 pm Worksheet A Line Number Reported Repor	Hea	Ith Financial Systems	MC	CDONOUGH DIST	RICT HOSPITAL		In Lie	u of Form CMS-2	2552-10
Worksheet A Line Number Reported On of Salaries (from (col. 2 ± col. Salaries in col. 5) To 06/30/2015 Date/Time Prepared: 11/23/2015 5: 05 pm Adjusted Paid Hours Repared: 11/23/2015 5: 05 pm Average Hourly Reported (col. 2 ± col. Salaries in col. 5)	HOS	SPITAL WAGE INDEX INFORMATION			Provi der	CCN: 140089	Peri od:	Worksheet S-3	
Worksheet A Line Number Reported Report									
Worksheet A Line Number Reported Reclassificati Adjusted Reported Reported Reclassificati Adjusted Reported Reported Reclassificati Reclassif							To 06/30/2015		
Line Number Reported on of Salaries Salaries Related to Wage (col. 4 ÷ (from (col.2 ± col. Salaries in col. 5)								11/23/2015 5: (05 pm_
(from (col.2 ± col. Salaries in col. 5)			Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
			Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
Worksheet ∧-6) 3) col 4					(from	(col.2 ± col.	Salaries in	col. 5)	
Worksheet A-0) 3) Cor. 4					Worksheet A-6)	3)	col. 4	·	
1.00 2.00 3.00 4.00 5.00 6.00			1.00	2.00	3. 00	4. 00	5. 00	6. 00	
41.00 Medical Records & Medical 16.00 702,624 0 702,624 34,368.00 20.44 41.00	41.	00 Medical Records & Medical	16. 00	702, 624	0	702, 62	4 34, 368. 00	20. 44	41. 00
Records Library		Records Library							
42. 00 Social Service 17. 00 414, 529 0 414, 529 13, 920. 00 29. 78 42. 00	42.	00 Social Service	17. 00	414, 529	0	414, 52	9 13, 920. 00	29. 78	42.00
43.00 Other General Service 18.00 0 0 0 0.00 0.00 43.00	43.	00 Other General Service	18. 00	0	0		0.00	0. 00	43.00

		•						
HOSPITAL WAGE INDEX INFORMATION				Provi der		Period: From 07/01/2014 To 06/30/2015		
							11/23/2015 5:	
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col . 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2.00	3.00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		32, 058, 522	0	32, 058, 52	2 1, 074, 078. 00	29. 85	1. 00
	instructions)							
2.00	Excluded area salaries (see		10, 220, 336	-368, 402	9, 851, 93	4 252, 925. 00	38. 95	2. 00
	instructions)							
3.00	Subtotal salaries (line 1		21, 838, 186	368, 402	22, 206, 58	821, 153. 00	27. 04	3. 00
	minus line 2)							
4.00	Subtotal other wages & related		261, 359	0	261, 35	9 5, 164. 00	50. 61	4. 00
	costs (see inst.)							
5.00	Subtotal wage-related costs		10, 303, 997	0	10, 303, 99	7 0.00	46. 40	5. 00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		32, 403, 542	368, 402	32, 771, 94	4 826, 317. 00	39. 66	6. 00
7.00	Total overhead cost (see		8, 449, 879	12, 485	8, 462, 36	4 339, 685. 00	24. 91	7. 00
	instructions)							

Health Financial Systems	MCDONOUGH DISTRICT HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 140089	Period: Worksheet S-3 From 07/01/2014 Part IV
		To 06/30/2015 Date/Time Prepared:

PART IV - WAGE RELATED COSTS		To 06/30/2015	Date/Time Prep 11/23/2015 5:0	oared: 05 pm
PART IV - WAGE RELATED COSTS Part A - Core List RETIREMENT COST			Amount	•
PART IV - WAGE RELATED COSTS Part A - Core List RETIREMENT COST 401K Empl oyer Contributions 821, 919 1.00 401K Empl oyer Contributions 0.2.00 3.00 4.				
Part A - Core List RETIREMENT COST		DADT LV WACE DELATED COSTS	1.00	
RETIREMENT COST				
1.00				
2. 00	1 00		021 010	1 00
3.00 Nonqualified Defined Benefit Plan Cost (see instructions) 0 3.00 4.00 0 4.00 0 4.00 0 4.00 0 4.00 0 4.00 0 4.00 0 4.00 0 4.00 0 4.00 0 0 4.00 0 0 0 0 0 0 0 0 0				
A. 00				
PLAN ADMINISTRATIVE COSTS (Paid to External Organization) 401K/TSA Plan Administration fees 0 5.00 6.00 Legal /Accounting/Management Fees-Pension Plan 0 6.00 7.00 Employee Managed Care Program Administration Fees 0 7.00 HEALTH AND INSURANCE COST 8.00 Health Insurance (Purchased or Self Funded) 6,330,354 8.00 9.00 Prescription Drug Plan 0 9.00 10.00 Dental, Hearing and Vision Plan 266,498 10.00 10.00 Dental, Hearing and Vision Plan 266,498 10.00 10.00 20.00				
5.00 401K/TSA Plan Administration fees 0 6.00 1.	4.00		U	4.00
Legal / Accounting / Management Fees - Pension Plan 0 6.00	E 00		0	E 00
The column Table			- 1	
HEALTH AND INSURANCE COST			-	
8.00 Heal th Insurance (Purchased or Self Funded) 6, 330, 354 8.00 9.00 Prescription Drug Plan 0 9.00 0.0	7.00		U	7.00
9.00 Prescription Drug Plan 0 9.00 10.00 Dental, Hearing and Vision Plan 266,498 10.00 11.00 Life Insurance (If employee is owner or beneficiary) 40,946 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) 98,211 13.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 98,211 13.00 15.00 Workers' Compensation Insurance 248,502 15.00 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 Non cumulative portion) 2, 304, 290 17.00 18.00 18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 94,000 19.00 20.00 State or Federal Unemployment Taxes 0 20.00 0THER Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see 0 21.00 22.00 Day Care Cost and Allowances 58,268 23.00 23.00 Tuit tion Reimbursement	9 00		6 220 254	0 00
10.00 Dental, Hearing and Vision Plan 266,498 10.00 11.00 Life Insurance (If employee is owner or beneficiary) 40,946 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) 98,211 13.00 13.00 Disability Insurance (If employee is owner or beneficiary) 98,211 13.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 15.00 Workers' Compensation Insurance 248,502 15.00 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 Non cumulative portion 17.00 17.00 18.00 Medicare Taxes - Employers Portion Only 2,304,290 17.00 18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 94,000 19.00 20.00 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see 0 21.00 instructions)) 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuit ion Reimbursement 58,268 23.00 24.00 Part B - Other than Core Related Cost 24.00 Part B - Other than Core Related Cost 24.00 266,498 10.00 10.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 13.00 13.00 14.00 14.00 14		, ,		
11. 00				
12.00				
13. 00 Disability Insurance (If employee is owner or beneficiary) 14. 00 Long-Term Care Insurance (If employee is owner or beneficiary) 15. 00 'Workers' Compensation Insurance 16. 00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17. 00 FICA-Employers Portion Only 18. 00 Medicare Taxes - Employers Portion Only 19. 00 Unemployment Insurance 20. 00 State or Federal Unemployment Taxes 21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22. 00 Day Care Cost and Allowances 23. 00 Titi ti on Reimbursement 24. 00 Part B - Other than Core Related Cost				
14. 00 Long-Term Care Insurance (If employee is owner or beneficiary) 15. 00 16. 00 Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17. 00 FICA-Employers Portion Only 18. 00 Medicare Taxes - Employers Portion Only 19. 00 Unemployment Insurance 20. 00 State or Federal Unemployment Taxes 17. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22. 00 Day Care Cost and Allowances 23. 00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost			-	
15.00 'Workers' Compensation Insurance Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Retirement Health Care Cost in 6.00 16.00 17.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Retirement Health Care Cost and Allowances 7.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Retirement Health Care Cost and Allowances 7.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Retirement Health Care Cost (0nd 6.00 17.00 18.00 94,000 19.00 20.00 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see on the province of the province o				
Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17. 00 FI CA-Employers Portion Only 18. 00 Medicare Taxes - Employers Portion Only 19. 00 Unemployment Insurance 20. 00 State or Federal Unemployment Taxes 17. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22. 00 Day Care Cost and Allowances 21. 00 Tuit ion Reimbursement 21. 00 Total Wage Related cost (Sum of Lines 1 -23) 22. 00 Part B - Other than Core Related Cost			-	
Non cumulative portion TAXES				
TAXES	10.00		U	10.00
17. 00 FI CA-Employers Portion Only 2, 304, 290 17. 00 18. 00 18. 00 19. 00 1				
18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 94,000 19.00 20.00 State or Federal Unemployment Taxes 0 20.00 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 0 21.00 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuition Reimbursement 58,268 23.00 24.00 Total Wage Related cost (Sum of Lines 1 -23) 10,262,988 24.00 Part B - Other than Core Related Cost	17. 00		2, 304, 290	17. 00
19.00 Unempl oyment Insurance 94,000 19.00 20.00 State or Federal Unempl oyment Taxes 0 20.00 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 0 21.00 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuition Reimbursement 58,268 23.00 24.00 Total Wage Related cost (Sum of Lines 1 -23) 10,262,988 24.00 Part B - Other than Core Related Cost				
20.00 State or Federal Unemployment Taxes 0 20.00 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuition Reimbursement 58, 268 23.00 24.00 Total Wage Related cost (Sum of Lines 1 -23) 10, 262, 988 24.00 Part B - Other than Core Related Cost				
OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 7.00 Tuition Reimbursement 7.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions) 8.10 Day Care Cost and Allowances 9.10 Day Care Cost and Allowances 10.22.00 10.22.00 10.22.00 10.22.00 10.262.988 24.00 Part B - Other than Core Related Cost				
21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances Tuition Reimbursement Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost 21.00 22.00 23.00 10, 262, 988 24.00	20.00			20.00
22. 00 Day Care Cost and Allowances 0 22. 00 23. 00 Tuition Reimbursement 58, 268 23. 00 24. 00 Total Wage Related cost (Sum of lines 1 -23) 10, 262, 988 24. 00 Part B - Other than Core Related Cost 24. 00 24. 00	21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21. 00
23.00 Tuition Reimbursement 58, 268 23.00 24.00 Total Wage Related cost (Sum of lines 1 -23) 10, 262, 988 24.00 Part B - Other than Core Related Cost				
24.00 Total Wage Related cost (Sum of lines 1 -23) Part B - Other than Core Related Cost 10, 262, 988 24.00			-	
Part B - Other than Core Related Cost				
	24.00		10, 262, 988	24.00
25. UU UTHER WAGE RELATED COSTS (SPECIFY) 0 25. 00	25 62			25 00
	25.00	UTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

Health Financial Systems	MCDONOUGH DISTRICT HOSPITAL	In Lie	u of Form CMS-2	2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST		Period: From 07/01/2014 Fo 06/30/2015	Worksheet S-3 Part V Date/Time Pre 11/23/2015 5:0	pared:
Cost Center Description		Contract Labor	Benefit Cost	, i
		1. 00	2. 00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identi	fi cati on:			
1 00 Total facility's contract labor and banefit	and t		Ο,	1 00

	Cost Center Description	Contract Labor	Benefit Cost	
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	0	1. 00
2.00	Hospi tal	0	0	2. 00
3.00	Subprovi der - I PF			3. 00
4.00	Subprovi der - I RF			4. 00
5.00	Subprovi der - (Other)	0	0	5. 00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7. 00
8.00	Hospi tal -Based SNF	0	0	8. 00
9.00	Hospi tal -Based NF			9. 00
10.00	Hospi tal -Based OLTC			10.00
11.00	Hospi tal -Based HHA	0	0	11. 00
12.00	Separately Certified ASC			12. 00
13.00	Hospi tal -Based Hospi ce	0	0	13. 00
14.00	Hospital-Based Health Clinic RHC	0	0	14. 00
15.00	Hospital-Based Health Clinic FQHC			15. 00
16.00	Hospi tal -Based-CMHC			16. 00
17.00	Renal Dialysis			17. 00
18. 00	Other	0	0	18. 00

Heal th	Financial Systems	MCDONOUGH DISTE	RICT HOSPITAL		In Lie	eu of Form CMS-2	2552-10
HOME F	IEALTH AGENCY STATISTICAL DATA			CCN: 140089 t CCN: 147293	Peri od: From 07/01/2014 To 06/30/2015	Worksheet S-4 Date/Time Pre 11/23/2015 5:	pared:
					Home Health	PPS	OS PIII
					Agency I		
					1.	00	
0.00	County		T		MCDONOUGH		0.00
		1.00	Title XVIII 2.00	Title XIX	0ther 4.00	Total 5.00	
	HOME HEALTH AGENCY STATISTICAL DATA	1.00	2.00	3.00	4.00	J. 00	
1.00	Home Health Aide Hours	0		1	0 0		
2.00	Unduplicated Census Count (see instructions)	0. 00	0. 00		00 0.00 0.00 0.00 0.00		2. 00
				Number of Em	iproyees (ruir ii	me Equi vai ent)	
		Enter the numb	er of hours in	Staff	Contract	Total	
		your normal	work week				
)	1.00	2. 00	3. 00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3. 00 4. 00	Administrator and Assistant Administrator(s) Director(s) and Assistant Director(s)		40. 00	0. (l e	1
5. 00	Other Administrative Personnel			3.		l	
6.00	Direct Nursing Service			7. !		l	1
7. 00 8. 00	Nursing Supervisor Physical Therapy Service			0.0		l	1
9. 00	Physical Therapy Supervisor			0.0			1
10. 00	Occupational Therapy Service			0.8	0.00	0. 89	1
11. 00 12. 00	Occupational Therapy Supervisor Speech Pathology Service			0. (1
13. 00	Speech Pathology Supervisor			0.0		l	
14. 00	Medical Social Service			0.	12 0.00	0. 12	14. 00
15.00	Medical Social Service Supervisor			0.0		l	1
16. 00 17. 00	Home Health Aide Home Health Aide Supervisor			0. (1	1
18. 00	Other (specify)			0. (1	1
10.00	HOME HEALTH AGENCY CBSA CODES	I			4		10.00
19. 00	Enter in column 1 the number of CBSAs where you provided services during the cost				1		19. 00
	reporting period.						
20. 00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			99914			20. 00
			with Outliers	LUBA Enisodo	es PEP Only	Total (cols.	
		Outliers	with outriers	LUPA Epi Sode	Epi sodes	1-4)	
	T	1.00	2.00	3.00	4. 00	5. 00	
21. 00	PPS ACTIVITY DATA Skilled Nursing Visits	2, 036	24		75 15	2, 150	21. 00
22. 00	Skilled Nursing Visit Charges	318, 752					
23. 00	Physical Therapy Visits	971		1	47 10		1
24. 00 25. 00	Physical Therapy Visit Charges Occupational Therapy Visits	155, 721 385	0		20 1, 700 2 7	163, 541 394	1
26. 00	Occupational Therapy Visits Charges	65, 280		1	40 1, 190		1
27. 00	Speech Pathology Visits	41	0		0 0	41	27. 00
28. 00 29. 00	Speech Pathology Visit Charges Medical Social Service Visits	6, 970 21	0		0 0 1	6, 970 22	1
30.00	Medical Social Service Visit Charges	3, 570		1	0 170	l	1
31. 00	Home Health Aide Visits	189	0		0 0	189	31.00
32. 00 33. 00	Home Health Aide Visit Charges Total visits (sum of lines 21, 23, 25, 27,	20, 991 3, 643	0 24		0 24 33	20, 991 3, 824	1
33.00	29, and 31)	3,043	24	ή '΄		3, 024	33.00
	Other Charges Total Charges (sum of lines 22, 24, 26, 28,	0 571, 284	0 3, 910) 15, 8 ⁻	0 10 5, 270	0 596, 274	1
34. 00 35. 00		371, 204					
	30, 32, and 34)	219			31 2	252	36. 00

Health Financial Systems	MCDONOUGH DISTR	RICT HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIF			CCN: 140089	Peri od:	Worksheet S-8	
STATISTICAL DATA		Componen	t CCN: 148522	From 07/01/2014 To 06/30/2015	Date/Time Pre 11/23/2015 5:	
				Rural Health Clinic (RHC) I	Cost	
				1	00	-
Clinic Address and Identification					00	
1.00 Street				115 W. HAIL ST		1.00
<u> </u>		Ci	ty	State	ZIP Code	
		1.	00	2. 00	3. 00	
2.00 City, State, ZIP Code, County		BUSHNELL		IL	61422	2. 00
0.00 50110 0011 1 1 1 1 1 1 1					1.00	0.00
3.00 FQHCs ONLY: Designation - Enter "R" for rura	l or "U" for ur	ban		Coopt Award	0	3.00
				Grant Award 1.00	Date 2.00	-
Source of Federal Funds				1.00	2.00	
4.00 Community Health Center (Section 330(d), PHS	Act)			0		4.00
5.00 Mi grant Heal th Center (Section 329(d), PHS A				0		5.00
6.00 Health Services for the Homeless (Section 34)				0		6. 00
7. 00 Appal achi an Regi onal Commi ssi on	o(a)/ 11.0 /101/			0		7. 00
8.00 Look-Alikes				0		8.00
9.00 OTHER (SPECIFY)				0	•	9.00
				1. 00	2. 00	
10.00 Does this facility operate as other than an in oin column 1. If yes, indicate number of o	ther operations	in column 2.	(Enter in	N	0	10.00
subscripts of line 11 the type of other operations			- 		T	
	Sund			londay	Tuesday	-
	from 1.00	2. 00	3.00	4. 00	from 5.00	
Facility hours of operations (1)	1.00	2.00	3.00	4.00	5.00	
11. 00 Clinic			08: 30	17: 00	08: 30	11. 00
			1			
				1. 00	2. 00	
12.00 Have you received an approval for an exception 13.00 Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columnumber of providers included in this report. numbers below.	d in CMS Pub. 1 umn 1. If yes,	00-04, chapter enter in colur	9, section nn 2 the	N N	0	12. 00 13. 00
Trumber's below.			Provi	der name	CCN number	
				1. 00	2. 00	
14.00 Provider name, CCN number						14. 00
	Y/N	V	XVIII	XI X	Total Visits	
	1.00	2. 00	3. 00	4. 00	5. 00	
15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.						15. 00
(see instructions)			L			
			unty			
2.00 City, State, ZIP Code, County		MCDONOUGH	00			2.00
2.00 porty, State, Zir Coue, County	Tuesday		esday	Thur	sday	2.00
	to	from	to	from	to	
	6.00	7. 00	8.00	9. 00	10.00	
Facility hours of operations (1)						
11. 00 Cl i ni c	17: 00	08: 30	12: 00	08: 30	17: 00	11. 00

Health Financial Systems	MCDONOUGH DIST	RICT HOSPITAI	_	In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIF	FIED HEALTH CEN	TER Provi de	er CCN: 140089	Peri od: From 07/01/2014	Worksheet S-8	
STATISTICAL DATA		Compone	ent CCN: 148522	To 06/30/2015		
				Rural Health	Cost	•
				Clinic (RHC) I		
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12.00	13.00	14. 00		
Facility hours of operations (1)						
11. 00 Clinic	08: 30	17: 00				11. 00

Heal th	Financial Systems		MCDONOUGH DIST	RICT HOSPITAL		In lie	eu of Form CMS-2	2552_10
	TAL IDENTIFICATION DATA	<u>'</u>	WCDONGOOT DIST		CCN: 140089	Peri od:	Worksheet S-9	
1103F1	TAL TULNTITICATION DATA			Frovider	CCN. 140069	From 07/01/2014		
				Componen	t CCN: 141524	To 06/30/2015		pared:
							11/23/2015 5:	
						Hospi ce I		
		Unduplicated						
		Days						
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
				Skilled	Nursi ng		col s. 1, 2 &	
				Nursi ng	Facility		5)	
				Facility			Í	
		1.00	2. 00	3.00	4.00	5. 00	6. 00	
	PART I - ENROLLMENT DAYS				•			
1.00	Continuous Home Care	0	0	(0 0	0	1.00
2.00	Routine Home Care	5, 947	0			0 560	6, 507	2. 00
3.00	Inpatient Respite Care	5	0			0 0	5	3. 00
4.00	General Inpatient Care	3	0		ol	0 0	3	4.00
5.00	Total Hospice Days	5, 955	0		ol	0 560	6, 515	5. 00
	Part II - CENSUS DATA	, , , , , ,						
6.00	Number of Patients Receiving	140	0			0 16	156	6.00
5.00	Hospi ce Care	110]	1			0.00
7. 00	Total Number of Unduplicated	0. 00		0.00				7. 00
,.00	Continuous Care Hours Billable	0.00		0.00	1			/. 00
	t- M-di			1	1			1

0.00

0.00

0.00

35. 00

41. 76

136

42.54

135

8.00

9.00

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

Unduplicated Census Count

	Financial Systems MCDONOUGH DISTRICT HOS			In Lie	eu of Form CMS-2	
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA Pr	ovi der	CCN: 140089	Peri od:	Worksheet S-10	0
				From 07/01/2014 To 06/30/2015	Date/Time Pre	narod:
				10 00/30/2013	11/23/2015 5:0	
					1. 00	
4 00	Uncompensated and indigent care cost computation		200	0)	0.0407/0	4 00
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divide	a by III	ne 202 column	1 8)	0. 349760	1. 00
2. 00	Medicaid (see instructions for each line) Net revenue from Medicaid				112, 258, 662	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				112, 230, 002	3.00
4. 00	If line 3 is "yes", does line 2 include all DSH or supplemental pa	vments	from Medicaio	17		4.00
5. 00	If line 4 is "no", then enter DSH or supplemental payments from Me		irom meareare	•	0	5. 00
6. 00	Medi cai d charges				118, 113, 745	
7.00	Medicaid cost (line 1 times line 6)				41, 311, 463	
8.00	Difference between net revenue and costs for Medicaid program (line	e 7 min	us sum of lir	es 2 and 5; if	0	8. 00
	< zero then enter zero)					
	State Children's Health Insurance Program (SCHIP) (see instructions	s for ea	ach line)			
9.00	Net revenue from stand-alone SCHIP				0	
10.00	Stand-alone SCHIP charges				0	10.00
11. 00 12. 00	Stand-alone SCHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone SCHIP (li	no 11 m	inuc lino O	if a zoro thon	0	11. 00 12. 00
12.00	lenter zero)	ne ii iii	inus iine 9;	ii < zero then	U	12.00
	Other state or local government indigent care program (see instructions)	tions fo	or each line)			
13.00	Net revenue from state or local indigent care program (Not include				0	13. 00
14.00	Charges for patients covered under state or local indigent care pro-		0	14. 00		
	10)					
15. 00						15. 00
16. 00		nt care	program (lir	e 15 minus line	0	16. 00
	13; if < zero then enter zero) Uncompensated care (see instructions for each line)					
17. 00	Private grants, donations, or endowment income restricted to fundi	na char	ity care		52, 870	17 00
18. 00	Government grants, appropriations or transfers for support of hosp				117, 899	
19. 00	Total unreimbursed cost for Medicaid , SCHIP and state and local in			s (sum of lines	0	19.00
17.00	8, 12 and 16)	nai gent	care program	is (sum or rrines		17.00
			Uni nsured	Insured	Total (col. 1	
			pati ents	pati ents	+ col . 2)	
	I=		1.00	2. 00	3. 00	
20. 00	Total initial obligation of patients approved for charity care (at		1, 011, 63	9, 755, 232	10, 766, 870	20.00
21. 00	charges excluding non-reimbursable cost centers) for the entire factors of initial obligation of patients approved for charity care (353, 83	3, 411, 990	3, 765, 821	21. 00
21.00	times line 20)	TITIE I	333, 6	3,411,770	3, 703, 621	21.00
22. 00			32, 0	2 171, 658	203, 670	22. 00
	Cost of charity care (line 21 minus line 22)		321, 8		3, 562, 151	
					1. 00	
24. 00	Does the amount in line 20 column 2 include charges for patient day		nd a Length o	of stay limit		24. 00
25 02	imposed on patients covered by Medicaid or other indigent care pro					25 62
25. 00	If line 24 is "yes," charges for patient days beyond an indigent		ogram s rengt	n or stay limit	0 2 472 212	
26. 00 27. 00	Total bad debt expense for the entire hospital complex (see instruction) Medicare bad debts for the entire hospital complex (see instruction)				2, 672, 213 251, 193	
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line :	,	s line 27)		251, 193	
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (Tine		,	28)	2, 421, 020 846, 776	
30.00	·	C (TITIE	i times tille	. 20)	4, 408, 927	
	Total unreimbursed and uncompensated care cost (line 19 plus line s	30)			4, 408, 927	
00	1.212. 22. 200 dila dilampondatad adi a adat (17116 17 pi da 11116)	/			1, 100, 727	350

Health Financial Systems	MCDONOUGH DISTRICT		CCN: 140090		u of Form CMS-1	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der		Period: From 07/01/2014 To 06/30/2015	Worksheet A Date/Time Pre 11/23/2015 5:	
Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +-	F
	1.00	2.00	2.00	4.00	col . 4)	
GENERAL SERVICE COST CENTERS	1.00	2. 00	3. 00	4. 00	5. 00	
1.00		3, 391, 518 236, 391 323, 335 0	3, 391, 51 236, 39 323, 33	1 13, 161 5 9, 029 0 45, 975	0 3, 643, 212 249, 552 332, 364 45, 975 42	1. 00 1. 01 1. 02 1. 03 1. 04 1. 05
1. 06		12, 626 80, 665 53, 321 0 74, 260	12, 62 80, 66 53, 32	6 457 5 1, 216 1 7, 275 0 32, 654	13, 083 81, 881 60, 596 32, 654 80, 570	1. 06 1. 07 1. 08 1. 09 1. 10
3.00 00300 OTHER CAPITAL RELATED COSTS 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL 6.00 00600 MAINTENANCE & REPAIRS 6.01 00601 MAINTENANCE & REPAIRS-HSB I 6.02 00602 MAINTENANCE & REPAIRS-HSB II	345, 270 4, 170, 874 573, 549 20, 890 13, 400	769, 201 10, 613, 845 3, 886, 842 1, 155, 282 130, 288 91, 416	769, 20 10, 959, 11 8, 057, 71 1, 728, 83 151, 17	1 -675, 240 5 15, 312 6 -77, 059 1 0 8 0 6 0	93, 961 10, 974, 427 7, 980, 657 1, 728, 831 151, 178 104, 816	3. 00 4. 00 5. 00 6. 00 6. 01 6. 02
6. 03	0 3, 019 2, 074 2, 208 117, 423 208, 453 47, 534 14, 906	7, 049 15, 661 10, 616 22, 413 178, 056 527, 719 73, 334 50, 783	18, 68 12, 69 24, 62 295, 47 736, 17 120, 86	0 0 0 1 0 9 0 2 0	7, 049 18, 680 12, 690 24, 621 295, 479 736, 172 120, 868 65, 689	6. 03 6. 04 6. 05 6. 06 8. 00 9. 00 9. 01 9. 02
9. 03	2, 978 2, 057 122, 517 159, 864	6, 623 4, 384 110, 497 960, 788	9, 60 6, 44 233, 01 1, 120, 65	1 0 1 0 4 471, 140 2 -471, 140	9, 601 6, 441 704, 154 649, 512	9. 03 9. 04 10. 00 11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE	519, 740 281, 229 576, 905 702, 624 414, 529	27, 550 148, 272 2, 023, 060 286, 930 27, 998	429, 50 2, 599, 96 989, 55	1 12, 485 5 -206, 809 4 -11, 411	547, 290 441, 986 2, 393, 156 978, 143 442, 527	13. 00 14. 00 15. 00 16. 00 17. 00
19.00 01900 NONPHYSICIAN ANESTHETISTS 23.00 02300 PARAMED ED PRGM	0 28, 576	1, 621		0 1, 099, 286	1, 099, 286 30, 197	19. 00 23. 00
I NPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDIATRICS	3, 610, 209	659, 236	4, 269, 44	5 -694, 144	3, 575, 301	30.00
31.00 03100 INTENSIVE CARE UNIT	709, 004	42, 251	l .	5 0	751, 255	31.00
43. 00 04300 NURSERY 44. 00 04400 SKI LLED NURSI NG FACI LI TY ANCI LLARY SERVI CE COST CENTERS	0 0	0	1	0 355, 395 0 0	355, 395 0	43. 00 44. 00
50. 00 O5000 OPERATING ROOM	1, 165, 257	645, 862	1, 811, 11	9 0	1, 811, 119	50.00
51. 00 05100 RECOVERY ROOM 52. 00 05200 DELI VERY ROOM & LABOR ROOM	513, 109 0	225, 759			738, 868	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	1, 447, 665	195, 339			326, 264 543, 718	52. 00 53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 372, 845	721, 363			1, 434, 088	
57. 00 05700 CT SCAN 58. 00 05800 MAGNETIC RESONANCE MAGING (MRI)	0	0		0 660, 120 0 524, 528	660, 120 524, 528	57. 00 58. 00
60. 00 06000 LABORATORY	2, 721, 154	1, 643, 637		1 231, 828	4, 596, 619	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 65. 00 06500 RESPIRATORY THERAPY	0 703, 409	275, 804 84, 275	1		43, 976 339, 301	63. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY	1, 645, 951	56, 666	1		1, 704, 792	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0 (14	1	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	137, 638	2, 614 40, 131			140, 252 264, 384	68. 00 69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	Ö	1, 200			198, 901	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	430, 363	I .		456, 792	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS	0	1, 123, 472	1	2 0 0 0	1, 123, 472 0	72. 00 73. 00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	566, 792	13, 994	1	-	580, 786	76.00
76. 01 03950 DI ABETES/WOUND CARE/COUMADIN CNTR	455, 509 0	61, 281	516, 79	0 0	516, 790	76. 01
76. 02 03951 FLU CLINIC OUTPATIENT SERVICE COST CENTERS	U		ή	0 19, 764	19, 764	76. 02
88. 00 08800 RURAL HEALTH CLINIC 91. 00 09100 EMERGENCY	0 1, 477, 262	2, 163, 990		0 456, 507 2 0	456, 507 3, 641, 252	88. 00 91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92. 00
95. 00 09500 AMBULANCE SERVI CES 101. 00 10100 HOME HEALTH AGENCY	757, 645 1, 079, 158	98, 468 142, 260	l .		856, 113 1, 201, 654	

Health Financial Systems	MCDONOUGH DISTRICT	T HOSPITAL		In Lie	u of Form CMS-2	552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (OF EXPENSES	Provi der		Peri od:	Worksheet A	
				From 07/01/2014		
				To 06/30/2015	Date/Time Prep 11/23/2015 5:0	pared:
Cost Center Description	Sal ari es	Other	Total (col 1	Recl assi fi cati	Reclassi fi ed	DO DIII
cost center bescription	Sai ai i es	Other	+ col . 2)	ons (See A-6)	Trial Balance	
			+ (01. 2)	ons (see A-o)	(col. 3 +-	
					col. 4)	
	1, 00	2.00	3.00	4. 00	5. 00	
SPECIAL PURPOSE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
113. 00 11300 NTEREST EXPENSE		16, 854	16, 85	4 0	16, 854	113 00
116. 00 11600 HOSPI CE	600, 048	456, 412			1, 080, 542	
118.00 SUBTOTALS (SUM OF LINES 1-117)	27, 293, 274	34, 403, 617		•		
NONREI MBURSABLE COST CENTERS	21,275,214	34, 403, 017	01, 070, 07	1	02, 110, 141	110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	O	0		0	ol	192. 00
194.00 07950 DAY HEALTH	128, 771	33, 204	161, 97	5 0	161, 975	194. 00
194. 01 07962 OUTREACH	157, 022	31, 264			188, 286	
194. 02 07951 OCCUPATI ONAL MEDI CI NE	0	0	,	0		194. 02
194. 03 07952 FUND DEVELOPMENT	155, 041	208, 498	363, 53	9 -170, 158	193, 381	194. 03
194. 04 07953 OUTSI DE LAUNDRY	0	0	,	0		194. 04
194. 05 07954 PHYSI CI AN SUPPORT	98, 407	580, 789	679, 19	6 0	679, 196	194. 05
194. 06 07955 HOSPI TALI TY HOUSE	9, 187	15, 511			24, 698	
194. 07 07956 HSK DIALYSIS	5, 027	6, 334			11, 361	
194. 08 07957 LEASED SALARI ES	31, 636	0	31, 63		31, 636	
194. 09 07958 VISITING PHYSICIANS	0	265			·	194. 09
194. 10 07959 FARM LAND		0		0		194. 10
194. 11 07963 CONVENI ENCE CARE CLINIC	288, 787	74, 618	363, 40	5 0	363, 405	
194. 12 07960 MMG-PHYSI CI AN OFFI CES	6, 862, 779	849, 574			7, 462, 655	
194. 13 07961 VALET PARKING SERVICE	18, 252	017, 071			18, 252	
200.00 TOTAL (SUM OF LINES 118-199)	35, 048, 183	36, 203, 674			71, 251, 857	
	00,0.0,.00	-3, 200, 01 1	1, 20., 00	٠,	, ,, 20 ,, 00 ,	

Peri od: Worksheet A From 07/01/2014 Date/Time Prepared: 11/23/2015 5:05 pm

			11/23/2015	
Cost Center Description	Adj ustments	Net Expenses		
	(See A-8) 6.00	For Allocation 7.00		
GENERAL SERVICE COST CENTERS	0.00	7.00		
1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT	0	0		1.00
1. 01 00101 CAP REL COSTS-HOSPI TAL	44, 746	3, 687, 958		1. 01
1.02 O0102 CAP REL COSTS-HSB I	0			1. 02
1. 03 00103 CAP REL COSTS-HSB I	0			1. 03
1. 04 00104 CAP REL COSTS-REHAB CNT	0			1. 04
1. 05 O0105 CAP REL COSTS-DI AYSI S	-42	1		1. 05
1.06 00106 CAP REL COSTS-HOSPITALITY HOUSE 1.07 00107 CAP REL COSTS-MAB	0			1. 06 1. 07
1.08 00108 CAP REL COSTS-WAB				1.07
1. 09 00109 CAP REL COSTS-CONVENIENCE CARE CLINI				1. 09
1. 10 00110 CAP REL COSTS-BUSHNELL OFFICE BLDG	0			1. 10
3. 00 00300 OTHER CAPITAL RELATED COSTS	-93, 961	0		3. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	-3, 654, 042	7, 320, 385		4. 00
5.00 00500 ADMINISTRATIVE & GENERAL	-693, 593	7, 287, 064		5. 00
6.00 00600 MAINTENANCE & REPAIRS	0	1, 728, 831		6. 00
6.01 00601 MAI NTENANCE & REPAI RS-HSB I	0			6. 01
6. 02 00602 MAINTENANCE & REPAIRS-HSB I	0			6. 02
6. 03 00603 MAINTENANCE & REPAIRS-REHAB CLINIC	0	1		6. 03
6.04 00604 MAI NTENANCE & REPAI RS-MAB 6.05 00605 MAI NTENANCE & REPAI RS-ORTHO BLDG	0			6. 04 6. 05
6. 06 00606 MAI NTENANCE & REPAIRS-OKTHO BLDG				6. 06
8. 00 00800 LAUNDRY & LINEN SERVICE				8.00
9. 00 00900 HOUSEKEEPI NG	0	736, 172		9. 00
9. 01 00901 HOUSEKEEPI NG-HSB	Ö	1		9. 01
9. 02 00902 HOUSEKEEPI NG-HSB I	0	1		9. 02
9. 03 00903 HOUSEKEEPI NG-ORTHO	0	9, 601		9. 03
9. 04 00904 HOUSEKEEPI NG-MAB	0	6, 441		9. 04
10. 00 01000 DI ETARY	-55, 119	649, 035		10. 00
11. 00 01100 CAFETERI A	-265, 401	384, 111		11. 00
13. 00 01300 NURSING ADMINISTRATION	0			13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY	0	441, 986		14. 00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY	10, 420	2, 393, 156		15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY 17. 00 01700 SOCIAL SERVICE	-10, 620			16. 00 17. 00
19. 00 01900 NONPHYSI CI AN ANESTHETI STS	-1, 099, 286			19.00
23. 00 02300 PARAMED ED PRGM	-110	1		23. 00
I NPATIENT ROUTINE SERVICE COST CENTERS	<u>'</u>			
30. 00 03000 ADULTS & PEDIATRICS	-805, 714	2, 769, 587		30. 00
31.00 03100 INTENSIVE CARE UNIT	0	751, 255		31. 00
43. 00 04300 NURSERY	0			43. 00
44. 00 04400 SKILLED NURSING FACILITY	0	0		44. 00
ANCI LLARY SERVI CE COST CENTERS		1 011 110		F0.00
50.00 05000 0PERATING ROOM 51.00 05100 RECOVERY ROOM	0			50. 00 51. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM				52.00
53. 00 05300 ANESTHESI OLOGY	-396, 420	1		53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	-331	1		54.00
57. 00 05700 CT SCAN	0			57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	524, 528		58. 00
60. 00 06000 LABORATORY	-691, 712	3, 904, 907		60. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	1		63. 00
65. 00 06500 RESPI RATORY THERAPY	0	339, 301		65. 00
66. 00 06600 PHYSI CAL THERAPY	-13, 724			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	1		67. 00
68. 00 06800 SPEECH PATHOLOGY	0			68. 00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY		264, 384 198, 901		69. 00 70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-2, 481	454, 311		70.00
72. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-2, 461			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	Ö			73. 00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	-		76. 00
76. 01 03950 DI ABETES/WOUND CARE/COUMADIN CNTR	0	1		76. 01
76. 02 03951 FLU CLINIC	0	1		76. 02
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0			88. 00
91. 00 09100 EMERGENCY	-332, 964	3, 308, 288		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				92. 00
OTHER REIMBURSABLE COST CENTERS	0.244	044 040		05.00
95. 00 09500 AMBULANCE SERVI CES 101. 00 10100 HOME HEALTH AGENCY	-9, 264 0	1		95. 00 101. 00
SPECIAL PURPOSE COST CENTERS		1, 201, 004		101.00
113. 00 11300 NTEREST EXPENSE	-16, 854	0		113. 00
116. 00 11600 HOSPI CE	0	1		116. 00

Health FinancialSystemsMCDONOUGH DRECLASSIFICATIONAND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES MCDONOUGH DISTRICT HOSPITAL In Lieu of Form CMS-2552-10

Peri od: From 07/01/2014 To 06/30/2015 Date/Time Prepared: Provider CCN: 140089

			11/23/2015 5:05 pm
Cost Center Description	Adjustments	Net Expenses	
	(See A-8)	For Allocation	
	6.00	7.00	
118.00 SUBTOTALS (SUM OF LINES 1-117)	-8, 096, 892	54, 019, 855	118. 00
NONREI MBURSABLE COST CENTERS			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	192. 00
194. 00 07950 DAY HEALTH	0	161, 975	194. 00
194. 01 07962 OUTREACH	0	188, 286	194. 01
194. 02 07951 OCCUPATIONAL MEDICINE	0	0	194. 02
194.03 07952 FUND DEVELOPMENT	0	193, 381	194. 03
194. 04 07953 OUTSI DE LAUNDRY	0	0	194. 04
194. 05 07954 PHYSI CI AN SUPPORT	0	679, 196	194. 05
194. 06 07955 HOSPI TALI TY HOUSE	O	24, 698	194. 06
194. 07 07956 HSK DI ALYSI S	0	11, 361	194. 07
194. 08 07957 LEASED SALARI ES	0	31, 636	194. 08
194.09 07958 VISITING PHYSICIANS	0	265	194. 09
194. 10 07959 FARM LAND	0	0	194. 10
194. 11 07963 CONVENIENCE CARE CLINIC	0	363, 405	194. 11
194.12 07960 MMG-PHYSICIAN OFFICES	o	7, 462, 655	194. 12
194.13 07961 VALET PARKING SERVICE	o	18, 252	194. 13
200.00 TOTAL (SUM OF LINES 118-199)	-8, 096, 892	63, 154, 965	200. 00

					11/	23/2015 5:05 pm
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2.00	3. 00	4. 00	5. 00		
	A - RECLASS OB SALARY	40.00	255 225			
1.00	NURSERY	43.00	355, 395	0		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	326, 264	0		2.00
3. 00	CENTRAL SERVICES & SUPPLY	14.00	12, 485	0		3. 00
	0		694, 144	0		
1 00	B - RECLASS FOOD SERVICE	10.00	(7.200	402 021		1 00
1. 00	DI ETARY		6 <u>7, 2</u> 09	40 <u>3, 931</u>		1.00
	C - RECLASS CARIO SALARIES		67, 209	403, 931		
1 00	ELECTROCARDI OLOGY	69. 00	224 252	0		1 00
1.00		•	224, 253			1.00
2. 00	ELECTROENCEPHALOGRAPHY		197, 701	0		2. 00
	D - RECLASS CT EXPENSE		421, 954	O _I		
1. 00	CT SCAN	57.00	481, 327	178, 793		1. 00
1.00	O SCAIN		481, 327	17 <u>8, 7</u> 93		1.00
	E - RECLASS CRNA SALARIES		401, 327	176, 775		
1. 00	NONPHYSI CI AN ANESTHETI STS	19. 00	1, 040, 308	58, 978		1. 00
1.00	O ANESTHETISTS		1, 040, 308	5 <u>8, 978</u>		1.00
	F - RECLASS LEASE EXPENSE		1, 040, 300	30, 770		
1. 00	CAP REL COSTS-HOSPI TAL	1. 01	0	16, 627		1.00
2. 00	MAGNETIC RESONANCE I MAGING	58.00	o	524, 528		2.00
50	(MRI)	30.00	7	527, 520		2.00
3. 00	CAP REL COSTS-BUSHNELL	1. 10	o	4, 310		3.00
	OFFI CE BLDG	1. 19	7	., 510		5.00
4. 00	CAP REL COSTS-HOSPI TAL	1. 01	o	20, 744		4.00
5. 00	CAP REL COSTS-HOSPI TAL	1. 01	0	27, 000		5. 00
6. 00	PHYSI CAL THERAPY	66.00	o	2, 175		6. 00
7. 00	CAP REL COSTS-REHAB CNT	1. 04	o	45, 975		7. 00
8. 00	CAP REL COSTS-CONVENIENCE	1. 09	O	28, 800		8. 00
	CARE CLINI					
9. 00	CAP REL COSTS-ORTHO BLDG	1. 08	0	5, 081		9. 00
				675, 240		
	G - RECLASS DONATION EXPENSE					
1. 00	HOSPI CE	116. 00	0	24, 082		1.00
2.00	ADMINISTRATIVE & GENERAL	5. 00	0_	146, 076		2. 00
	0		0	170, 158		
	H - RECLASS COPY MACHINE EXPE					
1. 00	ADMI NI STRATI VE & GENERAL		0	1 <u>1, 4</u> 11		1.00
	0		0	11, 411		
	I - RECLASS 02 EXPENSE					
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	26, 429		1.00
	PATI ENTS	+				
	0		0	26, 429		
	J - RECLASS NON-BLOOD SUPPLIE					
1. 00	LABORATORY	60.00	0	231, 828		1.00
	0		0	231, 828		
	L - RECLASS BLDG I NSURANCE			101 100		
1.00	CAP REL COSTS-HOSPI TAL	1. 01	0	121, 489		1.00
2.00	CAP REL COSTS-HSB I	1. 02	0	12, 309		2.00
3.00	CAP REL COSTS HOSPITALITY	1. 03	0	9, 029		3.00
4. 00	CAP REL COSTS-HOSPITALITY HOUSE	1. 06	0	457		4. 00
5 00	CAP REL COSTS-BUSHNELL	1 10	0	2 000		F 00
5. 00	OFFICE BLDG	1. 10	Ч	2, 000		5. 00
6. 00	CAP REL COSTS-CONVENIENCE	1. 09	0	480		6. 00
0.00	CARE CLINI	1.09	۷	400		0.00
7. 00	CAP REL COSTS-ORTHO BLDG	1. 08	o	2, 194		7. 00
8. 00	CAP REL COSTS-MAB	1. 07	0	1, 216		8. 00
	0	'+-	 	149, 174		0.00
	M - RECLASS AUTO & AMBULANCE	COLLISION I	٩	117, 177		
1. 00	CAP REL COSTS-HOSPI TAL	1.01	0	7, 554		1.00
2. 00	CAP REL COSTS-HSB I	1. 02	ő	852		2.00
0	0	— — ··· ° - †	- — 	$- \frac{302}{8,406}$		2.00
	N - RECLASS FLU SHOT EXPENSE		3	2, 100		
1. 00	RURAL HEALTH CLINIC	88. 00	0	6, 114		1. 00
2. 00	FLU CLINIC	76. 02	727	19, 037		2. 00
3. 00	MMG-PHYSICIAN OFFICES	194. 12	727	18, 816		3. 00
	0		727	43, 967		3.00
	O - RECLASS CCC DEPRECIATION		, , , ,	.5, 767		
	CAP REL COSTS-CONVENIENCE	1. 09	0	3, 374		1.00
1. 00				0, 0. 4		1 1.00
1. 00	CARE CLINI					

Health Financial Systems	MCDONOUGH DISTRICT HOSPITAL	In Lieu of Form CMS-2552-10
RECLASSI FI CATI ONS	Provi der CCN: 140089	Peri od: Worksheet A-6 From 07/01/2014
		To 06/30/2015 Date/Time Prepared:

					'	0 00/30/2013	11/23/2015 5:	
		Increases						
	Cost Center	Li ne #	Sal ary	0ther				
	2. 00	3. 00	4. 00	5.00				
	P - RECLASS PHYSICIAN OFF. P	HARMACY EXP						
1.00	RURAL HEALTH CLINIC	88. 00	0	9, 358				1. 00
2.00	MMG-PHYSICIAN OFFICES	194. 12	0_	112, 810				2. 00
	0		0	122, 168				
	Q - RECLASS MITEL LEASE OF PH	ONE SERVICE						
1.00	CAP REL COSTS-HOSPITAL	1. 01	0	6 <u>1, 6</u> 54				1. 00
	0		0	61, 654				
	S - RECLASS RHC EXPENSES							
1.00	RURAL HEALTH CLINIC	8800	367, 675	60, 889				1. 00
	0		367, 675	60, 889				
	T - RECLASS EMPLOYEE VACCINES							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	15, 312				1. 00
	0		0	15, 312]
	U - RECLASS PNEUMOCOCCAL VACC	INE						
1.00	RURAL HEALTH CLINIC	88.00	0	12, 471				1. 00
2.00	MMG-PHYSICIAN OFFICES	194. 12	0_	4 <u>7, 2</u> 40				2. 00
	0		0	59, 711				
500.00	Grand Total: Increases		3, 073, 344	2, 281, 423				500.00

h Financial Systems	MCDONOUGH DISTRICT HOSPITAL				In Lieu of Form CMS-2552-		
ASSIFICATIONS	Provi der CCN: 1400			N: 140089 P	Period: Worksheet A-6 From 07/01/2014		
				To		Date/Time Prepar	
	Decreases			<u> </u>		11/23/2015 5: 05	
Cost Center	Li ne #	Sal ary	Other Wks	st. A-7 Ref.			
6. 00	7. 00	8.00	9. 00	10. 00			
A - RECLASS OB SALARY	22.22	(0.4.4.4					
ADULTS & PEDIATRICS	30. 00 0. 00	694, 144 0	0	0			
	0.00	o o	0	0			
		694, 144		- — – †			
B - RECLASS FOOD SERVICE							
CAFETERI A	<u>11.</u> 00	6 <u>7, 2</u> 09	403, 931	0			
0		67, 209	403, 931				
C - RECLASS CARIO SALARIES RESPIRATORY THERAPY	(F 00	421 054	0	0			
RESPIRATORY THERAPY	65. 00 0. 00	421, 954 0	0	0			
		421, 954		- — — 🏺		1	
D - RECLASS CT EXPENSE		12.17 70.1	<u> </u>				
RADI OLOGY-DI AGNOSTI C	54.00	481, 327	178, 793	0			
0		481, 327	178, 793				
E - RECLASS CRNA SALARIES							
ANESTHESI OLOGY	<u>53.</u> 00	1, 040, 308	<u>58, 978</u>	0			
F - RECLASS LEASE EXPENSE		1, 040, 308	58, 978				
OTHER CAPITAL RELATED COSTS	3.00	0	675, 240	10			
STILL GALLIAL RELATED COSTS	0.00	ol Ol	075, 240	10			
	0.00	Ö	Ö	10			
	0.00	O	0	10			
	0.00	0	0	10		;	
	0.00	0	0	0			
	0.00	0	0	10		-	
	0.00	0	0	10		8	
	0.00	0	0	10			
G - RECLASS DONATION EXPENSE		U	675, 240				
FUND DEVELOPMENT	194. 03	0	170, 158	0			
	0.00	o	0	ō			
0		0	170, 158				
H - RECLASS COPY MACHINE EXPEN							
MEDI CAL RECORDS & LI BRARY	<u>16.</u> 00	•	11, 411	0			
0 EVDENCE		0	11, 411				
I - RECLASS 02 EXPENSE RESPIRATORY THERAPY	65.00	0	26, 429	0			
0			26, 429	- — — 4			
J - RECLASS NON-BLOOD SUPPLIES		<u> </u>	20/ 12/				
BLOOD STORING, PROCESSING &	63.00	0	231, 828	0			
TRANS							
0		0	231, 828				
L - RECLASS BLDG INSURANCE	5 00	ما	140 474	4.0			
ADMINISTRATIVE & GENERAL	5. 00 0. 00	0	149, 174 0	12 12			
	0.00	0	0	12			
	0.00	0	0	12			
	0.00	ŏ	o	12			
	0.00	ō	ō	12			
	0.00	o	0	12			
	0.00		0	12		:	
0		0	149, 174				
M - RECLASS AUTO & AMBULANCE C		ما	0.40/	12			
ADMINISTRATIVE & GENERAL	5. 00 0. 00	0	8, 406 0	12			
+		뉴		- — — 12			
N - RECLASS FLU SHOT EXPENSE		Ψ	5, 400				
HOME HEALTH AGENCY	101.00	727	19, 037	0			
HOME HEALTH AGENCY PHARMACY	15. 00	О	24, 930	O			
	0.00		0	0		;	
0		727	43, 967				
O - RECLASS CCC DEPRECIATION	4 0.1	ما	0.074	5			
CAP REL COSTS-HOSPITAL		0	3, 374	9			
O P - RECLASS PHYSICIAN OFF. PH	ARMACY EXP	U	3, 374				
PHARMACY	15.00	0	122, 168	0			
FITARWACT	0.00	o	0	0			
	 	 	122, 168	- — — 		'	
Q - RECLASS MITEL LEASE OF PHO	NE SERVICE						
ADMINISTRATIVE & GENERAL	5. 00	0	61, 654	10			
		ol	61, 654				

Heal th	Financial Systems		MCDONOUGH DIST	RICT HOSPITAL		In Lie	u of Form CMS	-2552-10
RECLASS	SIFICATIONS			Provi der	CCN: 140089	Peri od:	Worksheet A-	6
						From 07/01/2014 To 06/30/2015	Date/Time Pr 11/23/2015 5	epared: :05 pm_
		Decreases						
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref	· .		
	6. 00	7.00	8. 00	9. 00	10. 00			
	S - RECLASS RHC EXPENSES							
1.00	MMG-PHYSICIAN_OFFICES	194. 12	36 <u>7, 6</u> 75	60, 889		0		1. 00
	0		367, 675	60, 889				
	T - RECLASS EMPLOYEE VACCINES	S						
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	15, 312		0		1. 00
	0		0	15, 312		7		
	U - RECLASS PNEUMOCOCCAL VACO	CINE						
1.00	PHARMACY	15. 00	0	59, 711		0		1. 00
2.00		0.00	0	0		0		2. 00
	0			59, 711		7		
500.00	Grand Total: Decreases		3, 073, 344	2, 281, 423				500.00
	•				'			•

			T	o 06/30/2015	Date/Time Pre 11/23/2015 5:	
			Acqui si ti ons			
	Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
	Bal ances				Retirements	
	1.00	2. 00	3.00	4. 00	5. 00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1. 00 Land	0	0	C	0	0	1. 00
2.00 Land Improvements	0	0	C	0	0	2. 00
3.00 Buildings and Fixtures	0	0	C	0	0	3. 00
4.00 Building Improvements	0	0	C	0	0	4. 00
5.00 Fixed Equipment	0	0	C	0	0	5. 00
6.00 Movable Equipment	0	0	C	0	0	6. 00
7.00 HIT designated Assets	0	0	C	0	0	7. 00
8.00 Subtotal (sum of lines 1-7)	0	0	C	0	0	8. 00
9.00 Reconciling Items	0	0	C	0	0	9. 00
10.00 Total (line 8 minus line 9)	0	0	C	0	0	10. 00
	Endi ng Bal ance	Fully				
		Depreci ated				
		Assets				
	6.00	7. 00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1. 00 Land	0	0				1. 00
2.00 Land Improvements	0	0				2. 00
3.00 Buildings and Fixtures	0	0				3. 00
4.00 Building Improvements	0	0				4. 00
5.00 Fixed Equipment	0	0				5. 00
6.00 Movable Equipment	0	0				6. 00
7.00 HIT designated Assets	0	0				7. 00
8.00 Subtotal (sum of lines 1-7)	0	0				8. 00
9.00 Reconciling Items	0	0				9. 00
10.00 Total (line 8 minus line 9)	0	0				10. 00

Health Financial Systems MCDONOUGH DISTRICT HOSPITAL In Lieu of Form CMS-2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140089 | Period: From 07/01/2014 To 06/30/2015 | Period: From 07/01/20

					10		Date/IIme Prep 11/23/2015 5:0	oared: 05 pm
			Sl	JMMARY OF CAP	I TA			•
	Cost Center Description	Depreciation	Lease	Interest	I	nsurance (see	Taxes (see	
					j	instructions) ii		
		9. 00	10. 00	11. 00		12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	IN 2, LINES 1 a	ind 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0)	0	0	0	1. 00
1. 01	CAP REL COSTS-HOSPITAL	3, 391, 518	0)	0	0	0	1. 01
1. 02	CAP REL COSTS-HSB I	236, 391	0)	0	0	0	1. 02
1.03	CAP REL COSTS-HSB II	323, 335	0)	0	0	0	1. 03
1.04	CAP REL COSTS-REHAB CNT	0	0)	0	0	0	1. 04
1. 05	CAP REL COSTS-DI AYSI S	42	0)	0	0	0	1. 05
1.06	CAP REL COSTS-HOSPITALITY HOUSE	12, 626)	0	0	0	1. 06
1.07	CAP REL COSTS-MAB	80, 665	0)	0	0	0	1. 07
1.08	CAP REL COSTS-ORTHO BLDG	53, 321	0)	0	0	0	1. 08
1. 09	CAP REL COSTS-CONVENIENCE CARE CLINI	0	0)	0	0	0	1. 09
1. 10	CAP REL COSTS-BUSHNELL OFFICE BLDG	74, 260	0)	0	0	0	1. 10
3.00	Total (sum of lines 1-2)	4, 172, 158)	0	0	0	3. 00
		SUMMARY 0	F CAPITAL					
	Cost Center Description		Total (1) (sum	1				
		Capi tal -Relate						
		d Costs (see	through 14)					
		instructions)		1				
		14. 00	15.00	L				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	1				1.00
1. 01	CAP REL COSTS-HOSPI TAL	0	3, 391, 518	•				1. 01
1. 02	CAP REL COSTS-HSB I	0	236, 391	•				1. 02
1.03	CAP REL COSTS-HSB II	0	323, 335	<u> </u>				1. 03
1. 04	CAP REL COSTS-REHAB CNT	0	0)				1. 04
1. 05	CAP REL COSTS-DI AYSI S	0	42	1				1. 05
1.06	CAP REL COSTS-HOSPITALITY HOUSE	0	12, 626					1. 06
1. 07	CAP REL COSTS-MAB	0	80, 665	•				1. 07
1. 08	CAP REL COSTS-ORTHO BLDG	0	53, 321	1				1. 08
1. 09	CAP REL COSTS-CONVENIENCE CARE CLINI	0	0	1				1. 09
1. 10	CAP REL COSTS-BUSHNELL OFFICE BLDG	0	74, 260	•				1. 10
3.00	Total (sum of lines 1-2)	0	4, 172, 158	3				3. 00

Heal th	Financial Systems	MCDONOUGH DISTI	RICT HOSPITAL		In Lie	u of Form CMS-2	2552-10
	CILIATION OF CAPITAL COSTS CENTERS		Provi der	F	Period: From 07/01/2014 To 06/30/2015	Worksheet A-7 Part III	nared·
		COMI	PUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPITAL	оз рііі
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col.	Ratio (see instructions)	Insurance	
		1.00		2)	4.00		
	DART III DECONCILIATION OF CARLTAL COCTO	1.00	2. 00	3. 00	4. 00	5. 00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS (NEW CAP REL COSTS-BLDG & FIXT	LENIERS 0) (0. 000000	0	1.00
1.00	CAP REL COSTS-HOSPITAL	63, 762, 665				0	1.00
1. 01	CAP REL COSTS-HOSFITAL	6, 064, 949		,,		0	1. 01
1. 02	CAP REL COSTS-HSB II	7, 380, 115				0	1. 02
1. 04	CAP REL COSTS-REHAB CNT	249, 443		249, 443		0	1. 04
1. 05	CAP REL COSTS-DI AYSI S	1, 518		1, 518		0	1. 05
1.06	CAP REL COSTS-HOSPITALITY HOUSE	276, 688		276, 688		0	1. 06
1.07	CAP REL COSTS-MAB	1, 106, 836		1, 106, 836		0	1. 07
1.08	CAP REL COSTS-ORTHO BLDG	777, 092	0	777, 092	0. 009489	0	1. 08
1.09	CAP REL COSTS-CONVENIENCE CARE CLINI	30, 237	0	30, 237	0. 000369	0	1. 09
1. 10	CAP REL COSTS-BUSHNELL OFFICE BLDG	2, 241, 004		2, 241, 004	0. 027366	0	1. 10
3.00	Total (sum of lines 1-2)	81, 890, 547	0	81, 890, 547	0. 000000	0	3. 00
			TION OF OTHER (CAPI TAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
	·		Capi tal -Rel ate	cols. 5	·		
		4.00	d Costs 7.00	through 7) 8.00	9. 00	10. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS (6.00 ENTERS	7.00	0.00	9.00	10.00	
1.00	NEW CAP REL COSTS-BLDG & FIXT	0) (0	0	1.00
1. 01	CAP REL COSTS-HOSPITAL	o o				125, 003	1. 01
1.02	CAP REL COSTS-HSB I	0				0	1. 02
1.03	CAP REL COSTS-HSB II	0	l c) c	323, 335	0	1. 03
1.04	CAP REL COSTS-REHAB CNT	0	0) c	0	45, 975	1. 04
1.05	CAP REL COSTS-DI AYSI S	0	0) c	0	0	1. 05
1.06	CAP REL COSTS-HOSPITALITY HOUSE	0	0) c	12, 626	0	1. 06
1.07	CAP REL COSTS-MAB	0	0) c	80, 665	0	1. 07
1.08	CAP REL COSTS-ORTHO BLDG	0	0) c	53, 321	5, 081	1. 08
1.09	CAP REL COSTS-CONVENIENCE CARE CLINI	0	0) C	3, 374	28, 800	1. 09
1. 10	CAP REL COSTS-BUSHNELL OFFICE BLDG	0	0) c	74, 260	4, 310	1. 10
3.00	Total (sum of lines 1-2)	0	C) C	4, 217, 884	209, 169	3. 00
			Sl	JMMARY OF CAPIT	ΓAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
	'				Capi tal -Rel ate		
					d Costs (see	through 14)	
					instructions)		
		11. 00	12.00	13. 00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS (_	_	_			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0					1.00
1.01	CAP REL COSTS-HOSPITAL	0				3, 687, 958	1.01
1.02	CAP REL COSTS-HSB I	0				249, 552	1.02
1.03	CAP REL COSTS DELIAR CNT	0			1	332, 364	1.03
1.04	CAP REL COSTS PLAYELS	0	1			45, 975	1.04
1.05	CAP REL COSTS-DI AYSI S CAP REL COSTS-HOSPI TALI TY HOUSE	0 0	-	1		12.002	1.05
1. 06 1. 07	CAP REL COSTS-HOSPITALITY HOUSE CAP REL COSTS-MAB			1		13, 083	1. 06 1. 07
1.07	CAP REL COSTS-MAB		1, 216 2, 194			81, 881 60, 596	1. 07
1.08	CAP REL COSTS-ORTHO BLDG CAP REL COSTS-CONVENIENCE CARE CLINI				-	32, 654	1. 08
1. 10	CAP REL COSTS-CONVENTENCE CARE CLINI CAP REL COSTS-BUSHNELL OFFICE BLDG	0	•	•		80, 570	1. 10
3.00	Total (sum of lines 1-2)	0					
5.00	1.2.2. (34 5. 1.1.35 . 2)	1	107,000	1	۱ ۷	., 551, 555	. 0.00

Peri od: From 07/01/2014 Provider CCN: 140089

				T	rom 07/01/2014 o 06/30/2015		
				Expense Classification on	Worksheet A	11/23/2015 5:	05 pm
	To/From Which the Amount is to be Adjuste						
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
1.00	Investment income - NEW CAP	1. 00	2.00	3.00 NEW CAP REL COSTS-BLDG &	4. 00	5. 00	1. 00
1.00	REL COSTS-BLDG & FIXT (chapter		C	FIXT	1.00	0	1.00
1. 01	2) Investment income - CAP REL			CAP REL COSTS-HOSPITAL	1. 01	0	1. 01
1.01	COSTS-HOSPITAL (chapter 2)			CAP REL COSTS-HOSPITAL	1.01	0	1.01
1. 02	Investment income - CAP REL COSTS-HSB I (chapter 2)		C	CAP REL COSTS-HSB I	1. 02	0	1. 02
1.03	Investment income - CAP REL		C	CAP REL COSTS-HSB II	1.03	0	1. 03
1. 04	COSTS-HSB II (chapter 2) Investment income - CAP REL		C	CAP REL COSTS-REHAB CNT	1. 04	0	1. 04
	COSTS-REHAB CNT (chapter 2)						
1. 05	Investment income - CAP REL COSTS-DIAYSIS (chapter 2)		C	CAP REL COSTS-DIAYSIS	1.05	0	1. 05
1.06	Investment income - CAP REL		C	CAP REL COSTS-HOSPI TALI TY	1. 06	0	1. 06
	COSTS-HOSPITALITY HOUSE (chapter 2)			HOUSE			
1. 07	Investment income - CAP REL		C	CAP REL COSTS-MAB	1. 07	0	1. 07
1. 08	COSTS-MAB (chapter 2) Investment income - CAP REL		C	CAP REL COSTS-ORTHO BLDG	1. 08	0	1. 08
1. 09	COSTS-ORTHO BLDG (chapter 2)			CAD DEL COSTS CONVENIENCE	1. 09	0	1. 09
1.09	Investment income - CAP REL COSTS-CONVENIENCE CARE CLINI			CAP REL COSTS-CONVENIENCE CARE CLINI	1.09	0	1.09
1. 10	(chapter 2) Investment income - CAP REL		C	CAP REL COSTS-BUSHNELL	1. 10	0	1. 10
1. 10	COSTS-BUSHNELL OFFICE BLDG			OFFI CE BLDG	1. 10		1. 10
2. 00	(chapter 2) Investment income - CAP REL		C) *** Cost Center Deleted ***	2. 00	0	2. 00
	COSTS-MVBLE EQUIP (chapter 2)						
3. 00	Investment income - other (chapter 2)	Α	-16, 854	INTEREST EXPENSE	113. 00	0	3. 00
4.00	Trade, quantity, and time		C		0. 00	0	4. 00
5.00	discounts (chapter 8) Refunds and rebates of	В	-79, 851	ADMINISTRATIVE & GENERAL	5. 00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		(0.00	0	6. 00
	suppliers (chapter 8)		_			_	
7. 00	Telephone services (pay stations excluded) (chapter	A	-213	CAP REL COSTS-HOSPITAL	1.01	9	7. 00
	21)	_				_	
8. 00	Television and radio service (chapter 21)	Α	-7, 023	CAP REL COSTS-HOSPITAL	1.01	9	8. 00
9.00	Parking Lot (chapter 21)	4.0.0	2 222 700	p e e e e e e e e e e e e e e e e e e e	0. 00	0	
10. 00	Provider-based physician adjustment	A-8-2	-2, 223, 788	3		0	10. 00
11. 00	Sale of scrap, waste, etc. (chapter 23)	В	-22, 162	CAP REL COSTS-HOSPITAL	1. 01	9	11. 00
12. 00	Related organization	A-8-1	C			0	12. 00
13. 00	transactions (chapter 10) Laundry and linen service		ſ		0.00	0	13. 00
14. 00	Cafeteria-employees and guests		-265, 401	CAFETERI A	11. 00	0	14. 00
15. 00	Rental of quarters to employee and others		C		0.00	0	15. 00
16. 00	Sale of medical and surgical	В	-2, 481	MEDICAL SUPPLIES CHARGED TO	71.00	0	16. 00
	supplies to other than patients			PATI ENTS			
17. 00	Sale of drugs to other than patients		C		0.00	0	17. 00
18. 00	Sale of medical records and	В	-10, 620	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	abstracts Nursing school (tuition, fees,	В	_110	PARAMED ED PRGM	23. 00	0	19. 00
	books, etc.)		-110	T			
20. 00 21. 00	Vending machines Income from imposition of	В	-187. 295) ADMINISTRATIVE & GENERAL	0. 00 5. 00	0	
	interest, finance or penalty		2.7=79				
22. 00	charges (chapter 21) Interest expense on Medicare		C		0.00	0	22. 00
	overpayments and borrowings to						
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	C	RESPIRATORY THERAPY	65.00		23. 00
	therapy costs in excess of limitation (chapter 14)						
	1 tation (onaptor 14)	ı l		1	<u> </u>	<u> </u>	<u> </u>

| Period: | Worksheet A-8 | From 07/01/2014 | To 06/30/2015 | Date/Time Prepared: Provider CCN: 140089

				To	06/30/2015	Date/Time Prep 11/23/2015 5:0	
	,			Expense Classification on		11/23/2015 5.	JS PIII
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
24. 00	Adjustment for physical	1.00 A-8-3	2.00	3.00 PHYSI CAL THERAPY	4. 00 66. 00	5. 00	24. 00
	therapy costs in excess of						
25. 00	limitation (chapter 14) Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00
	physicians' compensation						
26. 00	(chapter 21) Depreciation - NEW CAP REL		0	NEW CAP REL COSTS-BLDG &	1. 00	0	26. 00
26. 01	COSTS-BLDG & FIXT Depreciation - CAP REL		0	FIXT CAP REL COSTS-HOSPITAL	1. 01	0	26. 01
20.01	COSTS-HOSPI TAL		O	CAP REE COSTS-HOSFITAL	1.01		20.01
26. 02	Depreciation - CAP REL COSTS-HSB I		0	CAP REL COSTS-HSB I	1. 02	0	26. 02
26. 03	Depreciation - CAP REL		0	CAP REL COSTS-HSB II	1. 03	0	26. 03
26. 04	COSTS-HSB II Depreciation - CAP REL		0	CAP REL COSTS-REHAB CNT	1. 04	0	26. 04
	COSTS-REHAB CNT						
26. 05	Depreciation - CAP REL COSTS-DIAYSIS	A	-42	CAP REL COSTS-DIAYSIS	1. 05	9	26. 05
26. 06	Depreciation - CAP REL COSTS-HOSPITALITY HOUSE		0	CAP REL COSTS-HOSPITALITY HOUSE	1. 06	0	26. 06
26. 07	Depreciation - CAP REL		0	CAP REL COSTS-MAB	1. 07	0	26. 07
26. 08	COSTS-MAB Depreciation - CAP REL		0	CAP REL COSTS-ORTHO BLDG	1. 08	0	26. 08
	COSTS-ORTHO BLDG						
26. 09	Depreciation - CAP REL COSTS-CONVENIENCE CARE CLINI		0	CAP REL COSTS-CONVENIENCE CARE CLINI	1. 09	0	26. 09
26. 10	Depreciation - CAP REL			CAP REL COSTS-BUSHNELL	1. 10	0	26. 10
27. 00	COSTS-BUSHNELL OFFICE BLDG Depreciation - CAP REL			OFFICE BLDG *** Cost Center Deleted ***	2. 00	0	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist	Α	-1 099 286	NONPHYSICIAN ANESTHETISTS	19. 00		28. 00
29. 00	Physicians' assistant		0		0.00	0	29. 00
30. 00	Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30. 00
20.00	limitation (chapter 14)			ADULTS A DEDLATRICE	22.00		20.00
30. 99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
	limitation (chapter 14)						
32. 00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32. 00
33. 00	COUNTRY CLUB DUES	A		ADMINISTRATIVE & GENERAL	5. 00	0	
33. 01 33. 02	TELEPHONE LEASE	A	-1, 022 0	CAP REL COSTS-HOSPITAL	1. 01 0. 00	10 0	33. 01 33. 02
33. 03			0		0. 00	0	33. 03
33. 04 33. 05	TELEPHONE SERVICE OTHER ADJUSTMENTS (SPECIFY)	A	-42 0	CAP REL COSTS-HOSPITAL	1. 01 0. 00	9	33. 04 33. 05
	(3)		· ·				
33. 06	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0. 00	0	33. 06
33. 07	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	33. 07
33. 08	(3) OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 08
33. 09	(3) OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 09
	(3)		0				
34. 00 34. 50	DONATION TO IHREF IHHA/AHA DUES	A A		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5. 00 5. 00	0	34. 00 34. 50
35. 00	CRIMINAL BACKGROUND CHECK	В	· ·	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	35. 00
35. 50	TELEPHONE ANSWERING	В		ADMINISTRATIVE & GENERAL	5. 00	0	35. 50
36. 00 36. 50	RECLAIMED SILVER	B A		RADI OLOGY-DI AGNOSTI C CAP REL COSTS-HOSPI TAL	54. 00 1. 01	0	36. 00 36. 50
36. 50	LOSS ON DISPOSAL OF EQUIP DAY HEALTH MEALS	B B		DI ETARY	10.00	9	
38. 00	IDPA PARTICIPANT FEES	A		ADMINISTRATIVE & GENERAL	5. 00	0	38. 00
38. 50	RADIOLOGY BILLING	В		ADMINISTRATIVE & GENERAL	5. 00	0	
39. 00	NUTRITION COUNSELING	В		DI ETARY	10.00	0	39. 00
39. 50 40. 00	AMBULANCE OTHER REVENUE KARE-A-LOT	B B		AMBULANCE SERVICES ADULTS & PEDIATRICS	95. 00 30. 00	0	39. 50 40. 00
	CONSULTI NG-PT/OT	В		PHYSICAL THERAPY	66. 00		
	•	- '		· '	'		

Health Financial Systems	MCDONOUGH DISTRIC	CT HOSPITAL	In Lie	u of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES		Provi der CCN: 140089	Peri od: From 07/01/2014	Worksheet A-8	
			To 06/30/2015	Date/Time Prep 11/23/2015 5:0	
	To	Expense Classification of Expense Classification of Expense Classification of Expense Expense Classification of Expense Cl			

				Expense Classification on			
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	cost center bescription	1.00	2. 00	3.00	4. 00	5. 00	
44.00	TELEBUONE OFFICE OF ALLABASE						11 00
41. 00	TELEPHONE SERVI CES-SALARI ES	A	·	ADMINISTRATIVE & GENERAL	5. 00		
41. 50	SELF INSUR EMPLOYEE HEALTH	A	-3, 299, 328	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	41. 50
	I NSUR EXP						
42.00			0		0.00	0	42.00
42.50	HOSPITALIST RN COVERAGE	A	-2, 843	ADULTS & PEDIATRICS	30.00	0	42. 50
43.00			0		0.00	0	43.00
43.50	CRNA EMPLOYEE BENEFITS	l A	-130, 179	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	43. 50
44.00	PHYSICIAN PART B EMPLOYEE	l A 1	-224, 135	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	44.00
	BENEFITS		,,				
44. 01	ADVERTI SI NG	A	-254, 247	ADMINISTRATIVE & GENERAL	5. 00	0	44. 01
44.03	NSF FEE	В	-25	ADMINISTRATIVE & GENERAL	5. 00	0	44. 03
44. 05			0		0.00		44. 05
44. 06	NON-ALLOWABLE PROPERTY TAX	l A	-93 961	OTHER CAPITAL RELATED COSTS	3. 00		44. 06
44. 07	Non Allegande Fried Entre 1700		70, 701	omen on the needings soons	0.00		44. 07
45. 00			0		0.00		45. 00
50.00	TOTAL (sum of lines 1 thru 49)		-8, 096, 892		0.00		50.00
50.00			-0, 090, 692				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

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

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

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

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT | Peri od: | Worksheet A-8-2 | From 07/01/2014 | To 06/30/2015 | Date/Time Prepared: Provider CCN: 140089

						To 06/30/2015	Date/Time Pre 11/23/2015 5:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2.00	3.00	4. 00	5. 00	6. 00	7. 00	
1. 00	60.00	LABORATORY	907, 503	607, 120	300, 383	208, 000	2, 063	1. 00
2.00	53.00	ANESTHESI OLOGY	396, 420	396, 420	0	0	0	2. 00
3.00	91.00	EMERGENCY	332, 964	332, 964	0	0	0	3. 00
4.00	30.00	ADULTS & PEDIATRICS	802, 692	802, 692	0	0	0	4. 00
5.00	0.00			0	0	0	0	5. 00
6.00	0.00			0	0	0	0	6. 00
7.00	0.00			0	0	0	0	7. 00
8.00	0.00			0	0	0	0	8. 00
9.00	0.00			0	0	0	0	9. 00
10.00	0.00		l	0	0	0	0	10. 00
200.00			2, 439, 579	2, 139, 196	300, 383		2, 063	200. 00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE	Memberships &	Component	of Mal practice	
				Limit	Continuing	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8.00	9. 00	12. 00	13.00	14.00	
1.00		LABORATORY	206, 300	10, 315		4, 767	14, 271	1. 00
2.00		ANESTHESI OLOGY	0	0	2, 400	0	11, 495	2. 00
3.00		EMERGENCY	0	0	-,	0	23, 066	3. 00
4.00		ADULTS & PEDIATRICS	0	0	3, 734	0	11, 685	
5.00	0. 00		0	0	0	0	0	5. 00
6.00	0.00		0	0	0	0	0	6. 00
7. 00	0. 00		0	0	0	0	0	7. 00
8. 00	0. 00		0	0	0	0	0	8. 00
9. 00	0. 00		0	0	0	0	0	9. 00
10. 00	0. 00		0	0	0	0	0	1
200.00			206, 300			4, 767	60, 517	200. 00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		ldenti fi er	Component	Li mi t	Di sal I owance			
			Share of col.					
	1. 00	2.00	14 15. 00	16. 00	17. 00	18. 00		
1. 00		LABORATORY	4, 724	215, 791	84, 592	691, 712		1. 00
2. 00		ANESTHESI OLOGY	4,724	213, 791	04, 372	396, 420		2. 00
3.00		EMERGENCY		0	_	332, 964		3. 00
4. 00		ADULTS & PEDIATRICS			0	802, 692		4. 00
5.00	0.00				0	002, 092		5. 00
6.00	0.00					0		6. 00
7. 00	0.00				0	0		7. 00
8.00	0.00					0		8. 00
9. 00	0.00					0		9. 00
10.00	0.00					0		10.00
200.00	0.00		4, 724	215, 791	84, 592			200. 00
200.00	I	I	1 4,724	1 215, 791	04, 392	۷, ۷۷۵, ۱۵۵	l l	200.00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 07/01/2014 Part I
To 06/30/2015 Date/Time Prepared:
11/23/2015 5:05 pm

				10		11/23/2015 5:	
				CAPI TAL REL	ATED COSTS		
	Cost Center Description	Net Expenses	NEW BLDG &	CAP REL	CAP REL	CAP REL	
		for Cost	FIXT	COSTS-HOSPI TAL	COSTS-HSB I	COSTS-HSB II	
		Allocation (from Wkst A					
		col. 7)					
	GENERAL SERVICE COST CENTERS	0	1.00	1. 01	1. 02	1. 03	
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT	0	C				1.00
1.01	00101 CAP REL COSTS-HOSPI TAL	3, 687, 958	C	3, 687, 958			1. 01
1.02	00102 CAP REL COSTS-HSB I	249, 552	C		249, 552	222 244	1. 02
1. 03 1. 04	00103 CAP REL COSTS-HSB II 00104 CAP REL COSTS-REHAB CNT	332, 364 45, 975	C	1	0	332, 364 0	1. 03 1. 04
1. 05	00105 CAP REL COSTS-DI AYSI S	0	C	O	Ō	0	1. 05
1.06	00106 CAP REL COSTS-HOSPI TALITY HOUSE	13, 083	C	0	0	0	1.06
1. 07 1. 08	00107 CAP REL COSTS-MAB 00108 CAP REL COSTS-ORTHO BLDG	81, 881 60, 596	C		0	0	1. 07 1. 08
1. 09	00109 CAP REL COSTS-CONVENIENCE CARE CLINI	32, 654	C	o o	Ö	0	1. 09
1. 10	00110 CAP REL COSTS-BUSHNELL OFFICE BLDG	80, 570	C	1	0	0	1. 10
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	7, 320, 385 7, 287, 064	C		73, 856	0 128, 914	4. 00 5. 00
6. 00	00600 MAI NTENANCE & REPAI RS	1, 728, 831	C	1 .,,	73,030	0	6. 00
6. 01	00601 MAINTENANCE & REPAIRS-HSB I	151, 178	C	0	8, 715	0	6. 01
6. 02 6. 03	00602 MAINTENANCE & REPAIRS-HSB II 00603 MAINTENANCE & REPAIRS-REHAB CLINIC	104, 816 7, 049	C		0	49, 660 0	6. 02 6. 03
6. 04	00604 MAI NTENANCE & REPAI RS-MAB	18, 680	C	1	o	0	•
6.05	00605 MAINTENANCE & REPAIRS-ORTHO BLDG	12, 690	C	1	O	0	•
6. 06 8. 00	00606 MAI NTENANCE & REPAI RS-BUSHNELL 00800 LAUNDRY & LI NEN SERVI CE	24, 621 295, 479	C	1	0	0	6. 06 8. 00
9. 00	00900 HOUSEKEEPING	736, 172	C		0	0	9. 00
9. 01	00901 HOUSEKEEPI NG-HSB	120, 868	C	0	0	0	9. 01
9. 02 9. 03	00902 HOUSEKEEPI NG-HSB 11 00903 HOUSEKEEPI NG-ORTHO	65, 689 9, 601	C	0	0	0	9. 02 9. 03
9. 04	00904 HOUSEKEEPI NG-MAB	6, 441	C		0	0	
10.00	01000 DI ETARY	649, 035	C	1, 1	0	0	10. 00
11. 00 13. 00	O1100 CAFETERI A O1300 NURSI NG ADMI NI STRATI ON	384, 111 547, 290	C		0	0	11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	441, 986	C		0	0	14. 00
15. 00	01500 PHARMACY	2, 393, 156	C	33, 672	0	0	15. 00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	967, 523 442, 527	C	82, 527 9, 905	0	0	16. 00 17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	C		o	0	19. 00
23. 00	02300 PARAMED ED PRGM	30, 087	C	5, 515	0	0	23. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	2, 769, 587	C	586, 250	o	0	30.00
31. 00	03100 INTENSIVE CARE UNIT	751, 255	C	93, 729	o	0	31. 00
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY	355, 395 0	C		0	0	43. 00 44. 00
44.00	ANCI LLARY SERVICE COST CENTERS) U		η <u>Ο</u>	<u> </u>	0	44.00
	05000 OPERATING ROOM	1, 811, 119	C		0	0	
51. 00 52. 00	O5100 RECOVERY ROOM O5200 DELIVERY ROOM & LABOR ROOM	738, 868 326, 264	C		0	0	
53. 00	05300 ANESTHESI OLOGY	147, 298	C		o	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 433, 757	C	1,	0	0	54. 00
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	660, 120 524, 528	C	1 .,	0	0	57. 00 58. 00
60.00	06000 LABORATORY	3, 904, 907	C	1	Ö	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	43, 976	C	1	0	0	63.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	339, 301 1, 691, 068	C		0	0	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	C	1	o	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	140, 252	C	7 0,020	0	0	68. 00
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	264, 384 198, 901	C	1 -,1	0	0	69. 00 70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	454, 311	C	0	o	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	1, 123, 472	C	1 1	0	0	72.00
73. 00 76. 00	07300 DRUGS CHARGED TO PATIENTS 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0 580, 786	C	ή "Ι	0 13, 462	0	73. 00 76. 00
76. 00	03950 DI ABETES/WOUND CARE/COUMADI N CNTR	516, 790	C	1	13, 402	0	•
76. 02	03951 FLU CLINIC	19, 764	C		0	0	76. 02
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	456, 507	C	ol ol	ol	0	88. 00
91. 00	09100 EMERGENCY	3, 308, 288	C	1	Ö	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
95. 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	846, 849	C	29, 196	0	0	95. 00
					-1		·

HOSPITAL In Lieu of Form CMS-2552-10
Provider CCN: 140089 | Period: | Worksheet B | From 07/01/2014 | Part I

			To	o 06/30/2015		pared:
			CAPI TAL REI	ATED COCTO	11/23/2015 5:	U5 pm
			CAPITAL REI	LATED COSTS		
Cost Center Description	Net Expenses	NEW BLDG &	CAP REL	CAP REL	CAP REL	
	for Cost	FLXT	COSTS-HOSPI TAL	COSTS-HSB I	COSTS-HSB II	
	Allocation					
	(from Wkst A					
	col. 7)					
	0	1. 00	1. 01	1. 02	1. 03	
101.00 10100 HOME HEALTH AGENCY	1, 201, 654		0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	1, 080, 542	C	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	54, 019, 855		3, 674, 355	96, 033	178, 574	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C	10, 900	0		190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	C	0	116, 283		192. 00
194. 00 07950 DAY HEALTH	161, 975	C	0	13, 184		194. 00
194. 01 07962 OUTREACH	188, 286	C	0	1, 922		194. 01
194. 02 07951 OCCUPATI ONAL MEDI CI NE	0	C	0	0		194. 02
194. 03 07952 FUND DEVELOPMENT	193, 381	C	2, 703	0		194. 03
194. 04 07953 OUTSI DE LAUNDRY	0	C	0	0		194. 04
194. 05 07954 PHYSI CI AN SUPPORT	679, 196	C	0	3, 780		194. 05
194. 06 07955 HOSPI TALI TY HOUSE	24, 698	C	0	0		194. 06
194. 07 07956 HSK DI ALYSI S	11, 361	C	0	0		194. 07
194. 08 07957 LEASED SALARI ES	31, 636	(0	0		194. 08
194. 09 07958 VI SI TI NG PHYSI CI ANS	265	(0	0		194. 09
194. 10 07959 FARM LAND	0	(0	0		194. 10
194. 11 07963 CONVENI ENCE CARE CLI NI C	363, 405	(0	0		194. 11
194. 12 07960 MMG-PHYSICIAN OFFICES	7, 462, 655	(0	18, 350		
194. 13 07961 VALET PARKING SERVICE	18, 252	C	0	0	0	194. 13
200.00 Cross Foot Adjustments		_		_	_	200. 00
201.00 Negative Cost Centers	/0.454.045	C	0	0		201. 00
202.00 TOTAL (sum lines 118-201)	63, 154, 965	C	3, 687, 958	249, 552	332, 364	J202. 00

		CAPI	TAL RELATED CO	STS	11/23/2015 5:	05 pm
Cost Center Description	CAP REL	CAP REL	CAP REL	CAP REL	CAP REL	
	COSTS-REHAB CNT	COSTS-DI AYSI S	COSTS-HOSPITAL ITY HOUSE	COSTS-MAB	COSTS-ORTHO BLDG	
	1. 04	1. 05	1.06	1. 07	1. 08	
GENERAL SERVICE COST CENTERS 1. 00 00100 NEW CAP REL COSTS-BLDG & FIXT		1				1.00
1. 01 00100 New CAP REL COSTS-BLDG & FIXT						1. 00
1.02 00102 CAP REL COSTS-HSB						1. 02
1.03 00103 CAP REL COSTS-HSB I	45.075					1.03
1. 04 00104 CAP REL COSTS-REHAB CNT 1. 05 00105 CAP REL COSTS-DIAYSIS	45, 975					1. 04 1. 05
1.06 00106 CAP REL COSTS-HOSPITALITY HOUSE	d	o	13, 083			1. 06
1.07 00107 CAP REL COSTS-MAB 1.08 00108 CAP REL COSTS-ORTHO BLDG	C	0	0	81, 881	(0.50/	1. 07
1. 08 00108 CAP REL COSTS-ORTHO BLDG 1. 09 00109 CAP REL COSTS-CONVENIENCE CARE CLINI			0	0	60, 596 0	1. 08 1. 09
1.10 OO110 CAP REL COSTS-BUSHNELL OFFICE BLDG	C	0	0	0	0	1. 10
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	C	0	0	0	30, 298	4.00
5. 00 00500 ADMINISTRATIVE & GENERAL 6. 00 00600 MAINTENANCE & REPAIRS			0	0	0	5. 00 6. 00
6.01 00601 MAINTENANCE & REPAIRS-HSB I		o	0	0	0	6. 01
6. 02 00602 MAINTENANCE & REPAIRS-HSB II	C	0	0	0	0	6. 02
6. 03 00603 MAI NTENANCE & REPAI RS-REHAB CLINI C 6. 04 00604 MAI NTENANCE & REPAI RS-MAB			0	0	0	
6. 05 00605 MAINTENANCE & REPAIRS-ORTHO BLDG	d		0	0	0	6. 05
6. 06 00606 MAI NTENANCE & REPAI RS-BUSHNELL	C	0	0	0	0	6. 06
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG			0	0	0	8. 00 9. 00
9. 01 00901 HOUSEKEEPI NG-HSB		o o	0	0	0	9. 01
9. 02 00902 HOUSEKEEPING-HSB II	C	0	0	0	0	
9. 03 00903 HOUSEKEEPI NG-ORTHO 9. 04 00904 HOUSEKEEPI NG-MAB			0	0	0	
10. 00 01000 DI ETARY		o o	0	0	0	
11. 00 01100 CAFETERI A	C	0	0	0	0	11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY			0	0	0	13.00
15. 00 01500 PHARMACY		o o	0	0	0	15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	C	0	0	0	0	16. 00
17. 00 01700 SOCIAL SERVICE 19. 00 01900 NONPHYSICIAN ANESTHETISTS			0	0	0	17. 00 19. 00
23. 00 02300 PARAMED ED PRGM		1	0	0	0	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS	1					
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 NTENSIVE CARE UNIT		0	0	0	0	30.00
43. 00 04300 NURSERY		o	0	0	0	43. 00
44. 00 04400 SKILLED NURSING FACILITY		0	0	0	0	44. 00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM			0	0	0	50.00
51. 00 05100 RECOVERY ROOM		1	0	0	0	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	C	0	0	0	0	52.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C			0	0	0	53. 00 54. 00
57. 00 05700 CT SCAN		o o	0	0	0	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	C	0	0	0	0	58. 00
60. 00 06000 LABORATORY 63. 00 06300 BLOOD STORING, PROCESSING & TRANS.			0	0	0	60.00
65. 00 06500 RESPI RATORY THERAPY		o o	0	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	45, 975	0	0	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY			0	0	0	67. 00 68. 00
69. 00 06900 ELECTROCARDI OLOGY		o o	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	C	0	0	0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT			0	0	0	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS			0	0	0	73. 00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	C		0	0	0	76. 00
76. 01 03950 DI ABETES/WOUND CARE/COUMADIN CNTR 76. 02 03951 FLU CLINIC			0	0	0	76. 01 76. 02
OUTPATIENT SERVICE COST CENTERS		, 0	U	0	0	70.02
88. 00 08800 RURAL HEALTH CLINIC	C	1	0	0	0	
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	C		0	0	0	91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS						72.00
95. 00 09500 AMBULANCE SERVICES	C		0	0	0	
101.00 10100 HOME HEALTH AGENCY	(C	0	0	18, 722	0	101. 00

			To	06/30/2015	Date/Time Pre 11/23/2015 5:	
		CAP	ITAL RELATED CO	STS	1172072010 0.	J Pili
Cost Center Description	CAP REL	CAP REL	CAP REL	CAP REL	CAP REL	
	COSTS-REHAB	COSTS-DI AYSI S	COSTS-HOSPI TAL	COSTS-MAB	COSTS-ORTHO	
	CNT		ITY HOUSE		BLDG	
	1. 04	1. 05	1.06	1. 07	1. 08	
SPECIAL PURPOSE COST CENTERS	T T		1	ı		
113. 00 11300 INTEREST EXPENSE		•		44 074		113.00
116. 00 11600 HOSPI CE	45.075	0	0	11, 374		116.00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	45, 975	0	0	30, 096	30, 298	118. 00
NONREI MBURSABLE COST CENTERS				٥		190. 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	51, 785		190.00
194. 00 07950 DAY HEALTH	0	0		31, 763		194. 00
194. 01 07962 OUTREACH	0	0		0		194. 00
194. 02 07951 OCCUPATI ONAL MEDI CI NE		0		0		194. 02
194. 03 07952 FUND DEVELOPMENT	0	0		0		194. 02
194. 04 07953 OUTSI DE LAUNDRY	0	0	0	0		194. 04
194. 05 07954 PHYSI CI AN SUPPORT	0	0	o o	0		194. 05
194. 06 07955 HOSPI TALI TY HOUSE	0	0	13, 083	o		194. 06
194. 07 07956 HSK DI ALYSI S	0	0	0	o		194. 07
194. 08 07957 LEASED SALARIES	0	0	0	o		194. 08
194. 09 07958 VISITING PHYSICIANS	0	0	0	O	0	194. 09
194.10 07959 FARM LAND	0	0	0	0	0	194. 10
194. 11 07963 CONVENI ENCE CARE CLI NI C	0	0	0	0	0	194. 11
194.12 07960 MMG-PHYSICIAN OFFICES	O	0	0	0	30, 298	194. 12
194.13 07961 VALET PARKING SERVICE	0	0	0	O	0	194. 13
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201. 00
202.00 TOTAL (sum lines 118-201)	45, 975	0	13, 083	81, 881	60, 596	202. 00

| Period: | Worksheet B | From 07/01/2014 | Part I | Date/Time Prepared: | 11/23/2015 5: 05 pm Provider CCN: 140089

			0.00.7.1.00	ATER COOTS			11/23/2015 5:	05 pm
			CAPITAL REI	LATED COSTS				
		Cost Center Description	CONVENI ENCE	BUSHNELL	EMPLOYEE	Subtotal	ADMI NI STRATI VE	
			CARE CLINI	OFFICE BLDG	BENEFITS		& GENERAL	
			1. 09	1. 10	DEPARTMENT 4.00	4A	5. 00	
		AL SERVICE COST CENTERS						
1.00		NEW CAP REL COSTS-BLDG & FIXT						1.00
1. 01 1. 02		CAP REL COSTS-HOSPI TAL CAP REL COSTS-HSB I						1. 01 1. 02
1.03	1	CAP REL COSTS-HSB II						1. 03
1.04	1	CAP REL COSTS-REHAB CNT						1. 04
1.05		CAP REL COSTS-DIAYSIS						1.05
1. 06 1. 07		CAP REL COSTS-HOSPITALITY HOUSE CAP REL COSTS-MAB						1. 06 1. 07
1. 08		CAP REL COSTS-ORTHO BLDG						1. 08
1. 09		CAP REL COSTS-CONVENIENCE CARE CLINI	32, 654					1. 09
1. 10 4. 00		CAP REL COSTS-BUSHNELL OFFICE BLDG EMPLOYEE BENEFITS DEPARTMENT	0	80, 570 0	1			1. 10 4. 00
5. 00	1	ADMINISTRATIVE & GENERAL	0	3, 442	.,,	9, 485, 599	9, 485, 599	5. 00
6.00	1	MAINTENANCE & REPAIRS	0	0		2, 137, 807		6. 00
6. 01		MAINTENANCE & REPAIRS-HSB I	0	0	.,	164, 760		6. 01
6. 02 6. 03	1	MAINTENANCE & REPAIRS-HSB II MAINTENANCE & REPAIRS-REHAB CLINIC	0	0	-, .==	157, 598 7, 049		6. 02 6. 03
6. 04		MAINTENANCE & REPAIRS-REHAB CEINIC	0	0		19, 383		6. 04
6. 05		MAINTENANCE & REPAIRS-ORTHO BLDG	0	0		13, 173		6. 05
6.06		MAINTENANCE & REPAIRS-BUSHNELL	0	0		25, 135		6. 06
8. 00 9. 00		LAUNDRY & LINEN SERVICE HOUSEKEEPING	0	0	,	406, 466 829, 202		8. 00 9. 00
9. 01	1	HOUSEKEEPI NG-HSB	0	0		131, 943		9. 01
9. 02	1	HOUSEKEEPING-HSB II	0	0	1	69, 162		9. 02
9. 03		HOUSEKEEPI NG-ORTHO	0	0		10, 295		9. 03
9. 04 10. 00	1	HOUSEKEEPI NG-MAB DI ETARY	0	0		6, 920 751, 305		9. 04 10. 00
11. 00	1	CAFETERI A	0	0		546, 354		11. 00
13.00	01300	NURSING ADMINISTRATION	0	0		669, 680	118, 360	13. 00
14.00		CENTRAL SERVICES & SUPPLY	0	0		648, 891		14. 00
15. 00 16. 00	1	PHARMACY MEDICAL RECORDS & LIBRARY	0	0		2, 561, 238 1, 213, 751		15. 00 16. 00
17. 00	1	SOCIAL SERVICE	Ö	Ö	1	549, 011	97, 033	
19. 00		NONPHYSICIAN ANESTHETISTS	0	0		0	_	19. 00
23. 00		PARAMED ED PRGM ENT ROUTINE SERVICE COST CENTERS	0	0	6, 658	42, 260	7, 469	23. 00
30. 00		ADULTS & PEDIATRICS	0	0	587, 906	3, 943, 743	697, 021	30. 00
31. 00	03100	INTENSIVE CARE UNIT	0	0	165, 187	1, 010, 171		31. 00
43.00	1	NURSERY	0	0		458, 634		43. 00
44. 00		SKILLED NURSING FACILITY LARY SERVICE COST CENTERS	0	0	0	0	0	44. 00
50. 00		OPERATING ROOM	0	0	271, 487	2, 258, 926	399, 245	50. 00
51.00		RECOVERY ROOM	0			916, 158	161, 923	51. 00
52.00		DELIVERY ROOM & LABOR ROOM	0	1	1	445, 878		
53. 00 54. 00		ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	0	0		154, 218 1, 858, 056		
57. 00		CT SCAN	Ö	Ö		782, 102		57. 00
58. 00	1	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	524, 528		
60. 00 63. 00		LABORATORY BLOOD STORING, PROCESSING & TRANS.	0	0		4, 524, 023 43, 976		60. 00 63. 00
65. 00	1	RESPIRATORY THERAPY	0	0		483, 467		65. 00
66.00	06600	PHYSI CAL THERAPY	0	1, 665	1	2, 213, 345		66. 00
67. 00	1	OCCUPATIONAL THERAPY	0	0	0	175 240	0	67. 00
68. 00 69. 00		SPEECH PATHOLOGY ELECTROCARDIOLOGY	0	0	32, 068 52, 248	175, 348 319, 660		68. 00 69. 00
70. 00	1	ELECTROENCEPHALOGRAPHY	Ö	Ö	46, 061	249, 633		
71. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	454, 311		
72. 00		IMPL. DEV. CHARGED TO PATIENT	0	0	·	1, 123, 472		
73. 00 76. 00		DRUGS CHARGED TO PATIENTS PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	·	726, 302	_	73. 00 76. 00
76. 01	1	DI ABETES/WOUND CARE/COUMADIN CNTR	0	ő		640, 802		
76. 02		FLU CLINIC	0	0	169	19, 933	3, 523	76. 02
88. 00		TIENT SERVICE COST CENTERS RURAL HEALTH CLINIC	0	75, 463	99, 645	631, 615	111, 632	88. 00
91. 00	1	EMERGENCY	0	75, 463	1	3, 687, 004		
92. 00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			1	0		92. 00
05.00		REIMBURSABLE COST CENTERS			17/ 500	1 050 515	10/ 001	05.00
	1	AMBULANCE SERVICES HOME HEALTH AGENCY	0			1, 052, 565 1, 471, 634		
	.,.5100	1		,	201, 200	., ., ., ., ., .,	200, 070	

Peri od: Worksheet B
From 07/01/2014 Part I Provider CCN: 140089

			Т	o 06/30/2015	Date/Time Pre 11/23/2015 5:	
	CAPITAL REL	LATED COSTS				
Cost Center Description	CONVENIENCE CARE CLINI	BUSHNELL OFFICE BLDG	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
	1. 09	1. 10	4. 00	4A	5. 00	
SPECIAL PURPOSE COST CENTERS				1		
113. 00 11300 I NTEREST EXPENSE						113. 00
116. 00 11600 H0SPI CE	0	0	139, 802			
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	80, 570	5, 654, 408	51, 848, 204	7, 487, 209	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	10, 900		190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	168, 068	29, 705	
194. 00 07950 DAY HEALTH	0	0	30, 002	· ·	36, 260	
194. 01 07962 OUTREACH	0	0	36, 584	226, 792	40, 083	
194. 02 07951 OCCUPATI ONAL MEDI CI NE	0	0	0	0		194. 02
194. 03 07952 FUND DEVELOPMENT	0	0	36, 122	232, 206	41, 040	
194. 04 07953 OUTSI DE LAUNDRY	0	0	0	0	-	194. 04
194. 05 07954 PHYSI CI AN SUPPORT	0	0	22, 927	705, 903		
194. 06 07955 HOSPI TALI TY HOUSE	0	0	2, 140			194. 06
194. 07 07956 HSK DI ALYSI S	0	0	1, 171			194. 07
194. 08 07957 LEASED SALARI ES	0	0	7, 371	39, 007	· ·	194. 08
194. 09 07958 VISITING PHYSICIANS	0	0	0	265		194. 09
194. 10 07959 FARM LAND	0	0	0	0		194. 10
194. 11 07963 CONVENI ENCE CARE CLINIC	32, 654	0	67, 283		81, 892	
194. 12 07960 MMG-PHYSI CI AN OFFI CES	0	0	1, 515, 067			
194. 13 07961 VALET PARKING SERVICE	0	U	4, 252	22, 504	3, 9//	194. 13
200.00 Cross Foot Adjustments			_	0	_	200.00
201.00 Negative Cost Centers	22 (54	00 570	0	(2.154.0/5		201. 00
202.00 TOTAL (sum lines 118-201)	32, 654	80, 570	7, 377, 327	63, 154, 965	9, 485, 599	ZUZ. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 07/01/2014 | Part I | To 06/30/2015 | Date/Time Prepared: | 11/23/2015 5:05 pm Provider CCN: 140089

	Cost Center Description	MAI NTENANCE & REPAI RS			MAI NTENANCE & REPAI RS-REHAB	11/23/2015 5: MAI NTENANCE & REPAI RS-MAB	
	JOSEPH OF COOT OFFITTED	6.00	6. 01	6. 02	6. 03	6. 04	
1. 00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT		T .				1.00
1.00	00101 CAP REL COSTS-HOSPITAL						1. 00
1. 02	00102 CAP REL COSTS-HSB I						1. 02
1.03	00103 CAP REL COSTS-HSB II						1. 03
1.04	00104 CAP REL COSTS-REHAB CNT						1. 04
1. 05 1. 06	00105 CAP REL COSTS-DI AYSI S 00106 CAP REL COSTS-HOSPI TALI TY HOUSE						1. 05 1. 06
1.00	00107 CAP REL COSTS-MAB						1.00
1. 08	00108 CAP REL COSTS-ORTHO BLDG						1. 08
1.09	00109 CAP REL COSTS-CONVENIENCE CARE CLINI						1. 09
1. 10	00110 CAP REL COSTS-BUSHNELL OFFICE BLDG						1. 10
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
6. 00	00600 MAINTENANCE & REPAIRS	2, 515, 645					6.00
6. 01	00601 MAI NTENANCE & REPAI RS-HSB I	0		0			6. 01
6.02	00602 MAINTENANCE & REPAIRS-HSB II	0	(0 185, 45			6. 02
6. 03	00603 MAINTENANCE & REPAIRS-REHAB CLINIC	0		0	0 8, 295		6. 03
6. 04 6. 05	00604 MAI NTENANCE & REPAI RS-MAB 00605 MAI NTENANCE & REPAI RS-ORTHO BLDG				0	22, 809 0	1
6.06	00606 MAINTENANCE & REPAIRS-BUSHNELL				0 0	0	
8.00	00800 LAUNDRY & LINEN SERVICE	88, 942		0	0	0	
9.00	00900 HOUSEKEEPI NG	47, 288	(0	0	0	
9. 01	00901 HOUSEKEEPI NG-HSB	0		0	0	0	1
9. 02 9. 03	00902 HOUSEKEEPI NG-HSB I I 00903 HOUSEKEEPI NG-ORTHO				0	0	
9. 04	00904 HOUSEKEEPI NG-MAB				0 0	0	
10.00	01000 DI ETARY	61, 755		0	0 0	0	
11. 00	01100 CAFETERI A	155, 895		0	0	0	
13.00	01300 NURSI NG ADMI NI STRATI ON	1, 380	l .	0	0	0	
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	147, 270			0	0	
16. 00	01600 MEDI CAL RECORDS & LI BRARY	35, 811 87, 769			0 0	0	
17. 00	01700 SOCIAL SERVICE	10, 534		o	0 0	Ö	
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0		-	0	0	1
23. 00	02300 PARAMED ED PRGM	5, 865		0	0 0	0	23. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	623, 491	1	0	0 0	0	30.00
31. 00	03100 I NTENSI VE CARE UNI T	99, 683		1	0 0	1	
43.00	04300 NURSERY	21, 735		0	0	0	43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	(0	0 0	0	44. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	187, 520	ı ,	ol	0 0	0	50.00
51. 00	05100 RECOVERY ROOM	61, 410		1	0 0	0	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	46, 368	l .	0	0 0	Ō	
53.00	05300 ANESTHESI OLOGY	7, 360	l .	0	0	0	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	230, 347	l .	- I	0	0	
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	10, 465	l .	1	0 0	0	
60.00	06000 LABORATORY	209, 049	l '		0 0	0	1
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0		0	0 0	0	1
65. 00	06500 RESPI RATORY THERAPY	83, 583	l .	0	0	0	
66. 00	06600 PHYSI CAL THERAPY	96, 946	(0	0 8, 295	0	1
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	3, 220			0	0	
69. 00	06900 ELECTROCARDI OLOGY	3, 220	l .		0 0	0	
70. 00	07000 ELECTROENCEPHALOGRAPHY	4, 968	l .	o	0 0	Ö	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	0		0	0	0	
73. 00 76. 00	07300 DRUGS CHARGED TO PATI ENTS 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	15, 630		0	0	
76. 00	03950 DI ABETES/WOUND CARE/COUMADI N CNTR	19, 021	15, 650		0 0	0	
76. 02	03951 FLU CLINIC	0		Ö	0 0	Ö	
	OUTPATIENT SERVICE COST CENTERS	1	1				
88. 00	08800 RURAL HEALTH CLINIC	0			0		1
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	119, 233	1	0	0	0	91. 00 92. 00
72. UU	OTHER REIMBURSABLE COST CENTERS			1			72.00
95. 00	09500 AMBULANCE SERVICES	31, 050		0	0 0	0	95. 00
	10100 HOME HEALTH AGENCY	0	l .	0	0 0	5, 215	101. 00
112 0	SPECIAL PURPOSE COST CENTERS						112 00
) 11300 I NTEREST EXPENSE) 11600 HOSPI CE	0	,	0	0 0	3 168	113. 00 116. 00
. 13. 00		1	<u>'</u>	-1	-1 0	J, 100	1 3. 30

				rom 0//01/2014		
			T	o 06/30/2015		pared:
					11/23/2015 5: (05 pm
Cost Center Description					MAINTENANCE &	
	REPAI RS	REPAIRS-HSB I	REPAIRS-HSB II	REPAI RS-REHAB	REPAIRS-MAB	
				CLINIC		
	6. 00	6. 01	6. 02	6. 03	6. 04	
118.00 SUBTOTALS (SUM OF LINES 1-117)	2, 501, 178	15, 630	0	8, 295	8, 383	118. 00
NONREI MBURSABLE COST CENTERS	_					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	11, 592	0	0	0	0	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	135, 017	0	0	14, 426	192. 00
194.00 07950 DAY HEALTH	0	15, 307	0	0	ol	194. 00
194. 01 07962 OUTREACH	0	2, 231	0	0	ol	194. 01
194. 02 07951 OCCUPATIONAL MEDICINE	0	0	0	0	ol	194. 02
194.03 07952 FUND DEVELOPMENT	2, 875	0	0	0	ol	194. 03
194. 04 07953 OUTSI DE LAUNDRY	0	0	0	0	ol	194. 04
194. 05 07954 PHYSI CI AN SUPPORT	0	4, 389	0	0	ol	194. 05
194. 06 07955 HOSPI TALI TY HOUSE	0	0	0	0	ol	194. 06
194. 07 07956 HSK DIALYSIS	0	0	0	0	ol	194. 07
194. 08 07957 LEASED SALARI ES	0	0	0	0	ol	194. 08
194.09 07958 VISITING PHYSICIANS	0	0	0	0	ol	194. 09
194.10 07959 FARM LAND	0	0	0	0	ol	194. 10
194. 11 07963 CONVENIENCE CARE CLINIC	0	0	0	0	ol	194. 11
194.12 07960 MMG-PHYSICIAN OFFICES	0	21, 306	185, 452	0	ol	194. 12
194.13 07961 VALET PARKING SERVICE	0	0	0	0	ol	194. 13
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201. 00
202.00 TOTAL (sum lines 118-201)	2, 515, 645	193, 880	185, 452	8, 295	22, 809	202. 00
	*		•			-

		1			0 06/30/2015	11/23/2015 5:	
	Cost Center Description		MAI NTENANCE & REPAI RS-BUSHNE	LAUNDRY &	HOUSEKEEPI NG	HOUSEKEEPI NG-H SB	
		BLDG	LL		0.00		
	GENERAL SERVICE COST CENTERS	6. 05	6.06	8.00	9. 00	9. 01	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1. 01	00101 CAP REL COSTS-HOSPI TAL						1. 01
1. 02	00102 CAP REL COSTS-HSB I						1.02
1. 03 1. 04	00103 CAP REL COSTS-HSB II 00104 CAP REL COSTS-REHAB CNT						1. 03 1. 04
1. 05	00105 CAP REL COSTS-DI AYSI S						1.05
1.06	00106 CAP REL COSTS-HOSPI TALI TY HOUSE						1.06
1.07	00107 CAP REL COSTS-MAB						1. 07
1.08	00108 CAP REL COSTS-ORTHO BLDG						1.08
1. 09 1. 10	00109 CAP REL COSTS-CONVENIENCE CARE CLINI 00110 CAP REL COSTS-BUSHNELL OFFICE BLDG						1. 09 1. 10
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00	00500 ADMI NI STRATI VE & GENERAL						5. 00
6.00	00600 MAINTENANCE & REPAIRS						6. 00
6. 01	00601 MAI NTENANCE & REPAI RS-HSB I						6. 01
6. 02	00602 MAINTENANCE & REPAIRS-HSB II 00603 MAINTENANCE & REPAIRS-REHAB CLINIC						6. 02
6. 03 6. 04	00604 MAINTENANCE & REPAIRS-REHAB CLINIC						6. 03 6. 04
6. 05	00605 MAI NTENANCE & REPAI RS-ORTHO BLDG	15, 501					6. 05
6.06	00606 MAI NTENANCE & REPAI RS-BUSHNELL	0	29, 577	1			6.06
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	567, 247			8. 00
9.00	00900 HOUSEKEEPI NG	0	0	0	1, 023, 044	455.070	9. 00
9. 01 9. 02	00901 HOUSEKEEPI NG-HSB 00902 HOUSEKEEPI NG-HSB I I	0	0		0	155, 263 0	9. 01 9. 02
9. 02 9. 03	00903 HOUSEKEEPI NG-ORTHO				0	0	9. 02
9. 04	00904 HOUSEKEEPI NG-MAB	0	Ö	o o	0	Ö	9. 04
10.00	01000 DI ETARY	0	0	0	22, 870	0	10.00
11. 00	01100 CAFETERI A	0	0	0	61, 031	0	11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	0	0	6, 630	0	13.00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	0		31, 669 8, 109	0	14. 00 15. 00
16. 00	1				4, 809	0	16.00
17. 00	1	0	0	0	2, 147	0	17. 00
19. 00	+ I	0	ł c	0	_	0	19. 00
23. 00		0	0) 0	0	0	23. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	0	0	111, 646	313, 354	0	30.00
31. 00	1 1	Ö	B .			0	31.00
43.00	1 1	0	0	1	5, 370	0	43. 00
44. 00		0	0	0	0	0	44. 00
50. 00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	1 0	1 0	54, 648	107, 567	0	50.00
51. 00	05100 RECOVERY ROOM			46, 602		0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	Ō	0	10, 938	0	52.00
53. 00		0	0	0	0	0	53. 00
54. 00	l l	0	0	38, 810			54.00
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)		0	4, 175	11, 643	0	57. 00 58. 00
60.00				2, 743		0	60.00
63. 00		0	Ö	0	0	0	63. 00
65.00		0	0	7, 306		0	65. 00
66.00		0	639	19, 225	53, 628	0	66.00
67. 00 68. 00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	0	0		7 000	0	67. 00 68. 00
69.00	1 1	0	0	0	7, 009 4, 984	0	69.00
70. 00	1 1		0	o o	13, 714	0	70.00
71. 00		0	0	0	0	0	71. 00
72. 00		0	0	0	0	0	72.00
73.00	1 1	0	0	0	0	12 517	73.00
76. 00 76. 01	+ I	0		7, 689	0 17, 257	12, 517 0	76. 00 76. 01
76. 01	1 1			,, 587	0	0	76. 01
	OUTPATIENT SERVICE COST CENTERS						
88. 00	1 1	0	1	1		0	88. 00
91.00	+ I	0	0	71, 880	109, 069	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS			1			92. 00
95. 00		0	0	9, 040	1, 130	0	95. 00
	10100 HOME HEALTH AGENCY	0					101. 00
	SPECIAL PURPOSE COST CENTERS			1			
	D 11300 I NTEREST EXPENSE D 11600 HOSPI CE	0	0	526	0	_	113. 00 116. 00
110.00	of Frood Hose I CE	1 0	1 0	η 320	1 0	1 0	1110.00

330. NEESS. N. S. C.		1101140		rom 07/01/2014 o 06/30/2015		pared:
					11/23/2015 5:	
Cost Center Description	MAINTENANCE &				HOUSEKEEPI NG-H	
	REPAIRS-ORTHO		LINEN SERVICE		SB	
	BLDG	LL				
	6. 05	6. 06	8. 00	9. 00	9. 01	
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	29, 577	404, 486	1, 019, 456	12, 517]118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(3, 588	l	190. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	(0	108, 124	1
194. 00 07950 DAY HEALTH	0	0	(0	12, 258	
194. 01 07962 OUTREACH	0	0	(0	1, 787	194. 01
194. 02 07951 OCCUPATI ONAL MEDICINE	0	0	(0	0	194. 02
194.03 07952 FUND DEVELOPMENT	0	0	(0	0	194. 03
194. 04 07953 OUTSI DE LAUNDRY	0	0	160, 788	0	0	194. 04
194. 05 07954 PHYSI CLAN SUPPORT	0	0	(0	3, 515	194. 05
194. 06 07955 HOSPI TALI TY HOUSE	0	0	117	0	0	194. 06
194. 07 07956 HSK DI ALYSI S	0	0	(0	0	194. 07
194. 08 07957 LEASED SALARI ES	0	0	(0	0	194. 08
194.09 07958 VISITING PHYSICIANS	o	0	(0	0	194. 09
194.10 07959 FARM LAND	o	0	(0	0	194. 10
194. 11 07963 CONVENIENCE CARE CLINIC	o	0	(0	0	194. 11
194. 12 07960 MMG-PHYSICIAN OFFICES	15, 501	0	1, 856	0	17, 062	194. 12
194.13 07961 VALET PARKING SERVICE	o	0		0	0	194. 13
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	o	0		o	0	201. 00
202.00 TOTAL (sum lines 118-201)	15, 501	29, 577	567, 247	1, 023, 044	155, 263	202. 00

| Peri od: | Worksheet B | From 07/01/2014 | Part | To 06/30/2015 | Date/Time Prepared: | Provider CCN: 140089

	Cost Center Description	HOUSEKEEPI NG-H	HOUSEKEEPI NG-0	HOUSEKEEPI NG-M		Date/Ti me Pre 11/23/2015 5: CAFETERI A	
		SB 11 9. 02	RTH0 9. 03	AB 9. 04	10.00	11. 00	
	GENERAL SERVICE COST CENTERS	7. 02	7.03	7. 04	10.00	11.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1. 01 1. 02	00101 CAP REL COSTS-HOSPI TAL 00102 CAP REL COSTS-HSB I						1.01
1.02	00103 CAP REL COSTS-HSB II						1. 02 1. 03
1. 04	00104 CAP REL COSTS-REHAB CNT						1. 04
1.05	00105 CAP REL COSTS-DI AYSI S						1. 05
1.06	00106 CAP REL COSTS-HOSPITALITY HOUSE						1.06
1. 07 1. 08	00107 CAP REL COSTS-MAB 00108 CAP REL COSTS-ORTHO BLDG						1. 07 1. 08
1. 08	00109 CAP REL COSTS-CONVENIENCE CARE CLINI						1. 08
1. 10	00110 CAP REL COSTS-BUSHNELL OFFICE BLDG						1. 10
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 6. 00	00500 ADMINISTRATIVE & GENERAL						5.00
6. 01	00600 MAI NTENANCE & REPAI RS 00601 MAI NTENANCE & REPAI RS-HSB I						6. 00 6. 01
6. 02	00602 MAINTENANCE & REPAIRS-HSB II						6. 02
6.03	00603 MAINTENANCE & REPAIRS-REHAB CLINIC						6. 03
6. 04	00604 MAINTENANCE & REPAIRS MAB						6. 04
6. 05 6. 06	00605 MAI NTENANCE & REPAI RS-ORTHO BLDG 00606 MAI NTENANCE & REPAI RS-BUSHNELL						6. 05 6. 06
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
9. 01	00901 HOUSEKEEPI NG-HSB	04.004					9. 01
9. 02 9. 03	00902 HOUSEKEEPI NG-HSB 11 00903 HOUSEKEEPI NG-ORTHO	81, 386	10 115				9. 02 9. 03
9. 03 9. 04	00904 HOUSEKEEPI NG-MAB		12, 115 0				9. 03
10.00	01000 DI ETARY	o	0	1	968, 716		10.00
11. 00	01100 CAFETERI A	0	0	0	0	859, 843	
13. 00 14. 00	01300 NURSI NG ADMINI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	0	0		0	14, 345 18, 351	13. 00 14. 00
15. 00	01500 PHARMACY		0	0	0	14, 927	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	Ö	0	Ö	Ö	39, 137	16. 00
17. 00	01700 SOCIAL SERVICE	0	0	0	o	8, 185	17. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	0		0	0	19. 00
23. 00	02300 PARAMED ED PRGM INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	0	0	U	1, 012	23. 00
30.00	03000 ADULTS & PEDIATRICS	0	0	0	624, 978	101, 019	30. 00
31. 00	03100 INTENSIVE CARE UNIT	0	0		132, 382	23, 758	1
43. 00 44. 00		0	0		0	11, 782 0	43. 00 44. 00
44.00	ANCILLARY SERVICE COST CENTERS	ı o	0	0	<u> </u>	0	44.00
50.00	05000 OPERATING ROOM	0	0	0	0	40, 903	50. 00
51.00	1 1	0	0	0	0	18, 028	
52. 00 53. 00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0	0	0	0	12, 385 0	52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C		0	0	0	37, 543	
57. 00	05700 CT SCAN	o	0	0	О	13, 419	
58. 00		0	0	0	0	0	
60. 00 63. 00	06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	68, 516 0	60. 00 63. 00
65. 00			0	0	0	10, 403	
66.00	06600 PHYSI CAL THERAPY	o	0	0	О	44, 435	
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
68. 00 69. 00		0	0	0	0	3, 726 8, 293	
70.00			0	0	0	7, 302	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	О	0	0	О	0	71. 00
72.00		0	0	0	0	0	72. 00
73. 00 76. 00		0	0	0	0	0 24, 490	73. 00 76. 00
76. 00	1		0	0	0	15, 896	
76. 02	03951 FLU CLINIC	0	0	0	0	0	
00.00	OUTPATIENT SERVICE COST CENTERS			_	al	40.407	00.00
88. 00 91. 00	1	0	0		0	12, 407 45, 340	88. 00 91. 00
91.00	1		Ü		٩	45, 340	91.00
	OTHER REIMBURSABLE COST CENTERS						
		0	0		0	41, 506	
101.00	0 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	1, 862	0	32, 632	101.00
113. 00	0 11300 INTEREST EXPENSE						113. 00
116.00	0 11600 H0SPI CE	О	0		О	17, 253	116. 00
118. 00	SUBTOTALS (SUM OF LINES 1-117)	0	0	2, 993	757, 360	686, 993	118. 00

				00/30/2013	11/23/2015 5:	
Cost Center Description	HOUSEKEEPI NG-H	HOUSEKEEPI NG-0	HOUSEKEEPI NG-M	DI ETARY	CAFETERI A	
	SB II	RTH0	AB			
	9. 02	9. 03	9. 04	10.00	11. 00	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	5, 150	0	0	192. 00
194. 00 07950 DAY HEALTH	0	0	0	211, 356	6, 462	194. 00
194. 01 07962 OUTREACH	0	0	0	0	7, 625	194. 01
194. 02 07951 OCCUPATIONAL MEDICINE	0	0	0	0	0	194. 02
194.03 07952 FUND DEVELOPMENT	0	0	0	0	6, 009	194. 03
194. 04 07953 OUTSI DE LAUNDRY	0	0	0	0	0	194. 04
194. 05 07954 PHYSI CLAN SUPPORT	0	0	0	0	2, 154	194. 05
194. 06 07955 HOSPI TALI TY HOUSE	0	0	0	0	625	194. 06
194. 07 07956 HSK DIALYSIS	0	0	0	0	646	194. 07
194. 08 07957 LEASED SALARI ES	0	0	0	0	905	194. 08
194.09 07958 VISITING PHYSICIANS	0	0	0	0	0	194. 09
194.10 07959 FARM LAND	0	0	0	0	0	194. 10
194. 11 07963 CONVENIENCE CARE CLINIC	0	0	0	0	12, 988	194. 11
194.12 07960 MMG-PHYSICIAN OFFICES	81, 386	12, 115	0	0	133, 777	194. 12
194.13 07961 VALET PARKING SERVICE	0	0	0	0	1, 659	194. 13
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201. 00
202.00 TOTAL (sum lines 118-201)	81, 386	12, 115	8, 143	968, 716	859, 843	202. 00

				10	06/30/2015	Date/lime Pre 11/23/2015 5:	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
		ADMI NI STRATI ON	SERVICES & SUPPLY		RECORDS & LI BRARY		
		13. 00	14. 00	15. 00	16. 00	17. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1. 01 1. 02	O0101 CAP REL COSTS-HOSPI TAL O0102 CAP REL COSTS-HSB I						1. 01 1. 02
1. 02	00103 CAP REL COSTS-HSB I I						1. 02
1. 04	00104 CAP REL COSTS-REHAB CNT						1. 04
1.05	00105 CAP REL COSTS-DI AYSI S						1. 05
1.06	00106 CAP REL COSTS-HOSPI TALI TY HOUSE						1.06
1. 07 1. 08	00107 CAP REL COSTS-MAB 00108 CAP REL COSTS-ORTHO BLDG						1. 07 1. 08
1. 08	00109 CAP REL COSTS-CONVENIENCE CARE CLINI						1. 08
1. 10	00110 CAP REL COSTS-BUSHNELL OFFICE BLDG						1. 10
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
6. 00 6. 01	OO6OO MAINTENANCE & REPAIRS OO6O1 MAINTENANCE & REPAIRS I						6. 00 6. 01
6. 02	00602 MAINTENANCE & REPAIRS-HSB II						6. 02
6. 03	00603 MAINTENANCE & REPAIRS-REHAB CLINIC						6. 03
6.04	00604 MAINTENANCE & REPAIRS-MAB						6. 04
6.05	00605 MAI NTENANCE & REPAIRS-ORTHO BLDG						6. 05
6. 06 8. 00	OO606 MAINTENANCE & REPAIRS-BUSHNELL OO800 LAUNDRY & LINEN SERVICE						6. 06 8. 00
9. 00	00900 HOUSEKEEPING						9. 00
9. 01	00901 HOUSEKEEPI NG-HSB						9. 01
9. 02	00902 HOUSEKEEPING-HSB II						9. 02
9. 03	00903 HOUSEKEEPI NG-ORTHO						9. 03
9. 04 10. 00	O0904 HOUSEKEEPI NG-MAB O1000 DI ETARY						9. 04 10. 00
11. 00	01100 CAFETERI A						11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	810, 395					13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	960, 867				14. 00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0	9, 905 0	1	1, 559, 986		15. 00 16. 00
17. 00	01700 SOCIAL SERVICE	0	0		1, 559, 960	666, 910	
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0		0	0	19. 00
23. 00	02300 PARAMED ED PRGM	0	0	0	0	0	23. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	421, 370	59, 256	0	1 205 247	513, 520	30. 00
31. 00	03100 INTENSIVE CARE UNIT	99, 098	12, 013	i i	1, 385, 267 15, 600		•
43. 00	04300 NURSERY	49, 145	0	1	23, 400		43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
FO 00	ANCI LLARY SERVI CE COST CENTERS		0/ 101			I 0	F0 00
50. 00 51. 00	05000 OPERATI NG ROOM 05100 RECOVERY ROOM	0	86, 181 71, 965		0	0	50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	51, 660	71, 709		0	Ö	52. 00
53.00	05300 ANESTHESI OLOGY	0	16, 845		0	0	
	05400 RADI OLOGY-DI AGNOSTI C	0	7, 971		0	1	
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	9, 780	0	0	0	57. 00 58. 00
60.00	06000 LABORATORY	0	40, 648	0	0	0	60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	o	0	0	63. 00
65. 00	06500 RESPI RATORY THERAPY	0	6, 698		0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	5, 969		0	0	66. 00
67. 00 68. 00	O6700 OCCUPATI ONAL THERAPY O6800 SPEECH PATHOLOGY	0	0 125	_	0	0	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	852		0	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	1	0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	157, 296		0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	365, 231		0	0	72. 00
73. 00 76. 00	07300 DRUGS CHARGED TO PATIENTS 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0 717		0	0	73. 00 76. 00
76. 00	03950 DI ABETES/WOUND CARE/COUMADIN CNTR		3, 042	1	0	0	76. 00
76. 02	03951 FLU CLINIC	0	0	1	0	0	76. 02
00.00	OUTPATIENT SERVICE COST CENTERS	1	0.00	-1	_	-	00.00
88. 00 91. 00	08800 RURAL HEALTH CLINIC 09100 EMERGENCY	0 189, 122	2, 086 59, 552	1	0 135, 719	-	88. 00 91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	107, 122	37, 332		133, 717	40,013	92. 00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES	0	611	1	0		95.00
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	8, 334	0	0] 0	101. 00
113.00	11300 INTEREST EXPENSE						113. 00
	11600 HOSPI CE	O	4, 307	О	0	0	116. 00
		,					

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 07/01/2014 Part I

			T	o 06/30/2015	Date/Time Prepared: 11/23/2015 5:05 pm
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL SERVI CE
	ADMI NI STRATI ON	SERVICES &		RECORDS &	
		SUPPLY		LI BRARY	
	13. 00	14. 00	15. 00	16.00	17. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	810, 395	929, 386	3, 082, 666	1, 559, 986	666, 910 118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192. 00
194. 00 07950 DAY HEALTH	0	805	0	0	0 194. 00
194. 01 07962 OUTREACH	0	0	0	0	0 194. 01
194. 02 07951 OCCUPATIONAL MEDICINE	0	0	0	0	0 194. 02
194.03 07952 FUND DEVELOPMENT	0	0	0	0	0 194. 03
194. 04 07953 OUTSI DE LAUNDRY	0	0	0	0	0 194. 04
194. 05 07954 PHYSI CI AN SUPPORT	0	0	0	0	0 194. 05
194. 06 07955 HOSPI TALI TY HOUSE	0	0	0	0	0 194. 06
194. 07 07956 HSK DIALYSIS	0	0	0	0	0 194. 07
194. 08 07957 LEASED SALARI ES	0	0	0	0	0 194. 08
194.09 07958 VISITING PHYSICIANS	0	0	0	0	0 194. 09
194.10 07959 FARM LAND	0	0	0	0	0 194. 10
194. 11 07963 CONVENLENCE CARE CLINIC	0	3, 300	0	0	0 194. 11
194.12 07960 MMG-PHYSICIAN OFFICES	0	27, 376	0	0	0 194. 12
194.13 07961 VALET PARKING SERVICE	0	0	0	0	0 194. 13
200.00 Cross Foot Adjustments					200. 00
201.00 Negative Cost Centers	0	0	0	0	0 201.00
202.00 TOTAL (sum lines 118-201)	810, 395	960, 867	3, 082, 666	1, 559, 986	666, 910 202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS In Lieu of Form CMS-2552-10 MCDONOUGH DISTRICT HOSPITAL Worksheet B
Part I
Date/Time Prepared:
11/23/2015 5:05 pm Provi der CCN: 140089 Peri od: From 07/01/2014 To 06/30/2015 Cost Center Description NONPHYSI CI AN PARAMED ED Subtotal Intern & Total Residents Cost ANESTHETI STS PRGM

19.00 24.00 25.00 24.00 25.00 26.00						& Post Stepdown		
1			10.00	22.00	24.00	Adjustments	27, 00	
1.01 0.0101 CAP REL COSTS-HOSPI TAL		GENERAL SERVICE COST CENTERS	19.00	23.00	24.00	25.00	26.00	
1.02 001002 CAP REL COSTS - ISBN 1								1
1.03 0.0103 CAP REL COSTS-HANG VIT 1.03 1.03 1.05 1.0								1
1.04 001006 CAP REL COSTS-INFLAIR CMT		1						ı
1.06	1.04	00104 CAP REL COSTS-REHAB CNT						1
1.07 (00107) CAP REL COSTS-CHEN BLD (00109) CAP REL COSTS-CORTIN BLD (1.08) (00109) CAP REL COSTS-CORTIN BLD (1.09) CAP COSTS-CORTIN B								1
1.08 00109 CAP RELL COSTS-ORTHO BLDG		1						1
1.10 0.0110 CAP REL COSTS-RISNINGLE OFFICE BLOS								1
0.0400 CAPACOVER BENEFITS DEPARTMENT 0.0500 0.0500 (ABM IN STRATIVE & GEMERAL 0.500 0.0500 (ABM IN STRATIVE & GEMERAL 0.500 0.0500 (ABM IN STRATIVE & GEMERAL 0.600 0.0500 (ABM INTERNANCE & REPAIRS HSB I 0.600 0.0500 (ABM INTERNANCE & REPAIRS CLINIC 0.600 0.0500 (ABM INTERNANCE & REPAIRS CHINICA								1
0.000 0.0000 AMIN IN STRATIVE & GENERAL								1
6. 01 00000 [MIA INTERNACE & REPAIRS—HSB I 6. 0.02								1
0.002 MAINTERMACE & REPAIRS-RISE II								1
0.003 0.0003 MAI NTEARNICE & REPAI RS-REHAB CLINIC 0.004 0.0004 MAI NTEARNICE & REPAI RS-BUSINELL 0.000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000000		1						1
0.040 MAINTENANCE & REPAIRS - MORTHO BLDG 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.00000 0.00000								1
0.0060 MAINTENANCE & REPAIRS-BUSHNELL 6.006 0.000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000000	6.04	00604 MAINTENANCE & REPAIRS-MAB						1
B. 00 00000 LANDRY & LINEN SERVICE								1
9.00 00900H HOUSEKEEPING-HSB 9.00 9.01 00900H HOUSEKEEPING-HSB 9.02 9.02 9.03 00900ZH HOUSEKEEPING-HSB 9.02 9.03 9.030 HOUSEKEEPING-MORTHO 9.04 9.04 9.04 9.04 9.05								1
9. 02 00902 HOUSEKEEPI NG-HSB I I 9, 02 00904 HOUSEKEEPI NG-MSB								1
9. 03 00903 HOUSEKEEPING-ORTHO 10. 00 01000 DI ETARY 10. 00 01000 DI ETARY 11. 00 01100 CAFETRIA HOUSEKEEPING-MAB 13. 00 11300 NURD CAFETRIA HOUSEKEEPING HOUSEKEEPING HOUSEKEEPING-MAB 13. 00 11300 NURD CAFETRIA HOUSEKEEPING HOUSEKEEPING HOUSEKEEPING HOUSE HOUSEKEEPING HOUSEKEEP								1
9. 04 00904 BOUSKEEPI NG-MAB 9. 04 10. 00 11. 00 10. 10 10. 00 11. 0		1						1
11.00 01100 CAFERIA		1 I						1
13. 00 01300 NURSING ADMINISTRATION 14. 00 10400 CENTRAL SERVICES & SUPPLY 15. 00 14. 00 10400 CENTRAL SERVICES & SUPPLY 15. 00 16. 00 10600 MEDICAL RECORDS & LI BRARY 16. 00 10600 MEDICAL RECORDS & LI BRARY 17. 00 17								1
14. 00 01400 CENTRAL SERVICES & SUPPLY		1						1
16. 00 01600 MEDICAL, RECORDS & LIBRARY		1						1
17. 00 01700 01700 SOCI AL SERVICE		01500 PHARMACY						1
19. 00 01900 NOMPHYS ICI AN AMESTHETISTS 0 56,606 19. 00 19. 00 10								1
23.00			0					1
30.00 03000 ADULTS & PEDIATRICS 0 0 8, 794, 665 0 8, 794, 665 30.00	23. 00	02300 PARAMED ED PRGM		56, 606				23. 00
131.00 03100 INTENSI VE CARE UNIT 0 0 1,758,765 0 1,758,765 31.00	30 00			0	9 704 665	٥	9 704 665	30 00
44.00 04.00 SKILLED NURSING FACILITY 0 0 0 0 0 0 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATI NG ROOM 0 0 0 3, 134, 990 0 3, 134, 990 50.00 51.00 05000 OPERATI NG ROOM 0 0 0 1, 312, 746 0 1, 312, 746 51.00 52.00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 646, 034 0 646, 034 52.00 53.00 05300 ANESTHESI OLOGY 0 0 0 0 0 0 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 56, 606 2, 607, 184 0 2, 607, 184 54.00 55.00 055700 CT SCAN 0 0 0 0 0 0 0 0 55.00 05500 MAGNETI C RESONANCE IMAGI NG (MRI) 0 0 0 0 0 0 55.00 05500 STORI NG PROCESSI NG & TRANS. 0 0 0 5, 711, 962 0 56.00 06500 RESPI RATORY THERAPY 0 0 0 51, 748 0 51, 748 63.00 56.00 06500 RESPI RATORY THERAPY 0 0 0 2, 833, 671 0 2, 833, 671 56.00 06600 OFFICIAL HERAPY 0 0 0 0 0 0 56.00 06700 OCCUPATI ONAL THERAPY 0 0 0 2, 833, 671 0 2, 833, 671 56.00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 56.00 06900 ELECTROCARDI OLOGY 0 0 0 393, 506 0 393, 506 0 57.00 07000 ELECTROCERDE HALLOGRAPHY 0 0 0 393, 506 0 393, 506 0 57.00 07000 ELECTROCERDE HALLOGRAPHY 0 0 0 0 319, 737 0 319, 737 0 57.00 07000 ELECTROCERDE HALLOGRAPHY 0 0 0 0 0 0 57.00 07000 ELECTROCERDE HALLOGRAPHY 0 0 0 0 0 0 57.00 07000 ELECTROCERDE HALLOGRAPHY 0 0 0 0 0 57.00 07000 ELECTROCERDE HALLOGRAPHY 0 0 0 0 0 57.00 07000 ELECTROCED HALLOGRAPHY 0 0 0 0 0 57.00 07000 ELECTROCED HALLOGRAPHY 0 0 0 0 0 57.00 07000 ELECTROCED HALLOGRAPHY 0 0 0 0 0 57.00 07000 ELECTROCED HALLOGRAPHY 0 0 0 0 0 57.00 07000 ELECTROCED HALLOGRAPHY 0 0 0 0 0 57.00 07000 ELECTROCED HALLOGRAPHY 0 0 0 0 0 57.00 07000 DRUGS CHARGED TO PATI ENTS 0			١					1
ANCILLARY SERVICE COST CENTERS Service Cost Cost Centers Service Cost Centers Servi			0			I .		1
50. 00	44. 00		0	O	0	0	0	44.00
52.00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 646, 034 0 205, 680 0 205, 680 53.00 05300 ANESTHESI OLOGY 0 0 0 0 205, 680 0 205, 680 53.00 05300 05400 RADI OLOGY-DI AGNOSTI C 0 56, 606 2, 607, 184 0 2, 607, 184 54.00 05700 CT SCAN 0 0 965, 638 0 965, 638 57.00 05700 CT SCAN 0 0 0 621, 411 0 621, 411 58.00 00 00 00 00 00 00 00	50. 00		0	0	3, 134, 990	0	3, 134, 990	50.00
53.00 0.5300 ANESTHESI OLOGY 0 0 205, 680 0 205, 680 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 56, 606 2, 607, 184 0 2, 607, 184 54.00 57.00 05700 CT SCAN 0 0 965, 638 0 965, 638 0 965, 638 57.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 621, 411 0 621, 421 0 <td></td> <td></td> <td>0</td> <td>0</td> <td></td> <td>-</td> <td></td> <td>1</td>			0	0		-		1
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 56,606 2,607, 184 0 2,607, 184 54. 00 57. 00 05700 CT SCAN 0 0 0 065,638 0 965,638 57. 00 05700 CT SCAN 0 0 0 621,411 0 621,411 58. 00 06000 LABORATORY 0 0 0 5,711,962 0 5,711,962 0 5,711,962 0 63. 00 6300 BLOOD STORI NG, PROCESSING & TRANS. 0 0 51,748 0 51,748 0 51,748 63. 00 66. 00 06600 RESPIRATORY THERAPY 0 0 0 702,187			0	0		ĭ,		1
57. 00 05700 CT SCAN 58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 60. 00 06000 LABORATORY 60. 00 06000 LABORATORY 60. 00 06000 LABORATORY 60. 00 06000 LABORATORY 60. 00 06500 BLOOD STORING, PROCESSING & TRANS. 60. 00 06500 RESPIRATORY THERAPY 60. 00 06700 OCCUPATIONAL THERAPY 60. 00 06700 OCCUPATIONAL THERAPY 60. 00 06700 OCCUPATIONAL THERAPY 60. 00 06800 SPEECH PATHOLOGY 60. 00 06800 SPEECH PATHOLOGY 60. 00 07000 ELECTROCARDIOLOGY 60. 00 07000 ELECTROCARDIOLOGY 60. 00 07000 ELECTROCARDIOLOGY 60. 00 07000 ELECTROCARDIOLOGY 60. 00 07000 ELECTROENCEPHALOGRAPHY 60. 00 07000 MEDICAL SUPPLIES CHARGED TO PATIENTS 60. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 60. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 60. 00 07300 DRIGS CHARGED TO PATI			0	56, 606		-1		1
60. 00 06000 LABORATORY 0 0 5, 711, 962 0 5, 711, 962 60. 00 63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 51, 748 63. 00 650. 00 66500 RESPIRATORY THERAPY 0 0 0 702, 187 0 702, 187 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 2, 833, 671 0 2, 833, 671 0 0 67. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 220, 419 0 220, 419 68. 00 68. 00 06800 SPECH PATHOLOGY 0 0 0 220, 419 0 220, 419 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 333, 506 0 393, 506 69. 00 70. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 691, 902 0 691, 902 71. 00 71. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 3, 082, 666 0 3, 082, 666 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 3, 082, 666 0 3, 082, 666 73. 00 76. 01 03950 DI ABETES/WOUND CARE/COUMADIN CNTR 0 0 816, 963 76. 01 03950 DI ABETES/WOUND CARE/COUMADIN CNTR 0 0 0 816, 963 0 816, 963 76. 01 03950 DI ABETES/WOUND CARE/COUMADIN CNTR 0 0 786, 678 0 786, 678 88. 00 08800 RURAL HEALTH CLINIC 0 0 79200 DESERVATION BEDS (NON-DI STI NCT PART) 0 00 THER REI MBURSABLE COST CENTERS	57. 00	05700 CT SCAN	0		965, 638		965, 638	57. 00
63. 00			0					
65. 00 06500 RESPIRATORY THERAPY 0 0 702, 187 0 702, 187 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 2, 833, 671 0 2, 833, 671 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 0 67. 00 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 0 393, 506 69. 00 70. 00 07000 ELECTROCARDI OLOGY 0 0 393, 506 69. 00 70. 00 07000 ELECTROCARDI OLOGY 0 0 319, 737 0 319, 737 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 691, 902 0 691, 902 71. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 1, 687, 267 0 1, 687, 267 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0, 3850 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 98. 023 0 98. 023 76. 00 76. 01 03950 DI ABETES/WOUND CARE/COUMADI N CNTR 0 0 816, 963 0 816, 963 0 816, 963 76. 01 03950 DI ABETES/WOUND CARE/COUMADI N CNTR 0 0 786, 678 0 23, 456 76. 02 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 5, 108, 579 0 5, 108, 579 0 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0		- 1		1
67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 67. 00 68. 00 06800 SPECH PATHOLOGY 0 0 0 220, 419 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 393, 506 0 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 319, 737 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 691, 902 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 1, 687, 267 0 1, 687, 267 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 3, 082, 666 0 3, 082, 666 73. 00 76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 908, 023 0 908, 023 76. 00 76. 01 03950 DI ABETES/WOUND CARE/COUMADI N CNTR 0 0 816, 963 0 816, 963 76. 01 76. 02 03951 FLU CLI NI C 0 0 23, 456 0 23, 456 0 88. 00 08800 RURAL HEALTH CLI NI C 0 0 5, 108, 579 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 00 07100 EMERGENCY 0 0 0 0 0 00 07100 EMERGENCY 0 0 0 0 00 07100 EMERGENCY 0 0 0 00 07100	65.00	06500 RESPI RATORY THERAPY	0	0	702, 187			1
68. 00			0	0		-1		1
69. 00				0				1
71. 00		1	o	0	·	l l		1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 1, 687, 267 0 1, 687, 267 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 3, 082, 666 0 3, 082, 666 73. 00 03550 PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES 0 0 908, 023 0 908, 023 76. 00 76. 01 03950 DI ABETES/WOUND CARE/COUMADIN CNTR 0 0 816, 963 0 816, 963 76. 01 76. 02 03951 FLU CLINI C 0 0 23, 456 0 23, 456 0 23, 456 0 23, 456 0 23, 456 0 04. 02			0	0		0		1
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 3, 082, 666 0 3, 082, 666 73. 00 76. 00 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 0 0 908, 023 0 908, 023 76. 00 76. 01 03950 DIABETES/WOUND CARE/COUMADIN CNTR 0 0 816, 963 0 816, 963 76. 01 76. 02 03951 FLU CLINIC 0 0 23, 456 0 23, 456 0 23, 456 0 23, 456 0 23, 456 0 23, 456 0 23, 456 0 0 23, 456 0 0 23, 456 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0	·	I .		1
76. 01 03950 DI ABETES/WOUND CARE/COUMADI N CNTR 0 0 816, 963 0 816, 963 76. 01 76. 02 03951 FLU CLINI C 0 0 23, 456 0 23, 456 OUTPATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLINI C 0 786, 678 0 786, 678 80 91. 00 99100 EMERGENCY 0 0 5, 108, 579 0 5, 108, 579 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0 0THER REI MBURSABLE COST CENTERS				0		0		1
76. 02 03951 FLU CLINIC 0 0 23, 456 0 23, 456 76. 02 0UTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 0 0 786, 678 0 786, 678 88. 00 91. 00 09100 EMERGENCY 0 0 5, 108, 579 0 5, 108, 579 91. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 0THER REIMBURSABLE COST CENTERS			O	0				1
OUTPATIENT SERVICE COST CENTERS			0					1
88. 00	70.02		١	U	23, 450	U_	23, 430	70.02
92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART) O 92. 00 OTHER REIMBURSABLE COST CENTERS		08800 RURAL HEALTH CLINIC	-			I		1
OTHER REIMBURSABLE COST CENTERS			0	0	5, 108, 579		5, 108, 579	1
	92. UU					0		j 92. UU
		09500 AMBULANCE SERVICES	0	0	1, 321, 933			
101. 00 10100 HOME HEALTH AGENCY 0 0 1,779,775 0 1,779,775 101. 00	101.00	D 10100 HOME HEALTH AGENCY	0	O	1, 779, 775	0	1, 779, 775	101. 00

Health Financial Systems	MCDONOUGH DISTE	RICT HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Peri od: From 07/01/2014	Worksheet B Part I	
				To 06/30/2015		nared:
					11/23/2015 5:	
Cost Center Description	NONPHYSI CI AN	PARAMED ED	Subtotal	Intern &	Total	
	ANESTHETI STS	PRGM		Residents Cost		
				& Post		
				Stepdown		
	10.00	22.00	24.00	Adjustments	24 00	
SPECIAL PURPOSE COST CENTERS	19. 00	23. 00	24. 00	25. 00	26. 00	
113. 00 11300 I NTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	0	0	1, 475, 79	ρ 0	1, 475, 798	
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	56, 606			48, 618, 285	
NONREI MBURSABLE COST CENTERS	<u> </u>	50, 600	10, 010, 20	<u> </u>	10, 010, 200	1110.00
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	0	0	28, 00	6 0	28, 006	190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	460, 49		460, 490	
194. 00 07950 DAY HEALTH	0	O	487, 60	9 0	487, 609	194. 00
194. 01 07962 OUTREACH	0	0	278, 51	8 0	278, 518	194. 01
194. 02 07951 OCCUPATI ONAL MEDI CI NE	0	0		0	0	194. 02
194.03 07952 FUND DEVELOPMENT	0	0	282, 13	0 0	282, 130	194. 03
194. 04 07953 OUTSI DE LAUNDRY	0	0	160, 78	8 0	160, 788	194. 04
194.05 07954 PHYSICIAN SUPPORT	0	0	840, 72	3 0	840, 723	194. 05
194. 06 07955 HOSPI TALI TY HOUSE	0	0	47, 71			194. 06
194. 07 07956 HSK DI ALYSI S	0	0	15, 39			194. 07
194. 08 07957 LEASED SALARI ES	0	0	46, 80			194. 08
194.09 07958 VISITING PHYSICIANS	0	0	31	2 0		194. 09
194.10 07959 FARM LAND	0	0		0 0		194. 10
194. 11 07963 CONVENI ENCE CARE CLI NI C	0	0	561, 52		561, 522	
194. 12 07960 MMG-PHYSI CI AN OFFI CES	0	0	11, 298, 52		11, 298, 524	
194. 13 07961 VALET PARKING SERVICE	0	0	28, 14	0		194. 13
200.00 Cross Foot Adjustments	0	0		0		200.00
201.00 Negative Cost Centers	0	E, (2)	(2.454.0)			201.00
202.00 TOTAL (sum lines 118-201)	0	56, 606	63, 154, 96	b 0	63, 154, 965	J202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 07/01/2014 | Part II | To 06/30/2015 | Date/Time Prepared: | 11/23/2015 5: 05 pm

				CADITAL DEL	ATED COSTS	11/23/2015 5:	05 pm
				CAPI TAL REI	LATED COSTS		
	Cost Center Description	Directly	NEW BLDG &	CAP REL	CAP REL	CAP REL	
		Assigned New	FIXT	COSTS-HOSPI TAL	COSTS-HSB I	COSTS-HSB II	
		Capital Related Costs					
		0	1. 00	1. 01	1. 02	1. 03	
	GENERAL SERVICE COST CENTERS						
1. 00 1. 01	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 CAP REL COSTS-HOSPITAL						1. 00 1. 01
1. 02	00102 CAP REL COSTS-HSB I						1. 02
1.03	00103 CAP REL COSTS-HSB II						1. 03
1.04	00104 CAP REL COSTS-REHAB CNT 00105 CAP REL COSTS-DI AYSI S						1. 04 1. 05
1. 05 1. 06	00106 CAP REL COSTS-HIAYSIS						1.05
1. 07	00107 CAP REL COSTS-MAB						1. 07
1. 08	00108 CAP REL COSTS-ORTHO BLDG						1. 08
1. 09 1. 10	OO109 CAP REL COSTS-CONVENIENCE CARE CLINI OO110 CAP REL COSTS-BUSHNELL OFFICE BLDG						1. 09 1. 10
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	o	0	26, 644	0	0	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	O	0		73, 856	128, 914	5. 00
6.00	00600 MAINTENANCE & REPAIRS	0	0	275, 348	0	0	6. 00
6. 01 6. 02	00601 MAINTENANCE & REPAIRS-HSB I 00602 MAINTENANCE & REPAIRS-HSB II	0	0		8, 715 0	0 49, 660	6. 01 6. 02
6. 03	00603 MAINTENANCE & REPAIRS-REHAB CLINIC	0	0	o o	0	0	6. 03
6.04	00604 MAINTENANCE & REPAIRS-MAB	O	0	0	0	0	6. 04
6. 05 6. 06	00605 MAINTENANCE & REPAIRS-ORTHO BLDG	0	0	0	0	0	6. 05
8. 00	00606 MAI NTENANCE & REPAI RS-BUSHNELL 00800 LAUNDRY & LI NEN SERVI CE	0	0	83, 629	0	0	6. 06 8. 00
9. 00	00900 HOUSEKEEPI NG	O	0	44, 464	0	0	9. 00
9. 01	00901 HOUSEKEEPI NG-HSB	0	0	0	0	0	9. 01
9. 02 9. 03	00902 HOUSEKEEPI NG-HSB II 00903 HOUSEKEEPI NG-ORTHO	0	0	0	0	0	9. 02 9. 03
9. 04	00904 HOUSEKEEPI NG-MAB	0	0		0	0	9. 04
10.00	01000 DI ETARY	0	0	58, 067	0	0	10. 00
11.00	01100 CAFETERI A	0	0	146, 584	0	0	11.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	0	0	1, 298 138, 474	0	0	13. 00 14. 00
15. 00	01500 PHARMACY	0	0	33, 672	0	0	15. 00
16. 00		0	0	82, 527	0	0	16. 00
17. 00	01700 SOCIAL SERVICE	0	0	9, 905	0	0	17.00
19. 00 23. 00	1 I	0	0	1	0	0	19. 00 23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	-	-		_		
30.00	03000 ADULTS & PEDIATRICS	0	0		0	0	30.00
31. 00 43. 00	· · · · · · · · · · · · · · · · · · ·	0	0	1	0	0	31. 00 43. 00
44. 00	+ I	0	0		0	0	44. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00 51. 00	05000 OPERATI NG ROOM 05100 RECOVERY ROOM	0	0		0	0	50.00
52. 00		0	0	57, 743 43, 599	0	0	51. 00 52. 00
53.00	1 1	0	0	6, 920	0	0	53. 00
54.00		0	0	216, 589	0	0	54.00
57. 00 58. 00		0	0	9, 840	0	0	57. 00 58. 00
60.00	1 1	0	0	196, 563	0	0	60.00
63. 00	·	0	0	0	0	0	63. 00
65.00	1 1	0	0	78, 591 91, 155	0	0	65.00
66. 00 67. 00	1 1	0	0	91, 155	0	0	66. 00 67. 00
68. 00	1 1	0	0	3, 028	0	0	68. 00
69. 00	1	0	0	3, 028	0	0	69. 00
70. 00 71. 00		0	0	4, 671	0	0	70. 00 71. 00
71.00			0		0	0	71.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	o o	0	0	73. 00
76.00	1 1	0	0	0	13, 462	0	76.00
76. 01 76. 02	· · · · · · · · · · · · · · · · · · ·	0	0	17, 885	0	0	76. 01 76. 02
70.02	OUTPATIENT SERVICE COST CENTERS	<u> </u>		,, 0	0	<u> </u>	70.02
88. 00	08800 RURAL HEALTH CLINIC	0	0	•	0	0	88. 00
91. 00 92. 00		0	0	112, 112	0	0	91. 00 92. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						J 92.00
	09500 AMBULANCE SERVI CES	0	0	29, 196	0	0	95. 00
101.0	0 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00

			To	06/30/2015	Date/Time Pre 11/23/2015 5:	
			CAPI TAL REL	ATED COSTS	11/23/2013 3.	T Dill
			CALLIAL KLL	LATED COSTS		
Cost Center Description	Directly	NEW BLDG &	CAP REL	CAP REL	CAP REL	
	Assigned New	FLXT	COSTS-HOSPI TAL	COSTS-HSB I	COSTS-HSB II	
	Capi tal					
	Related Costs					
	0	1. 00	1. 01	1. 02	1. 03	
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	0	(0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	(3, 674, 355	96, 033	178, 574	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	(10, 900	0		190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	(0	116, 283		192. 00
194. 00 07950 DAY HEALTH	0	(0	13, 184		194. 00
194. 01 07962 OUTREACH	0	(0	1, 922		194. 01
194. 02 07951 OCCUPATI ONAL MEDICINE	0	(0	0		194. 02
194.03 07952 FUND DEVELOPMENT	0	(2, 703	0	0	194. 03
194. 04 07953 OUTSI DE LAUNDRY	0	(0	0		194. 04
194. 05 07954 PHYSI CI AN SUPPORT	0	(0	3, 780		194. 05
194. 06 07955 HOSPI TALI TY HOUSE	0	(0	0		194. 06
194. 07 07956 HSK DI ALYSI S	0	(0	0		194. 07
194. 08 07957 LEASED SALARI ES	0	(0	0		194. 08
194.09 07958 VISITING PHYSICIANS	0	(0	0		194. 09
194.10 07959 FARM LAND	0	(0	0		194. 10
194. 11 07963 CONVENI ENCE CARE CLI NI C	0	(0	0		194. 11
194.12 07960 MMG-PHYSICIAN OFFICES	0	(0	18, 350	153, 790	194. 12
194.13 07961 VALET PARKING SERVICE	0	(0	0	0	194. 13
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers		(0	0		201. 00
202.00 TOTAL (sum lines 118-201)	0	(3, 687, 958	249, 552	332, 364	202. 00

		CAPI	TAL RELATED CO	STS	11/23/2015 5:	05 pm
Cost Center Description	CAP REL	CAP REL	CAP REL	CAP REL	CAP REL	
· ·	COSTS-REHAB CNT	COSTS-DI AYSI S	COSTS-HOSPITAL	COSTS-MAB	COSTS-ORTHO BLDG	
AFTIFFAL AFFILLAR AGOT AFTIFFA	1.04	1. 05	1.06	1. 07	1. 08	
1.00 OO100 NEW CAP REL COSTS-BLDG & FIXT						1. 00
1. 01 00101 CAP REL COSTS-HOSPITAL						1. 01
1. 02 00102 CAP REL COSTS-HSB 1. 03 00103 CAP REL COSTS-HSB						1. 02 1. 03
1.04 O0104 CAP REL COSTS-REHAB CNT						1. 04
1. 05 00105 CAP REL COSTS-DI AYSI S 1. 06 00106 CAP REL COSTS-HOSPI TALI TY HOUSE						1. 05 1. 06
1.07 O0107 CAP REL COSTS-MAB						1. 07
1.08 00108 CAP REL COSTS-ORTHO BLDG 1.09 00109 CAP REL COSTS-CONVENIENCE CARE CLINI						1. 08 1. 09
1. 10 O0110 CAP REL COSTS-BUSHNELL OFFICE BLDG						1. 10
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	30, 298	4.00
5. 00 00500 ADMINISTRATIVE & GENERAL 6. 00 00600 MAINTENANCE & REPAIRS	0	0	0	0	0	5. 00 6. 00
6. 01 00601 MAINTENANCE & REPAIRS-HSB I	0	0	0	0	0	6. 01
6. 02 00602 MAINTENANCE & REPAIRS-HSB II 6. 03 00603 MAINTENANCE & REPAIRS-REHAB CLINIC	0	0	0	0	0	6. 02 6. 03
6. 04 00604 MAINTENANCE & REPAIRS-MAB	0	O	0	0	0	6. 04
6. 05 00605 MAI NTENANCE & REPAI RS-ORTHO BLDG 6. 06 00606 MAI NTENANCE & REPAI RS-BUSHNELL	0	0	0	0	0	6. 05 6. 06
8. 00 00800 LAUNDRY & LINEN SERVICE	0	Ö	0	Ö	0	8. 00
9. 00 00900 HOUSEKEEPI NG 9. 01 00901 HOUSEKEEPI NG-HSB	0	0	0	0	0	9. 00 9. 01
9. 02 00901 HOUSEKEEPING-HSB 1	0	0	0	0	0	9. 01
9. 03 00903 HOUSEKEEPI NG-ORTHO	0	0	0	0	0	9. 03
9. 04 00904 HOUSEKEEPI NG-MAB 10. 00 01000 DI ETARY	0	0	0	0	0	9. 04 10. 00
11. 00 01100 CAFETERI A	0	0	0	0	0	11.00
13. 00 O1300 NURSI NG ADMINI STRATI ON 14. 00 O1400 CENTRAL SERVI CES & SUPPLY	0	0	0	0	0	13. 00 14. 00
15. 00 01500 PHARMACY	0	0	0	0	0	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE	0	0	0	0	0	16. 00 17. 00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19. 00
23. 00 O2300 PARAMED ED PRGM I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	0	0	0	23. 00
30. 00 03000 ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31. 00 03100 INTENSI VE CARE UNI T 43. 00 04300 NURSERY	0 0	0	0	0	0	31. 00 43. 00
44. 00 04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	0	0	0	0	0	50. 00
51. 00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	0 0	0	0	0	0	52. 00 53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	54.00
57. 00 05700 CT SCAN 58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0	0	0	57. 00 58. 00
60. 00 06000 LABORATORY	0	0	0	0	0	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 65. 00 06500 RESPIRATORY THERAPY	0	0	0	0	0	63. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY	45, 975	0	0	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	0	0	0	0	67. 00 68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	O	0	0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	70. 00 71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	O	0	0	0	72. 00
73. 00 O7300 DRUGS CHARGED TO PATIENTS 76. 00 O3550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0	0	0	73. 00 76. 00
76.01 03950 DIABETES/WOUND CARE/COUMADIN CNTR	ő	ő	0	ő	0	76. 01
76. 02 03951 FLU CLINIC OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	76. 02
88. 00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES 101. 00 10100 HOME HEALTH AGENCY	0	0	0	0 18, 722	0	95. 00 101. 00
	,	·	١	10, 722	O	1.000

			To	06/30/2015	Date/Time Pre 11/23/2015 5:	pared: 05 pm
		CAP	ITAL RELATED CO	STS		
	OAD DEL	OAD DEL	OAD DEL	OAD DEL	OAD DEL	
Cost Center Description	CAP REL COSTS-REHAB	CAP REL	CAP REL COSTS-HOSPI TAL	CAP REL COSTS-MAB	CAP REL COSTS-ORTHO	
	CNT	C0313-D1A1313	ITY HOUSE	COSTS-WAD	BLDG	
	1.04	1. 05	1.06	1. 07	1. 08	
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	0	0	0	11, 374		116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	45, 975	0	0	30, 096	30, 298	118. 00
NONREI MBURSABLE COST CENTERS	1		1	al		
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	51, 785		192. 00 194. 00
194. 00 07950 DAY HEALTH 194. 01 07962 OUTREACH	0	0	0	U		194. 00
194. 01 07962 001REACH 194. 02 07951 0CCUPATI ONAL_MEDI CI NE	0	0	0	U O		194. 01
194. 03 07952 FUND_DEVELOPMENT	0	0		0		194. 02
194. 04 07953 OUTSI DE LAUNDRY	0	0		0		194. 04
194. 05 07954 PHYSI CLAN SUPPORT	0	0		0		194. 05
194. 06 07955 HOSPI TALI TY HOUSE	0	0	13, 083	Ö		194. 06
194. 07 07956 HSK DI ALYSI S	0	0	0	ol		194. 07
194. 08 07957 LEASED SALARI ES	0	0	o	o		194. 08
194. 09 07958 VISITING PHYSICIANS	0	0	0	o	0	194. 09
194.10 07959 FARM LAND	0	0	0	o	0	194. 10
194. 11 07963 CONVENIENCE CARE CLINIC	0	0	0	o	0	194. 11
194.12 07960 MMG-PHYSICIAN OFFICES	0	0	0	o	30, 298	194. 12
194.13 07961 VALET PARKING SERVICE	0	0	0	0	0	194. 13
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0		201. 00
202.00 TOTAL (sum lines 118-201)	45, 975	0	13, 083	81, 881	60, 596	202. 00

In Lieu of Form CMS-2552-10

| Period: | Worksheet B |
| From 07/01/2014 | Part II |
| To 06/30/2015 | Date/Time Prepared: | 11/23/2015 5:05 pm Provider CCN: 140089

					06/30/2015	11/23/2015 5:	
		CAPITAL REL	ATED COSTS				
	Cost Center Description	CONVENIENCE CARE CLINI	BUSHNELL OFFICE BLDG	Subtotal	EMPLOYEE BENEFITS	ADMI NI STRATI VE & GENERAL	
		1. 09	1. 10	2A	DEPARTMENT 4. 00	5. 00	
	GENERAL SERVICE COST CENTERS	1.07	1. 10	2/(1. 00	0.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1. 01 1. 02	00101 CAP REL COSTS-HOSPI TAL 00102 CAP REL COSTS-HSB I						1. 01 1. 02
1.02	00102 CAP REL COSTS-HSB II						1. 02
1. 04	00104 CAP REL COSTS-REHAB CNT						1. 04
1.05	00105 CAP REL COSTS-DI AYSI S						1. 05
1.06	00106 CAP REL COSTS-HOSPI TALI TY HOUSE						1. 06
1. 07 1. 08	00107 CAP REL COSTS-MAB 00108 CAP REL COSTS-ORTHO BLDG						1. 07 1. 08
1.08	00109 CAP REL COSTS-CONVENIENCE CARE CLINI						1. 08
1. 10	00110 CAP REL COSTS-BUSHNELL OFFICE BLDG						1. 10
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	56, 942	56, 942		4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	0	3, 442	1, 226, 784	7, 499		5. 00
6. 00 6. 01	OO6OO MAI NTENANCE & REPAI RS OO6O1 MAI NTENANCE & REPAI RS - HSB I	0	0	275, 348 8. 715	1, 031 38	49, 165 3, 789	6. 00 6. 01
6. 02	00602 MAINTENANCE & REPAIRS-HSB II	0	0	49, 660	24		6. 02
6. 03	00603 MAINTENANCE & REPAIRS-REHAB CLINIC	0	0	0	0	162	6. 03
6.04	00604 MAINTENANCE & REPAIRS-MAB	0	0	0	5	446	6. 04
6.05	00605 MAINTENANCE & REPAIRS-ORTHO BLDG	0	0	0	4	303	6. 05
6. 06 8. 00	00606 MAINTENANCE & REPAIRS-BUSHNELL 00800 LAUNDRY & LINEN SERVICE	0	0	83, 629	4 211	578 9, 348	6. 06 8. 00
9. 00	00900 HOUSEKEEPING	0	0	44, 464	375	19, 070	9. 00
9. 01	00901 HOUSEKEEPI NG-HSB	0	0	0	85		9. 01
9. 02	00902 HOUSEKEEPING-HSB II	0	0	0	27	1, 591	9. 02
9. 03	00903 HOUSEKEEPI NG-ORTHO	0	0	0	5	237	9. 03
9. 04 10. 00	00904 HOUSEKEEPI NG-MAB 01000 DI ETARY	0	0	58, 067	4 341	159 17, 279	9. 04 10. 00
11. 00	01100 CAFETERI A	0	0	146, 584	121	12, 565	11. 00
13. 00	01300 NURSING ADMINISTRATION	0	0	1, 298	934		13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	0	138, 474	528		14. 00
15.00	01500 PHARMACY	0	0	33, 672	1, 037		
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0	0	82, 527 9, 905	1, 263 745		16. 00 17. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0, 703	0		19. 00
23. 00	02300 PARAMED ED PRGM	0	0	5, 515	51	972	23. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS			F0/ 2F0	4 527	00.700	20.00
30. 00 31. 00	03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T	0	0	586, 250 93, 729	4, 537 1, 275		30. 00 31. 00
43. 00	04300 NURSERY	0	Ö	20, 437	639		
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
50.00	ANCILLARY SERVICE COST CENTERS		ا م	47, 000	0.005	54.054	
50. 00 51. 00	O5000 OPERATI NG ROOM O5100 RECOVERY ROOM	0	0	176, 320 57, 743	2, 095 923	51, 951 21, 070	50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	43, 599	587		
53.00	05300 ANESTHESI OLOGY	0	0	6, 920	0	3, 547	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	216, 589	1, 603		54. 00
57. 00	05700 CT SCAN	0	0	9, 840	865 0	17, 987	57. 00
58. 00 60. 00	05800 MAGNETIC RESONANCE MAGING (MRI) 06000 LABORATORY	0	0	196, 563	3, 261	12, 063 104, 043	
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	Ö	0	0, 201	1, 011	63. 00
65.00	06500 RESPI RATORY THERAPY	0	0	78, 591	506	11, 119	65. 00
66.00	06600 PHYSI CAL THERAPY	0	1, 665	138, 795	2, 959		66. 00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0	0 3, 028	0	0 4, 033	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	3, 028	247 403		69.00
	07000 ELECTROENCEPHALOGRAPHY	0	Ö	4, 671	355		70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	0	0	0	25, 838	
73. 00 76. 00	07300 DRUGS CHARGED TO PATIENTS 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	13, 462	0 1, 019	0 16, 703	73. 00 76. 00
76. 00	03950 DI ABETES/WOUND CARE/COUMADI N CNTR	0	0	17, 885	819		76. 00
	03951 FLU CLINIC	0	Ö	0	1	458	
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	75, 463	75, 463	769		88. 00
91. 00 92. 00	O9100 EMERGENCY O9200 OBSERVATI ON BEDS (NON-DISTINCT PART)	0	0	112, 112 0	2, 057	84, 794	91. 00 92. 00
7Z. UU	OTHER REIMBURSABLE COST CENTERS			U		I	72.00
	09500 AMBULANCE SERVICES	0	0	29, 196	1, 362		95. 00
101.00	10100 HOME HEALTH AGENCY	0	o	18, 722	1, 939	33, 845	101. 00

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 07/01/2014 Part II Provider CCN: 140089

			T	06/30/2015	Date/Time Pre 11/23/2015 5:	
	CAPITAL REL	ATED COSTS				
Cost Center Description	CONVENIENCE CARE CLINI	BUSHNELL OFFICE BLDG	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
	1. 09	1. 10	2A	4. 00	5. 00	
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113. 00
116. 00 11600 H0SPI CE	0	0	11, 374	·		116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	80, 570	4, 135, 901	43, 632	974, 256	118. 00
NONREI MBURSABLE COST CENTERS	T _	_		_		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	10, 900			190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	168, 068			192. 00
194. 00 07950 DAY HEALTH	0	0	13, 184			194. 00
194. 01 07962 OUTREACH	0	0	1, 922	282		194. 01
194. 02 07951 OCCUPATI ONAL MEDI CI NE	0	0	0 700	0		194. 02
194. 03 07952 FUND DEVELOPMENT	0	0	2, 703	279		194. 03
194. 04 07953 OUTSI DE LAUNDRY	0	0	2 700	177		194. 04
194. 05 07954 PHYSI CI AN SUPPORT	0	0	3, 780	177		194. 05 194. 06
194. 06 07955 HOSPI TALI TY HOUSE 194. 07 07956 HSK_DLALYSLS	0	0	13, 083	17		194. 06
194. 08 07957 LEASED SALARI ES	0	0	0	57		194. 07
194.08 07957 LEASED SALARTES 194.09 07958 VI SI TI NG PHYSI CI ANS	0	0	0	57		194. 08
194. 10 07959 FARM_LAND	0	0	0	0		194. 09
194. 11 07963 CONVENI ENCE CARE CLINIC	32, 654	0	32, 654	519		
194. 12 07960 MMG-PHYSI CLAN OFFI CES	32,034	0	202, 438			
194. 13 07961 VALET PARKING SERVICE	0	0	202, 430	33		194. 12
200.00 Cross Foot Adjustments			0	55	310	200.00
201.00 Negative Cost Centers	0	0	1 0	0	0	201. 00
202.00 TOTAL (sum lines 118-201)	32, 654	80, 570	4, 584, 633	56, 942		

| Peri od: | Worksheet B | From 07/01/2014 | Part II | To 06/30/2015 | Date/Time Prepared:

	MALNITENANOE O	I MALNITENANOE O		o 06/30/2015	11/23/2015 5:	
Cost Center Description	REPAIRS		MAINTENANCE & REPAIRS-HSB II		MAINTENANCE & REPAIRS-MAB	
	6. 00	6. 01	6. 02	6. 03	6. 04	
GENERAL SERVICE COST CENTERS 1.00 OO100 NEW CAP REL COSTS-BLDG & FLXT						1. 00
1. 01 00101 CAP REL COSTS-HOSPI TAL						1. 01
1. 02 00102 CAP REL COSTS-HSB I						1. 02
1. 03 00103 CAP REL COSTS - HSB I						1. 03
1. 04 00104 CAP REL COSTS-REHAB CNT 1. 05 00105 CAP REL COSTS-DI AYSI S						1. 04 1. 05
1. 06 00106 CAP REL COSTS-HOSPITALITY HOUSE						1. 06
1.07 O0107 CAP REL COSTS-MAB						1. 07
1.08 OO108 CAP REL COSTS-ORTHO BLDG						1. 08
1.09 O0109 CAP REL COSTS-CONVENIENCE CARE CLINI						1. 09
1.10 00110 CAP REL COSTS-BUSHNELL OFFICE BLDG 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						1. 10 4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL						5. 00
6.00 00600 MAINTENANCE & REPAIRS	325, 544					6. 00
6. 01 00601 MAINTENANCE & REPAIRS-HSB I	0		•			6. 01
6. 02 00602 MAI NTENANCE & REPAI RS-HSB I	0	0	53, 308			6. 02
6.03 00603 MAI NTENANCE & REPAI RS-REHAB CLINIC 6.04 00604 MAI NTENANCE & REPAI RS-MAB				162	451	6. 03 6. 04
6. 05 00605 MAI NTENANCE & REPAI RS-ORTHO BLDG	Ö		ol o	o	0	6. 05
6.06 00606 MAINTENANCE & REPAIRS-BUSHNELL	0	O	0	0	0	6. 06
8.00 00800 LAUNDRY & LINEN SERVICE	11, 510		0	0	0	8. 00
9. 00 00900 HOUSEKEEPI NG	6, 119	0	0	0	0	9. 00
9. 01 00901 HOUSEKEEPI NG-HSB 9. 02 00902 HOUSEKEEPI NG-HSB I	0			0	0	9. 01 9. 02
9. 03 00903 HOUSEKEEPI NG-0RTH0				0	0	9. 02
9. 04 00904 HOUSEKEEPI NG-MAB	0	O	0	0	0	9. 04
10. 00 01000 DI ETARY	7, 992		0	-	0	10.00
11. 00 01100 CAFETERI A	20, 174		0	0	0	11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY	179 19, 058		0	0	0	13. 00 14. 00
15. 00 01500 PHARMACY	4, 634			0	0	15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	11, 358	Ö		Ö	0	16. 00
17.00 01700 SOCIAL SERVICE	1, 363	0	0	0	0	17. 00
19. 00 01900 NONPHYSI CI AN ANESTHETI STS	0		0	0	0	19. 00
23. 00 02300 PARAMED ED PRGM I NPATI ENT ROUTI NE SERVI CE COST CENTERS	759	0) 0	0	0	23. 00
30. 00 03000 ADULTS & PEDIATRICS	80, 683) 0	0	0	30. 00
31.00 03100 INTENSIVE CARE UNIT	12, 900	ł .	0	0	0	31.00
43. 00 04300 NURSERY	2, 813		1		0	43.00
44. 00 04400 SKI LLED NURSI NG FACI LI TY	0	0) 0	0	0	44. 00
ANCI LLARY SERVICE COST CENTERS 50. 00 05000 0PERATI NG ROOM	24, 267) 0	O	0	50. 00
51. 00 05100 RECOVERY ROOM	7, 947				0	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	6,000		0	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	952		0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	29, 809		0	0	0	54.00
57. 00 05700 CT SCAN 58. 00 05800 MAGNETI C RESONANCE MAGING (MRI)	1, 354			0	0	57. 00 58. 00
60. 00 06000 LABORATORY	27, 053		ol o	0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	o	0	0	0	63.00
65. 00 06500 RESPIRATORY THERAPY	10, 816		0	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	12, 546			162	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	417			0	0	67. 00 68. 00
69. 00 06900 ELECTROCARDI OLOGY	417			0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	643		0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72. 00
73. 00 O7300 DRUGS CHARGED TO PATIENTS 76. 00 O3550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	1, 011		0	0	73. 00 76. 00
76. 01 03950 DI ABETES/WOUND CARE/COUMADIN CNTR	2, 461	1,011		0	0	76. 00 76. 01
76. 02 03951 FLU CLINIC	0	O	o	0	0	76. 02
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	15 420	0	0		0	88. 00
91. 00 09100 EMERGENCY 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART)	15, 430		0	0	0	91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS		l .				7Z. UU
95. 00 09500 AMBULANCE SERVICES	4, 018	О) 0	0	0	95. 00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	103	101. 00
SPECIAL PURPOSE COST CENTERS						112 00
113. 00 11300 NTEREST EXPENSE 116. 00 11600 HOSPI CE	0	0		0	63	113. 00 116. 00
	1	,	1	<u>, </u>		

MCDONOUGH DISTRICT HOSPITAL

Provider CCN: 140089

Period:
From 07/01/2014
To 06/30/2015

MAINTENANCE & MAINTENANCE & MAINTENANCE & MAINTENANCE & REPAIRS REPAIRS-HSB I REPAIRS-HSB I REPAIRS-REHAB REPAIRS-MAB Cost Center Description

	REPAI RS	REPAIRS-HSB I	REPAIRS-HSB II	REPAI RS-REHAB	REPAIRS-MAB	
				CLI NI C		
	6. 00	6. 01	6. 02	6. 03	6. 04	
118.00 SUBTOTALS (SUM OF LINES 1-117)	323, 672	1, 011	0	162	166	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 500	0	0	0	0	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	8, 735	0	0	285	192. 00
194. 00 07950 DAY HEALTH	0	990	0	0	0	194. 00
194. 01 07962 OUTREACH	0	144	0	0	0	194. 01
194. 02 07951 OCCUPATI ONAL MEDI CI NE	0	0	0	0	0	194. 02
194. 03 07952 FUND DEVELOPMENT	372	0	0	0	0	194. 03
194. 04 07953 OUTSI DE LAUNDRY	0	0	0	0	0	194. 04
194. 05 07954 PHYSI CI AN SUPPORT	0	284	0	0	0	194. 05
194. 06 07955 HOSPI TALI TY HOUSE	0	0	0	0	0	194. 06
194. 07 07956 HSK DI ALYSI S	0	0	0	0	0	194. 07
194. 08 07957 LEASED SALARI ES	0	0	0	0	0	194. 08
194. 09 07958 VISITING PHYSICIANS	0	l o	0	0	0	194. 09
194. 10 07959 FARM_LAND	0	l o	0	0	0	194. 10
194. 11 07963 CONVENIENCE CARE CLINIC	0	0	0	0	0	194. 11
194. 12 07960 MMG-PHYSICIAN OFFICES	0	1, 378	53, 308	0	0	194. 12
194. 13 07961 VALET PARKING SERVICE	0	0	0	0	0	194, 13
200.00 Cross Foot Adjustments		-			·	200. 00
201.00 Negative Cost Centers	0	0	0	o		201. 00
202.00 TOTAL (sum lines 118-201)	325, 544	12, 542	53, 308	162		202.00
				'		

				'	0 06/30/2015	Date/lime Pre 11/23/2015 5:	
	Cost Center Description	MAINTENANCE &	MAINTENANCE & REPAIRS-BUSHNE	LAUNDRY &	HOUSEKEEPI NG	HOUSEKEEPI NG-H SB	
		BLDG	LL				
	GENERAL SERVICE COST CENTERS	6. 05	6. 06	8. 00	9. 00	9. 01	
1. 00	00100 NEW CAP REL COSTS-BLDG & FLXT						1.00
1. 01	00101 CAP REL COSTS-HOSPITAL						1. 01
1.02	00102 CAP REL COSTS-HSB I						1. 02
1.03	00103 CAP REL COSTS-HSB II						1. 03
1.04	00104 CAP REL COSTS-REHAB CNT						1. 04
1.05	00105 CAP REL COSTS-DI AYSI S						1. 05
1. 06 1. 07	O0106 CAP REL COSTS-HOSPITALITY HOUSE O0107 CAP REL COSTS-MAB						1. 06 1. 07
1. 07	00107 CAP REL COSTS-WAB						1.07
1. 09	00109 CAP REL COSTS-CONVENIENCE CARE CLINI						1. 09
1. 10	00110 CAP REL COSTS-BUSHNELL OFFICE BLDG						1. 10
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
6.00	00600 MAI NTENANCE & REPAI RS						6.00
6. 01	00601 MAI NTENANCE & REPAIRS-HSB I						6. 01
6. 02 6. 03	OO6O2 MAINTENANCE & REPAIRS-HSB II OO6O3 MAINTENANCE & REPAIRS-REHAB CLINIC						6. 02 6. 03
6. 04	00604 MAI NTENANCE & REPAI RS-MAB					•	6. 04
6. 05	00605 MAINTENANCE & REPAIRS-ORTHO BLDG	307					6. 05
6.06	00606 MAINTENANCE & REPAIRS-BUSHNELL	0	582				6. 06
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	104, 698			8. 00
9.00	00900 HOUSEKEEPI NG	0	0	0	70, 028		9. 00
9. 01	00901 HOUSEKEEPI NG-HSB	0	0	·	0	0,	1
9. 02	00902 HOUSEKEEPING-HSB II	0	0	0	0	0	
9. 03 9. 04	00903 HOUSEKEEPI NG-ORTHO 00904 HOUSEKEEPI NG-MAB	0	0	0	0	0	9. 03 9. 04
10. 00	01000 DI ETARY				1, 565		10.00
11. 00	01100 CAFETERI A	0	0	0	4, 178		11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	0	0	454		13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	2, 168	0	14. 00
15. 00	01500 PHARMACY	0	0	0	555	0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0	0	329		16. 00
17. 00	01700 SOCIAL SERVICE	0	0	0	147	0	17. 00
19. 00 23. 00	O1900 NONPHYSICIAN ANESTHETISTS O2300 PARAMED ED PRGM	0	0	0	0	_	19. 00 23. 00
23.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0				0	23.00
30. 00	03000 ADULTS & PEDI ATRI CS	0	0	20, 607	21, 448	0	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0	4, 876	3, 267	0	31.00
43.00	04300 NURSERY	0	ł	-	368	l .	
44. 00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
EO 00	ANCI LLARY SERVI CE COST CENTERS	1 0		10.004	7 2/2	1 0	F0 00
50. 00 51. 00	O5000 OPERATI NG ROOM O5100 RECOVERY ROOM	0	0	10, 086 8, 601	7, 363 2, 509	l .	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0,001	749		
53. 00	05300 ANESTHESI OLOGY	0	Ö	Ö	0		1
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	7, 163	3, 385	0	54.00
	05700 CT SCAN	0	0		797	0	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	771		0	58. 00
60.00	06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	506	4, 614	0	60.00
63. 00 65. 00	06500 RESPIRATORY THERAPY	0	0	1, 348	1, 731	0	63. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	0	13			0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0,010	0,071	ő	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	480	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	341	0	69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	0	0	939		70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
	07200 DRUCS CHARGED TO PATIENT]	0	0	0	72.00
73. 00 76. 00	07300 DRUGS CHARGED TO PATIENTS 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES					251	73. 00 76. 00
76. 00 76. 01	03950 DI ABETES/WOUND CARE/COUMADI N CNTR			1, 419	1, 181	0	76. 00
	03951 FLU CLINIC	0	0	., ., ,	0	ő	1
	OUTPATIENT SERVICE COST CENTERS				-		
88. 00	08800 RURAL HEALTH CLINIC	0	l		0	_	
	09100 EMERGENCY	0	0	13, 267	7, 466	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
95. 00	09500 AMBULANCE SERVICES	0	0	1, 669	77	0	95. 00
	10100 HOME HEALTH AGENCY	0	l e		0		101.00
	SPECIAL PURPOSE COST CENTERS						1
	11300 I NTEREST EXPENSE						113. 00
116.00	11600 HOSPI CE	0	0	97	0	0	116. 00

| Peri od: | Worksheet B | From 07/01/2014 | Part II | To 06/30/2015 | Date/Time Prepared:

			11	0 06/30/2015	11/23/2015 5:	
Cost Center Description		MAINTENANCE & REPAIRS-BUSHNE		HOUSEKEEPI NG	HOUSEKEEPI NG-H SB	
	BLDG	LL				
	6. 05	6. 06	8. 00	9. 00	9. 01	
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	582	74, 655	69, 782	251	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	246	0	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	2, 172	192. 00
194.00 07950 DAY HEALTH	0	0	0	0	246	194. 00
194. 01 07962 OUTREACH	0	0	0	0	36	194. 01
194. 02 07951 OCCUPATIONAL MEDICINE	0	0	0	0	0	194. 02
194.03 07952 FUND DEVELOPMENT	0	0	0	0	0	194. 03
194. 04 07953 OUTSI DE LAUNDRY	0	0	29, 678	0	0	194. 04
194. 05 07954 PHYSI CI AN SUPPORT	0	0	0	0	71	194. 05
194. 06 07955 HOSPI TALI TY HOUSE	0	0	22	0	0	194. 06
194. 07 07956 HSK DI ALYSI S	0	0	0	0	0	194. 07
194. 08 07957 LEASED SALARI ES	0	0	0	0	0	194. 08
194.09 07958 VISITING PHYSICIANS	0	0	0	0	0	194. 09
194.10 07959 FARM LAND	0	0	0	0	0	194. 10
194. 11 07963 CONVENIENCE CARE CLINIC	0	0	0	0	0	194. 11
194.12 07960 MMG-PHYSICIAN OFFICES	307	0	343	0	343	194. 12
194.13 07961 VALET PARKING SERVICE	0	0	0	0	0	194. 13
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201. 00
202.00 TOTAL (sum lines 118-201)	307	582	104, 698	70, 028	3, 119	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Control Description Desc					10	06/30/2015	Date/lime Pre 11/23/2015 5:	
STREAM SERVICE COST INSTITUTE 1.00 DOTOID FOR PICE COSTS IN DEA FLYT 1.00 DOTOID FOR PICE COSTS IN DEA FLYT 1.02 DOTOID FOR PICE COSTS IN DEA FLYT 1.03 DOTOID FOR PICE COSTS IN DEA FLYT 1.04 DOTOID FOR PICE COSTS IN DEA FLYT 1.05 DOTOID FOR PICE COSTS IN DEA FLYT 1.05 DOTOID FOR PICE COSTS IN DEA FLYT 1.06 DOTOID FOR PICE COSTS IN DEA FLYT 1.07 DOTOID FOR PICE COSTS IN DEA FLYT 1.08 DOTOID FOR PICE COSTS IN DEA FLYT 1.09 DOTOID FOR PICE COSTS IN DEA FLYT 1.00 DOTOID FOR PICE COSTS IN DE		Cost Center Description	HOUSEKEEPI NG-H	HOUSEKEEPI NG-0	HOUSEKEEPI NG-M	DI ETARY		
To CO COUNTY CAP PR. LOSS SENDER FIXT						10.00	11 00	
1.00		GENERAL SERVICE COST CENTERS	9.02	9.03	9.04	10.00	11.00	
1.02 001002 CAR PET LOSTS-1881 I	1.00							1.00
1.03 00100 [AP REL OSTS-1458] 1	1.01	00101 CAP REL COSTS-HOSPI TAL						1. 01
1-04 0.0104 CAP PEL COSTS-REHAS (OVT		1						ı
1.05 0.0106 CAP RELL COSTS FOR YATS 1.01 1.02 1.05 1.00								1
1.06 00100 CAP REL COSTS-HOSPITALITY HOUSE								1
1.07 (DOTO) CAP REL COSTS-CORPORED RICE CARE CLINI 1.08 COTORO CAP REL COSTS-CORPORED RICE CARE CLINI 1.09 COTORO CAP REL COSTS-CORPORED RICE CARE CLINI 1.10 COTTOR CAP REL COSTS-CORPORED RICE CAPE CLINI 1.10 COTTOR CAP REL COSTS-CORPORED RICE CAPE CLINICAL RICE CAPE CLI								1
1.09								1
1.10 D0 1100 CAP REL COSTS-BUSHNELL OFFICE BLDG		00108 CAP REL COSTS-ORTHO BLDG						1. 08
0.0400 DIPLOYME BENEFITS DEPARTEINT								1
0.000 0.00								1
6.00 0.0600 MI NETAMICE & REPAIRS—RES 1		1						1
6. 02 0.0062 MAINTENNINCE & REPAIR S-HSB LI								1
0.03 0.0003 MAINTENNINCE & REPAIRS-REHARD CLINIC 0.03 0.0006 MAINTENNINCE & REPAIRS-ROPHING BLDG 0.000 0.0006 MAINTENNINCE & REPAIRS-ROPHING BLDG 0.000 0.0000 MAINTENNINCE & REPAIRS-ROPHING BLDG 0.000 0.0000 MAINTENNINCE & REPAIRS-ROPHING BLDG 0.000 0.0000 MAINTENNINCE & REPAIRS-ROPHING BLDG 0.000 0.000 MAINTENNINCE & REPAIRS-ROPHING BLDG 0.000 0.000 MAINTENNINCE & REPAIRS-ROPHING BLDG 0.000 MAINTENNINCE & REPAIRS BLDG BLDG BLDG BLDG BLDG BLDG BLDG BLDG		1						1
6. 04 00600 [MAINTENMENT & REPAIRS AMB 6. 05 00600 [MAINTENMENT & REPAIRS BUSINELL 8. 00 00000 [MAINTENMENT & REPAIRS BUSINELL 8. 00 00 00 0 0 1633		1						1
0.005 MAINTERMACE & REPAIRS—DRINKELL		1 1						ı
0.0000 MAINTERNANCE & REPAIRS-BUSHNELL								ı
B. 00 00900 LAUNDRY & LINEN SERVICE		1						ı
9.01 0.0901 HUSEKEEPI NG-HSB 1								ı
9.02 0.0902 HULSKEEPING-HSB 1		1						ı
9.03 0.0903 HOUSEKEEPING-ORTHO 0 242 0 0 0 163 9.04 10.00 10000 DI ETARY 0 0 0 0 85,244 10.00 10100 CAFTERIA 0 0 0 0 0 83,241 11.00 0.1100 CAFTERIA 0 0 0 0 0 3,063 13.00 13.00 0.1300 NURSING ADMINISTRATION 0 0 0 0 0 3,063 13.00 0.1000 CENTRAL SERVICES & SUPPLY 0 0 0 0 0 3,193 15.00 0.1500 PHARMACY 0 0 0 0 0 3,193 15.00 0.1500 PHARMACY 0 0 0 0 0 3,193 17.00 0.1500 MEDICAL RECORDS & LIBRARY 0 0 0 0 0 0 0 8,358 16.00 0.1600 MEDICAL RECORDS & LIBRARY 0 0 0 0 0 0 0 1,748 17.00 0.1700 MONHYSICIAN AMESTHETISTS 0 0 0 0 0 0 0 0 0			4 (40					•
9. 04 00904 HOUSEKEPING-MAB 0 0 0 163 85, 24 10.00 11.00 01000 BETARY 0 0 0 0 85, 24 11.00 11.00 01100 CAFETERIA 0 0 0 0 0 0 85, 24 11.00 11.00 01100 CAFETERIA 0 0 0 0 0 0 0 3, 363 13.00 13.00 01300 NURSI NG ADM INISTRATI ON 0 0 0 0 0 0 3, 3.91 14.00 13.00 01300 NURSI NG ADM INISTRATI ON 0 0 0 0 0 0 3, 3.91 14.00 13.00 01300 NURSI NG ADM INISTRATI ON 0 0 0 0 0 0 3, 3.91 14.00 15.00 01500 PHARMACY 0 0 0 0 0 0 0 3, 3.91 14.00 15.00 01500 PHARMACY 0 0 0 0 0 0 0 3, 3.91 14.00 15.00 01500 PHARMACY 0 0 0 0 0 0 0 0 0 3, 3.88 15.00 16.00 15.00 01500 PHARMACY 0 0 0 0 0 0 0 0 0 0 0 1, 749 17.00 17.00 17.00 17.00 17.00 50 CIAL SERVICE COST CENTERS 0 0 0 0 0 0 0 0 1, 749 17.00 17.0		1 1	1, 618	242				•
10. 00 01000 DIETRRY 0 0 0 85,244 10. 00 13.0 00 15.0 00 0 0 0 0 0 0 0 0		1 1	0					ı
13. 00 01300 NURSIN O ADMINISTRATION 0 0 0 0 3. 0.63 13. 00		1 1	Ö	0		85, 244		ı
14. 00 01400 CENTRAL SERVICES & SUPPLY 0 0 0 0 3,919 14, 00	11. 00	01100 CAFETERI A	0	0	0		183, 622	11. 00
15.00 01500 PHARMACY 0 0 0 0 3,188 15.00 17.00 01700 SOCIAL SERVICE 0 0 0 0 0 1,748 17.00 23.00 01200 PARAMED ED PROM 0 0 0 0 0 0 0 0 0 17.00 01700 SOCIAL SERVICE 0 0 0 0 0 0 0 0 0			0	0	0	0		1
16. 00 014000 MEDICAL RECORDS & LIBRARY 0 0 0 0 0 8, 358 16. 00. 01900 01900 SOCIAL SERVICE 0 0 0 0 0 0 1.748 17. 00. 1700 01700 SOCIAL SERVICE 0 0 0 0 0 0 0 0 1.748 17. 00. 1700 01700 SOCIAL SERVICE SOCIAL SERVICE 0 0 0 0 0 0 0 0 1.748 17. 00. 1700 01700 SOCIAL SERVICE COST CENTERS 0 0 0 0 0 0 0 0 216 23. 00. 01700 SOCIAL SERVICE COST CENTERS 0 0 0 0 0 0 54, 996 21, 573 30. 00. 01700 AUDITS & PEPIDATRIC SOCIAL SERVICE COST CENTERS 0 0 0 0 0 54, 996 21, 573 30. 00. 01700 AUDITS & PEPIDATRIC SOCIAL SERVICE SOCIA			0	0	0	0		1
17.00 01700 001.4 SERVICE 0 0 0 0 0 1.748 17.00			0	0	0	0		1
23.00			o o		1	- 1		1
INPATI ENT ROUTINE SERVICE COST CENTERS 0	19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0		1
30. 00 03000 ADULTS & PEDIATRICS 0 0 0 54,996 21,573 30. 00 31. 00 3100 INTERSITY CAPE UNIT 0 0 0 0 11,649 5,074 31. 00 31. 00 300 NURSERY 0 0 0 0 0 0 0 0 2,516 43. 00 44. 00 ADULTS & PROVED TO THE RESERVE COST CENTERS 0 0 0 0 0 0 0 0 0	23. 00		0	0	0	0	216	23. 00
31 00 03100 INTENSIVE CARE UNIT 0 0 0 0 0 11, 649 5,074 31.00	20.00			0		E4 00/	21 572	20.00
43.00 04300 NURSERY			0				•	•
A4.00 04400 SKI LLED NURSING FACILITY			0					1
50.00 050000 05000 05000 05000 05000 05000 05000 05000 050000 05000 05000 05000 05000 050000 050000 050000 050000 050000 050000 050000 050000 050000 050000 050000 0500000 0500000 0500000 05000000 050000000 0500000000	44.00		0	0	0	0		1
S1-00 05100 RECOVERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 0 0			-1			_1		
52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 2, 645 52.00			0			- 1		1
53.00 05300 ANESTHESI OLOGY 0 0 0 0 0 53.00 54.00 05400 RADI OLOGY-JOLIGNOSTI C 0 0 0 0 0 8, 017 57.00 05500 CT SCAN 0 0 0 0 0 0 0 2, 866 57.00 05700 CT SCAN 0 0 0 0 0 0 0 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 0 0 0 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 0 0 60.00 06000 LABORATORY 0 0 0 0 0 14, 632 60.00 63.00 06300 BLOOD STORI NG , PROCESSI NG & TRANS. 0 0 0 0 0 0 65.00 06500 RESPI RATORY THERAPY 0 0 0 0 0 0 65.00 06500 RESPI RATORY THERAPY 0 0 0 0 0 0 67.00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 68.00 06600 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 70.00 07000 ELECTROCARDI OLOGY 0 0 0 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 72.00 07200 IMPLE DEV. CHARGED TO PATIENTS 0 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 74.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 76.01 03950 DIABETES/WOUND CAREZ/COUMADI N CNTR 0 0 0 0 76.01 03950 DIABETES/WOUND CAREZ/COUMADI N CNTR 0 0 0 0 76.01 03950 DIABETES/WOUND CAREZ/COUMADI N CNTR 0 0 0 0 76.01 03950 DIABETES/WOUND CAREZ/COUMADI N CNTR 0 0 0 0 76.02 005950 AMBULANCE SERVI CES 0 0 0 0 76.03 08800 RURAL HEALTH CLINI C 0 0 0 0 76.04 09900 08ERGENCY 0 0 0 0 76.05 09900 08ERGENCY 0 0 0 76.07 09900 08ERGENCY 0 0 0 76.08 09900 08ERGENCY 0 0 0 76.09 09900 08ERGENCY 0 0 0 76.00 09900 08ERGENCY 0 0 0 76.01 09900 08ERGENCY 0 0 0 76.02 09900 08ERGENCY 0 0 0 76.03 09900 08ERGENCY 0 0 0 76.04 09900 08ERGENCY 0 0 76.05 09900			0	0	0	0		ı
57.00 05700 CT SCAN 0 0 0 0 0 0 0 0 0 2,866 57.00		1 1	Ö	0	Ö	ő		1
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 0 0 58. 00 60. 00 06000 LABORATORY 0 0 0 0 14,632 60. 00 63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0 65. 00 06500 RESPIRATORY THERAPY 0 0 0 0 0 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 67. 00 06700 OCCUPATIONAL THERAPY 0 0 0 0 0 68. 00 06800 SPECH PATHOLOGY 0 0 0 0 69. 00 06900 ELECTROCARDIOLOGY 0 0 0 0 70. 00 07000 ELECTROCARDIOLOGY 0 0 0 0 71. 00 07000 ELECTROCARDIOLOGY 0 0 0 0 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 74. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 75. 01 03950 DIABETES/WOUND CARE/COUMADIN CNTR 0 0 0 0 76. 01 03950 DIABETES/WOUND CARE/COUMADIN CNTR 0 0 0 76. 02 03951 FLU CLINIC 0 0 0 76. 02 0000 0000 0000 0000 76. 02 0000 0000 0000 0000 76. 02 0000 0000 0000 0000 76. 02 0000 0000 0000 76. 02 0000 0000 0000 76. 02 0000 0000 0000 76. 02 0000 0000 0000 76. 02 0000 0000 0000 76. 02 0000 0000 0000 76. 02 0000 0000 0000 76. 02 0000 0000 76. 02 0000 0000 76. 02 0000 0000 76. 02 0000 76. 02 0000 0000 76. 02 0000 76. 02 0000 76. 02 0000 76. 02 0000 76. 02 0000 76. 02 0000 76. 03 0000 76. 04 0000 76. 05 0000 76. 05 0000 76. 06 0000 76. 07 0000 76. 08 0000 76. 0900 76. 000 77. 000 0000 77. 000 78. 00	54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	0	0		
60.00 06000 LABORATORY 0 0 0 0 14,632 60.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0 0 65.00 06500 RESPIRATORY THERAPY 0 0 0 0 0 66.00 06600 PHYSICAL THERAPY 0 0 0 0 0 67.00 06700 0CCUPATIONAL THERAPY 0 0 0 0 0 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 69.00 06800 SPEECH PATHOLOGY 0 0 0 0 69.00 06900 ELECTROCARDIOLOGY 0 0 0 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 72.00 07200 IMPL DEV. CHARGED TO PATIENTS 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 76.00 03550 PSYCHIATRIC/PSYCHOLOGI CAL SERVICES 0 0 0 76.01 03950 DI ABETES/WOUND CARE/COUMADIN CNTR 0 0 0 76.02 03951 FLU CLINIC 0 0 0 76.02 00TPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 79.00 09200 0BERGENCY 0 0 0 79.00 09200 0BERGENCY 0 0 0 79.00 09200 0BERGENCY 0 0 0 79.00 09000 00 0 79.00 09000 00 0 79.00 09000 00 0 79.00 09000 00 0 79.00 09000 00 0 79.00 09000 00 0 79.00 09000 00 0 79.00 09000 00 0 79.00 09000 00 0 79.00 09000 00 0 79.00 09000 00 0 79.00 09000 00 0 79.00 09000 00 0 79.00 00 00 79.00 00 00 79.00 00 00 79.00 00 00 79.00 00 00 79			0	ū	1 1	٦		
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0 0 63. 00 65. 00 06500 RESPIRATORY THERAPY 0 0 0 0 0 0 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 67. 00 06700 OCCUPATIONAL THERAPY 0 0 0 0 0 68. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 69. 00 06700 OCCUPATIONAL THERAPY 0 0 0 0 0 69. 00 06900 ELECTROCARDIOLOGY 0 0 0 0 70. 00 07000 ELECTROCARDIOLOGY 0 0 0 0 71. 00 07000 ELECTROCARDIOLOGY 0 0 0 0 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 74. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 75. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 76. 01 03950 PSYCHI ATRI C/PSYCHOLOGI CAL SERVICES 0 0 0 0 76. 02 03951 FLU CLINIC 0 0 0 0 76. 02 03951 FLU CLINIC 0 0 0 76. 02 03951 FLU CLINIC 0 0 0 76. 02 03951 FLU CLINIC 0 0 0 76. 02 03950 DRURAL HEALTH CLINIC 0 0 0 76. 02 07100 DRUGS COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 76. 02 07100 DRUGS COST CENTERS 89. 00 09500 OBSERVATION BEDS (NON-DISTINCT PART) 92. 00 79. 00 09500 OBSERVATION BEDS (NON-DISTINCT PART) 92. 00 79. 00 09500 OBSERVATION BEDS (NON-DISTINCT PART) 92. 00 79. 00 09500 OBSERVATION BEDS (NON-DISTINCT PART) 92. 00 79. 00 00 00 00 00 00 79. 682 01 00 00 79. 69. 00 00 00 00 79. 69. 00 00 00 79. 69. 00 00 00 79. 69. 00 00 00 79. 69. 00 00 00 79. 69. 00 00 00 79. 69. 00 00 00 79. 69. 00 00 00 79. 69. 00 00 79. 69. 00 79. 69. 00 00 00 79. 69. 00 79. 69. 00 79. 69. 00 79. 69. 00 79. 69. 00 79. 69. 00 79. 69. 00 79. 69. 00 79. 69. 00 79. 69. 00 79. 69. 00 79. 69. 00 79. 69. 00 79. 69. 00 79. 69. 00			0	0	0	0		
65. 00			0	0	0	0		1
66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 9, 489 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 68. 00 06800 SPECH PATHOLOGY 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 70. 00 07000 ELECTROCARDI OLOGY 0 0 0 0 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENT 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENT 0 0 0 0 76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 76. 01 03950 DI ABETES/WOUND CARE/COUMADI N CNTR 0 0 0 76. 02 03951 FLU CLI NI C 0 0 0 00 07500 DRUGS CHARGED TO PATI ENTS 0 0 00 0 0 0 00 0 0			0	0	Ö	o		1
68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 796 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 1, 771 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 1, 771 69. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 0 0 0 72. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 0 72. 00 76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 0 0 0 73. 300 76. 01 03950 DI ABETES/WOUND CARE/COUMADI N CNTR 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		06600 PHYSI CAL THERAPY	0	0	0	0		1
69. 00			0	0	0	0		1
70. 00			0	0	0	0		•
71. 00			0	0	0	0		1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 73. 00 76. 00 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 0 0 0 0 0 5, 230 76. 00 76. 01 03950 DIABETES/WOUND CARE/COUMADIN CNTR 0 0 0 0 0 3, 395 76. 01 76. 02 03951 FLU CLINIC 0 0 0 0 0 0 0 76. 02 OUTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 2, 649 88. 00 91. 00 09100 EMERGENCY 0 0 0 0 0 9, 682 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92. 00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 0 0 0 0 8, 864 95. 00 101. 00 10100 HOME HEALTH AGENCY 0 0 0 37 0 6, 969 101. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113. 00 116. 00 11600 HOSPICE 0 0 0 23 0 3, 684 116. 00			0	0	o	0		1
76. 00			0	0	O	O		1
76. 01			0	0	0	0		1
76. 02 03951 FLU CLINIC 0 0 0 0 0 0 76. 02 OUTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 0 2, 649 88. 00 91. 00 09100 EMERGENCY 0 0 0 0 0 9, 682 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 92. 00 OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 0 0 0 37 0 6, 969 101. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 116. 00 11600 HOSPICE 0 0 3, 684 116. 00			0	0	0	0		
SECULAR SERVICE COST CENTERS SERVICES SER			0	0	0	0		1
88. 00	70.02		<u> </u>	0	1 0	U ₁	0	70.02
91. 00	88. 00		O	0	O	ol	2, 649	88. 00
OTHER REIMBURSABLE COST CENTERS O O O O O O O O O O O O O O O O O O	91.00	09100 EMERGENCY						1
95. 00	92. 00							92. 00
101. 00	05.00			^		ام	0.074	05.00
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 11600 HOSPI CE 0 0 23 0 3,684 116.00 116			1					1
113. 00	.01.00		, O	0	37	<u> </u>	0, 707	
		11300 INTEREST EXPENSE				I		113. 00
118. UU SUBTUTALS (SUM UF LINES 1-117) 0 0 60 66, 645 146, 710 118. 00			1			0		
	118.00	DI PORTOTAT2 (20W OF FLUE2 1-11/)	0	0	<u> </u> 60	66, 645	146, /10	1118.00

| Peri od: | Worksheet B | From 07/01/2014 | Part II | To 06/30/2015 | Date/Time Prepared:

			10	00/30/2013	11/23/2015 5:	
Cost Center Description	HOUSEKEEPI NG-H	HOUSEKEEPI NG-0	HOUSEKEEPI NG-M	DI ETARY	CAFETERI A	
	SB II	RTH0	AB			
	9. 02	9. 03	9. 04	10.00	11. 00	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	103	0	0	192. 00
194. 00 07950 DAY HEALTH	0	0	0	18, 599	1, 380	194. 00
194. 01 07962 OUTREACH	0	0	0	0	1, 628	194. 01
194. 02 07951 OCCUPATIONAL MEDICINE	0	0	0	0	0	194. 02
194.03 07952 FUND DEVELOPMENT	0	0	0	0	1, 283	194. 03
194. 04 07953 OUTSI DE LAUNDRY	0	0	0	0	0	194. 04
194. 05 07954 PHYSI CI AN SUPPORT	0	0	0	0	460	194. 05
194. 06 07955 HOSPI TALI TY HOUSE	0	0	0	0	133	194. 06
194. 07 07956 HSK DI ALYSI S	0	0	0	0	138	194. 07
194. 08 07957 LEASED SALARI ES	0	0	0	0	193	194. 08
194.09 07958 VISITING PHYSICIANS	0	0	0	0	0	194. 09
194.10 07959 FARM LAND	0	0	0	0	0	194. 10
194. 11 07963 CONVENIENCE CARE CLINIC	0	0	0	0	2, 774	194. 11
194.12 07960 MMG-PHYSICIAN OFFICES	1, 618	242	0	0	28, 569	194. 12
194.13 07961 VALET PARKING SERVICE	0	0	0	0	354	194. 13
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201. 00
202.00 TOTAL (sum lines 118-201)	1, 618	242	163	85, 244	183, 622	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 140089

In Lieu of Form CMS-2552-10

| Period: | Worksheet B |
| From 07/01/2014 | Part II |
| To 06/30/2015 | Date/Time Prepared: | 11/23/2015 5:05 pm

					06/30/2015	11/23/2015 5:	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
		ADMI NI STRATI ON	SERVICES & SUPPLY		RECORDS & LI BRARY		
		13. 00	14.00	15. 00	16. 00	17. 00	
	GENERAL SERVI CE COST CENTERS	1		1		T	
1. 00 1. 01	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 CAP REL COSTS-HOSPITAL						1. 00 1. 01
1. 01	00102 CAP REL COSTS-HSB I						1. 01
1.03	00103 CAP REL COSTS-HSB II						1. 03
1.04	00104 CAP REL COSTS-REHAB CNT						1. 04
1.05	00105 CAP REL COSTS-DI AYSI S						1. 05
1. 06 1. 07	00106 CAP REL COSTS-HOSPI TALI TY HOUSE 00107 CAP REL COSTS-MAB						1. 06 1. 07
1.07	00107 CAF REL COSTS-WAB						1. 07
1. 09	00109 CAP REL COSTS-CONVENIENCE CARE CLINI						1. 09
1. 10	00110 CAP REL COSTS-BUSHNELL OFFICE BLDG						1. 10
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 6. 00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS						5. 00 6. 00
6. 01	00600 MAINTENANCE & REPAIRS 00601 MAINTENANCE & REPAIRS-HSB I						6. 01
6. 02	00602 MAINTENANCE & REPAIRS-HSB II						6. 02
6.03	00603 MAINTENANCE & REPAIRS-REHAB CLINIC						6. 03
6. 04	00604 MAINTENANCE & REPAIRS-MAB						6. 04
6. 05 6. 06	00605 MAI NTENANCE & REPAI RS-ORTHO BLDG 00606 MAI NTENANCE & REPAI RS-BUSHNELL						6. 05 6. 06
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00	00900 HOUSEKEEPI NG						9. 00
9. 01	00901 HOUSEKEEPI NG-HSB						9. 01
9. 02	00902 HOUSEKEEPING-HSB II						9. 02
9. 03 9. 04	00903 HOUSEKEEPI NG-ORTHO 00904 HOUSEKEEPI NG-MAB						9. 03 9. 04
10. 00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11. 00
13.00	01300 NURSING ADMINISTRATION	21, 329					13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	179, 070				14.00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0	1, 846 0	103, 835	131, 749		15. 00 16. 00
17. 00	01700 SOCIAL SERVICE	0	0	-	131, 747		1
19. 00	01900 NONPHYSICIAN ANESTHETISTS	o	0		0		1
23. 00	02300 PARAMED ED PRGM	0	0	0	0	0	23. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	11 000	11 042		11/ 004	20.421	20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	11, 090 2, 608	11, 043 2, 239		116, 994 1, 317		30.00
43. 00	04300 NURSERY	1, 293	2, 237	Ö	1, 976		1
44.00	04400 SKILLED NURSING FACILITY	0	0	1	. 0		1
	ANCI LLARY SERVI CE COST CENTERS	1 -1		T		Т	
50. 00 51. 00	O5000 OPERATI NG ROOM O5100 RECOVERY ROOM	0	16, 061 13, 412	0	0	_	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1, 360	13, 412	i I	0	0	
53. 00	05300 ANESTHESI OLOGY	0	3, 139	o	0	0	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	1, 486		0	0	
57. 00	05700 CT SCAN	0	1, 823	0	0	0	
58. 00 60. 00	05800 MAGNETIC RESONANCE MAGING (MRI) 06000 LABORATORY	0	7, 575		0	0	58. 00 60. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.		7, 379	1	0	0	1
65. 00	06500 RESPIRATORY THERAPY	0	1, 248	0	0	0	1
66. 00	06600 PHYSI CAL THERAPY	0	1, 112	1	0	0	66. 00
67. 00	06700 OCCUPATIONAL THERAPY	0	0		0	0	67.00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	23 159		0	0	68. 00 69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY		0		0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	29, 314	0	0	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENT	0	68, 065		0	0	
	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 03950 DI ABETES/WOUND CARE/COUMADI N CNTR	0	134 567	1	0	0	
	03951 FLU CLINIC		0	1	0	0	76. 01
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	389	1	0		
91.00	09100 EMERGENCY	4, 978	11, 098	0	11, 462	1, 592	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
95. 00	09500 AMBULANCE SERVICES	0	114	0	0	0	95. 00
	10100 HOME HEALTH AGENCY	0	1, 553	0	0	0	101. 00
112 00	SPECIAL PURPOSE COST CENTERS						112 00
	11300 I NTEREST EXPENSE 11600 HOSPI CE	0	803	0	0	0	113. 00 116. 00
		١	303	1 0		1 0	1

| Period: | Worksheet B | From 07/01/2014 | Part II | To 06/30/2015 | Date/Time Prepared: Provider CCN: 140089

			To	06/30/2015	
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	11/23/2015 5:05 pm SOCIAL SERVICE
oost center bescription	ADMI NI STRATI ON	SERVICES &	THARWACT	RECORDS &	SOCIAL SERVICE
	ADMINITION ON	SUPPLY		LI BRARY	
	13. 00	14. 00	15. 00	16. 00	17. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	21, 329	173, 203	103, 835	131, 749	26, 534 118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192. 00
194.00 07950 DAY HEALTH	O	150	0	0	0 194. 00
194. 01 07962 OUTREACH	0	0	0	0	0 194. 01
194. 02 07951 OCCUPATIONAL MEDICINE	0	0	0	0	0 194. 02
194.03 07952 FUND DEVELOPMENT	0	0	0	0	0 194. 03
194. 04 07953 OUTSI DE LAUNDRY	0	0	0	0	0 194. 04
194. 05 07954 PHYSI CI AN SUPPORT	0	0	0	0	0 194. 05
194. 06 07955 HOSPI TALI TY HOUSE	0	0	0	0	0 194. 06
194. 07 07956 HSK DIALYSIS	0	0	0	0	0 194. 07
194. 08 07957 LEASED SALARI ES	0	0	0	0	0 194. 08
194.09 07958 VISITING PHYSICIANS	0	0	0	0	0 194. 09
194.10 07959 FARM LAND	0	0	0	0	0 194. 10
194. 11 07963 CONVENIENCE CARE CLINIC	0	615	0	0	0 194. 11
194. 12 07960 MMG-PHYSICIAN OFFICES	0	5, 102	0	0	0 194. 12
194. 13 07961 VALET PARKING SERVICE	0	0	0	0	0 194. 13
200.00 Cross Foot Adjustments					200. 00
201.00 Negative Cost Centers	0	0	0	0	0 201. 00
202.00 TOTAL (sum lines 118-201)	21, 329	179, 070	103, 835	131, 749	26, 534 202. 00

	Financial Systems	MCDONOUGH DISTR		0011 4 40000		u of Form CMS-2	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provi der		Period: From 07/01/2014	Worksheet B Part II	
					To 06/30/2015		
	Cost Center Description	NONPHYSI CI AN	PARAMED ED	Subtotal	Intern &	Total	US PIII
		ANESTHETI STS	PRGM		Residents Cost		
					& Post Stepdown		
					Adjustments		
	CENEDAL CEDVICE COCT CENTEDO	19. 00	23. 00	24. 00	25. 00	26. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1. 01	00101 CAP REL COSTS-HOSPI TAL						1. 01
1.02	00102 CAP REL COSTS-HSB I						1. 02
1. 03 1. 04	O0103 CAP REL COSTS-HSB I O0104 CAP REL COSTS-REHAB CNT						1. 03 1. 04
1.04	00105 CAP REL COSTS-REITAB CNT						1. 04
1.06	00106 CAP REL COSTS-HOSPITALITY HOUSE						1. 06
1.07	00107 CAP REL COSTS-MAB						1. 07
1. 08 1. 09	00108 CAP REL COSTS-ORTHO BLDG 00109 CAP REL COSTS-CONVENIENCE CARE CLINI						1. 08 1. 09
1. 10	00110 CAP REL COSTS-BUSHNELL OFFICE BLDG						1. 10
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 6. 00	OO5OO ADMINISTRATIVE & GENERAL OO6OO MAINTENANCE & REPAIRS						5. 00 6. 00
6. 01	00601 MAINTENANCE & REPAIRS-HSB I						6. 01
6.02	00602 MAINTENANCE & REPAIRS-HSB II						6. 02
6.03	00603 MAINTENANCE & REPAIRS-REHAB CLINIC						6. 03
6. 04 6. 05	O0604 MAINTENANCE & REPAIRS-MAB O0605 MAINTENANCE & REPAIRS-ORTHO BLDG						6. 04 6. 05
6.06	00606 MAINTENANCE & REPAIRS-BUSHNELL						6. 06
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 9. 01	00900 HOUSEKEEPI NG 00901 HOUSEKEEPI NG-HSB						9. 00 9. 01
9. 02	00902 HOUSEKEEPING-HSB II						9. 02
9. 03	00903 HOUSEKEEPI NG-ORTHO						9. 03
9. 04	00904 HOUSEKEEPI NG-MAB						9. 04
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A						10. 00 11. 00
13. 00	01300 NURSING ADMINISTRATION						13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY						14.00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY						15. 00 16. 00
	01700 SOCIAL SERVICE						17. 00
19.00	01900 NONPHYSI CLAN ANESTHETI STS	0	7 540				19.00
23. 00	02300 PARAMED ED PRGM INPATIENT ROUTINE SERVICE COST CENTERS		7, 513				23. 00
30.00	03000 ADULTS & PEDIATRICS			1, 040, 350	0	1, 040, 350	30. 00
31.00	03100 I NTENSI VE CARE UNI T			166, 67		166, 677	
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY			41, 28		41, 287 0	1
11.00	ANCILLARY SERVICE COST CENTERS				<u>م</u>		11.00
	05000 OPERATING ROOM			296, 878		296, 878	
51. 00 52. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM			116, 05! 65, 194		116, 055 65, 194	
53. 00	05300 ANESTHESI OLOGY			14, 558		14, 558	
54. 00	05400 RADI OLOGY-DI AGNOSTI C			310, 78		310, 784	
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)			35, 532 12, 834		35, 532 12, 834	
60.00	06000 LABORATORY			358, 24		358, 247	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.			1, 01	ı o	1, 011	63. 00
65. 00	06500 RESPIRATORY THERAPY			107, 58		107, 581 223, 198	1
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY			223, 198		223, 198	ı
68. 00	06800 SPEECH PATHOLOGY			9, 024	1 0	9, 024	
69.00	06900 ELECTROCARDI OLOGY			13, 47		13, 471	
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			13, 908 39, 762		13, 908 39, 762	
	07200 I MPL. DEV. CHARGED TO PATIENT			93, 903		93, 903	
	07300 DRUGS CHARGED TO PATIENTS			103, 83!		103, 835	
76. 00 76. 01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 03950 DIABETES/WOUND CARE/COUMADIN CNTR			37, 810 42, 46		37, 810 42, 464	1
76. 01	03951 FLU CLINIC			45, 46,		459	1
	OUTPATIENT SERVICE COST CENTERS	· .					
	08800 RURAL HEALTH CLINIC			94, 36!		94, 365	1
91. 00 92. 00	O9100 EMERGENCY O9200 OBSERVATI ON BEDS (NON-DISTINCT PART)			273, 938	0 0	273, 938	91. 00 92. 00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVI CES			69, 50			95.00
101.00	10100 HOME HEALTH AGENCY	ı		63, 168	3 0	03, 108	101. 00

Health Financial Systems	MCDONOUGH DISTE	RICT HOSPITAL		Inlie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS	MODERAGE PER			Period: From 07/01/2014 To 06/30/2015	Worksheet B Part II	pared:
Cost Center Description	NONPHYSI CI AN ANESTHETI STS	PARAMED ED PRGM	Subtotal	Intern & Resi dents Cost & Post Stepdown Adj ustments	Total	
	19. 00	23. 00	24. 00	25. 00	26.00	
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 INTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE			45, 45		45, 450	1
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	0	3, 691, 25	0	3, 691, 250	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN			12, 89			190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES			183, 22		183, 228	
194. 00 07950 DAY HEALTH			39, 49			194. 00
194. 01 07962 OUTREACH			9, 22	3 0		194. 01
194. 02 07951 OCCUPATIONAL MEDICINE				0		194. 02
194.03 07952 FUND DEVELOPMENT			9, 97			194. 03
194. 04 07953 OUTSI DE LAUNDRY			29, 67	3 0	29, 678	194. 04
194.05 07954 PHYSICIAN SUPPORT			21, 00	6 0	21, 006	194. 05
194. 06 07955 HOSPI TALI TY HOUSE			14, 17	3 0	14, 173	194. 06
194. 07 07956 HSK DI ALYSI S			43	5 0	435	194. 07
194. 08 07957 LEASED SALARI ES			1, 14	7 0	1, 147	194. 08
194.09 07958 VISITING PHYSICIANS				6 0	6	194. 09
194. 10 07959 FARM LAND				0	0	194. 10
104 11 07043 CONVENIENCE CARE CLINIC			47 21	ما ما	47 210	104 11

47, 218 194. 11 516, 473 194. 12 905 194. 13 7, 513 200. 00

4, 584, 633 202. 00

0 201.00

47, 218

516, 473 905

4, 584, 633

7, 513

7, 513

7, 513

194.11 07963 CONVENIENCE CARE CLINIC 194.12 07960 MMG-PHYSICIAN OFFICES 194.13 07961 VALET PARKING SERVICE 200.00 Cross Foot Adjustments

201.00

202.00

Cross Foot Adjustments Negative Cost Centers

TOTAL (sum lines 118-201)

Period: Worksheet B-1 From 07/01/2014 To 06/30/2015 Date/Time Prepared: 11/23/2015 5:05 pm

			CAD	ITAL DELATED CO	nete	11/23/2015 5:	05 pm
CAPITAL RELATED COSTS							
	Cost Center Description	NEW BLDG &	CAP REL	CAP REL	CAP REL	CAP REL	
		FIXT	COSTS-HOSPI TAL		COSTS-HSB II	COSTS-REHAB	
		(SQUARE FEET)	(SQUARE	(SQUARE FEET)	(SQUARE FEET)	CNT (PER	
		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	FEET)	'''	I LLI)	CENT)	
		1.00	1.01	1. 02	1. 03	1. 04	
1 00	GENERAL SERVICE COST CENTERS OO100 NEW CAP REL COSTS-BLDG & FIXT	170, 530					1. 00
1. 00 1. 01	00100 NEW CAP REL COSTS-BLDG & FIXT	170, 530	170, 530				1.00
1. 02	00102 CAP REL COSTS-HSB I		170, 330				1. 02
1.03	00103 CAP REL COSTS-HSB II		O	0	21, 564		1. 03
1.04	00104 CAP REL COSTS-REHAB CNT	(0	0	0	100	1
1. 05 1. 06	00105 CAP REL COSTS-DI AYSI S 00106 CAP REL COSTS-HOSPI TALI TY HOUSE			0	0	0	1. 05 1. 06
1. 07	00107 CAP REL COSTS-MAB		Ö	ő	o	0	1
1.08	00108 CAP REL COSTS-ORTHO BLDG		O	0	0	0	
1.09	00109 CAP REL COSTS-CONVENIENCE CARE CL		0	0	0	0	
1. 10 4. 00	00110 CAP REL COSTS-BUSHNELL OFFICE BLDG	1, 232	1, 232	0	0	0	1
5.00	00500 ADMINISTRATIVE & GENERAL	47, 191			8, 364	0	1
6.00	00600 MAINTENANCE & REPAIRS	12, 732	12, 732		0	0	6. 00
6. 01 6. 02	00601 MAI NTENANCE & REPAI RS-HSB I 00602 MAI NTENANCE & REPAI RS-HSB I I		0	1, 660	0 3, 222	0	6. 01 6. 02
6. 03	00603 MAINTENANCE & REPAIRS-REHAB CLINI			0	3, 222	0	
6.04	00604 MAINTENANCE & REPAIRS-MAB		o	0	0	0	6. 04
6.05	00605 MAINTENANCE & REPAIRS-ORTHO BLDG	(0	0	0	0	
6. 06 8. 00	00606 MAINTENANCE & REPAIRS-BUSHNELL 00800 LAUNDRY & LINEN SERVICE	3, 867	0 3, 867	1	0	0	6. 06 8. 00
9. 00	00900 HOUSEKEEPI NG	2, 056		1	o	0	1
9. 01	00901 HOUSEKEEPI NG-HSB		O	0	0	0	
9. 02	00902 HOUSEKEEPING-HSB II		0	0	0	0	
9. 03 9. 04	00903 HOUSEKEEPI NG-ORTHO 00904 HOUSEKEEPI NG-MAB			0	0	0	
10.00	· ·	2, 685	2, 685	Ō	0	0	1
11. 00	· I	6, 778		1	0	0	11. 00
13. 00 14. 00		6, 403		1	0	0	13. 00 14. 00
15. 00	1 1	1, 557	1	1	0	0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	3, 816	l ·	1	0	0	16. 00
17. 00	1	458	l .	1	0	0	17. 00
19. 00 23. 00	1 1	255	_		0	0	
20.00	INPATIENT ROUTINE SERVICE COST CENTERS				<u> </u>		20.00
30.00		27, 108	l .	1	0	0	1
31. 00 43. 00	1	4, 334			0	0	31. 00 43. 00
44. 00	1 1	745		1	0	0	1
	ANCILLARY SERVICE COST CENTERS						
50.00		8, 153		1 _	0	0	1
51. 00 52. 00	1 1	2, 670			0	0	
53. 00	1	320		1	Ö	0	1
54. 00		10, 015			0	0	54. 00
57. 00 58. 00		455		1	0	0	57. 00 58. 00
60.00		9, 089	_		0	0	
63.00	_ I		0	1	0	0	1
65.00	1	3, 634	l .	1	0	0	
66. 00 67. 00		4, 215			0	100 0	1
68. 00	1	140	_		0	0	
69. 00	1 1	140	l .	1	0	0	69. 00
70.00	1 1	216			0	0	
71. 00 72. 00	· •	115	0	0	0	0	1
73. 00	1		Ö	ő	o	0	1
76. 00			0		0	0	
76. 01		827	827 0	1	0	0	1
76. 02	03951 FLU CLINIC OUTPATIENT SERVICE COST CENTERS		1 0	η <u></u>	ı U	0	76. 02
88. 00	08800 RURAL HEALTH CLINIC	(C	0	0	0	88. 00
91.00		5, 184	5, 184	0	0	0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PAI OTHER REIMBURSABLE COST CENTERS	(1)					92.00
95. 00		1, 350	1, 350	0	0	0	95. 00
-	/	<u> </u>	-	-	· '		-

			T ₁	rom 07/01/2014 o 06/30/2015	Date/Time Pre 11/23/2015 5:	
		CAP	ITAL RELATED CO	STS		
Cost Center Description	NEW BLDG & FLXT (SQUARE FEET)	CAP REL COSTS-HOSPI TAL (SQUARE FEET)	CAP REL COSTS-HSB I (SQUARE FEET)	CAP REL COSTS-HSB II (SQUARE FEET)	CAP REL COSTS-REHAB CNT (PER CENT)	
	1.00	1. 01	1. 02	1. 03	1. 04	
101.00 10100 HOME HEALTH AGENCY	C	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 I NTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	C	0	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	169, 901	169, 901	18, 291	11, 586	100	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	504	504				190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	C	0	22, 148	0		192. 00
194. 00 07950 DAY HEALTH	C	0	2, 511	0		194. 00
194. 01 07962 OUTREACH	C	0	366	0		194. 01
194. 02 07951 OCCUPATI ONAL MEDI CI NE	C	0	0	0		194. 02
194. 03 07952 FUND DEVELOPMENT	125	125	0	0		194. 03
194. 04 07953 OUTSI DE LAUNDRY	C	0	0	0		194. 04
194. 05 07954 PHYSI CI AN SUPPORT	C	0	720	0		194. 05
194. 06 07955 HOSPI TALI TY HOUSE	C	0	0	0		194. 06
194. 07 07956 HSK DI ALYSI S	C	0	0	0		194. 07
194. 08 07957 LEASED SALARI ES	(0	0	0		194. 08
194.09 07958 VISITING PHYSICIANS	C	0	0	0		194. 09
194.10 07959 FARM LAND	C	0	0	0		194. 10
194. 11 07963 CONVENI ENCE CARE CLINIC	C	0	0	0		194. 11
194.12 07960 MMG-PHYSICIAN OFFICES	C	0	3, 495	9, 978		194. 12
194. 13 07961 VALET PARKING SERVICE	C	0	0	0		194. 13
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. B, Part I)	C	3, 687, 958	249, 552	332, 364	45, 975	202. 00
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 000000	21. 626447	5. 250300	15. 412910	459. 750000	203. 00
204.00 Cost to be allocated (per Wkst. B,	3. 000000	2020117	3.200000	.5. 112710	.57.700000	204. 00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part						205. 00
1 1117	1	1	I			ı

Provider CCN: 140089

Peri od: From 07/01/2014 To 06/30/2015 Date/Time Prepared:

		CAP	ITAL RELATED CO	06/30/2015 05TS	11/23/2015 5:	
Cost Center Description	CAP REL COSTS-DI AYSI S (PER CENT)	CAP REL COSTS-HOSPITAL ITY HOUSE (PER	CAP REL COSTS-MAB (SQUARE FEET)	CAP REL COSTS-ORTHO BLDG (SQUARE	CONVENIENCE CARE CLINI (PER CENT)	
	,	CENT)	<u> </u>	FEET)		
GENERAL SERVICE COST CENTERS	1. 05	1.06	1. 07	1. 08	1. 09	
1. 00	100 0 0 0 0 0 0 0	100 0 0 0 0 0 0 0	7, 588 0 0 0 0 0 0 0	7, 296 0 0 3, 648 0 0 0	100 0 0 0 0	1. 00 1. 01 1. 02 1. 03 1. 04 1. 05 1. 06 1. 07 1. 08 1. 09 1. 10 4. 00 6. 00 6. 01 6. 02
6. 03	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	6. 03 6. 04 6. 05 6. 06 8. 00 9. 00 9. 01 9. 02 9. 03 9. 04 10. 00 11. 00 13. 00 14. 00 15. 00 17. 00 19. 00 23. 00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 43. 00 04300 NURSERY 44. 00 04400 SKI LLED NURSI NG FACI LITY	0 0 0 0	0 0 0 0	0 0 0 0	0 0 0 0	0 0 0 0	30. 00 31. 00 43. 00 44. 00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM 51. 00 05100 RECOVERY ROOM 52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C 57. 00 05700 CT SCAN 58. 00 05800 MAGNETI C RESONANCE IMAGING (MRI) 60. 00 06900 LABORATORY 63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 65. 00 06500 RESPIRATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 72. 00 07200 IMPL DEV CHARGED TO PATI ENTS 73. 00 07300 DRUGS CHARGED TO PATI ENTS 74. 01 03950 DI ABETES/WOUND CARE/COUMADI N CNTR 75. 02 03951 FLU CLI NI C 0UTPATI ENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLI NI C 91. 00 09100 EMERDINATION REDS (NON INICIDATION DATE DATE DATE DATE DATE 91. 00 09100 EMERDINATION REDS (NON INICIDATION DATE DATE DATE 91. 00 09100 EMERDINATION REDS (NON INICIDATION DATE DATE DATE 91. 00 09100 EMERDINATION REDS (NON INICIDATION DATE DATE DATE 91. 00 09100 EMERDINATION REDS (NON INICIDATION DATE DATE DATE 91. 00 09100 EMERDINATION REDS (NON INICIDATION DATE DATE DATE DATE 91. 00 09100 EMERDINATION REDS (NON INICIDATION DATE DATE DATE 91. 00 09100 EMERDINATION REDS (NON INICIDATION DATE DATE 91. 00 09100 EMERDINATION REDS (NON INICIDATION DATE DATE 91. 00 09100 EMERDINATION REDS (NON INICIDATION DATE DATE 91. 00 09100 EMERDINATION REDS (NON INICIDATION DATE DATE 91. 00 09100 EMERDINATION REDS (NON INICIDATION DATE DATE 91. 00 09100 EMERDINATION REDS (NON INICIDATION DATE DATE 91. 00 09100 EMERDINATION REDS (NON INICIDA	000000000000000000000000000000000000000	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	50. 00 51. 00 52. 00 53. 00 54. 00 58. 00 60. 00 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 76. 01 76. 01 88. 00 91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92. 00
95. 00 09500 AMBULANCE SERVI CES	0	0	0	0	0	95. 00

			To	06/30/2015	Date/Time Prepared: 11/23/2015 5:05 pm
		CAP	ITAL RELATED CO	STS	
Cost Center Description	CAP REL COSTS-DI AYSI S (PER CENT)	CAP REL COSTS-HOSPITAL ITY HOUSE (PER CENT)	CAP REL COSTS-MAB (SQUARE FEET)	CAP REL COSTS-ORTHO BLDG (SQUARE	CONVENI ENCE CARE CLI NI (PER CENT)
	1. 05	1. 06	1. 07	FEET) 1. 08	1. 09
101.00 10100 HOME HEALTH AGENCY	0			0	0 101. 00
SPECIAL PURPOSE COST CENTERS	<u> </u>				
113.00 11300 INTEREST EXPENSE					113. 00
116. 00 11600 H0SPI CE	0	0		0	0 116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	0	2, 789	3, 648	0 118. 00
NONREI MBURSABLE COST CENTERS					
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	0 190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	4, 799	0	0 192. 00
194. 00 07950 DAY HEALTH	0	0	0	0	0 194. 00
194. 01 07962 0UTREACH 194. 02 07951 0CCUPATI ONAL MEDI CI NE	0	0	0	0	0 194. 01 0 194. 02
194. 03 07951 OCCOPATIONAL MEDICINE	0	0	0	0	0 194. 02
194. 04 07953 OUTSI DE LAUNDRY		0	0	0	0 194.03
194. 05 07954 PHYSI CLAN SUPPORT		0	0	0	0 194. 05
194. 06 07955 HOSPI TALI TY HOUSE	0	100	0	0	0 194.06
194. 07 07956 HSK DI ALYSI S	100		Ö	0	0 194. 07
194. 08 07957 LEASED SALARI ES	0	0	Ö	O	0 194. 08
194.09 07958 VISITING PHYSICIANS	0	0	0	0	0 194. 09
194.10 07959 FARM LAND	0	0	О	0	0 194. 10
194. 11 07963 CONVENIENCE CARE CLINIC	0	0	0	0	100 194. 11
194.12 07960 MMG-PHYSICIAN OFFICES	0	0	0	3, 648	0 194. 12
194.13 07961 VALET PARKING SERVICE	0	0	0	0	0 194. 13
200.00 Cross Foot Adjustments					200. 00
201.00 Negative Cost Centers					201. 00
202.00 Cost to be allocated (per Wkst. B, Part I)	0	13, 083	81, 881	60, 596	32, 654 202. 00
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 000000	130. 830000	10. 790854	8. 305373	
204.00 Cost to be allocated (per Wkst. B, Part II)					204. 00
205.00 Unit cost multiplier (Wkst. B, Part					205. 00

	Financial Systems	MCDONOUGH DISTR				u of Form CMS-2	
COST A	LLOCATION - STATISTICAL BASIS		Provi der		eriod: rom 07/01/2014 o 06/30/2015	Worksheet B-1 Date/Time Pre 11/23/2015 5:	pared:
	Cost Center Description	CAPITAL RELATED COSTS BUSHNELL OFFICE BLDG (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	MAI NTENANCE & REPAI RS (SQUARE FEET)	
		1. 10	4.00	5A	5. 00	6. 00	
	GENERAL SERVICE COST CENTERS						
1.00 1.01 1.02 1.03 1.04 1.05 1.06 1.07 1.08 1.09 1.10 4.00 5.00 6.01 6.02 6.03 6.04 6.05 6.06 8.00 9.01 9.02 9.03 9.01 9.02 9.03 9.01 1.00 11.00 13.00 14.00 15.00 16.00 17.00	OO100 NEW CAP REL COSTS-BLDG & FIXT	5, 806 0 248 0 0 0 0 0 0 0 0 0 0 0 0 0	31, 664, 320 4, 170, 874 573, 549 20, 890 13, 400 0 3, 019 2, 074 2, 208 117, 423 208, 453 47, 534 14, 906 2, 978 2, 057 189, 726 67, 209 519, 740 293, 714 576, 905 702, 624 414, 529	-9, 485, 599 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 137, 807 164, 760 157, 598 7, 049 19, 383 13, 173 25, 135 406, 466 829, 202 131, 943 69, 162 10, 295 6, 920 751, 305 546, 354 669, 680 648, 891 2, 561, 238 1, 213, 751 549, 011	109, 375 0 0 0 0 0 0 3, 867 2, 056 0 0 0 0 2, 685 6, 778 60 6, 403	11. 00 13. 00 14. 00 15. 00 16. 00 17. 00
23. 00	02300 PARAMED ED PRGM	0	28, 576	0	42, 260	255	23. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		2 522 274	1 0	2 042 742	27 100	20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0	2, 523, 364 709, 004	1		27, 108 4, 334	1
	04300 NURSERY		355, 395				43.00
	04400 SKILLED NURSING FACILITY	o	0	i			44. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	1, 165, 257	1		8, 153	
51.00	05100 RECOVERY ROOM	0	513, 109	1			51.00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0	326, 264	0			ı
54. 00	05400 RADI OLOGY-DI AGNOSTI C	o o	891, 518				
57.00	05700 CT SCAN	0	481, 327	0		455	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	1			
60.00	06000 LABORATORY	0	1, 813, 651	0	4, 524, 023	9, 089	1
63. 00 65. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06500 RESPIRATORY THERAPY		281, 455	0	43, 976 483, 467	0 3, 634	
66. 00	06600 PHYSI CAL THERAPY	120	1, 645, 951	1		4, 215	1
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	Ō	, , , , , , , , , , , , , , , , , , , ,	0	1
68. 00	06800 SPEECH PATHOLOGY	0	137, 638	0	175, 348	140	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	224, 253	1			69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	197, 701	1			•
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0		0	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		0	1
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	566, 792	0	726, 302	0	1
76. 01	03950 DIABETES/WOUND CARE/COUMADIN CNTR	O	455, 509			827	
76. 02	03951 FLU CLINIC	0	727	0	19, 933	0	76. 02
go ^^	OUTPATIENT SERVICE COST CENTERS	E 420	127 400	^	401 41F	^	90 00
88. 00 91. 00	08800 RURAL HEALTH CLINIC 09100 EMERGENCY	5, 438	427, 688 1, 144, 298	1			
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1, 144, 270		3, 007, 004	5, 104	91.00
00	OTHER REIMBURSABLE COST CENTERS						1 33
95. 00	09500 AMBULANCE SERVI CES	0	757, 645	0	1, 052, 565	1, 350	95. 00
-							

Health Financial Systems	MCDONOUGH DISTE				eu of Form CMS-25!	52-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Period: From 07/01/2014	Worksheet B-1	
				o 06/30/2015	Date/Time Prepa	red.
			'	0 00/30/2013	11/23/2015 5: 05	pm
	CAPI TAL					
	RELATED COSTS					
Cost Center Description	BUSHNELL	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	MAINTENANCE &	
	OFFICE BLDG	BENEFITS		& GENERAL	REPAI RS	
	(SQUARE	DEPARTMENT		(ACCUM.	(SQUARE	
	FEET)	(GROSS		COST)	FEET)	
		SALARI ES)				
	1. 10	4. 00	5A	5. 00	6. 00	
101.00 10100 HOME HEALTH AGENCY	0	1, 078, 431		1, 471, 634	0 10	01.00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 INTEREST EXPENSE						13.00
116. 00 11600 HOSPI CE	0	600, 048	1	.,,		16. 00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	5, 806	24, 269, 413	-9, 485, 599	42, 362, 605	108, 746 11	18. 00
NONREI MBURSABLE COST CENTERS				10.000	50446	20.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	400 774		168, 068		92.00
194. 00 07950 DAY HEALTH	0	128, 771	1	205, 161		94.00
194. 01 07962 OUTREACH	0	157, 022	(226, 792		94. 01 94. 02
194. 02 07951 OCCUPATI ONAL MEDI CI NE 194. 03 07952 FUND DEVELOPMENT	0	155 041		222 204	125 19	
	0	155, 041		232, 206		94. 03 94. 04
194. 04 07953 OUTSLDE LAUNDRY 194. 05 07954 PHYSLCI AN SUPPORT	0	98, 407		,		94. 04 94. 05
194. 06 07955 HOSPI TALI TY HOUSE	0	98, 407		705, 903 39, 921		94. 05 94. 06
194. 07 07955 HOSPITALITY HOUSE 194. 07 07956 HSK DIALYSIS	0	5, 027		12, 532		94. 06 94. 07
194. 08 07957 LEASED SALARI ES	0	31, 636	•	39, 007		94. 07 94. 08
194. 09 07958 VISITING PHYSICIANS	0	31,030		265		94. 09
194. 10 07959 FARM LAND	0			200		94. 10
194. 11 07963 CONVENI ENCE CARE CLINIC		288, 787	,	463, 342		94. 10 94. 11
194. 12 07960 MMG-PHYSI CLAN OFFI CES		6, 502, 777		9, 180, 160		94. 11
194. 13 07961 VALET PARKING SERVICE		18, 252		22, 504		94. 12
200.00 Cross Foot Adjustments		10, 232		22, 304		00.00
201.00 Negative Cost Centers						01.00
202.00 Cost to be allocated (per Wkst. B,	80, 570	7, 377, 327	,	9, 485, 599		
202.00 Cost to be directed (per most. b,	55, 576	,, 5, ,, 52,	1	,, 100, 077	2, 515, 545 20	J 00

13. 877024

0. 232985 56, 942

0.001798

0. 176741 1, 234, 283

0. 022998

23. 000183 203. 00 325, 544 204. 00

2. 976402 205. 00

Part I)

11)

203.00

204. 00 205. 00 Unit cost multiplier (Wkst. B, Part I)
Cost to be allocated (per Wkst. B,
Part II)

Unit cost multiplier (Wkst. B, Part

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 140089 Peri od: Worksheet B-1 From 07/01/2014 06/30/2015 Date/Time Prepared: 11/23/2015 5:05 pm Cost Center Description MAINTENANCE & MAINTENANCE & MAINTENANCE & MAINTENANCE & MAINTENANCE & REPAIRS-HSB I REPAIRS-HSB II REPAIRS-REHAB REPAIRS-MAB REPAIRS-ORTHO (SQUARE **CLINIC** (SQUARE BLDG FEET) (SOUARE (PFR (SOUARE FEET) FEET) CENT) FEET) 6.01 6.02 6.03 6.04 6.05 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00101 CAP REL COSTS-HOSPITAL 1.01 1.01 1.02 1.02 00102 CAP REL COSTS-HSB I 00103 CAP REL COSTS-HSB II 1.03 1.03 00104 CAP REL COSTS-REHAB CNT 1.04 1.04 00105 CAP REL 1.05 COSTS-DLAYSLS 1.05 1.06 00106 CAP REL COSTS-HOSPI TALI TY HOUSE 1.06 1.07 00107 CAP REL COSTS-MAB 1.07 00108 CAP REL COSTS-ORTHO BLDG 1 08 1 08 00109 CAP REL COSTS-CONVENIENCE CARE CLINI 1.09 1.09 1.10 00110 CAP REL COSTS-BUSHNELL OFFICE BLDG 1.10 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 00601 MAINTENANCE & REPAIRS-HSB I 6.01 31,804 6.01 00602 MAINTENANCE & REPAIRS-HSB II 9.978 6 02 6 02 6.03 00603 MAINTENANCE & REPAIRS-REHAB CLINIC 0 100 6.03 6.04 00604 MAINTENANCE & REPAIRS-MAB 0 7, 588 C 6.04 6.05 00605 MAINTENANCE & REPAIRS-ORTHO BLDG 0000000000000000 3,648 6.05 0 0 00606 MAINTENANCE & REPAIRS-BUSHNELL O 0 6.06 Ω 0 6 06 8.00 00800 LAUNDRY & LINEN SERVICE C 0 0 0 8.00 00900 HOUSEKEEPI NG 0 9.00 9.00 9.01 00901 HOUSEKEEPI NG-HSB 0 0 0 0 0 0 0 0 0 0 0 0 9.01 0 9.02 00902 HOUSEKEEPING-HSB LL Ω 0 9 02 0 9.03 00903 HOUSEKEEPI NG-ORTHO 0 9.03 00904 HOUSEKEEPI NG-MAB 0 9.04 9.04 01000 DI ETARY 0 10.00 0 10.00 0 01100 CAFETERI A 11.00 0 0 11.00 01300 NURSING ADMINISTRATION 0 0 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 15.00 01500 PHARMACY 0 0 0 15.00 01600 MEDICAL RECORDS & LIBRARY 0 16 00 C 0 16.00 0 01700 SOCIAL SERVICE 17.00 17.00 0 0 o 19.00 01900 NONPHYSICIAN ANESTHETISTS C 0 0 19.00 02300 PARAMED ED PRGM 0 0 23.00 0 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 0 0 0 0 30.00 31.00 03100 INTENSIVE CARE UNIT 0 0 0 0 31.00 0 0 43.00 04300 NURSERY Λ 0 0 Ω 43.00 44.00 04400 SKILLED NURSING FACILITY 0 0 0 0 44.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 50.00 0 0 0 0 0 50.00 05100 RECOVERY ROOM 0 0 0 51.00 C 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 05300 ANESTHESI OLOGY 0 0 53.00 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 54 00 0 0 54 00 57.00 05700 CT SCAN 0 0 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 00000000 0 58.00 0 0 58.00 06000 LABORATORY 60.00 0 0 60.00 0 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 63.00 65.00 06500 RESPIRATORY THERAPY 0 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 100 66.00 0 67 00 06700 OCCUPATIONAL THERAPY Ω O 67 00 0 68.00 06800 SPEECH PATHOLOGY C 0 0 68.00 06900 ELECTROCARDI OLOGY 69.00 69.00 0 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 70.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS Ω 0 71 00 71 00 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 73.00 0 0 73.00 0 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 2.564 0 0 0 76, 00 03950 DIABETES/WOUND CARE/COUMADIN CNTR O 76.01 0 Ω 0 76.01 03951 FLU CLINIC 0 0 0 0 0 76.02 76.02 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 88.00 0 91.00 09100 EMERGENCY 0 C 0 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 95. 00 09500 AMBULANCE SERVICES 0 0 0 0 0 101.00 10100 HOME HEALTH AGENCY 0 0 1, 735 0 101.00

Health Financial Systems	MCDONOUGH DISTRICT HOSPITAL	In Lieu of Form CMS-2552-10
COCT ALLOCATION CTATICTICAL DACIC	D	David and Wardingham D 1

Health Financial Systems		MCDONOUGH DISTI	RICT HOSPITAL		In Lie	eu of Form CMS-	2552-10
COST ALLOCATION - STATISTI	CAL BASIS		Provi der		Peri od:	Worksheet B-1	
					From 07/01/2014 To 06/30/2015		narad.
				'	To 06/30/2015	Date/Time Pre 11/23/2015 5:	
Cost Center De	escription	MAI NTENANCE &	MAINTENANCE &	MAINTENANCE &	MAINTENANCE &		OS PIII
oost conten be	3611 611 611			REPAI RS-REHAB		REPAIRS-ORTHO	
		(SQUARE		CLINIC	(SQUARE	BLDG	
		FEET)	(SQUARE	(PER	FEET)	(SQUARE	
			FEET)	CENT)	ĺ	FEET)	
		6. 01	6. 02	6. 03	6. 04	6. 05	
SPECIAL PURPOSE COST	CENTERS	·					
113.00 11300 INTEREST EXPEN	ISE						113. 00
116. 00 11600 HOSPI CE		0	0	(1, 054	0	116. 00
118.00 SUBTOTALS (SUN	1 OF LINES 1-117)	2, 564	0	100	2, 789	0	118. 00
NONREI MBURSABLE COST							
190.00 19000 GIFT, FLOWER,		0	0	(190. 00
192.00 19200 PHYSI CLANS' PR	RIVATE OFFICES	22, 148	0	(4, 799		192. 00
194.00 07950 DAY HEALTH		2, 511	0	(0		194. 00
194. 01 07962 OUTREACH		366	0	(0		194. 01
194. 02 07951 OCCUPATI ONAL N	MEDI CI NE	0	0	(0		194. 02
194.03 07952 FUND DEVELOPME		0	0	(0		194. 03
194. 04 07953 OUTSI DE LAUNDR		0	0	(0		194. 04
194. 05 07954 PHYSI CI AN SUPP	PORT	720	0	(0		194. 05
194. 06 07955 HOSPI TALI TY HC	DUSE	0	0	(0		194. 06
194. 07 07956 HSK DIALYSIS		0	0	(0		194. 07
194. 08 07957 LEASED SALARI E	ES .	0	0) c	0		194. 08
194.09 07958 VISITING PHYSI	CLANS	0	0) c	0	0	194. 09
194.10 07959 FARM LAND		0	0	(0		194. 10
194. 11 07963 CONVENI ENCE CA		0	0	(0		194. 11
194. 12 07960 MMG-PHYSI CI AN	OFFICES	3, 495	9, 978	(0	3, 648	194. 12
194. 13 07961 VALET PARKING	SERVI CE	0	0	(0	0	194. 13
200.00 Cross Foot Adj							200. 00
201.00 Negative Cost							201. 00
	ocated (per Wkst. B,	193, 880	185, 452	8, 295	22, 809	15, 501	202. 00
Part I)							
	iplier (Wkst. B, Part I)	6. 096089					
	ocated (per Wkst. B,	12, 542	53, 308	162	451	307	204. 00
Part II)							
	iplier (Wkst. B, Part	0. 394353	5. 342554	1. 620000	0. 059436	0. 084156	205. 00
11)				[l	

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS MCDONOUGH DISTRICT HOSPITAL In Lieu of Form CMS-2552-10 Provi der CCN: 140089 Peri od: From 07/01/2014 To 06/30/2015 Worksheet B-1 HOUSEKEEPING HOUSEKEEPING-H HOUSEKEEPING-H SB SB II

SPENT) (SOLIAPE MAI NTENANCE & LAUNDRY & REPAI RS-BUSHNE LI NEN SERVI CE (POUNDS OF Cost Center Description

		(SQUARE	(POUNDS OF LI NEN)	SPENT)	(SQUARE FEET)	(SQUARE FEET)	
		FEET) 6. 06	8. 00	9. 00	9. 01	9. 02	
1 00	GENERAL SERVICE COST CENTERS						1 00
1. 00 1. 01	OO100 NEW CAP REL COSTS-BLDG & FIXT OO101 CAP REL COSTS-HOSPITAL						1. 00 1. 01
1.02	00102 CAP REL COSTS-HSB I						1. 02
1.03	00103 CAP REL COSTS-HSB II						1.03
1. 04 1. 05	O0104 CAP REL COSTS-REHAB CNT O0105 CAP REL COSTS-DIAYSIS						1. 04 1. 05
1.06	00106 CAP REL COSTS-HOSPI TALITY HOUSE						1.06
1.07	00107 CAP REL COSTS-MAB						1. 07
1.08	00108 CAP REL COSTS-ORTHO BLDG						1.08
1. 09 1. 10	OO109 CAP REL COSTS-CONVENIENCE CARE CLINI OO110 CAP REL COSTS-BUSHNELL OFFICE BLDG						1. 09 1. 10
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
6. 00 6. 01	OO6OO MAINTENANCE & REPAIRS OO6O1 MAINTENANCE & REPAIRS - HSB						6. 00 6. 01
6. 02	00602 MAINTENANCE & REPAIRS-HSB II						6. 02
6.03	00603 MAINTENANCE & REPAIRS-REHAB CLINIC						6. 03
6. 04	00604 MAINTENANCE & REPAIRS MAB						6. 04
6. 05 6. 06	O0605 MAI NTENANCE & REPAI RS-ORTHO BLDG O0606 MAI NTENANCE & REPAI RS-BUSHNELL	5, 558					6. 05 6. 06
8. 00	00800 LAUNDRY & LINEN SERVICE	0,000	270, 514				8. 00
9. 00	00900 HOUSEKEEPI NG	0	0	134, 872			9. 00
9. 01 9. 02	O0901 HOUSEKEEPI NG-HSB O0902 HOUSEKEEPI NG-HSB I	0	0	0	31, 804	9, 978	9. 01 9. 02
9. 02	00903 HOUSEKEEPI NG-ORTHO	0	0	0	ol ol	9, 976	9. 02
9. 04	00904 HOUSEKEEPI NG-MAB	0	0	0	ō	0	1
10.00	01000 DI ETARY	0	0	3, 015	0	0	
11. 00 13. 00	O1100 CAFETERI A O1300 NURSI NG ADMI NI STRATI ON	0	0	8, 046 874	0	0	11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	0	4, 175	Ö	0	14. 00
15. 00	01500 PHARMACY	0	0	1, 069	О	0	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	634	0	0	16.00
17. 00 19. 00	01700 SOCI AL SERVI CE 01900 NONPHYSI CI AN ANESTHETI STS	0	0	283	0	0	17. 00 19. 00
23. 00	02300 PARAMED ED PRGM	0	0		0	0	1
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	_	F2 242	44 244	ما		1 20 00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0	53, 243 12, 599		0	0	30. 00 31. 00
43. 00	04300 NURSERY	0	1, 801	708	Ö	0	43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0	26, 061	14, 181	O	0	50. 00
51.00	05100 RECOVERY ROOM	0	22, 224		ol ol	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		o	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0	0	-	0	0	53.00
54. 00 57. 00	05400 RADI OLOGY-DI AGNOSTI C 05700 CT SCAN	0	18, 508 0		0	0	54. 00 57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	1, 991		Ö	0	
60.00	06000 LABORATORY	0	1, 308		o	0	•
63.00	06300 BLOOD STORING, PROCESSING & TRANS. 06500 RESPIRATORY THERAPY	0	2 494	-	0	0	63. 00 65. 00
65. 00 66. 00	06600 PHYSI CAL THERAPY	120	3, 484 9, 168		ol ol	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	1	o	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0		O	0	68.00
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0	0	657 1, 808	O O	0	69. 00 70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o o	0	0	Ö	0	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	О	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76. 00 76. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 03950 DI ABETES/WOUND CARE/COUMADI N CNTR	0	3, 667	2, 275	2, 564 0	0	76. 00 76. 01
76. 02	03951 FLU CLINIC	0	0		ō	0	76. 02
00.00	OUTPATIENT SERVICE COST CENTERS		-	-1			00.00
88. 00 91. 00	08800 RURAL HEALTH CLINIC 09100 EMERGENCY	5, 438 0	0 34, 279		0	0	88. 00 91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		34, 279	14, 379			92.00
	OTHER REIMBURSABLE COST CENTERS						
95. 00 101. 00	09500 AMBULANCE SERVICES 10100 HOME HEALTH AGENCY	0	4, 311 0		0		95. 00 101. 00
101.00	PIOTOGINOME HEALTH AGENCT	ı	0	١	ОĮ	O	1101.00

Health Financial Systems	MCDONOUGH DISTI	RICT HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Peri od: From 07/01/2014	Worksheet B-1	
					Date/Time Pre 11/23/2015 5:	
Cost Center Description	MAINTENANCE &	LAUNDRY &	HOUSEKEEPI NG	HOUSEKEEPI NG-H	HOUSEKEEPI NG-H	
	REPAI RS-BUSHNE	LINEN SERVICE	(TIME	SB	SB II	
	LL	(POUNDS OF	SPENT)	(SQUARE	(SQUARE	
	(SQUARE	LI NEN)		FEET)	FEET)	
	FEET)					
	6.06	8 00	9 00	0 01	0 02	

Cost Center Description	MAINTENANCE &				HOUSEKEEPI NG-H	50 p
	REPAIRS-BUSHNE		(TIME	SB	SB 11	
		(POUNDS OF	SPENT)	(SQUARE	(SQUARE	
	(SQUARE	LI NEN)		FEET)	FEET)	
	FEET) 6. 06	8. 00	9. 00	9. 01	9. 02	
SPECIAL PURPOSE COST CENTERS	0.00	0.00	7.00	7.01	7.02	
113. 00 11300 NTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	0	251	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	5, 558			2, 564		118. 00
NONREI MBURSABLE COST CENTERS	,	,		,	-	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	473	0	0	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	22, 148	0	192. 00
194.00 07950 DAY HEALTH	0	0	0	2, 511	0	194.00
194. 01 07962 OUTREACH	0	0	0	366	0	194. 01
194. 02 07951 OCCUPATIONAL MEDICINE	0	0	0	0	0	194. 02
194.03 07952 FUND DEVELOPMENT	0	0	0	0	0	194. 03
194. 04 07953 OUTSI DE LAUNDRY	0	76, 678	0	0	0	194. 04
194. 05 07954 PHYSI CI AN SUPPORT	0	0	0	720		194. 05
194. 06 07955 HOSPI TALI TY HOUSE	0	56	0	0		194. 06
194. 07 07956 HSK DI ALYSI S	0	0	0	0		194. 07
194. 08 07957 LEASED SALARI ES	0	0	0	0		194. 08
194.09 07958 VISITING PHYSICIANS	0	0	0	0		194. 09
194.10 07959 FARM LAND	0	0	0	0		194. 10
194. 11 07963 CONVENIENCE CARE CLINIC	0	0	0	0		194. 11
194.12 07960 MMG-PHYSICIAN OFFICES	0	885	0	3, 495		194. 12
194.13 07961 VALET PARKING SERVICE	0	0	0	0	0	194. 13
200.00 Cross Foot Adjustments					1	200.00
201.00 Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. B, Part I)	29, 577	567, 247	1, 023, 044	155, 263	81, 386	202. 00
203.00 Unit cost multiplier (Wkst. B, Part I)	5. 321519	2. 096923	7. 585296	4. 881870	8. 156544	203. 00
204.00 Cost to be allocated (per Wkst. B,	582	104, 698	70, 028	3, 119	1, 618	204. 00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	0. 104714	0. 387034	0. 519218	0. 098069	0. 162157	205. 00

COST A	Financial Systems ALLOCATION - STATISTICAL BASIS		Provi der (eriod: com 07/01/2014	Worksheet B-1 Date/Time Pre 11/23/2015 5:	pared:
	Cost Center Description	HOUSEKEEPI NG-OH RTHO (SQUARE FEET)	OUSEKEEPI NG-M AB (SQUARE FEET)	DI ETARY (MEALS SERVED)	CAFETERI A (FTE' S)	NURSI NG ADMI NI STRATI ON (DI RECT	
		9. 03	9. 04	10.00	11. 00	NRSI NG HRS) 13.00	
4 00	GENERAL SERVICE COST CENTERS						1 00
1. 00 1. 01 1. 02 1. 03 1. 04 1. 05 1. 06 1. 07 1. 08 1. 09 1. 10 4. 00 5. 00 6. 01 6. 02 6. 03 6. 04 6. 05 6. 06 8. 00 9. 00 9. 01 9. 02 9. 03 9. 04 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00	00100 NEW CAP REL COSTS-BLOG & FIXT 00101 CAP REL COSTS-HOSPITAL 00102 CAP REL COSTS-HOSPITAL 00103 CAP REL COSTS-HSB I 00103 CAP REL COSTS-HSB II 00104 CAP REL COSTS-HSB II 00105 CAP REL COSTS-HSB II 00106 CAP REL COSTS-DIAYSIS 00106 CAP REL COSTS-HOSPITALITY HOUSE 00107 CAP REL COSTS-MAB 00108 CAP REL COSTS-ONTHO BLDG 00109 CAP REL COSTS-SUSHNELL OFFICE BLDG 00109 CAP REL COSTS-BUSHNELL OFFICE BLDG 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS-HSB II 00601 MAINTENANCE & REPAIRS-HSB II 00602 MAINTENANCE & REPAIRS-HSB II 00603 MAINTENANCE & REPAIRS-BB II 00604 MAINTENANCE & REPAIRS-BUSHNELL 00605 MAINTENANCE & REPAIRS-BUSHNELL 00606 MAINTENANCE & REPAIRS-BUSHNELL 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 00901 HOUSEKEEPING-HSB II 00903 HOUSEKEEPING-HSB II 00903 HOUSEKEEPING-MAB 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS 02300 PARAMED ED PRGM INPATIENT ROUTINE SERVICE COST CENTERS	3, 648 0 0 0 0 0 0	7, 588 0 0 0 0 0 0 0	1, 705 0 0 0 0 0 0	39, 920 666 852 693 1, 817 380 0	9, 020 0 0 0 0 0	14. 00 15. 00 16. 00 17. 00 19. 00
30. 00	03000 ADULTS & PEDIATRICS	0	0	1, 100	4, 690	4, 690	30.00
31. 00	03100 NTENSIVE CARE UNIT	0	0	233	1, 103		1
43.00	04300 NURSERY	0	0	0	547	547	1
44. 00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	0	υ <u>l</u>	0	0	0	44.00
50. 00		0	0	0	1, 899	0	50.00
51. 00 52. 00 53. 00 54. 00 57. 00 68. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 76. 01 76. 02 88. 00 91. 00 92. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05700 CT SCAN 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 06000 LABORATORY 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 07200 I MPL. DEV. CHARGED TO PATI ENTS 07200 I MPL. DEV. CHARGED TO PATI ENTS 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 03950 DI ABETES/WOUND CARE/COUMADI N CNTR 03951 FLU CLI NI C 0UTPATI ENT SERVI CE COST CENTERS 08800 RURAL HEALTH CLI NI C 09100 EMERGENCY 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) OTHER REI MBURSABLE COST CENTERS	000000000000000000000000000000000000000	000000000000000000000000000000000000000	0 0 0 0 0 0 0 0 0 0 0 0 0 0	837 575 0 1, 743 623 0 3, 181 0 483 2, 063 0 173 385 339 0 0 1, 137 738 0 0 1, 137 738 0	0 575 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	51. 00 52. 00 53. 00 54. 00 57. 00 68. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 76. 01 76. 02 88. 00 91. 00 92. 00
	09500 AMBULANCE SERVICES	0	O	0	1, 927	0	95. 00
	10100 HOME HEALTH AGENCY		1, 735	0			101.00

Health Financial Systems	MCDONOUGH DISTRICT HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 140089	Peri od: Worksheet B-1

Hearth Financial Systems	MCDONOUGH DISTR	RICI HUSPITAL		In Lie	eu of Form CMS-2	552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der	CCN: 140089	Peri od:	Worksheet B-1	
				From 07/01/2014		
				To 06/30/2015		pared:
Cost Center Description	HOUSEKEEPI NG-0	HUNGEREEDI NO W	DI ETARY	CAFETERI A	11/23/2015 5: C	ווון כנ
cost center bescriptron	RTHO	AB	(MEALS		ADMI NI STRATI ON	
	(SQUARE	(SQUARE	SERVED)	(LIL 3)	ADMINISTRATION	
	FEET)	FEET)	JERVED)		(DI RECT	
	1	1 221)			NRSING HRS)	
	9. 03	9. 04	10.00	11.00	13. 00	
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	o	1, 054		0 801	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	o	2, 789	1, 33	3 31, 895	9, 020	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	4, 799		0 0	0	192. 00
194.00 07950 DAY HEALTH	0	0	37	2 300	0	194. 00
194. 01 07962 OUTREACH	0	0		0 354	0	194. 01
194. 02 07951 OCCUPATI ONAL MEDI CI NE	0	0		0 0	0	194. 02
194.03 07952 FUND DEVELOPMENT	0	0		0 279	0	194. 03
194. 04 07953 OUTSI DE LAUNDRY	0	0		0 0	0	194. 04
194.05 07954 PHYSICIAN SUPPORT	0	0		0 100	0	194. 05
194. 06 07955 HOSPI TALI TY HOUSE	0	0		0 29	0	194. 06
194. 07 07956 HSK DI ALYSI S	0	0		0 30	0	194. 07
194. 08 07957 LEASED SALARI ES	0	0		0 42	0	194. 08
194.09 07958 VISITING PHYSICIANS	0	0		0 0	0	194. 09
194.10 07959 FARM LAND	O	0		0 0	0	194. 10
194. 11 07963 CONVENIENCE CARE CLINIC	0	0		0 603	0	194. 11
194.12 07960 MMG-PHYSICIAN OFFICES	3, 648	0		0 6, 211	0	194. 12
194.13 07961 VALET PARKING SERVICE	0	0		0 77	0	194. 13
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. B,	12, 115	8, 143	968, 71	6 859, 843	810, 395	202. 00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	3. 320998	1. 073142	568. 16187	7 21. 539153	89. 844235	203. 00
204.00 Cost to be allocated (per Wkst. B,	242	163	85, 24	4 183, 622	21, 329	204. 00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	0. 066338	0. 021481	49. 99648	1 4. 599749	2. 364634	205. 00
)						

Health Financial Systems COST ALLOCATION - STATISTICAL	RASIS	MCDONOUGH DISTRI		CCN: 140089 P	In Lie	u of Form CMS- Worksheet B-1	
COST ALLOCATION - STATISTICAL I	טאטו ט		Frovider	F	rom 07/01/2014 o 06/30/2015	Date/Time Pre	
Cost Contar Dosori	ntion	CENTRAL	PHARMACY	MEDI CAL		11/23/2015 5:	
Cost Center Descri	ption	SERVICES &	(COSTED	RECORDS &	SOCIAL SERVICE	NONPHYSI CI AN ANESTHETI STS	
		SUPPLY (COSTED	REQUIS.)	LI BRARY (TI ME	(TIME SPENT)	(ASSI GNED TIME)	
		REQUIS.)		SPENT)	SFLIT)	IIWL)	
GENERAL SERVICE COST CEN	ITEDS	14. 00	15. 00	16. 00	17. 00	19. 00	
1.00 O0100 NEW CAP REL COSTS-							1.00
1. 01 00101 CAP REL COSTS-HOS							1. 01
1. 02 00102 CAP REL COSTS-HSB 1. 03 00103 CAP REL COSTS-HSB							1. 02
1.04 00104 CAP REL COSTS-REH							1. 04
1. 05 00105 CAP REL COSTS-DIA 1. 06 00106 CAP REL COSTS-HOS							1. 05 1. 06
1. 07 00107 CAP REL COSTS-MAB							1. 07
1.08 O0108 CAP REL COSTS-ORT							1.08
1. 09 00109 CAP REL COSTS-CONV 1. 10 00110 CAP REL COSTS-BUSH							1. 09 1. 10
4.00 00400 EMPLOYEE BENEFITS	DEPARTMENT						4. 00
5.00 00500 ADMINISTRATIVE & G 6.00 00600 MAINTENANCE & REPA							5. 00 6. 00
6. 01 00601 MAI NTENANCE & REPA							6. 01
6. 02 00602 MAI NTENANCE & REPA							6. 02
6. 03 00603 MAI NTENANCE & REPA 6. 04 00604 MAI NTENANCE & REPA							6. 03 6. 04
6. 05 00605 MAI NTENANCE & REPA							6. 05
6. 06 00606 MAI NTENANCE & REPA							6.06
8.00 00800 LAUNDRY & LINEN SE 9.00 00900 HOUSEKEEPING	RVICE						8. 00 9. 00
9. 01 00901 HOUSEKEEPI NG-HSB							9. 01
9. 02 00902 HOUSEKEEPI NG-HSB 1							9. 02
9. 04 00904 HOUSEKEEPI NG-MAB							9. 04
10. 00 01000 DI ETARY							10.00
11. 00 01100 CAFETERIA 13. 00 01300 NURSI NG ADMINI STRA	TION						11.00
14.00 01400 CENTRAL SERVICES &		2, 955, 449					14. 00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS &	LIDDADV	30, 466	100 0	1, 000			15. 00 16. 00
17. 00 01700 SOCIAL SERVICE	LI DRAKT	0	0	1,000	100		17. 00
19. 00 01900 NONPHYSICIAN ANEST	HETI STS	0	0	C		0	1
23. 00 02300 PARAMED ED PRGM I NPATI ENT ROUTI NE SERVI C	CF COST CENTERS	0	0	C	0		23. 00
30. 00 03000 ADULTS & PEDI ATRI C	S	182, 261	0	888		0	
31. 00 03100 I NTENSI VE CARE UNI 43. 00 04300 NURSERY	Т	36, 951 0	0	10 15	I	0	
44. 00 04400 SKI LLED NURSI NG FA	CILITY	0	0	C		0	1
ANCILLARY SERVICE COST C	ENTERS	0/5 070					F0 00
50. 00 05000 OPERATI NG ROOM 51. 00 05100 RECOVERY ROOM		265, 078 221, 352	0		0	0	
52.00 05200 DELIVERY ROOM & LA	BOR ROOM	O	0	C	0	0	52. 00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOST	ıc	51, 813 24, 518	0	C	0	0	
57. 00 05700 CT SCAN	10	30, 083	0	C	o	0	
58. 00 05800 MAGNETIC RESONANCE	IMAGING (MRI)	6	0	C	0	0	1
60. 00 06000 LABORATORY 63. 00 06300 BLOOD STORI NG, PRO	CESSING & TRANS.	125, 026	0		ol ol	0	1
65. 00 06500 RESPIRATORY THERAP		20, 602	0	C	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERA	DV	18, 360	0	C	0	0	
68. 00 06800 SPEECH PATHOLOGY	rı	384	0	C	0	0	
69. 00 06900 ELECTROCARDI OLOGY		2, 622	0	C	0	0	
70. 00 07000 ELECTROENCEPHALOGR 71. 00 07100 MEDI CAL SUPPLI ES C		0 483, 815	0	C	0	0	
72.00 07200 I MPL. DEV. CHARGED	TO PATIENT	1, 123, 377	0	C	Ö	0	
73. 00 07300 DRUGS CHARGED TO P		0	100	C	0	0	
76. 00 03550 PSYCHI ATRI C/PSYCHO 76. 01 03950 DI ABETES/WOUND CAR		2, 204 9, 358	0		O	0	1
76. 02 03951 FLU CLINIC		0	0	C	0	0	
OUTPATIENT SERVICE COST 88. 00 08800 RURAL HEALTH CLINI		6, 415	0	C	ol	0	88. 00
91.00 09100 EMERGENCY		183, 170	0	87		0	
92. 00 09200 OBSERVATI ON BEDS (92. 00
95. 00 OTHER REIMBURSABLE COST 95. 00 O9500 AMBULANCE SERVICES		1, 878	0	C	ol	0	95. 00
101.00 10100 HOME HEALTH AGENCY		25, 633	0	C			101.00

Health Finan	cial Systems	MCDONOUGH DISTI	RICT HOSPITAL		In lie	u of Form CMS-	2552-10
	TON - STATISTICAL BASIS	Weberroodi Bran			Period: From 07/01/2014 To 06/30/2015	Worksheet B-1	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	11/23/2015 5: NONPHYSI CI AN	05 pm
	·	SERVICES & SUPPLY (COSTED REQUIS.)	(COSTED REQUIS.)	RECORDS & LI BRARY (TI ME SPENT)	(TIME SPENT)	ANESTHETI STS (ASSI GNED TI ME)	
		14. 00	15. 00	16.00	17. 00	19.00	
SPECI /	AL PURPOSE COST CENTERS	1		•	-		
113. 00 11300	INTEREST EXPENSE						113. 00
116. 00 11600	HOSPI CE	13, 248	(0 0	0	116. 00
118. 00	SUBTOTALS (SUM OF LINES 1-117)	2, 858, 620	100	1, 00	0 100	0	118. 00
	MBURSABLE COST CENTERS						
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	(0		190. 00
	PHYSICIANS' PRIVATE OFFICES	0	(0		192. 00
194. 00 07950		2, 476	(0		194. 00
194. 01 07962		0	(0		194. 01
	OCCUPATIONAL MEDICINE	0	(0		194. 02
	FUND DEVELOPMENT	0	(0		194. 03
	OUTSI DE LAUNDRY	0	(0		194. 04
	PHYSI CI AN SUPPORT	0	(0		194. 05
	HOSPI TALI TY HOUSE	0	(0		194. 06
	HSK DIALYSIS	0	(0		194. 07
	LEASED SALARIES	0	(0		194. 08
	VISITING PHYSICIANS	0	(0		194. 09
194. 10 07959		0	(0		194. 10
	CONVENIENCE CARE CLINIC	10, 149			0		194. 11
	MMG-PHYSICIAN OFFICES	84, 204	(0		194. 12
	VALET PARKING SERVICE	0	(0	0	194. 13
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B, Part I)	960, 867					202. 00
202 00	Unit cost multiplion (What D Dart I)	0 225117	20 026 660000	1 1 550 00600	0 6 660 100000	0 000000	1202 00

0. 325117 30, 826. 660000

103, 835

1, 038. 350000

179, 070

0.060590

1, 559. 986000

131. 749000

131, 749

6, 669. 100000

265. 340000

26, 534

0. 000000 203. 00 0 204. 00

0. 000000 205. 00

Unit cost multiplier (Wkst. B, Part I)
Cost to be allocated (per Wkst. B,

Unit cost multiplier (Wkst. B, Part

203.00

204.00

205.00

Part II)

Health Financial Systems MCDONOUGH DISTRICT HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 140089 Period: Worksheet B-1

From 07/01/2014 06/30/2015 Date/Time Prepared: 11/23/2015 5:05 pm Cost Center Description PARAMED ED PRGM (ASSI GNED TIME) 23.00 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.00 00101 CAP REL COSTS-HOSPITAL 1.01 1.01 00102 CAP REL COSTS-HSB I 1.02 1 02 1.03 00103 CAP REL COSTS-HSB II 1.03 00104 CAP REL COSTS-REHAB CNT 1.04 1.04 00105 CAP REL COSTS-DIAYSIS 1.05 1.05 00106 CAP REL COSTS-HOSPITALITY HOUSE 1.06 1.06 1.07 00107 CAP REL COSTS-MAB 1.07 1.08 00108 CAP REL COSTS-ORTHO BLDG 1.08 00109 CAP REL COSTS-CONVENIENCE CARE CLINI 1.09 1. 09 00110 CAP REL COSTS-BUSHNELL OFFICE BLDG 1.10 1.10 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 6.01 00601 MAINTENANCE & REPAIRS-HSB I 6.01 00602 MAINTENANCE & REPAIRS-HSB II 6.02 6.02 00603 MAINTENANCE & REPAIRS-REHAB CLINIC 6 03 6 03 6.04 00604 MAINTENANCE & REPAIRS-MAB 6.04 6.05 00605 MAINTENANCE & REPAIRS-ORTHO BLDG 6.05 00606 MAINTENANCE & REPAIRS-BUSHNELL 6.06 6.06 00800 LAUNDRY & LINEN SERVICE 8 00 8 00 9.00 00900 HOUSEKEEPI NG 9.00 9.01 00901 HOUSEKEEPI NG-HSB 9.01 9.02 00902 HOUSEKEEPING-HSB II 9.02 00903 HOUSEKEEPI NG-ORTHO 9.03 9.03 9.04 00904 HOUSEKEEPI NG-MAB 9.04 10.00 01000 DI ETARY 10.00 01100 CAFETERIA 11 00 11 00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 15.00 01500 PHARMACY 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 17.00 01700 SOCIAL SERVICE 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 23.00 02300 PARAMED ED PRGM 100 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 0 31.00 03100 INTENSIVE CARE UNIT 0 31.00 04300 NURSERY 0 43.00 43.00 04400 SKILLED NURSING FACILITY 44.00 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 05100 RECOVERY ROOM 0 51.00 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 52.00 53.00 05300 ANESTHESI OLOGY 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 100 54.00 05700 CT SCAN 0 57.00 57 00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 60.00 06000 LABORATORY 00000000000 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 63.00 65.00 06500 RESPIRATORY THERAPY 65.00 66.00 06600 PHYSI CAL THERAPY 66.00 06700 OCCUPATIONAL THERAPY 67.00 67.00 06800 SPEECH PATHOLOGY 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 73.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76.00 0 76.00 76 01 03950 DIABETES/WOUND CARE/COUMADIN CNTR 76 01 03951 FLU CLINIC 76.02 76.02 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 0 88.00 91.00 09100 EMERGENCY 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95 00 09500 AMBULANCE SERVICES 0 95.00 101.00 10100 HOME HEALTH AGENCY 0 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113. 00

Health Financial Systems	MCDONOUGH DISTRICT	HOSPI TAL	In Lieu	of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der CCN: 140089	Peri od: From 07/01/2014 To 06/30/2015	Worksheet B-1 Date/Time Prepared: 11/23/2015 5:05 pm
Cost Center Description	PARAMED ED PRGM (ASSI GNED TI ME) 23. 00			
116. 00 11600 HOSPI CE	0			116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	100			118. 00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTE	EEN O			190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	o			192. 00
194.00 07950 DAY HEALTH	o			194. 00
194. 01 07962 OUTREACH	o			194. 01
194. 02 07951 OCCUPATIONAL MEDICINE	o			194. 02
194.03 07952 FUND DEVELOPMENT	0			194. 03
194. 04 07953 OUTSI DE LAUNDRY	0			194. 04
194. 05 07954 PHYSI CLAN SUPPORT	0			194. 05
194. 06 07955 HOSPI TALI TY HOUSE	0			194. 06
194. 07 07956 HSK DI ALYSI S	0			194. 07
194. 08 07957 LEASED SALARI ES	0			194. 08
194.09 07958 VISITING PHYSICIANS	0			194. 09
194.10 07959 FARM LAND	o			194. 10
194. 11 07963 CONVENIENCE CARE CLINIC	o			194. 11
194.12 07960 MMG-PHYSICIAN OFFICES	o			194. 12
194. 13 07961 VALET PARKING SERVICE	o			194. 13
200 00 Craca Fact Adi yetmanta				200.00

56, 606

7, 513

566. 060000

75. 130000

200. 00 201. 00

203. 00 204. 00

205. 00

200.00

201.00

202.00

203.00

204.00

205.00

Cross Foot Adjustments

Negative Cost Centers

Part I)

Part II)

11)

Cost to be allocated (per Wkst. B,

Cost to be allocated (per Wkst. B,

Unit cost multiplier (Wkst. B, Part

Unit cost multiplier (Wkst. B, Part I)

Health Financial Systems	MCDONOUGH DISTRICT HOSPITAL	In Lie	eu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 14008		Worksheet C
		From 07/01/2014	

				rom 07/01/2014 o 06/30/2015	Date/Time Pre	
		Ti +I	e XVIII	Hospi tal	11/23/2015 5: PPS	US PIII
		11.61	CAVIII	Costs	113	
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
oost conten bescription	(from Wkst. B,	Adj.	l rotal oosts	Di sal I owance	10141 00313	
	Part I, col.	7.69		Di Gai i Gilanos		
	26)					
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	8, 794, 665		8, 794, 665	0	8, 794, 665	30. 00
31.00 03100 INTENSIVE CARE UNIT	1, 758, 765		1, 758, 765	0	1, 758, 765	31.00
43. 00 04300 NURSERY	654, 902		654, 902	. 0	654, 902	43.00
44.00 04400 SKILLED NURSING FACILITY	0		C	0	0	44. 00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	3, 134, 990		3, 134, 990	0	3, 134, 990	50.00
51.00 05100 RECOVERY ROOM	1, 312, 746		1, 312, 746	0	1, 312, 746	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	646, 034		646, 034	. 0	646, 034	52. 00
53. 00 05300 ANESTHESI OLOGY	205, 680		205, 680	0	205, 680	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 607, 184		2, 607, 184	0	2, 607, 184	54.00
57.00 05700 CT SCAN	965, 638		965, 638	0	965, 638	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	621, 411		621, 411		621, 411	58. 00
60. 00 06000 LABORATORY	5, 711, 962		5, 711, 962	84, 592	5, 796, 554	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	51, 748		51, 748	0	51, 748	63. 00
65. 00 06500 RESPI RATORY THERAPY	702, 187	0			702, 187	
66. 00 06600 PHYSI CAL THERAPY	2, 833, 671	0	2, 833, 671	0	2, 833, 671	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0				0	
68.00 06800 SPEECH PATHOLOGY	220, 419		220, 419		220, 419	
69. 00 06900 ELECTROCARDI OLOGY	393, 506		393, 506		393, 506	
70. 00 07000 ELECTROENCEPHALOGRAPHY	319, 737		319, 737		319, 737	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	691, 902		691, 902	. 0	691, 902	71. 00
72.00 O7200 MPL. DEV. CHARGED TO PATIENT	1, 687, 267		1, 687, 267		1, 687, 267	
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 082, 666		3, 082, 666		3, 082, 666	
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	908, 023		908, 023		908, 023	1
76.01 03950 DIABETES/WOUND CARE/COUMADIN CNTR	816, 963		816, 963		816, 963	1
76. 02 03951 FLU CLINIC	23, 456		23, 456	0	23, 456	76. 02
OUTPATIENT SERVICE COST CENTERS		ı		1		
88. 00 08800 RURAL HEALTH CLINIC	786, 678		786, 678	1		
91. 00 09100 EMERGENCY	5, 108, 579		5, 108, 579	1		
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 417, 897		1, 417, 897		1, 417, 897	92. 00
OTHER REIMBURSABLE COST CENTERS		T	1			4
95. 00 09500 AMBULANCE SERVICES	1, 321, 933		1, 321, 933			
101. 00 10100 HOME HEALTH AGENCY	1, 779, 775		1, 779, 775		1, 779, 775	101.00
SPECIAL PURPOSE COST CENTERS		T	T	1		
113. 00 11300 NTEREST EXPENSE	4 475 700		4 475 700		4 475 700	113. 00
116. 00 11600 HOSPI CE	1, 475, 798		1, 475, 798		1, 475, 798	
200.00 Subtotal (see instructions)	50, 036, 182		,,			
201.00 Less Observation Beds	1, 417, 897	l e	1, 417, 897		1, 417, 897	
202.00 Total (see instructions)	48, 618, 285	0	48, 618, 285	84, 592	48, 702, 877	J2U2. UU

Health Financial Systems	MCDONOUGH DISTRICT HOSPITAL	In Lie	eu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 14008		Worksheet C
		From 07/01/2014	

					rom 07/01/2014 o 06/30/2015	Part I Date/Time Prep 11/23/2015 5:0	
			Ti tl	e XVIII	Hospi tal	PPS	03 piii
			Charges				
	Cost Center Description	Inpati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	'	·	·	+ col. 7)	Ratio	I npati ent	
						Ratio	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	5, 714, 379		5, 714, 379			30. 00
31. 00	03100 I NTENSI VE CARE UNI T	1, 741, 958		1, 741, 958		· '	31. 00
43.00	04300 NURSERY	771, 670		771, 670		,	43. 00
44. 00	04400 SKILLED NURSING FACILITY	0		<u> </u>)		44. 00
	ANCILLARY SERVICE COST CENTERS	,					
50. 00	05000 OPERATING ROOM	2, 659, 899	10, 375, 315			0. 000000	1
51.00	05100 RECOVERY ROOM	633, 392	5, 151, 438			0. 000000	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	351, 072	0	351, 072		0. 000000	
53.00	05300 ANESTHESI OLOGY	433, 060	2, 339, 091	2, 772, 151		0. 000000	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	686, 865	7, 882, 966			0. 000000	
57. 00	05700 CT SCAN	1, 584, 655	12, 144, 591	13, 729, 246		0. 000000	1
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	164, 014	4, 600, 085			0. 000000	1
60. 00	06000 LABORATORY	4, 596, 920	23, 033, 219			0. 000000	
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	286, 542	353, 156			0. 000000	
65. 00	06500 RESPI RATORY THERAPY	868, 465	1, 043, 829			0. 000000	
66. 00	06600 PHYSI CAL THERAPY	729, 763	5, 475, 805	6, 205, 568		0. 000000	1
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0.000000	0. 000000	1
68. 00	06800 SPEECH PATHOLOGY	41, 540	439, 127			0.000000	1
69. 00	06900 ELECTROCARDI OLOGY	652, 777	2, 929, 732			0. 000000	1
70.00	07000 ELECTROENCEPHALOGRAPHY	6, 846	1, 124, 533			0.000000	
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	1, 720, 412	1, 868, 207	3, 588, 619		0.000000	1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	1, 997, 685	1, 931, 893			0.000000	1
73.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	2, 472, 921	4, 587, 710			0.000000	1
76. 00	03950 DI ABETES/WOUND CARE/COUMADI N CNTR	160	1, 041, 273			0.000000	1
76. 01	03950 DIABETES/WOUND CARE/COUMADIN CNTR	3, 520	717, 511	721, 031		0.000000	1
76. 02		U U	6, 488	6, 488	3. 615290	0. 000000	76. 02
00.00	OUTPATIENT SERVICE COST CENTERS	ام	007 104	007.104			00 00
88. 00	08800 RURAL HEALTH CLINIC	0	887, 134			0.000000	88. 00
91.00	09100 EMERGENCY	1, 572, 375	12, 606, 055			0.000000	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	371, 105	2, 631, 933	3, 003, 038	0. 472154	0. 000000	92. 00
05 00	OTHER REIMBURSABLE COST CENTERS O9500 AMBULANCE SERVICES		2 122 202	2 122 202	0 422205	0.000000	05 00
	10100 HOME HEALTH AGENCY	0 0	3, 122, 292			0. 000000	•
101.00		l d	1, 165, 349	1, 165, 349	1		101. 00
112 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE			I			1 113. 00
	111600 HOSPI CE		1 402 040	1, 483, 848			116. 00
200.00		30, 061, 995	1, 483, 848 108, 942, 580			 	200. 00
200.00		30,001,995	100, 742, 380	137,004,375	ή		200.00
201.00		30, 061, 995	108, 942, 580	139, 004, 575			201.00
202.00	Trotal (see Histractions)	30,001,993	100, 742, 360	137,004,575	'l l		1202.00

Health Financial Systems	MCDONOUGH DISTRICT HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 140089	From 07/01/2014	Worksheet C Part I Date/Time Prepared: 11/23/2015 5:05 pm

				11/23/2015 5: 05 pm
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
43. 00 04300 NURSERY				43.00
44.00 04400 SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS	·			
50. 00 05000 OPERATING ROOM	0. 240502			50.00
51.00 05100 RECOVERY ROOM	0. 226929			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1. 840175			52. 00
53. 00 05300 ANESTHESI OLOGY	0. 074195			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 304228			54.00
57. 00 05700 CT SCAN	0. 070334			57. 00
58. 00 05800 MAGNETIC RESONANCE MAGING (MRI)	0. 130436			58. 00
60. 00 06000 LABORATORY	0. 209791			60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 080894			63.00
65. 00 06500 RESPIRATORY THERAPY	0. 367196			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 456634			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67.00
68. 00 06800 SPEECH PATHOLOGY	0. 458569			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 109841			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 282608			70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 192805			71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 429376			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 436599			73.00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 871898			76.00
76. 01 03950 DI ABETES/WOUND CARE/COUMADI N CNTR	1. 133048			76.00
76. 02 03951 FLU CLI NI C	3. 615290			76. 02
OUTPATIENT SERVICE COST CENTERS	3. 013270			70.02
88. 00 08800 RURAL HEALTH CLINIC				88.00
91. 00 09100 EMERGENCY	0. 360306			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 472154			92.00
OTHER REIMBURSABLE COST CENTERS	0. 472134			72.00
95. 00 09500 AMBULANCE SERVICES	0. 423385			95. 00
101. 00 10100 HOME HEALTH AGENCY	0. 423363			101. 00
SPECIAL PURPOSE COST CENTERS				101.00
113. 00 11300 NTEREST EXPENSE				113. 00
116. 00 11600 H0SPI CE				116. 00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				200.00
202.00 Total (see instructions)				202. 00
202. 00 Total (See Histractions)	1 1			J202. 00

Health Financial Systems	MCDONOUGH DISTRICT	HOSPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 140089	Peri od: From 07/01/2014	Worksheet C Part I

To 06/30/2015 Date/Time Prepared: 11/23/2015 5:05 pm Title XIX Hospi tal Cost Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 4. 00 1.00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 30 00 03000 ADULTS & PEDIATRICS 8, 794, 665 8, 794, 665 0 8, 794, 665 31.00 03100 INTENSIVE CARE UNIT 1, 758, 765 1, 758, 765 0 1, 758, 765 31.00 o 43.00 04300 NURSERY 654, 902 654, 902 654, 902 43.00 04400 SKILLED NURSING FACILITY 44.00 44.00 0 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 3, 134, 990 3, 134, 990 3, 134, 990 50.00 51.00 05100 RECOVERY ROOM 1, 312, 746 1, 312, 746 0 1, 312, 746 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 646, 034 646, 034 646, 034 52.00 53.00 05300 ANESTHESI OLOGY 205, 680 205, 680 0 205, 680 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 2, 607, 184 2, 607, 184 0 2, 607, 184 54.00 o 57.00 05700 CT SCAN 965, 638 965, 638 965, 638 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 621, 411 621, 411 0 621, 411 58.00 60.00 06000 LABORATORY 5, 711, 962 5, 711, 962 84, 592 5, 796, 554 60.00 51, 748 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 51,748 0 51, 748 63.00 0 06500 RESPIRATORY THERAPY 65 00 702 187 702 187 702 187 65 00 66.00 06600 PHYSI CAL THERAPY 2, 833, 671 2, 833, 671 2, 833, 671 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 67.00 0 0 68.00 06800 SPEECH PATHOLOGY 220, 419 220, 419 220, 419 68.00 06900 ELECTROCARDI OLOGY 393, 506 393, 506 393, 506 69 00 69 00 0 70.00 07000 ELECTROENCEPHALOGRAPHY 319, 737 319, 737 319, 737 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 691, 902 691, 902 0 0 0 691, 902 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 72 00 1 687 267 1, 687, 267 1, 687, 267 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 3, 082, 666 3, 082, 666 3, 082, 666 73.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 908, 023 908, 023 908, 023 76.00 76.00 ol 76. 01 03950 DIABETES/WOUND CARE/COUMADIN CNTR 816, 963 816, 963 816, 963 76.01 76.02 03951 FLU CLINIC 23, 456 23, 456 0 23<u>, 456</u> 76.02 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 786, 678 786, 678 0 786, 678 88.00 91.00 09100 EMERGENCY 5, 108, 579 5. 108. 579 0 5, 108, 579 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1, 417, 897 92.00 1, 417, 897 1, 417, 897 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 1, 321, 933 1, 321, 933 1, 321, 933 95.00 101.00 10100 HOME HEALTH AGENCY 1, 779, 775 1, 779, <u>775</u> 1, 779, 775 101. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 116.00 11600 HOSPI CE 1, 475, 798 1, 475, 798 1, 475, 798 116. 00 200.00 0 50, 120, 774 200. 00 Subtotal (see instructions) 50, 036, 182 50, 036, 182 84, 592 1, 417, 897 201. 00 201.00 Less Observation Beds 1, 417, 897 1, 417, 897 202.00 Total (see instructions) 48, 618, 285 48, 618, 285 84, 592 48, 702, 877 202. 00

Health Financial Systems	MCDONOUGH DISTRICT HO	OSPI TAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	P	Provi der CCN: 140089	Peri od:	Worksheet C
			From 07/01/2014	
			To 04 /20 /2015	Doto/Time Drangrad.

				To 06/30/2015	Date/Time Pre 11/23/2015 5:	pared:
		Ti t	le XIX	Hospi tal	Cost	00 piii
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpati ent Rati o	
	6.00	7. 00	8. 00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	5, 714, 379		5, 714, 379	9		30. 00
31.00 03100 INTENSIVE CARE UNIT	1, 741, 958		1, 741, 958	3		31.00
43. 00 04300 NURSERY	771, 670		771, 670			43.00
44.00 04400 SKILLED NURSING FACILITY	0					44.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	2, 659, 899	10, 375, 315	13, 035, 214	0. 240502	0.000000	50.00
51.00 05100 RECOVERY ROOM	633, 392	5, 151, 438	5, 784, 830	0. 226929	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	351, 072	0			0.000000	52. 00
53. 00 05300 ANESTHESI OLOGY	433, 060	2, 339, 091	2, 772, 15°	0. 074195	0.000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	686, 865	7, 882, 966	8, 569, 83°	0. 304228	0.000000	54.00
57. 00 05700 CT SCAN	1, 584, 655	12, 144, 591	13, 729, 246	0. 070334	0.000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	164, 014	4, 600, 085	4, 764, 099	0. 130436	0.000000	58. 00
60. 00 06000 LABORATORY	4, 596, 920	23, 033, 219	27, 630, 139	0. 206729	0.000000	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	286, 542	353, 156	639, 698	0. 080894	0.000000	63.00
65. 00 06500 RESPIRATORY THERAPY	868, 465	1, 043, 829	1, 912, 29	0. 367196	0.000000	65. 00
66. 00 06600 PHYSI CAL THERAPY	729, 763	5, 475, 805			0.000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0. 000000	0.000000	67. 00
68. 00 06800 SPEECH PATHOLOGY	41, 540	439, 127	480, 66	0. 458569	0.000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	652, 777	2, 929, 732	3, 582, 509	0. 109841	0.000000	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	6, 846	1, 124, 533	1, 131, 379	0. 282608	0.000000	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 720, 412	1, 868, 207	3, 588, 619	0. 192805	0.000000	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	1, 997, 685	1, 931, 893	3, 929, 578	0. 429376	0.000000	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 472, 921	4, 587, 710	7, 060, 63°	0. 436599	0.000000	73. 00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	160	1, 041, 273	1, 041, 433	0. 871898	0.000000	76. 00
76. 01 03950 DIABETES/WOUND CARE/COUMADIN CNTR	3, 520	717, 511	721, 03°	1. 133048	0.000000	76. 01
76. 02 03951 FLU CLINIC	0	6, 488	6, 488	3. 615290	0.000000	76. 02
OUTPATIENT SERVICE COST CENTERS	·					
88.00 08800 RURAL HEALTH CLINIC	0	887, 134	887, 134	0. 886763	0. 000000	88. 00
91. 00 09100 EMERGENCY	1, 572, 375	12, 606, 055	14, 178, 430	0. 360306	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	371, 105	2, 631, 933	3, 003, 038	0. 472154	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0	3, 122, 292	3, 122, 292	0. 423385	0.000000	95. 00
101.00 10100 HOME HEALTH AGENCY	0	1, 165, 349	1, 165, 349	9		101. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	0	1, 483, 848	1, 483, 848	3		116. 00
200.00 Subtotal (see instructions)	30, 061, 995	108, 942, 580	139, 004, 57!	5		200. 00
201.00 Less Observation Beds						201. 00
202.00 Total (see instructions)	30, 061, 995	108, 942, 580	139, 004, 57	5		202. 00

Health Financial Systems	MCDONOUGH DISTRICT HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 140089	From 07/01/2014	Worksheet C Part I Date/Time Prepared: 11/23/2015 5:05 pm

			10 00/00/2010	11/23/2015 5: 05 pm
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient		· ·	
· ·	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
43. 00 04300 NURSERY				43.00
44.00 04400 SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 000000			50.00
51. 00 05100 RECOVERY ROOM	0. 000000			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
57. 00 05700 CT SCAN	0. 000000			57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			58.00
60. 00 06000 LABORATORY	0. 000000			60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	0. 000000			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000			76. 00
76. 01 03950 DI ABETES/WOUND CARE/COUMADI N CNTR	0. 000000			76. 01
76. 02 03951 FLU CLINI C	0. 000000			76. 02
OUTPATIENT SERVICE COST CENTERS	0.000000			70.02
88. 00 08800 RURAL HEALTH CLINIC	0. 000000			88. 00
91. 00 09100 EMERGENCY	0. 000000			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92. 00
OTHER REIMBURSABLE COST CENTERS	0.00000			72.00
95. 00 09500 AMBULANCE SERVICES	0. 000000			95. 00
101. 00 10100 HOME HEALTH AGENCY	0.00000			101. 00
SPECIAL PURPOSE COST CENTERS				101.00
113. 00 11300 NTEREST EXPENSE				113. 00
116. 00 11600 HOSPI CE				116. 00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00
202.00 10tal (300 113t)	1			1202.00

Health Financial Systems	MCDONOUGH DIST	RICT HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der	CCN: 140089	Period: From 07/01/2014	Worksheet D Part I	
				To 06/30/2015	Date/Time Pre 11/23/2015 5:	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col . 1 - col			
	26)		2)			
	1. 00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	1, 040, 350	0	1, 040, 35	5, 694	182. 71	30. 00
31.00 INTENSIVE CARE UNIT	166, 677		166, 67	7 691	241. 21	31.00
43. 00 NURSERY	41, 287		41, 28	596	69. 27	43.00
44.00 SKILLED NURSING FACILITY	0			0	0.00	44. 00
200.00 Total (lines 30-199)	1, 248, 314		1, 248, 31	4 6, 981		200. 00
Cost Center Description	I npati ent	Inpati ent		•		
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	2, 355	430, 282	!			30.00
31.00 INTENSIVE CARE UNIT	446	107, 580)			31. 00
43. 00 NURSERY	0	O)			43.00
44.00 SKILLED NURSING FACILITY	0	o c				44. 00
200.00 Total (lines 30-199)	2, 801	537, 862				200. 00

Health Financial Systems	MCDONOUGH DIST	RICT HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der		Peri od: From 07/01/2014 To 06/30/2015		
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
	Related Cost	(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	296, 878	13, 035, 214	0. 02277	5 1, 176, 537	26, 796	50.00
51.00 05100 RECOVERY ROOM	116, 055	5, 784, 830	0. 02006	265, 338	5, 323	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	65, 194	351, 072	0. 18570	0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	14, 558	2, 772, 151	0.00525	2 179, 168	941	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	310, 784	8, 569, 831	0. 03626	5 511, 870	18, 563	54.00
57. 00 05700 CT SCAN	35, 532	13, 729, 246	0. 00258	1, 051, 242	2, 721	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	12, 834	4, 764, 099	0. 00269	93, 874	253	58. 00
60. 00 06000 LABORATORY	358, 247	27, 630, 139	0. 01296	6 2, 760, 545	35, 793	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	1, 011	639, 698	0. 00158	181, 898	287	63.00
65. 00 06500 RESPIRATORY THERAPY	107, 581	1, 912, 294	0. 05625	8 595, 664	33, 511	65.00
66. 00 06600 PHYSI CAL THERAPY	223, 198	6, 205, 568	0. 03596	7 446, 693	16, 066	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0.00000	0 0	0	67. 00
68.00 06800 SPEECH PATHOLOGY	9, 024	480, 667	0. 01877	4 33, 023	620	68. 00
69. 00 06900 ELECTROCARDI OLOGY	13, 471	3, 582, 509	0. 00376	0 442, 749	1, 665	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	13, 908	1, 131, 379	0. 01229	3, 423	42	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	39, 762	3, 588, 619	0. 01108	1, 014, 838	11, 244	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	93, 903	3, 929, 578	0. 02389	6 1, 044, 121	24, 950	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	103, 835	7, 060, 631	0. 01470	1, 263, 100	18, 575	73. 00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	37, 810	1, 041, 433	0. 03630	160	6	76. 00
76.01 03950 DIABETES/WOUND CARE/COUMADIN CNTR	42, 464	721, 031	0. 05889	1, 887	111	76. 01
76. 02 03951 FLU CLINIC	459	6, 488	0. 07074	6 0	0	76. 02

94, 365

273, 938 167, 727

2, 432, 538

887, 134

14, 178, 430 3, 003, 038

125, 005, 079

0. 106371

0.019321

0.055852

956, 187

158, 005

12, 180, 322

0 88.00

91.00

92. 00 95. 00

18, 474

8, 825

224, 766 200. 00

OUTPATIENT SERVICE COST CENTERS

88. 00 08800 RURAL HEALTH CLINIC

Total (lines 50-199)

92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS
95. 00 09500 AMBULANCE SERVICES

91. 00 09100 EMERGENCY

200.00

Health Financial Systems	MCDONOUGH DISTI	RICT HOSPITAL		In Li€	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS	TS Provi der		Peri od:	Worksheet D	
				From 07/01/2014		
				To 06/30/2015	Date/Time Prep 11/23/2015 5:0	
		Ti +I	e XVIII	Hospi tal	PPS	05 piii
Cost Center Description	Nursing School			Swi ng-Bed	Total Costs	
oost denter bescription	ital strig series	Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos		1 through 3,	
			Ludouti on oos		minus col. 4)	
	1.00	2, 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
30. 00 03000 ADULTS & PEDIATRICS	0	0		0 0	0	30. 00
31. 00 03100 I NTENSI VE CARE UNI T	0	0	,	0	0	31. 00
43. 00 04300 NURSERY	0	0	1	0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0		0		44. 00
200.00 Total (lines 30-199)	0	0		0	0	200. 00
Cost Center Description	Total Patient	Per Diem (col.	Inpati ent	Inpatient	Ü	200.00
	Days	5 ÷ col. 6)	Program Days			
				Pass-Through		
				Cost (col. 7 x		
				col . 8)		
	6.00	7. 00	8.00	9. 00		
INPATIENT ROUTINE SERVICE COST CENTERS				<u> </u>		
30. 00 03000 ADULTS & PEDIATRICS	5, 694	0.00	2, 35	5 0		30. 00
31.00 03100 INTENSIVE CARE UNIT	691	0.00	44	6 0		31. 00
43. 00 04300 NURSERY	596	0.00		0 0		43.00
44.00 04400 SKILLED NURSING FACILITY	0	0.00		0 0		44.00
200.00 Total (lines 30-199)	6, 981	•	2, 80	1 0		200. 00
	•	•	•	•		•

Non Physician Nursing School Allied Health All Other Medical Education Cost Cos	e Prep 15 5: (PPS ost ol 1	05 pm 50.00
Non Physician Nursing School Allied Health All Other Medical Education Cost Cos	ost ol 1 col.	
Ancillary Service Cost Centers Ancillary Service Cost Centers 1.00 2.00 3.00 4.00 5.00	ol 1 col.	
ANCILLARY SERVICE COST CENTERS 50. 00 05000 0PERATING ROOM 0 0 0 0 0 51. 00 05100 RECOVERY ROOM 0 0 0 0 0 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 53. 00 05300 ANESTHESI OLOGY 0 0 0 0 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 56, 606 0 5 57. 00 05700 CT SCAN 0 0 0 0 58. 00 05800 MAGNETI C RESONANCE IMAGI NG (MRI) 0 0 0 0 58. 00 05800 MAGNETI C RESONANCE IMAGI NG (MRI) 0 0 0 0 60. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0 0 0 65. 00 06500 RESPI RATORY THERAPY 0 0 0 0 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 68. 00 06800 SPEECH PATHOLOGY 0 0 0 68. 00 06800 SPEECH PATHOLOGY 0 0 0 68. 00 06800 SPEECH PATHOLOGY 0 0 0 69. 00 00 00 0 0 60 00 00 0	-	
50. 00 05000 OPERATI NG ROOM 0 <td>-</td> <td></td>	-	
51. 00 05100 RECOVERY ROOM 0 <td>-</td> <td></td>	-	
52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 5 6 6 0 5 5 7 0	0	I 51 00
53. 00 05300 ANESTHESI OLOGY 0 0 0 0 0 0 0 0 0 0 5 0 0 0 0 5 0 0 5 6 6 0 5 5 6 6 0 5 5 6 6 0 5 5 6 6 0 </td <td></td> <td></td>		
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 56, 606 0 5 57. 00 05700 CT SCAN 0 0 0 0 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 0 60. 00 06000 LABORATORY 0 0 0 0 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0 0 0 65. 00 06500 RESPI RATORY THERAPY 0 0 0 66. 00 06600 PHYSI CAL THERAPY 0 0 0 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 68. 00 06800 SPEECH PATHOLOGY 0 0 0	0	52. 00
57. 00 05700 CT SCAN 0 0 0 0 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 0 60. 00 06000 LABORATORY 0 0 0 0 63. 00 06300 BLODD STORI NG, PROCESSI NG & TRANS. 0 0 0 0 65. 00 06500 RESPI RATORY THERAPY 0 0 0 0 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0	0	
58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 60. 00 06000 LABORATORY 0 0 0 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0 0 65. 00 06500 RESPI RATORY THERAPY 0 0 0 66. 00 06600 PHYSI CAL THERAPY 0 0 0 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 68. 00 06800 SPEECH PATHOLOGY 0 0 0	5, 606	
60. 00	0	
63. 00	0	58. 00
65. 00	0	60.00
66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 0 0	0	63. 00
67. 00 06700 OCCUPATIONAL THERAPY 0 0 0 0 0 0 0 0 88. 00 06800 SPEECH PATHOLOGY 0 0 0 0	0	65.00
68. 00 06800 SPEECH PATHOLOGY 0 0 0	0	66.00
	0	67.00
	0	68.00
69. 00 06900 ELECTROCARDI OLOGY 0 0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	70.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0	0	1 ,
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 0	0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0	0	73.00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0	0	76.00
76. 01 03950 DI ABETES/WOUND CARE/COUMADI N CNTR 0 0 0 0	0	76. 01
76. 02 03951 FLU CLINI C	0	76. 02
OUTPATIENT SERVICE COST CENTERS		
88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0	0	
91. 00 09100 EMERGENCY	0	91.00

0 0 0

0

0 0 0

56, 606

0

0

91. 00 92. 00 0

95.00

56, 606 200. 00

0

Total (lines 50-199)

200.00

Health Financial Systems	MCDONOUGH DISTI	RICT HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	S Provi der		Peri od:	Worksheet D	
THROUGH COSTS				From 07/01/2014	Part IV	
				To 06/30/2015	Date/Time Pre 11/23/2015 5:	
		Ti tl	e XVIII	Hospi tal	PPS	оо рііі
Cost Center Description	Total	Total Charges			Inpati ent	
555 551151 55551 Pt 1511		(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of	Part I, col.			Charges	
	col . 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)	ĺ	,	7)		
	6.00	7. 00	8.00	9. 00	10.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	13, 035, 214	0.00000	0.000000	1, 176, 537	50.00
51.00 05100 RECOVERY ROOM	0	5, 784, 830	0. 00000	0. 000000	265, 338	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	351, 072	0.00000	0. 000000	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0	2, 772, 151	0.00000	0. 000000	179, 168	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	56, 606	8, 569, 831	0.00660	5 0. 006605	511, 870	54.00
57. 00 05700 CT SCAN	0	13, 729, 246	0.00000	0. 000000	1, 051, 242	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	4, 764, 099	0.00000	0. 000000	93, 874	58. 00
60. 00 06000 LABORATORY	0	27, 630, 139	0.00000	0. 000000	2, 760, 545	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	639, 698	0.00000	0. 000000	181, 898	63. 00
65. 00 06500 RESPIRATORY THERAPY	0	1, 912, 294	0.00000	0. 000000	595, 664	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	6, 205, 568	0.00000	0. 000000	446, 693	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0. 00000	0. 000000	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	480, 667	0.00000	0. 000000	33, 023	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	3, 582, 509	0. 00000	0. 000000	442, 749	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	1, 131, 379	0. 00000	0. 000000	3, 423	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3, 588, 619	0. 00000	0. 000000	1, 014, 838	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	3, 929, 578	0.00000	0. 000000	1, 044, 121	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	7, 060, 631	0.00000	0. 000000	1, 263, 100	73. 00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	1, 041, 433	0.00000	0. 000000	160	76. 00
76.01 03950 DIABETES/WOUND CARE/COUMADIN CNTR	0	721, 031	0.00000	0. 000000	1, 887	76. 01
76. 02 03951 FLU CLINIC	0	6, 488	0.00000	0. 000000	0	76. 02

0

0

56, 606

887, 134

14, 178, 430 3, 003, 038

125, 005, 079

0.000000

0.000000

0.000000

0.000000

0.000000

0.000000

88. 00

91.00

92. 00 95. 00

0

956, 187

158, 005

12, 180, 322 200. 00

OUTPATIENT SERVICE COST CENTERS

88. 00 08800 RURAL HEALTH CLINIC

Total (lines 50-199)

92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS
95. 00 09500 AMBULANCE SERVICES

91. 00 09100 EMERGENCY

200.00

Health Financial Systems	MCDONOUGH DISTRICT	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 140089	Peri od: From 07/01/2014 To 06/30/2015	Worksheet D Part IV Date/Time Prepared: 11/23/2015 5:05 pm

					11/23/2015 5:	05 pm
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8		Costs (col. 9			
	x col. 10)		x col. 12)			
	11.00	12.00	13.00			
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	2, 569, 275	5)		50.00
51.00 05100 RECOVERY ROOM	0	1, 162, 077	' C			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C				52. 00
53. 00 05300 ANESTHESI OLOGY	o	586, 454	. c			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 381	1, 801, 401	11, 898	3		54.00
57. 00 05700 CT SCAN	O	3, 747, 907	' C			57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	o	1, 113, 419				58. 00
60. 00 06000 LABORATORY	ol	3, 570, 740				60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	ol	173, 021				63.00
65. 00 06500 RESPIRATORY THERAPY	o	416, 725	1			65. 00
66. 00 06600 PHYSI CAL THERAPY	o	266, 415				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	o	C				67. 00
68.00 06800 SPEECH PATHOLOGY	o	C				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	1, 014, 573	s c			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	o	303, 978	1			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	659, 502	1			71. 00
72.00 07200 MPL. DEV. CHARGED TO PATIENT	o	336, 994	1			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	o	1, 743, 340				73. 00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	o	153, 259				76. 00
76. 01 03950 DIABETES/WOUND CARE/COUMADIN CNTR	0	308, 565				76. 01
76. 02 03951 FLU CLI NI C	o	3, 126				76. 02
OUTPATIENT SERVICE COST CENTERS	-1	2, 1=0				1
88. 00 08800 RURAL HEALTH CLINIC	0	(88. 00
91. 00 09100 EMERGENCY	o	2, 721, 618				91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	809, 503				92.00
OTHER REIMBURSABLE COST CENTERS	<u> </u>	227,000	1	-1		1 /2:00
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50-199)	3, 381	23, 461, 892	11, 898	3		200. 00
	1 0,001	20, .0.,072	, 070	1		1-00.00

Health Financial Systems	MCDONOUGH DISTR	RICT HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVI	CES AND VACCINE COST	Provi der		Period: From 07/01/2014 To 06/30/2015	Worksheet D Part V Date/Time Pre 11/23/2015 5:0	pared: 05 pm
		Ti tl	e XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
·	Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2 00	3.00	4 00	5.00	

				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	·	Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 240502	2, 569, 275	0	0	617, 916	50.00
51.00	05100 RECOVERY ROOM	0. 226929	1, 162, 077	0	0	263, 709	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1. 840175	0	0	0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0. 074195	586, 454	0	0	43, 512	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 304228	1, 801, 401	0	0	548, 037	54.00
57.00	05700 CT SCAN	0. 070334	3, 747, 907	0	0	263, 605	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 130436	1, 113, 419	0	0	145, 230	58. 00
60.00	06000 LABORATORY	0. 206729			3, 140	738, 176	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 080894			0	13, 996	63.00
65.00	06500 RESPIRATORY THERAPY	0. 367196			0	153, 020	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 456634			0	121, 654	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	0	l o	0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0. 458569	l .	0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 109841		0	0	111, 442	1
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 282608			0	85, 907	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 192805			0	127, 155	1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	0. 429376			0	144, 697	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0. 436599			0	761, 141	73. 00
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 871898			0	133, 626	1
76. 01	03950 DI ABETES/WOUND CARE/COUMADI N CNTR	1. 133048			0	349, 619	76. 01
	03951 FLU CLINIC	3. 615290			0	11, 301	76. 02
	OUTPATIENT SERVICE COST CENTERS			-	_		
88. 00	08800 RURAL HEALTH CLINIC	0. 000000				0	88. 00
91. 00	09100 EMERGENCY	0. 360306		0	0	980, 615	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 472154					
,2.00	OTHER REIMBURSABLE COST CENTERS	0. 1,2.01	0077000			002,210	/2:00
95. 00	09500 AMBULANCE SERVI CES	0. 423385		0			95. 00
200.00		0. 120000	23, 461, 892	0	3, 140	5, 996, 568	
201.00	, ,		23, 101, 072	١	0,110	5, 770, 000	201.00
201.00	Only Charges			Ĭ			
202.00			23, 461, 892	0	3, 140	5, 996, 568	202 00
202.00	1 Shar gos (11110 200 17 11110 201)	1	20, 101, 072	1	0, 140	0, 7,0,000	1-02.00

Health Financial Systems		MCDONOUGH DISTE	RICT HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 140089	Peri od: From 07/01/2014 To 06/30/2015	Worksheet D Part V Date/Time Pre 11/23/2015 5:0	
			Ti tl	e XVIII	Hospi tal	PPS	
·		Cos					
C+ C+ D		C+	C+				

			'		11/23/2015 5:	05 pm
		Title	XVIII	Hospi tal	PPS	
	Costs					
Cost Center Description	Cost	Cost				
	Reimbursed R	Rei mbursed				
	Servi ces Se	ervices Not				
	Subject To S	Subject To				
	Ded. & Coins. De	d. & Coins.				
	(see inst.) (see inst.)				
	6.00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0				50. 00
51.00 05100 RECOVERY ROOM	0	0				51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53. 00 05300 ANESTHESI OLOGY	0	0				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
57. 00 05700 CT SCAN	0	0				57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58. 00
60. 00 06000 LABORATORY	0	649				60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0				63. 00
65. 00 06500 RESPI RATORY THERAPY	0	0				65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0				67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0				73. 00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0				76. 00
76.01 03950 DIABETES/WOUND CARE/COUMADIN CNTR	0	0				76. 01
76. 02 03951 FLU CLINIC	0	0				76. 02
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0	0				88. 00
91. 00 09100 EMERGENCY	0	0				91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0					95. 00
200.00 Subtotal (see instructions)	0	649				200. 00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)	0	649				202. 00

eal th	Financial Systems	MCDONOUGH DISTRICT	HOSPI TAL	In Lie	u of Form CMS-2	2552-
COMPUTA	ATION OF INPATIENT OPERATING COST		Provi der CCN: 140089	Peri od:	Worksheet D-1	
				From 07/01/2014 To 06/30/2015	Date/Time Pre 11/23/2015 5:	
			Title XVIII	Hospi tal	PPS	
	Cost Center Description					
l.	PART I - ALL PROVIDER COMPONENTS				1. 00	-
	INPATIENT DAYS					ł
-	Inpatient days (including private ro	om days and swing-bed days	excluding newborn)		5, 759	1.0
	Inpatient days (including private ro				5, 694	
	Private room days (excluding swing-b			ivate room davs.	0	1
	do not complete this line.		, 3			
	Semi-private room days (excluding sw				4, 776	4.
. 00	Total swing-bed SNF type inpatient d	ays (including private room	days) through Decembe	r 31 of the cost	0	5.
	reporting period					
	Total swing-bed SNF type inpatient d		days) after December	31 of the cost	65	6.
	reporting period (if calendar year,			04 6 11		_
	Total swing-bed NF type inpatient da reporting period	ys (including private room o	days) through becember	31 of the cost	0	7.
	reporting period Total swing-bed NF type inpatient da	us (including private room	davs) after December 3	1 of the cost	0	8.
	reporting period (if calendar year,		days) arter becember 5	i oi the cost	O	0.
	Total inpatient days including priva		the Program (excluding	swing-bed and	2, 355	9.
	newborn days)	to room days apprisable to	the trogram (exercating	oming boa and	2,000	'
	Swing-bed SNF type inpatient days ap	olicable to title XVIII only	y (including private r	oom days)	0	10.
	through December 31 of the cost repo	rting period (see instruction	ons)	,		
	Swing-bed SNF type inpatient days ap			oom days) after	0	11.
	December 31 of the cost reporting pe					
	Swing-bed NF type inpatient days app		only (including privat	e room days)	0	12.
	through December 31 of the cost repo		anly (including privat	a maam daysa)	0	13.
	Swing-bed NF type inpatient days app after December 31 of the cost report				U	13.
	Medically necessary private room day				0	14.
	Total nursery days (title V or XIX o		(exertaining swring bea	uuys)	0	
	Nursery days (title V or XIX only)	37			0	
	SWING BED ADJUSTMENT					
. 00	Medicare rate for swing-bed SNF serv	ces applicable to services	through December 31 o	f the cost	0.00	17.
	reporting period					
	Medicare rate for swing-bed SNF serv	ces applicable to services	after December 31 of	the cost	0. 00	18.
	reporting period					
	Medicaid rate for swing-bed NF servi	ces applicable to services	through December 31 of	the cost	0. 00	19.
	reporting period Medicaid rate for swing-bed NF servi	ess applicable to services	ofter December 21 of t	ho cost	0.00	20.
	reporting period	tes applicable to services a	arter becember 31 or t	ile cost	0.00	20.
	Total general inpatient routine serv	ce cost (see instructions)			8, 794, 665	21.
	Swing-bed cost applicable to SNF typ	,	31 of the cost report	ing period (line	0,771,000	
	5 x line 17)					
. 00	Swing-bed cost applicable to SNF typ	e services after December 3	1 of the cost reportin	g period (line 6	0	23.
	x line 18)					
	Swing-bed cost applicable to NF type	services through December	31 of the cost reporti	ng period (line	0	24.
	7 x line 19)				_	l
	Swing-bed cost applicable to NF type	services after December 31	of the cost reporting	period (line 8	0	25.
- 1	x line 20)	20)			0	1 2/
	Total swing-bed cost (see instruction		ine 21 minus line 24)		0 704 665	
	General inpatient routine service co	st het of Swing-bed cost (I	THE 21 HITHUS TIME 26)		8, 794, 665	27.
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service ch	arges (eycluding swing-bod	and observation had ch	arnes)	0	28.
	Private room charges (excluding swin	3 1	und observation bed CII	ui ges <i>j</i>	0	
		swing-bed charges)			U	1 - /

3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3. 00
	do not complete this line.		
4.00	Semi-private room days (excluding swing-bed and observation bed days)	4, 776	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5. 00
	reporting period	/ -	/ 00
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	65	6. 00
7 00	reporting period (if calendar year, enter 0 on this line)	0	7 00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
0.00	reporting period	0	0.00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	2 255	9. 00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	2, 355	9.00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10. 00
10.00	through December 31 of the cost reporting period (see instructions)	U	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	U	11.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12. 00
12.00	through December 31 of the cost reporting period	O	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13. 00
10.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	Ö	10.00
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. 00
15. 00	Total nursery days (title V or XIX only)	0	15. 00
16. 00	Nursery days (title V or XIX only)	0	16. 00
10.00	SWING BED ADJUSTMENT	5	
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17. 00
	reporting period		
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18. 00
	reporting period		
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19. 00
	reporting period		
20.00	Medicald rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20. 00
	reporting period		
21.00	Total general inpatient routine service cost (see instructions)	8, 794, 665	21. 00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22. 00
	5 x line 17)		
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23.00
	x line 18)		
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
	7 x line 19)		
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
	x line 20)		
26. 00	Total swing-bed cost (see instructions)	0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	8, 794, 665	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	0	29. 00
30. 00	Semi-private room charges (excluding swing-bed charges)	0	30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	0. 00	32. 00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00	
34. 00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00	
35. 00	Average per diem private room cost differential (line 34 x line 31)	0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	8, 794, 665	37. 00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
00.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	4	00.00
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 544. 55	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	3, 637, 415	
40. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.()()	Total Program general inpatient routine service cost (line 39 + line 40)	3, 637, 415	41.00

OMPUT	Financial Systems ATION OF INPATIENT OPERATING COST	MCDONOUGH DISTE		er CCN: 140089	Peri od:	worksheet D-1	
					From 07/01/2014 To 06/30/2015	Date/Time Pre 11/23/2015 5:	
				tle XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Da		9	Program Cost (col. 3 x col.	
		1.00	2. 00	col . 2) 3.00	4. 00	4) 5. 00	
2. 00	NURSERY (title V & XIX only)	0			00 0		42. 0
2 00	Intensive Care Type Inpatient Hospital Units	1 750 7/5		01 2 545	25 444	1 125 102	42.0
3. 00	INTENSIVE CARE UNIT	1, 758, 765		91 2, 545.	25 446	1, 135, 182	43. 0 44. 0
5. 00	BURN INTENSIVE CARE UNIT						45. 0
	SURGICAL INTENSIVE CARE UNIT						46. 0
7. 00	OTHER SPECIAL CARE (SPECIFY)						47.0
	Cost Center Description					1. 00	
8. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	, line 200)			3, 296, 522	48. 0
9. 00		41 through 48)(see instruc	i ons)		8, 069, 119	49.0
0. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	ationt routino	convices (fi	com Wkst D si	um of Darts L and	537, 862	 50 0
0.00		attent routine	services (11	OIII WKSt. D, St	iii Oi Faits i aliu	557, 802	30.0
1. 00	Pass through costs applicable to Program inp	atient ancillar	y services	from Wkst. D,	sum of Parts II	228, 147	51.0
2. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				744 000	52. 0
3. 00	Total Program inpatient operating cost exclu		lated non-	hvsician anest	hetist and	766, 009 7, 303, 110	
0.00	medical education costs (line 49 minus line	5 1	. a cou,o ,	yor or air airoo	otroti ana	7, 555, 115]
	TARGET AMOUNT AND LIMIT COMPUTATION						
4. 00 5. 00						l	54. 0 55. 0
6. 00						0.00	
7. 00	Difference between adjusted inpatient operat	ing cost and ta	rget amount	(line 56 minus	line 53)	0	57. C
8. 00	1 ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '					0	
9. 00	Lesser of lines 53/54 or 55 from the cost re market basket	porting period	ending 1996,	updated and c	compounded by the	0.00	59.0
0.00	Lesser of lines 53/54 or 55 from prior year	cost report, up	dated by the	market basket		0.00	60.0
1. 00	If line 53/54 is less than the lower of line					0	61.0
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		s (lines 54	x 60), or 1% c	of the target		
2. 00	1	riisti deti olis)				0	62.0
3. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	63.0
4. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Doso	mbor 21 of	ho cost roport	ing pariod (Saa	0	64. 0
4. 00	instructions) (title XVIII only)	ts through bece	iliber 31 01	.ne cost report	ing perrou (see		04.0
5. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the	e cost reportir	ng period (See	0	65.0
6. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi</pre>	no costs (lino	64 plus line	\ 65\(+i+l\\\\\\\\	II only) For	0	66.0
0.00	CAH (see instructions)	ne costs (Title	04 prus rriik	: 05)(title XVI	TT OHLY). TO		00.0
7. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 3	of the cost r	reporting period	0	67.0
.0 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	o costs after D	locombor 21	of the cost ron	porting ported	0	68. 0
0.00	(line 13 x line 20)	e costs after b	ecelliber 31 (n the cost rep	orting perrou		00.0
9. 00	Total title V or XIX swing-bed NF inpatient					0	69. 0
0 00	PART III - SKILLED NURSING FACILITY, OTHER N				'\		70.0
0. 00 1. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c	-		•)		70. 0 71. 0
2. 00	,			,			72. 0
3. 00	Medically necessary private room cost applic	9	•	,			73. C
4. 00 5. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•		,	Part II column		74. C
5.00	26, line 45)	routine service	COSTS (110	i worksneet b,	rait II, Corumii		75.0
6. 00	Per diem capital-related costs (line 75 ÷ li	,					76.0
7. 00	Program capital -related costs (line 9 x line	,					77.0
8. 00 9. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces	•	rovi den reco	ords)			78. C
0.00	00 0			•	nus line 79)		80.0
1.00	Inpatient routine service cost per diem limi						81.0
2.00	Inpatient routine service cost limitation (I		•				82.0
3. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		13)				83. 0 84. 0
	Utilization review - physician compensation		ns)				85. 0
	Total Program inpatient operating costs (sum	of lines 83 th					86. C
7. 00	PART IV - COMPUTATION OF OBSERVATION BED PAS					010	07 ^
/ ()()	Total observation bed days (see instructions	•					87.0
8. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			1, 544. 55	1 88 N

Health Financial Systems	MCDONOUGH DISTI	RICT HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period: From 07/01/2014	Worksheet D-1	
				To 06/30/2015	Date/Time Pre 11/23/2015 5:	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	1, 040, 350	8, 794, 665	0. 11829	3 1, 417, 897	167, 727	90.00
91.00 Nursing School cost	0	8, 794, 665	0.00000	0 1, 417, 897	0	91.00
92.00 Allied health cost	0	8, 794, 665	0.00000	0 1, 417, 897	0	92.00
93.00 All other Medical Education	0	8, 794, 665	0.00000	0 1, 417, 897	0	93.00

	Financial Systems MCDONOUGH DISTRIC			u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 140089	Peri od: From 07/01/2014	Worksheet D-1	
			To 06/30/2015	Date/Time Pre 11/23/2015 5:	
		Title XIX	Hospi tal	Cost	
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	NPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day			5, 759	
2.00	Inpatient days (including private room days, excluding swing-		ivata raam dava	5, 694 0	
3. 00	Private room days (excluding swing-bed and observation bed da do not complete this line.	ys). If you have only pr	ivate room days,	0	3. 00
4. 00	Semi-private room days (excluding swing-bed and observation b	ed days)		4, 776	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private ro		r 31 of the cost	0	5. 00
	reporting period				
. 00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	65	6. 00
	reporting period (if calendar year, enter 0 on this line)	m daya) thrayah Dagamban	21 of the cost	0	7 00
. 00	Total swing-bed NF type inpatient days (including private roc reporting period	iii days) tiii ougii beceiibei	31 OF THE COST	0	7. 00
3. 00	Total swing-bed NF type inpatient days (including private roo	m davs) after December 3	1 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)				
9. 00	Total inpatient days including private room days applicable t	o the Program (excluding	swing-bed and	655	9. 00
0 00	newborn days)	nly (including private r	an daya)	0	10 00
0. 00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruc		oom days)	0	10.00
1. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		oom davs) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, e				
12.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	e room days)	0	12. 00
	through December 31 of the cost reporting period				
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13. 00
4. 00	Medically necessary private room days applicable to the Progr			0	14. 00
	Total nursery days (title V or XIX only)			596	15. 00
16.00	Nursery days (title V or XIX only)			310	16. 00
	SWING BED ADJUSTMENT				
7. 00	Medicare rate for swing-bed SNF services applicable to servic	es through December 31 o	f the cost	0. 00	17. 00
8. 00	reporting period Medicare rate for swing-bed SNF services applicable to servic	os after December 21 of	the cost	0.00	18. 00
0.00	reporting period	es arter becember 31 or	the cost	0.00	18.00
9. 00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	the cost	0.00	19. 00
	reporting period				
20. 00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	he cost	0. 00	20. 00
1. 00	reporting period	2)		8, 794, 665	21 00
	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ing period (line	8, 794, 665	1
2.00	5 x line 17)	er 31 of the cost report	riig perrou (Triie	0	22.00
3. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	g period (line 6	0	23. 00
	x line 18)				
4. 00	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost reporti	ng period (line	0	24. 00
5. 00	7 x line 19) Swing-bed cost applicable to NF type services after December	21 of the cost reporting	ported (line 9	0	25. 00
3. 00	x line 20)	si or the cost reporting	perrou (Trile o	0	25.00
5. 00	Total swing-bed cost (see instructions)			0	26. 00
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		8, 794, 665	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-be	d and observation bed ch	arges)	0	28. 00 29. 00
29. 00	Private room charges (excluding swing-bed charges)				

	reporting period	'	
20 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20. 00
20.00	reporting period	0.00	20.00
21 00	Total general inpatient routine service cost (see instructions)	8, 794, 665	21 00
	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0, 7,74, 003	22. 00
22.00	5 x line 17)	١	22.00
33 UU	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
23.00	Swing-bed cost approache to Swingsper services after become 31 of the cost reporting period (The o	١	23.00
24 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
24.00	Try Line 19)	١	24.00
25 00	[Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
23.00	In line 20)	١	25.00
26 00	Total swing-bed cost (see instructions)	0	26. 00
	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	8, 794, 665	
27.00	PRIVATE ROOM DI FFERENTI AL ADJUSTMENT	0, 774, 003	27.00
28 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
	Pri vate room charges (excluding swing-bed charges)		29.00
	Semi -pri vate room charges (excluding swing-bed charges)		30.00
31. 00		0. 000000	
32. 00			32.00
33.00			33.00
34.00			34.00
	Average per diem private room cost differential (line 34 x line 31)		35. 00
	Private room cost differential adjustment (line 3 x line 35)	0	00.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	8, 794, 665	37.00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
	Adjusted general inpatient routine service cost per diem (see instructions)	1, 544. 55	
	Program general inpatient routine service cost (line 9 x line 38)	1, 011, 680	
	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	
41. 00	Total Program general inpatient routine service cost (line 39 + line 40)	1, 011, 680	41.00

	Financial Systems ATION OF INPATIENT OPERATING COST	MCDONOUGH DISTE			CCN: 140089	In Lie	u of Form CMS-2 Worksheet D-1	
COMPUT	ATION OF INPATIENT OPERATING COST		Provid	uer.		From 07/01/2014		
				_		To 06/30/2015	Date/Time Prep 11/23/2015 5:0	
	Coot Contor Description	T-+-!		Ti t	le XIX	Hospi tal	Cost	
	Cost Center Description	Total Inpatient Cost	Total Inpatient D	avs	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x col.	
			<u> </u>		col . 2)		4)	
42.00	NURSERY (title V & XIX only)	1. 00 654, 902	2. 00	596	3. 00 1, 098. 8	4. 00	5. 00 340, 637	42.00
42.00	Intensive Care Type Inpatient Hospital Units			370	1,070.0	310	340, 037	42.00
43. 00	INTENSIVE CARE UNIT	1, 758, 765		691	2, 545. 2	5 74	188, 349	1
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT							44. 00 45. 00
46. 00	1							46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)							47. 00
	Cost Center Description						1. 00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	, line 200)				1, 225, 453	48. 00
49. 00	Total Program inpatient costs (sum of lines	41 through 48)(see instruc	tio	ns)		2, 766, 119	49. 00
50.00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine	services (f	rom	Wkst D sum	of Parts L and	0	50.00
00.00			•					00.00
51. 00	Pass through costs applicable to Program inp	atient ancillar	y services	(fr	om Wkst. D, s	um of Parts II	0	51.00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)					0	52.00
53.00	Total Program inpatient operating cost exclu	ding capital re	lated, non-	phy	sician anesth	etist, and	0	53. 00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)						
54. 00	Program discharges						0	54.00
	Target amount per discharge							55. 00
56. 00 57. 00	, ,	ing cost and ta	raot amount	. (1	ino 56 minus	lino 52)	0	56. 00 57. 00
58. 00	Bonus payment (see instructions)	ing cost and ta	ii get alliouiit	. (1	THE 50 IIITIUS	111le 53)	0	
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	ending 1996	, u	pdated and co	mpounded by the	0. 00	59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report un	ndated by th	ne m	arket hasket		0.00	60.00
61. 00	If line 53/54 is less than the lower of line					the amount by	0	
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		s (lines 54	X	60), or 1% of	the target		
62. 00	Relief payment (see instructions)	i iisti ucti oiis)					0	62. 00
63. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	ıcti ons)				0	63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of	the	cost reporti	na period (See	0	64.00
	instructions)(title XVIII only)	Ü			·			
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	er 31 of th	ne c	ost reporting	period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus lir	ne 6	5)(title XVII	I only). For	0	66. 00
(7.00	CAH (see instructions)				6.11			47.00
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	December 3	3 I O	T the cost re	porting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routin	e costs after D	ecember 31	of	the cost repo	rting period	0	68. 00
69 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (line 67 ± 1	i na	68)		0	69. 00
07.00	PART III - SKILLED NURSING FACILITY, OTHER N						O	0 7. 00
70. 00	Skilled nursing facility/other nursing facil							70. 00
71. 00 72. 00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		ine 70 ÷ li	ne .	2)			71. 00
73. 00	Medically necessary private room cost applic		(line 14 x	Cli	ne 35)			73. 00
74.00	Total Program general inpatient routine serv	•		,				74.00
75. 00	Capital-related cost allocated to inpatient 26. line 45)	routine service	costs (fro	om W	orksheet B, P	art II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)						76. 00
77. 00	Program capital -related costs (line 9 x line							77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		rovi der rec	cord	s)			78. 00 79. 00
80.00	Total Program routine service costs for comp	arison to the c			•	us line 79)		80.00
81.00	Inpatient routine service cost per diem limi		`					81.00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (* .					82. 00 83. 00
84. 00	Program inpatient ancillary services (see in	structions)						84. 00
85.00	Utilization review - physician compensation							85.00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		ıı ougri 85)					86.00
87. 00	Total observation bed days (see instructions)						87. 00
88.00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	•					1, 544. 55 1, 417, 807	1
U7. UU	Tonservation bed cost (Time of X Time 88) (Se	e mstructions)					1, 417, 897	J 07. UU

Health Financial Systems	MCDONOUGH DISTI	RICT HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 07/01/2014 To 06/30/2015		
		Ti t	le XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	1, 040, 350	8, 794, 665	0. 11829	3 1, 417, 897	167, 727	90.00
91.00 Nursing School cost	0	8, 794, 665	0.00000	0 1, 417, 897	0	91.00
92.00 Allied health cost	0	8, 794, 665	0.00000	0 1, 417, 897	0	92. 00
93.00 All other Medical Education	0	8, 794, 665	0.00000	0 1, 417, 897	0	93. 00

NPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT		CCN: 140089	Peri od: From 07/01/2014 To 06/30/2015	Worksheet D-3 Date/Time Pre 11/23/2015 5:0	pared
		Ti tl	e XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1.00	0.00	2)	
	INDATI DATE DOUTING CEDI/LOG COCT CENTEDO		1. 00	2. 00	3. 00	
00.00	INPATIENT ROUTINE SERVICE COST CENTERS		I	2 011 240		1 20 /
30.00	03000 ADULTS & PEDIATRICS			2, 811, 349		30.0
31.00	03100 I NTENSI VE CARE UNI T			1, 108, 589		31. (
13. 00	04300 NURSERY					43. (
-0.00	ANCI LLARY SERVI CE COST CENTERS		0.2405	00 1 17/ 507	202.070	/
0.00	05000 OPERATI NG ROOM		0. 24050		282, 960	
51.00	05100 RECOVERY ROOM		0. 22692		60, 213	
2. 00	05200 DELIVERY ROOM & LABOR ROOM		1. 8401		0	52. (
3.00	05300 ANESTHESI OLOGY		0. 07419		13, 293	
4.00	05400 RADI OLOGY-DI AGNOSTI C		0. 30422			1
7.00	05700 CT SCAN		0. 07033		73, 938	
8.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 13043		12, 245	
0.00	06000 LABORATORY		0. 20979		579, 137	60.
3. 00	06300 BLOOD STORING, PROCESSING & TRANS.		0. 08089			
5. 00	06500 RESPI RATORY THERAPY		0. 36719		218, 725	65.
6.00	06600 PHYSI CAL THERAPY		0. 45663		203, 975	
7. 00	06700 OCCUPATI ONAL THERAPY		0.00000		0	67.
8. 00	06800 SPEECH PATHOLOGY		0. 45856		15, 143	
9.00	06900 ELECTROCARDI OLOGY		0. 10984		48, 632	
0.00	07000 ELECTROENCEPHALOGRAPHY		0. 28260		967	70.
1.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		0. 19280			1
2.00	07200 I MPL. DEV. CHARGED TO PATI ENT		0. 4293		448, 320	
3. 00	07300 DRUGS CHARGED TO PATIENTS		0. 43659		551, 468	1
6. 00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0. 87189		140	
6. 01	03950 DIABETES/WOUND CARE/COUMADIN CNTR		1. 13304		2, 138	
6. 02	03951 FLU CLI NI C		3. 61529	90 0	0	76.
	OUTPATIENT SERVICE COST CENTERS				_	
8. 00	08800 RURAL HEALTH CLINIC		0. 00000		0	
1. 00	09100 EMERGENCY		0. 36030		344, 520	91.
2. 00	09200 OBSERVATI ON BEDS (NON-DISTINCT PART)		0. 4721	54 158, 005	74, 603	92.
	OTHER REIMBURSABLE COST CENTERS		1			
5. 00	09500 AMBULANCE SERVI CES					95.
00.00				12, 180, 322	3, 296, 522	
201.00	Less PBP Clinic Laboratory Services-Program only charges (I	ine 61)		0		201.
02.00	Net Charges (line 200 minus line 201)		I	12, 180, 322		202.

I NPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 140089	Peri od:	Worksheet D-3	
				From 07/01/2014 To 06/30/2015		pared:
		Ti t	le XIX	Hospi tal	Cost	
	Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
			To Charges		Program Costs	
				Charges	(col. 1 x col.	
			1.00	0.00	2)	
	INDATIENT DOUTINE CEDVICE COCT CENTERS		1.00	2. 00	3. 00	
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS			736, 757		30.0
30.00	03100 INTENSIVE CARE UNIT			183, 150		31.0
	04300 NURSERY			266, 566		43. 0
+3.00	ANCI LLARY SERVI CE COST CENTERS			200, 300		43.0
50. 00	05000 OPERATING ROOM		0. 24050	02 410, 672	98, 767	50.0
51. 00	05100 RECOVERY ROOM		0. 2269:	·		1
52. 00	05200 DELIVERY ROOM & LABOR ROOM		1. 8401			1
53. 00	05300 ANESTHESI OLOGY		0. 07419			
54. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 3042	·		
57. 00	05700 CT SCAN		0. 0703			57.0
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 1304	7, 920	1, 033	58.0
60.00	06000 LABORATORY		0. 20672	29 611, 278	126, 369	60.0
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.		0. 08089	94 0	0	63.0
65. 00	06500 RESPI RATORY THERAPY		0. 36719			
66. 00	06600 PHYSI CAL THERAPY		0. 4566		15, 965	66.0
57. 00	06700 OCCUPATI ONAL THERAPY		0.00000		0	
58. 00	06800 SPEECH PATHOLOGY		0. 4585		0	
69. 00	06900 ELECTROCARDI OLOGY		0. 1098			
70. 00	07000 ELECTROENCEPHALOGRAPHY		0. 28260		0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 19280			1
72. 00	07200 I MPL. DEV. CHARGED TO PATI ENT		0. 4293		0	
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 43659			
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0. 87189		0	
76. 01	03950 DIABETES/WOUND CARE/COUMADIN CNTR		1. 1330			
76. 02	03951 FLU CLINIC		3. 61529	90 0	0	76. 0
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC		0. 8867	63 0	0	88. 0
91.00	09100 EMERGENCY		0. 36030		_	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 30030			
, 2. 00	OTHER REIMBURSABLE COST CENTERS		0.4/21	J-I 04, 200	37, 190	72.0
5. 00	09500 AMBULANCE SERVICES					95. C
200. OC				2, 723, 100	1, 225, 453	
200. 00 201. 00		(Line 61)		2, 723, 100	1, 220, 400	201. 0
201. 00 202. 00		(2, 723, 100		202. 0

MARI A - INVALLENT ROPE IAL SERVICES UNDER LIPS 1.00 1.01 7.00	CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der		Period: From 07/01/2014	Worksheet E Part A	
PMPH A - IMPATIENT HOSPITAL SERVICES UNDER IPPS					To 06/30/2015		
Description			Ti tl	e XVIII	Hospi tal		05 piii
Next A - Inpatriest Insperital Services Works - Insperitus 90 1.00						0.00	
1.00 1.00		DADT A _ INDATIENT HOSDITAL SERVICES LINDER LDDS	0	1.00	1. 01	2. 00	
1.00 DRG amounts other than outlier payments for discharges 997,360 1.01	1. 00				ol		1.00
1.02 BGG uncount's other than outlier payments for discharges 3.127.042 1.02	1.01	DRG amounts other than outlier payments for discharges		987, 39	О		1. 01
Descripting on or after dictaber 1 (see instructions) 1,03 1,03 1,04 1,04 1,04 1,05	1 00			2 127 04	2		1 00
1.03 SRC for Febraria Specific operating payment for Model 4 SRC for discharges courring prior to October 1 (See Instructions) 1.04 SRC for discharges courring prior to October 1 (See Instructions) 1.04 SRC for discharges courring on or after October 1 (See Instructions) 1.04 SRC for discharges for Wodel 4 BRC (See Instructions) 1.47,536 2.00	1.02			3, 127, 04	2		1.02
Instructions	1.03				О		1. 03
1.04 DRG for rederial specific concating payment for Model 4 0 1.04							
BPC For discharge's occurring on or after October 1 (see 10 147,534 2.00 147,534 2.00 147,534 2.00 147,534 2.00 147,534 2.00 2.01 147,534 2.00 2.01 147,534 2.00 2.01 147,534 2.00 2.01 147,534 2.00 2.01 2.00	1 04				0		1 04
2.00 Outlier payments for discharges. (see Instructions)	1.04						1.04
2.00 Outlier reconciliation amount 0 2.01 1.00 2.02 1.00 1.00 1.00 1.00 2.02 2.02 2.00 1.00 1.00 1.00 2.02 2.02 2.02 1.00 2.00 2.02 2.02 2.00							
2.02 Outlier payment for discharges for Model 4 BPCI (see 0 2.02 Instructions) Annaged Care Similar ted Payments 851,428 3.00 Annaged Care Similar ted by minimater of days in the cost 37,81 4.00 Annaged Care Similar ted by minimater of days in the cost 37,81 4.00 Annaged Care Similar ted by minimater of days in the cost 37,81 4.00 Annaged Care Similar ted and support of the cost 37,81 4.00 Annaged Care Similar ted and support of the cost Annaged Care Similar ted and support of the cost Annaged Care Similar ted and support of the cost Annaged Care Similar ted and support of the cost Annaged Care Similar ted Ann							
Instructions 1.00 Managed Care Staulated Payments 3.00 Managed Care Staulated Payments 3.00 Managed Care Staulated Payments 3.30 4.0					-		
Bed days available divided by number of days in the cost reporting period (see instructions) Filter time period (see instructions) Filtronia	2.02						2.02
reporting period (sees instructions)							
Indirect Medical Education Adjustment	4.00			37.8	1		4.00
most recent cost réporting period ending on or before 12/31/19/96, (see instructions) 6.00 6							1
12/31/1996, (see Instructions) 6.00 6.	5.00			0.0	0		5. 00
FTE count for allopathic and osteopathic programs which neet the criteria for an add-not to the cap for new programs in accordance with 42 CFR 413.79(e) 7.00 MM Section 422 reduction anount to the IME cap as specified under 42 CFR 412.105(f)(1)(1)(1)(8)(1) 7.01 7.01 7.01 7.02 7.01 7.02 7.02 7.01 7.03 7.0							
meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e) 7.00 MMA Section 422 reduction amount to the IME cap as \$ 0.00 \$ 7.00 \$ 1.	6 00			0.0	0		6.00
1.00 MMA Section 422 reduction amount to the IME cap as specified under 42 CFR 9412 - 105(f(1)(1)(1)(8)(1)	0.00			0.0			0.00
specified under 42 CFR \$412.105(f)(1)(iv)(8)(1) 7.01 ACR Section 5503 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(8)(2) If the cost report straddle suly 1, 2011 then see instructions. 8.00 Adjustment (Increase or decrease) to the FTE count for all lopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 25340 (Mey 12, 1998), and 67 FR 5006/r (August 1, 2008/r (August 1,		11 9					
7.01 ACA Section 5503 reduction amount to the life cap as specified under 42 CFR 9412. 105(f)(1)(iv)(i)(8)(2) If the cost report straddles July 1, 2011 then see instructions. 8.00 All ustment (increase or decrease) to the FTE count for all lopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b). 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002). 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. 8.02 storage of the ACA. If the cost report straddles July 1, 2011, see Instructions. 8.02 slots from a closed teaching hospital under section 5506 of ACA. (see Instructions) 9.00 Sum of lines 5 plus 6 minus lines (2 and 7.01) plus/minus in see (3, 8, 01 and 8, 02) (see Instructions) 10.00 FTE count for allopathic and osteopathic programs in the current year from your records 11.00 FTE count for relidents in dental and podiatric programs. 12.00 Current year allowable FTE (see instructions) 13.00 Total allowable FTE count for the penultimate year if that very ended on or after September 30, 1997, otherwise enter 2670. 15.00 Sum of lines 12 through 14 divided by 3. 16.00 Adjustment for residents in initial years of the program 0.000 17.00 Adjustment for residents in initial years of the program 0.000 18.00 Current year residents in initial years of the program 0.000 19.00 Individed rolling average FTE count 19.00 Individed rolling average FTE count or hospital 0.000 19.00 Individed rolling average FTE count or hospital 0.000 19.00 Individed rolling average FTE count or hospital 0.000 19.00 Individed rolling average FTE count or hospital 0.000 19.00 Individed rolling average FTE count or hospital 0.000 19.00 Individed rolling average FTE count or hospital 0.000 20.00 Individed rolling average FTE count or hospital 0.000 21.00 Individed rolling average FTE count 0.000 22.00 IME payment adjustment (see instructions) 23.00 Ind	7. 00			0.0	0		7.00
specified under 42 CFR \$412.105(Y)(1)(1)(B)(2)* If the cost report straddles July 1, 2011 then see instructions.	7. 01			0.0	o		7. 01
Agustment (Increase or decrease) to the FTE count for all opathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(1)(1), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the					
al lopathic and osteopathic programs for affill ated programs in accordance with 42 CFR 413.75(b), 413.79(c) (2) (1v), 64 FR 26340 (May 12, 1998), and 67 FR 50009 (August 1, 2002). 8.01 The amount of increase if the hospital was awarded FTE cap storts under section 5503 of the ACA. If the cost report straddle sully 1, 2011, see instructions. 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) 9.00 Increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions) 9.00 Increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions) 10.00 Increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions) 10.00 Increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions) 10.00 FTE count for all opathic and osteopathic programs in the current year from your records 11.00 FTE count for residents in dental and podiatric programs. 10.00 Increate year increase if the prior year. 11.00 Total all owable FTE count for the penul timate year if that year ended on or after September 30, 1997, otherwise enter zero. 15.00 Sum of Lines 12 through 14 divided by 3. 15.00 Sum of Lines 12 through 14 divided by 3. 16.00 Adjustment for residents in initial years of the program 0.00 16.00 Adjustment for residents in initial years of the program 0.00 17.00 Closure 18.00 Adjustment for resident to bed ratio (line 18 divided by 0.000000 19.00 Current year resident to bed ratio (see instructions) 0.000000 19.00 Current year resident to bed ratio (see instructions) 0.000000 19.00 Current year resident to bed ratio (see instructions) 0.000000 19.00 Current year resident to bed ratio (see instructions) 0.000000 19.00 Current year resident to bed ratio (see instructions) 0.000000 19	0.00			0.0			0.00
programs in accordance with 42°CFR 413.75(b), 413.79(c)(2)(1)(-), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	8.00			0.0	U .		8.00
S00.69 (August 1, 2002).							
8.01 The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddle July 1, 2011, see instructions.							
Slots under section 5503 of the ACA. If the cost report straddle sully 1, 2011, see instructions	8 01			0.0	0		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) 9.00 9.00 9.00 Sum of lines 5g lus 6 minus lines (7 and 7.01) plus/minus 0.00 10.00 10.00 FTE count for allopathic and osteopathic programs in the current year from your records 11.00 FTE count for residents in dental and podiatric programs. 0.00 11.00 10.00 FTE count for residents in dental and podiatric programs. 0.00 12.00 10.00 Total allowable FTE count for the prior year. 0.00 12.00 10.00 Total allowable FTE count for the prior year. 0.00 13.00 10.00 Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero. 15.00 Sum of lines 12 through 14 divided by 3. 0.00 15.00 15.00 Sum of lines 12 through 14 divided by 3. 0.00 15.00 16.00 Adjustment for residents in initial years of the program 0.00 16.00 17.00 Adjusted rolling average FTE count 0.00 17.00 18.00 Adjusted rolling average FTE count 0.00 17.00 19.00 Current year resident to bed ratio (line 18 divided by 0.000000 19.00 10.00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 20.00 10.00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21.00 10.00 IME payment adjustment - Managed Care (see instructions) 0.00 22.00 10.00 IME payment adjustment for the Add-on for Section 422 of the MMA 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(1)(0)(0) 1.0000000 1.0000000 1.0000000 1.000000 1.000000000 1.0000000 1.00000000 1.0000000000	0.01			0.0			0.01
Slots from a closed teaching hospital under section 5506 of ACA. (see instructions) 9.00 Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus 0.00 11 nes (8, 8, 01 and 8, 02) (see instructions) 10.00 11 nes (8, 8, 01 and 8, 02) (see instructions) 10.00 11 nes (8, 8, 01 and 8, 02) (see instructions) 11.00 12 new from your records 12.00 13 new from your records 13.00 14.00 15 new from your records 14.00 15 new from your residents in dental and podiatric programs. 0.00 12.00 12.00 13.00 14.00 14.00 14.00 15 new from your residents in dental and podiatric programs. 0.00 13.00 14.00 15 new from your residents from the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero. 15.00 15 new from your residents in initial years of the program 0.00 15.00 16.00 17.00 18.00 17.00 18.00 17.00 18.00 18.00 19.00							
of ACA. (see instructions) 9.00	8. 02			0.0	0		8.02
lines (8, 8, 01 and 8, 02) (see instructions) 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 11.0							
10.00 FTE count for allopathic and osteopathic programs in the current year from your records 11.00 TTE count for residents in dental and podiatric programs. 0.00 11.00 11.00 12.00 12.00 12.00 12.00 13.00 10.01 10.00 12.00 13.00 10.01 10.00 13.00 10.01 10.00 13.00 10.01 10.00 13.00 10.01 10.00 13.00 10.01 10.00 13.00 10.00 13.00 10.00 13.00 10.00 13.00 10.00 13.00 10.00 14.00 10.00 14.00 16.00	9.00			0.0	0		9. 00
Current year from your records	10 00			0.0	0		10 00
11.00 FTE count for residents in dental and podiatric programs. 0.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 13.00 16.00 13.00 16.00 13.00 16.00 13.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 17.00 16.00 17.00 16.00 17.00 17.00 17.00 18.00 18.00 19.00 18.00 19.00 1	10.00			0.0			10.00
13. 00 Total allowable FTE count for the prior year 13. 00 Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero. 14. 00 15. 00 15. 00 15. 00 15. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 17. 00 Adjustment for residents in initial years of the program 0. 00 16. 00 17. 00 20.	11. 00						11. 00
14.00 Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero. 15.00		1					
year ended on or after September 30, 1997, otherwise enter zero. 15.00 Sum of lines 12 through 14 divided by 3. 16.00 Adjustment for residents in initial years of the program 0.00 16.00 17.00 Adjustment for residents displaced by program or hospital 0.00 17.00 closure 18.00 Adjusted rolling average FTE count 0.00 18.00 19.00 Current year resident to bed ratio (line 18 divided by 19.00) 19.00 19		1					1
15.00 Sum of lines 12 through 14 divided by 3. 15.00 16.00 Adjustment for residents in initial years of the program 0.00 16.00 17.00 Adjustment for residents displaced by program or hospital closure 0.00 17.0	14.00			0.0			14.00
16.00 Adj ustment for residents in initial years of the program 0.00 16.00 17.00 Adj usment for residents displaced by program or hospital closure 0.00 17.00 18.00 Adj usted rolling average FTE count 0.00 18.00 19.00 Current year resident to bed ratio (line 18 divided by line 4). 0.000000 19.00 20.00 Prior year resident to bed ratio (see instructions) 0.000000 20.00 21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21.00 22.01 IME payment adj ustment (see instructions) 0.000000 22.00 10.1 IME payment adj ustment - Managed Care (see instructions) 0.000000 22.01 10.00 Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 0.00 22.01 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C). 23.00 23.00 24.00 IME FTE Resident Count Over Cap (see instructions) 0.00 24.00 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 0.000000 25.00 26.00 Resident to bed ratio (divide line 2							
17.00							1
18.00 Adjusted rolling average FTE count 18.00 19.00		, ,					
19.00 Current year resident to bed ratio (line 18 divided by line 4). 20.00 Prior year resident to bed ratio (see instructions) 21.00 Enter the lesser of lines 19 or 20 (see instructions) 22.00 IME payment adjustment (see instructions) 22.01 IME payment adjustment - Managed Care (see instructions) 22.01 Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C). 24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter 0.00 25.00 If the amount on line 24 (see instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see 0 28.01 instructions)		closure					
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20.00	19.00	, ,		0.00000	O		19.00
22.00 IME payment adjustment (see instructions) 1 IME payment adjustment - Managed Care (see instructions) 1 Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C). 24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter 0.00 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 22.00 22.01 23.00 23.00 24.00 25.00 25.00 26.00 26.00 27.00 28.01 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see 0 0 0 28.01)	20. 00	1		0. 00000	О		20.00
22.01 IME payment adjustment - Managed Care (see instructions) 0 22.01 Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C). 24.00 IME FTE Resident Count Over Cap (see instructions) 0.00 24.00 25.00 If the amount on line 24 is greater than -0-, then enter 0.00 25.00 the lower of line 23 or line 24 (see instructions) 0.000000 26.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 IME add-on adjustment amount (see instructions) 0.000000 28.00 IME add-on adjustment amount - Managed Care (see 0.00 0.000000 0.000000 0.0000000 0.000000				i			
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 23.00 Number of additional allopathic and osteopathic IME FTE cesident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C). 24.00 IME FTE Resident Count Over Cap (see instructions) 0.00 24.00 25.00 If the amount on line 24 is greater than -O-, then enter the lower of line 23 or line 24 (see instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 27.00 27.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 28.00 IME add-on adjustment amount (see instructions) 0 28.00 1 IME add-on adjustment amount - Managed Care (see instructions) 0 28.01 instructions)		, , , , , , , , , , , , , , , , , , , ,			-		1
23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C). 24.00 IME FTE Resident Count Over Cap (see instructions) O.00 1f the amount on line 24 is greater than -O-, then enter the lower of line 23 or line 24 (see instructions) Resident to bed ratio (divide line 25 by line 4) O.000000 O.0000000 O.00000000	22.01		on 422 of t		U _I		22.01
24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions)	23. 00	Number of additional allopathic and osteopathic IME FTE			0		23. 00
25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 28.01 instructions) 25.00 26.00 27.00 28.00 28.01	24.00	1					24.00
the lower of line 23 or line 24 (see instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 28.01 instructions)							1
26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 28.01 instructions) 26.00 27.00 28.00 28.01	25.00]	<u> </u>		25.00
28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 28.00 28.01 instructions)		Resident to bed ratio (divide line 25 by line 4)					1
28.01 IME add-on adjustment amount - Managed Care (see 0 28.01 instructions)				ı			1
instructions)							
29.00 Total IME payment (sum of lines 22 and 28) 0 29.00 Total IME payment (sum of lines 22 and 28)		instructions)					
	29. 00	Total IME payment (sum of lines 22 and 28)		l	0		29.00

3, 381

5, 675, 348

5, 675, 348

628, 508

58.00

59.00

60 00

61.00

62.00

58)

through 35).

Primary payer payments

58.00

59.00

60.00

61.00

Ancillary service other pass through costs

from Wkst. D, Pt. IV, col. 11 line 200) Total (sum of amounts on lines 49 through

Total amount payable for program

beneficiaries (line 59 minus line 60) 62.00 Deductibles billed to program beneficiaries

Health Financial Systems	MCDONOUGH DISTRICT	HOSPI TAL		In Lieu of Form CMS-2552			
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der	CCN: 140089	Peri od: From 07/01/2014 To 06/30/2015	Worksheet E Part A Date/Time Prep 11/23/2015 5:0		
		Ti tl	e XVIII	Hospi tal	PPS		
			Prior to		On/After		
			October 1		October 1		

						11/23/2015 5:	05 pm
			Ti tl	e XVIII	Hospi tal	PPS	
				Prior to		On/After	
				October 1		October 1	
		0		1. 00	1. 01	2. 00	
63.00	Coinsurance billed to program beneficiaries			1, 890			63. 00
64.00	Allowable bad debts (see instructions)			161, 116			64.00
65.00	Adjusted reimbursable bad debts (see			104, 725			65. 00
	instructions)						
66.00	Allowable bad debts for dual eligible			161, 116			66. 00
	beneficiaries (see instructions)						
67.00	Subtotal (line 61 plus line 65 minus lines			5, 149, 675			67. 00
	62 and 63)			., .,			
68. 00	Credits received from manufacturers for			0			68. 00
00.00	replaced devices for applicable to MS-DRGs			0			00.00
	(see instructions)						
40.00	Outlier payments reconciliation (sum of			0			69. 00
69. 00				U			09.00
	lines 93, 95 and 96). (For SCH see						
70.00	instructions)						70.00
70. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS)			0			70. 00
	(SPECIFY)			_			
70. 50	RURAL DEMONSTRATION PROJECT			0			70. 50
70. 89	Pioneer ACO demonstration payment adjustment			0			70. 89
	amount (see instructions)						
70. 90	HSP bonus payment HVBP adjustment amount			0			70. 90
	(see instructions)						
70. 91	HSP bonus payment HRR adjustment amount (see			0			70. 91
	instructions)						
70. 92	Bundled Model 1 discount amount (see			0			70. 92
	instructions)						
70. 93	HVBP payment adjustment amount (see			0			70. 93
	instructions)						
70. 94	HRR adjustment amount (see instructions)			0			70. 94
70. 95	Recovery of accelerated depreciation			0			70. 95
70. 96	Low volume adjustment for federal fiscal		2014	126, 110			70. 96
70. 70	year (yyyy) (Enter in column 0 the		2014	120, 110			70. 70
	corresponding federal year for the period						
70 07	prior to 10/1)		2015	475 172			70.07
70. 97	Low volume adjustment for federal fiscal		2015	475, 173			70. 97
	year (yyyy) (Enter in column 0 the						
	corresponding federal year for the period						
	ending on or after 10/1)						
70. 98	Low Volume Payment-3			0			70. 98
70. 99	HAC adjustment amount (see instructions)			0			70. 99
71. 00	Amount due provider (line 67 minus lines 68			5, 750, 958			71. 00
	plus/minus lines 69 & 70)						
71. 01	Sequestration adjustment (see instructions)			115, 019			71. 01
72.00	Interim payments			5, 769, 232			72. 00
73.00	Tentative settlement (for contractor use			0			73. 00
	only)						
74.00	Balance due provider (Program) (line 71			-133, 293			74. 00
	minus lines 71.01, 72, and 73)						
75. 00	Protested amounts (nonallowable cost report			0			75. 00
	items) in accordance with CMS Pub. 15-2,						
	chapter 1, §115.2						
	TO BE COMPLETED BY CONTRACTOR (lines 90 throu	iah 96)					
90. 00	Operating outlier amount from Wkst. E, Pt.	1911 70)		0			90.00
70.00	A, line 2 (see instructions)			O			70.00
91. 00	Capital outlier from Wkst. L, Pt. I, line 2			0			91. 00
							•
92. 00	Operating outlier reconciliation adjustment			0			92. 00
	amount (see instructions)						
93. 00	Capital outlier reconciliation adjustment			0			93. 00
	amount (see instructions)						
94. 00	The rate used to calculate the time value of			0. 00			94. 00
	money (see instructions)						1
95. 00				0			95. 00
	(see instructions)						
96.00	Time value of money for capital related			0			96. 00
	expenses (see instructions)						

Health Financial Systems	MCDONOUGH DISTRICT	HOSPI TAL			In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der	CCN: 140089	Perion From	od: 07/01/2014	Worksheet E Part A	
					06/30/2015		oared: O5 pm
		Ti tl	e XVIII	H	lospi tal	PPS	
			Prior to 10/	′1		On/After 10/1	
			1.00		1. 01	2. 00	
HSP Bonus Payment Amount							
100.00 HSP bonus amount (see instructions)				0		0	100.00
HVBP Adjustment for HSP Bonus Payment							
101.00 HVBP adjustment factor (see instructions)				0		0	101.00
102.00 HVBP adjustment amount for HSP bonus paymen	t (see instructions)			0		0	102.00
HRR Adjustment for HSP Bonus Payment							
103.00 HRR adjustment factor (see instructions)			0.00	00		0.0000	103.00
104.00 HRR adjustment amount for HSP bonus payment	(see instructions)			0		0	104.00

Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Provider CCN: 140089

Department Dep						,	0 06/30/2015	11/23/2015 5:	
1		,							
1.00 Disc anounts other than outlier 1.00 0 0 0 0 0 0 0 0 0									
1.00 1.00									
1.01 1.06 1.06 1.07	1. 00	DRG amounts other than outlier							1. 00
Descripting prior to October 1,02 3,127,042 0 0 3,127,042 3,127,042 1.0	1. 01	DRG amounts other than outlier	1. 01	987, 390	0	987, 390	0	987, 390	1. 01
Degree D	1 02	occurring prior to October 1	1 02	3 127 042	0	0	3 127 042	3 127 042	1 02
perating payment for Model 4 BRCL occurring prior to Cotober 1 1.04 BRCL occurring prior to position of the Model 4 BRCL occurring prior to model 4 BRCL occurring payment for Model 4 BRCL occurring on or after Cotober 1 Cotober 2 Cotober 2 Cotober 2 Cotober 2 Cotober 3 Cotober 3 Cotober 3 Cotober 3 Cotober 3 Cotober 3 Cotober 4	1.02	payments for discharges	1. 02	3, 127, 042	0	U	3, 127, 042	3, 127, 042	1.02
1.04 08C for Federal Specific operating payment for Model 4 BPCI occurring payment from Model 5 Per Company 1.04 0 0 0 0 0 0 0 0 0	1.03	operating payment for Model 4 BPCI occurring prior to	1. 03	0	0	0	0	0	1. 03
discharges (see instructions) 2.02	1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after	1. 04	0	0	0	0	0	1. 04
2.01 Outlier payments for 2.02 0 0 0 0 0 2.0	2. 00		2. 00	147, 536	0	32, 690	114, 846	147, 536	2. 00
2.01 0 0 0 0 0 0 0 0 0	2. 01		2. 02	0	0	0	0	0	2. 01
payments Indirect Medical Education Adjustment	3. 00		2. 01	0	0	0	0	0	3. 00
5.00 Amount From Worksheet E, Part 21.00 0.00000000	4.00	payments		851, 428	0	213, 483	637, 945	851, 428	4. 00
A, I Ine 21 (See instructions) 6.01 IME payment adjustment (See 22.00 0 0 0 0 0 0 0 0 0 0 0 6.0 instructions) 6.11 IME payment adjustment for 22.01 0 0 0 0 0 0 0 0 0 0 0 6.0 managed care (See instructions) 7.00 IME payment adjustment factor 27.00 0.000000 0.000000 0.000000 0.000000 0.000000	5. 00			0. 000000	0. 000000	0. 000000	0. 000000		5. 00
Instructions	6. 00	A, line 21 (see instructions)	22. 00	0	0	0	0	0	6. 00
Instructions	6. 01	instructions)	22. 01	0	0	0	0	0	6. 01
1.00 IME payment adjustment factor 27.00 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.00000000		instructions)							
See instructions See							1		
10	7. 00		27. 00	0. 000000	0. 000000	0. 000000	0. 000000		7. 00
8.01 IME payment adjustment add on for managed care (see instructions) 9.00 Total IME payment (sum of lines 6 and 8) 9.01 Total IME payment for managed 29.01 0 0 0 0 0 0 0 0 0	8.00	IME adjustment (see	28. 00	0	0	0	0	0	8. 00
9.01 Total IME payment (sum of lines 6 and 8) 9.01 Total IME payment for managed care (sum of lines 6.01 and 8.01) 10.00 All lowable disproportionate Share Adjustment 10.00 All lowable disproportionate share adjustment 11.00 Disproportionate share adjustment (see instructions) 11.01 Uncompensated care payments 12.00 Total IME payment for high percentage of ESR0 beneficiary discharges 11.00 (see instructions) 13.00 Subtotal (see instructions) 14.00 Hospital specific payments 15.00 Total ESR0 additional payment (see instructions) 16.00 Potal ESR0 additional payments 17.00 Subtotal (see instructions) 18.00 Total ESR0 additional payments 18.00 Total ESR0 additional payments 18.00 Total payment for inpatient definition of the payments additional payments 18.00 Total payment for inpatient operating costs (see instructions) 19.00 Total payment for inpatient operating costs (see instructions) 19.00 Total payment for inpatient definition of the payment operating costs (see instructions) 19.00 Total payment for inpatient operating costs (see instructions) 19.00 Total payment for inpatient definition of the payment operating costs (see instructions) 19.00 Total payment for inpatient operating costs (see instructions) 19.00 Total payment for inpatient definition of the payment operating costs (see instructions) 19.00 Total payment for inpatient operating costs (see instructions) 19.00 Total payment for inpatient definition of the payment of the payment operating costs (see instructions) 19.00 Total payment for inpatient operating costs (see instructions) 19.00 Total payment for inpatient operating costs (see instructions) 19.00 Total payment for inpatient operating costs (see instructions) 19.00 Total payment for inpatient operating costs (see instructions) 19.00 Total payment for inpatient operating costs (see instructions) 19.00 Total payment for inpatient operat	8. 01	IME payment adjustment add on for managed care (see	28. 01	O	0	0	О	0	8. 01
9.01 Total IME payment for managed care (sum of lines 6.01 and a.01) Disproportionate Share Adjustment	9. 00	Total IME payment (sum of	29. 00	0	0	0	0	0	9. 00
Disproportionate Share Adjustment	9. 01	Total IME payment for managed care (sum of lines 6.01 and	29. 01	0	0	0	O	0	9. 01
Share percentage (see instructions) 11.00 10 10 10 10 10 10		Disproportionate Share Adjustme							
11. 00 Disproportionate share adjustment (see instructions) 34. 00 93, 193 0 22, 365 70, 828 93, 193 11. 01	10. 00	share percentage (see	33. 00	0. 0906	0. 0906	0. 0906	0. 0906		10. 00
11. 01 Uncompensated care payments 36. 00 269, 655 0 68, 350 201, 305 269, 655 11. 00 Additional payment for high percentage of ESRD beneficiary discharges 12. 00 Total ESRD additional payment 46. 00 0 0 0 0 0 0 0 0 0	11. 00	Di sproporti onate share	34.00	93, 193	0	22, 365	70, 828	93, 193	11. 00
12.00 Total ESRD additional payment (see instructions) 13.00 Subtotal (see instructions) 14.00 Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient operating costs (see instructions) 16.00 Payment for inpatient program capital 17.00 Special add-on payments for new technologies 17.01 Net organ aquisition cost of capital organ aduisition cost of capital organ aduisition adjustment amount (see	11. 01	1 3	36.00	269, 655	0	68, 350	201, 305	269, 655	11. 01
13.00 Subtotal (see instructions) 47.00 4,624,816 0 1,110,795 3,514,021 4,624,816 13.0 14.00 Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient operating costs (see instructions) 16.00 Payment for inpatient program capital 17.00 Special add-on payments for new technologies 17.01 Net organ aquisition cost 55.00 0 0 0 0 0 0 17.0 17.02 Credits received from manufacturers for replaced devices for applicable MS-DRGs Capital outlier reconciliation 93.00 0 0 0 0 0 0 0 18.0 18.00 Capital outlier reconciliation 93.00 0 0 0 0 0 0 0 0 0				RD beneficiary					
14.00 Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) 48.00 5,327,093 0 1,263,268 4,063,825 5,327,093 14.0 15.00 Total payment for inpatient operating costs (see instructions) 49.00 5,327,093 0 1,263,268 4,063,825 5,327,093 15.0 16.00 Payment for inpatient program capital 50.00 344,874 0 81,905 262,969 344,874 16.0 17.00 Special add-on payments for new technologies 54.00 0 0 0 0 0 0 0 0 0 17.0 17.01 Net organ aquisition cost devices for applicable MS-DRGs 68.00 0 0 0 0 0 0 0 0 0 0 0 17.0 0 18.00 Capital outlier reconciliation adjustment amount (see 93.00 0		(see instructions)		0		_			
15.00 (see instructions) 49.00 (see instructions) 15.00 Total payment for inpatient operating costs (see instructions) 49.00 (see instructions) 16.00 Payment for inpatient program capital 50.00 (see instructions) 17.00 Special add-on payments for new technologies 54.00 (see instructions) 17.01 Net organ aquisition cost (see instructions) 55.00 (see instructions) 17.01 Net organ aquisition cost (see instructions) 50.00 (see instructions) 17.01 Net organ aquisition cost (see instructions) 55.00 (see instructions) 17.02 Credits received from (see instructions) 68.00 (see instructions) 18.00 Capital outlier reconciliation adjustment amount (see instructions) 93.00 (see instructions)		Hospital specific payments (completed by SCH and MDH,			-				
16.00 Payment for inpatient program 50.00 344,874 0 81,905 262,969 344,874 16.00 17.00 Special add-on payments for new technologies 17.01 Net organ aquisition cost 55.00 0 0 0 0 0 0 0 17.00 17.00 Credits received from 68.00 0 0 0 0 0 0 0 0 17.00 17.00 Compute technologies 18.00 Capital outlier reconciliation 93.00 0 0 0 0 0 0 0 0 18.00 0 0 0 0 0 0 0 0 0	15. 00	(see instructions) Total payment for inpatient	49. 00	5, 327, 093	0	1, 263, 268	4, 063, 825	5, 327, 093	15. 00
17.00 Special add-on payments for new technologies 54.00 0 0 0 0 0 0 0 0 0 17.01 17.01 Net organ aquisition cost 55.00 0	16. 00	instructions) Payment for inpatient program	50. 00	344, 874	0	81, 905	262, 969	344, 874	16. 00
17.01 Net organ aquisition cost 55.00 0 0 0 0 0 0 0 17.00 17.02 Credits received from manufacturers for replaced devices for applicable MS-DRGs 0 0 0 0 0 0 0 0 0 0 0 18.00 0 0 0 0 0 0 0 0 0 0 0 18.00	17. 00	Special add-on payments for	54. 00	0	0	0	0	0	17. 00
manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation 93.00 0 0 0 0 18.0 adjustment amount (see		Net organ aquisition cost			0	-	-		
adjustment amount (see	17. 02	manufacturers for replaced	68. 00	0	0	0	0	0	17. 02
	18. 00	Capital outlier reconciliation adjustment amount (see	93. 00	0	0	0	0	0	18. 00

Health Financial Systems	MCDONOUGH DISTRICT HOSPI	AL	In Lie	u of Form CMS-2552-10
LOW VOLUME CALCULATION EXHIBIT 4	Provi	der CCN: 140089		Worksheet E Part A Exhibit 4

06/30/2015 Date/Time Prepared: To 11/23/2015 5:05 pm Title XVIII Hospi tal PPS W/S E, Part A Amounts (from Pre/Post Period Prior Total (Col 2 Peri od to 10/01 Part A) On/After 10/01 line Ε, Entitlement through 4) 2 00 4 00 0 1.00 3 00 5 00 19.00 SUBTOTAL 5, 671, 967 19. 00 1, 345, 173 4, 326, 794 W/S L, line (Amounts from L) 2.00 3.00 4.00 5.00 0 1.00 20.00 Capital DRG other than outlier 77, 750 323, 899 20.00 1 00 323, 899 246, 149 20.01 Model 4 BPCI Capital DRG other 1.01 20.01 than outlier 21.00 Capital DRG outlier payments 2.00 20, 975 4, 155 16, 820 20, 975 21.00 Model 4 BPCI Capital DRG 21.01 2.01 21.01 outlier payments 22.00 Indirect medical education 5.00 0.0000 0.0000 0.0000 0.0000 22.00 percentage (see instructions) Indirect medical education 6.00 23.00 23.00 adjustment (see instructions) Allowable disproportionate 0.0000 0.0000 24.00 10 00 0.0000 0.0000 24.00 share percentage (see instructions) 25.00 Di sproporti onate share 11.00 0 25.00 adjustment (see instructions) 26.00 Total prospective capital 12.00 344, 874 81, 905 262, 969 344, 874 26.00 payments (see instructions) W/S E, Part A (Amounts to E, line Part A) 2.00 1.00 3.00 4.00 5.00 27.00 Low volume adjustment factor 0.093750 0. 109821 27. 00 28.00 Low volume adjustment 70.96 126, 110 28.00 126, 110 (transfer amount to Wkst. E, Pt. A, line) 29.00 Low volume adjustment 70.97 475, 173 475, 173 29.00 (transfer amount to Wkst. E, Pt. A. line) 100.00 Transfer low volume 100.00 adjustments to Wkst. E, Pt. A.

	, ,			Т	rom 07/01/2014 o 06/30/2015	11/23/2015 5:	pared:
				e XVIII	Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3. 00	4. 00	
1. 00 1. 01	DRG amounts other than outlier payments DRG amounts other than outlier payments for discharges occurring prior to October 1	1. 00 1. 01	987, 390	987, 390		987, 390	1. 00 1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	3, 127, 042	2	3, 127, 042	3, 127, 042	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1.03	C	C		0	1. 03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	C		0	0	1. 04
2.00	Outlier payments for discharges (see instructions)	2.00	147, 536	32, 690	114, 846	147, 536	2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	C	C	0	0	2. 01
3.00	Operating outlier reconciliation	2. 01	C) c	0	0	3. 00
4.00	Managed care simulated payments	3. 00	851, 428	213, 483	637, 945	851, 428	4. 00
F 00	Indirect Medical Education Adjustment	21 00	0.000000	0.000000	0.000000	I	F 00
5. 00	Amount from Worksheet E, Part A, line 21 (see instructions)	21. 00	0. 000000	0. 000000	0. 000000		5. 00
6.00	IME payment adjustment (see instructions)	22. 00	(0	0	6. 00
6. 01	IME payment adjustment for managed care (see				Ö	Ö	
	instructions)						
	Indirect Medical Education Adjustment for the						
7. 00	IME payment adjustment factor (see instructions)	27. 00	0. 000000	0.000000	0. 000000		7. 00
8.00	IME adjustment (see instructions)	28. 00	0	0	0	0	8. 00
8. 01	IME payment adjustment add on for managed care (see instructions)	28. 01		C	0	0	8. 01
9. 00 9. 01	Total IME payment (sum of lines 6 and 8)	29. 00 29. 01			0	0	
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment	29.01			0	0	9. 01
10. 00	Allowable disproportionate share percentage	33.00	0.0906	0. 0906	0. 0906		10. 00
10.00	(see instructions)	00.00	0.0700	0.0700	0.0700		10.00
11. 00	Disproportionate share adjustment (see instructions)	34.00	93, 193	22, 365	70, 828	93, 193	11. 00
11. 01	Uncompensated care payments	36. 00	269, 655	68, 350	201, 305	269, 655	11. 01
	Additional payment for high percentage of ESF		di scharges				
12. 00	Total ESRD additional payment (see instructions)	46. 00	C	C	0	0	12. 00
13. 00	Subtotal (see instructions)	47. 00	4, 624, 816	1			
14. 00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see	48. 00	5, 327, 093	1, 263, 268	4, 063, 825	5, 327, 093	14. 00
15. 00	<pre>instructions) Total payment for inpatient operating costs (see instructions)</pre>	49. 00	5, 327, 093	1, 263, 268	4, 063, 825	5, 327, 093	15. 00
16.00	Payment for inpatient program capital	50. 00	344, 874	86, 927	257, 947	344, 874	16. 00
17. 00	Special add-on payments for new technologies	54.00	(0	0	0	17. 00
17. 01	Net organ aquisition cost	55. 00	() C	0	0	
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00) C	0	0	17. 02
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00		C	0	0	
19. 00	SUBTOTAL			1, 350, 195	4, 321, 772	5, 671, 967	19. 00

Health Financial Systems	MCDONOUGH DISTE	RICT HOSPITAL		In Lie	eu of Form CMS-2	2552-10
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	ATION EXHIBIT 5	Provi der		Period: From 07/01/2014 To 06/30/2015		pared:
		Ti tl	e XVIII	Hospi tal	PPS	
	Wkst. L, line	Wkst. L)				
	0	1. 00	2. 00	3. 00	4. 00	
20.00 Capital DRG other than outlier	1.00	323, 899	81, 64	0 242, 259	323, 899	20. 00
20.01 Model 4 BPCI Capital DRG other than outlier	1. 01	0		0	0	20. 01
21.00 Capital DRG outlier payments	2. 00	20, 975	5, 28	7 15, 688	20, 975	1
21.01 Model 4 BPCI Capital DRG outlier payments	2. 01	0		0	0	21. 01
22.00 Indirect medical education percentage (see instructions)	5. 00	0.0000	0.000	0.0000		22. 00
23.00 Indirect medical education adjustment (see instructions)	6. 00	0		0 0	0	23. 00
24.00 Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.000	0. 0000		24. 00
25.00 Disproportionate share adjustment (see instructions)	11.00	0		0 0	0	25. 00
26.00 Total prospective capital payments (see instructions)	12. 00	344, 874	86, 92	7 257, 947	344, 874	26. 00
	Wkst. E, Pt.	(Amt. from				
	A, line	Wkst. E, Pt. A)				
	0	1. 00	2. 00	3. 00	4. 00	
27. 00						27. 00
28.00 Low volume adjustment prior to October 1	70. 96	126, 110			126, 110	
29.00 Low volume adjustment on or after October 1	70. 97	475, 173		475, 173	475, 173	
30.00 HVBP payment adjustment (see instructions)	70. 93	0		0	0	
30.01 HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0		0 0	0	30. 01
31 00 HRR adjustment (see instructions)	70 94	l o		0	l o	31 00

70.94

70. 91

0

70. 99

0

3. 00

2.00

1.00

Υ

0 31.00

0 32.00

(Amt. to Wkst. E, Pt. A)

4.00

0 31.01

100. 00

31.00 HRR adjustment (see instructions)
31.01 HRR adjustment for HSP bonus payment (see

32.00 HAC Reduction Program adjustment (see

100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.

instructions)

instructions)

Health Financial Systems	MCDONOUGH DISTRICT HOSPITAL	In Li€	eu of Form CMS-:	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14008	From 07/01/2014	Worksheet E Part B Date/Time Pre 11/23/2015 5:	
	Title XVIII	Hospi tal	PPS	

		10	00/30/2013	11/23/2015 5:	
		Title XVIII	Hospi tal	PPS	<u> </u>
		-	'		
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1. 00	Medical and other services (see instructions)			649	1. 00
2.00	Medical and other services reimbursed under OPPS (see instruction	ons)		5, 984, 670	
3.00	PPS payments			4, 787, 318	
4.00	Outlier payment (see instructions)			0	4. 00
5.00	Enter the hospital specific payment to cost ratio (see instructi	ions)		0. 822	
6. 00 7. 00	Line 2 times line 5 Sum of line 3 plus line 4 divided by line 6			4, 919, 399 97. 32	
8. 00	Transitional corridor payment (see instructions)			97. 32	8. 00
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV,	col 13 line 200		11, 898	
10. 00	Organ acqui si ti ons	10, 11110 200		0	
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			649	
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e charges				
12.00	Ancillary service charges			3, 140	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line	e 69)		0	13. 00
14.00	Total reasonable charges (sum of lines 12 and 13)			3, 140	14. 00
	Customary charges				
15. 00	Aggregate amount actually collected from patients liable for pay				15. 00
16. 00	Amounts that would have been realized from patients liable for	payment for services on a	chargebasis	0	16. 00
17 00	had such payment been made in accordance with 42 CFR §413.13(e)			0.000000	17 00
17. 00 18. 00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0. 000000 3, 140	
19. 00	Excess of customary charges over reasonable cost (complete only	if line 18 eveneds line	11) (600	2, 491	
17.00	instructions)	TI TITLE TO EXCEEUS TITLE	(366	2, 471	19.00
20.00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds line	18) (see	0	20. 00
	instructions)		, (_	
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		649	21. 00
22. 00	Interns and residents (see instructions)			0	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instruc	ctions)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)			4, 799, 216	24. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	Deductibles and coinsurance (for CAH, see instructions)	2411 !+!>		1 070 500	
26. 00	Deductibles and Coinsurance relating to amount on line 24 (for (1 221 (000	1, 079, 580	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pluinstructions)	us the sum of fines 22 and	ı 23] (See	3, 720, 285	27. 00
28. 00	Direct graduate medical education payments (from Wkst. E-4, line	e 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)	5 55)		0	
30. 00	Subtotal (sum of lines 27 through 29)			3, 720, 285	30.00
31.00	Primary payer payments			5, 419	•
32.00	Subtotal (line 30 minus line 31)			3, 714, 866	32. 00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES	5)			
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)			0	
34.00	Allowable bad debts (see instructions)			225, 336	
35.00	Adjusted reimbursable bad debts (see instructions)			146, 468	
36. 00 37. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	ctions)		225, 336	
38. 00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			3, 861, 334 0	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	
39. 98	Partial or full credits received from manufacturers for replace	d devices (see instruction	ns)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION		,	0	39. 99
40.00	Subtotal (see instructions)			3, 861, 334	1
40. 01	Sequestration adjustment (see instructions)			77, 227	1
41.00	Interim payments			3, 598, 501	41.00
42.00	Tentative settlement (for contractors use only)			0	42. 00
43.00	Balance due provider/program (see instructions)			185, 606	1
44. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2, chap	oter 1,	0	44. 00
	§115. 2				
00.00	TO BE COMPLETED BY CONTRACTOR				00.00
90.00	Original outlier amount (see instructions)			0	
91. 00 92. 00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0 0. 00	
93.00	Time Value of Money (see instructions)			0.00	
	Total (sum of lines 91 and 93)				94. 00
55	1 ('	٥١	

Peri od: Worksheet E-1 From 07/01/2014 Part I To 06/30/2015 Date/Time Prepared: Provi der CCN: 140089

						11/23/2015 5: 0	05 pm
		Т	itle X	(VIII	Hospi tal	PPS	
		Inpat	ient P	Part A	Par	t B	
		mm/dd/yyy	v T	Amount	mm/dd/yyyy	Amount	
		1. 00	^	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider			5, 805, 83		3, 628, 271	1. 00
2.00	Interim payments payable on individual bills, either)	0	2. 00
	submitted or to be submitted to the contractor for						
	services rendered in the cost reporting period. If none,						
	write "NONE" or enter a zero						
3.00	List separately each retroactive lump sum adjustment						3.00
	amount based on subsequent revision of the interim rate						
	for the cost reporting period. Also show date of each						
	payment. If none, write "NONE" or enter a zero. (1)						
	Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER			(02/10/2015	2, 601	3. 01
3.02				()	0	3. 02
3.03				()	0	3. 03
3.04				(O	0	3.04
3.05				(O	0	3. 05
	Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM	02/10/201	5	28, 09		0	3. 50
3.51		06/23/201	5	8, 50	4 06/23/2015	32, 371	3. 51
3.52					O	0	3. 52
3.53				(O	0	3. 53
3.54					O	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			-36, 59	9	-29, 770	3. 99
	3. 50-3. 98)						
4.00	Total interim payments (sum of lines 1, 2, and 3.99)			5, 769, 23	2	3, 598, 501	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as						
	appropri ate)						
	TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after						5. 00
	desk review. Also show date of each payment. If none,						
	write "NONE" or enter a zero. (1)						
5. 01	Program to Provider TENTATIVE TO PROVIDER					0	5. 01
5. 01	TENTATIVE TO PROVIDER		-				5. 02
5. 02							5. 02
5.05	Provider to Program			<u> </u>	<u> </u>	0	5. 03
5. 50	TENTATI VE TO PROGRAM					I 0	5. 50
5. 51	TERMINI VE TO TRIGORUM		1			0	5. 51
5. 52			1				5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		1)	ا	5. 99
0. , ,	5. 50-5. 98)						0. ,,
6. 00	Determined net settlement amount (balance due) based on						6. 00
	the cost report. (1)						2. 20
6. 01	SETTLEMENT TO PROVIDER			(o	185, 606	6. 01
6. 02	SETTLEMENT TO PROGRAM			133, 29	3	0	6. 02
7. 00	Total Medicare program liability (see instructions)			5, 635, 93		3, 784, 107	7. 00
	, , , , , , , , , , , , , , , , , , , ,			.,, ,0	Contractor	NPR Date	
					Number	(Mo/Day/Yr)	
			0		1. 00	2.00	
8.00	Name of Contractor						8. 00
					•	•	

Health Financial Systems MCDON ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

		Component	1 CCN. 140069 1	0 00/30/2013	11/23/2015 5:	
		Ti tl	e XVIII S	wing Beds - SNF		•
		I npati er	nt Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		C		0	1.00
2.00	Interim payments payable on individual bills, either		C		0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider		1			
3. 01	ADJUSTMENTS TO PROVIDER		C		0	1
3. 02			C		0	
3. 03			C		0	
3.04			C		0	
3. 05			C		0	3.05
3. 50	Provider to Program ADJUSTMENTS TO PROGRAM				0	3.50
3. 50	ADJUSTMENTS TO PROGRAM				0	
3. 51					0	
3. 52					0	0.02
3. 54						
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines				0	
3. 77	3. 50-3. 98)					3. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		0		0	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR	•	•			1
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider			_		
5. 01	TENTATI VE TO PROVI DER		C		0	
5.02			0		0	
5.03			C		0	5. 03
	Provi der to Program			T		
5. 50	TENTATI VE TO PROGRAM		C		0	
5. 51			0		0	1 0.0.
5. 52 5. 99	Cultural (cum of lines 5 01 5 40 minus cum of lines		0		0	
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)				0	5. 99
6.00	Determined net settlement amount (balance due) based on					6.00
0.00	the cost report. (1)] 0.00
6. 01	SETTLEMENT TO PROVIDER				0	6. 01
6. 02	SETTLEMENT TO PROGRAM				0	
7. 00	Total Medicare program liability (see instructions)				0	
	The second of th			Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
			0	1. 00	2. 00	
8.00	Name of Contractor					8.00

Heal th	Financial Systems MCDONOUGH DISTRICT	T HOSPI TAL	In Lie	u of Form CMS-2	2552-10						
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Period: From 07/01/2014 To 06/30/2015									
		Title XVIII	Hospi tal	PPS							
				1.00							
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS										
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION										
1.00	.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14 1,610 1										
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-	12		2, 801	2. 00						
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			574	3. 00						
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-	12		5, 467	4. 00						
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			139, 004, 575	5. 00						
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 li			10, 766, 870	6. 00						
7. 00	CAH only - The reasonable cost incurred for the purchase of ce line 168	rtified HIT technology	Wkst. S-2, Pt. I	0	7. 00						
8.00	Calculation of the HIT incentive payment (see instructions)			1, 050, 075	8. 00						
9.00	Sequestration adjustment amount (see instructions)			21, 002	9. 00						
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		1, 029, 073	10. 00						
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH										
30.00	Initial/interim HIT payment adjustment (see instructions)			967, 165	30. 00						
31.00	Other Adjustment (specify)			0	31. 00						
22 00	O Palance due provider (line 0 (an line 10) minus line 20 and line 21) (assimptivations)										

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

967, 165 30. 00 0 31. 00 61, 908 32. 00

Health Financial Systems	MCDONOUGH DISTRICT	HOSPI TAL	In Lieu of Form CMS-2552-10						
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provider CCN: 140089	Peri od: From 07/01/2014	Worksheet E-2					
		Component CCN: 14U089							
		Title XVIII	Swing Beds - SNF	PPS					
	<u> </u>		Part A	Part B					

				11/23/2015 5:0	05 pm
		Title XVIII	Swing Beds - SNF	PPS	
			Part A	Part B	
			1. 00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		0	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A,	and sum of Wkst. D,			3.00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instruc				
4.00	Per diem cost for interns and residents not in approved teaching p	program (see		0. 00	4.00
	instructions)				
5.00	Program days		0	0	5. 00
6.00	Interns and residents not in approved teaching program (see instru		0	6.00	
7.00	Utilization review - physician compensation - SNF optional method	onl y	0		7. 00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		0	0	8. 00
9.00	Primary payer payments (see instructions)		0	0	9. 00
10.00	Subtotal (line 8 minus line 9)		0	0	10.00
11. 00	Deductibles billed to program patients (exclude amounts applicable	e to physician	0	0	11. 00
	professional services)				
	Subtotal (line 10 minus line 11)		0	0	12.00
13. 00	Coinsurance billed to program patients (from provider records) (ex	xcl ude coi nsurance	0	0	13.00
	for physician professional services)				
	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		0	0	15.00
16. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16. 50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0	16. 50
16. 55	410A RURAL DEMONSTRATION PROJECT		0		16. 55
17. 00	Allowable bad debts (see instructions)		0	0	17. 00
17. 01	Adjusted reimbursable bad debts (see instructions)		0	0	17. 01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructi	ions)	0	0	18.00
19.00	Total (see instructions)		0	0	19.00
19. 01	Sequestration adjustment (see instructions)		0	0	19. 01
20.00	Interim payments		0	0	20.00
21. 00	, , , , , , , , , , , , , , , , , , , ,		0	0	21. 00
22. 00			0	0	22. 00
23. 00		WITH CMS Pub. 15-2,	0	0	23. 00
	chapter 1, §115.2		1		

Health Financial Systems	HOSPI TAL		In Lieu of Form CMS-2552-10					
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN	: 140089	Peri od: From 07/01/2014 To 06/30/2015	Worksheet E-3 Part VII Date/Time Prepared: 11/23/2015 5:05 pm			
		T1 11 1			<u> </u>			

			10 00/30/2013	11/23/2015 5:	05 pm
		Title XIX	Hospi tal	Cost	
			Inpati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	ICES FOR TITLES V OR XIX	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		2, 766, 119		1. 00
2.00	Medical and other services			0	2. 00
3.00	Organ acquisition (certified transplant centers only)		0		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		2, 766, 119	0	4. 00
5.00	Inpatient primary payer payments		0		5. 00
6.00	Outpatient primary payer payments			0	6. 00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		2, 766, 119	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
8. 00	Routi ne servi ce charges		0	_	8. 00
9.00	Ancillary service charges		2, 723, 100	0	
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0 700 100		11.00
12. 00	Total reasonable charges (sum of lines 8 through 11)		2, 723, 100	0	12. 00
12 00	CUSTOMARY CHARGES	comit coo en a change	0	0	12.00
13. 00	Amount actually collected from patients liable for payment for basis	services on a charge	٩	U	13. 00
14. 00	Amounts that would have been realized from patients liable for	navment for services on	0	0	14. 00
14.00	a charge basis had such payment been made in accordance with 42			O	14.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	CIR 3413. 13(c)	0. 000000	0. 000000	15. 00
16. 00	Total customary charges (see instructions)		2, 723, 100	0.00000	
17. 00	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds	0	Ö	
	line 4) (see instructions)			_	
18. 00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds line	43, 019	0	18. 00
	16) (see instructions)				
19.00	Interns and Residents (see instructions)		o	0	19. 00
20.00	Cost of physicians' services in a teaching hospital (see instru	ıctions)	0	0	20. 00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	2, 723, 100	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be c	ompleted for PPS provide	ers.		
	Other than outlier payments		0	0	
	1		0	0	23. 00
	Program capital payments		0		24. 00
25. 00			0		25. 00
26. 00	Routine and Ancillary service other pass through costs		0	0	
27. 00	Subtotal (sum of lines 22 through 26)		0	0	27. 00
28. 00			0	0	
29. 00	Titles V or XIX (sum of lines 21 and 27)		2, 723, 100	0	29. 00
20.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		43, 019	0	30.00
30.00	Excess of reasonable cost (from line 18) Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)			0	
32. 00	Deductibles		2, 723, 100	0	32.00
33. 00	Coinsurance			0	
34. 00	Allowable bad debts (see instructions)			0	34. 00
	Utilization review			U	35. 00
36. 00		33)	2, 723, 100	0	36. 00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	33)	2, 723, 100	0	1
	Subtotal (line 36 ± line 37)	2, 723, 100	0	38. 00	
	Direct graduate medical education payments (from Wkst. E-4)	2, 723, 100		39. 00	
40. 00		2, 723, 100	0	40.00	
41. 00	Interim payments		0	0	1
42. 00	Balance due provider/program (line 40 minus line 41)		2, 723, 100	0	
43. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub 15-2,	0	0	43. 00
	chapter 1, §115.2	•			
			·		

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

				0 06/30/2015	Date/IIme Pre 11/23/2015 5:	
		General Fund	Speci fi c	Endowment Fund	Plant Fund	OS PIII
			Purpose Fund			
	CHIDDENT ASSETS	1.00	2. 00	3. 00	4. 00	
1.00	CURRENT ASSETS Cash on hand in banks	2, 383, 670) 0	0	1.00
2. 00	Temporary investments	2,000,070			0	2. 00
3.00	Notes recei vabl e	O	d	0	0	3. 00
4.00	Accounts receivable	30, 927, 550	C	0	0	4. 00
5.00	Other recei vable	0	C C	0	0	
6.00	Allowances for uncollectible notes and accounts receivable	-18, 653, 983	l .	0	0	6.00
7. 00 8. 00	Inventory Prepaid expenses	1, 904, 685 1, 803, 733	l .	0	0	7. 00 8. 00
9. 00	Other current assets	1,003,733		o o	0	9.00
10.00	Due from other funds	0	d	0	0	10.00
11. 00	Total current assets (sum of lines 1-10)	18, 365, 655	c	0	0	11. 00
	FI XED ASSETS		1	_		
12.00	Land	111, 602			0	
13. 00 14. 00	Land improvements Accumulated depreciation	2, 798, 736 -1, 500, 943	1		0	13. 00 14. 00
15. 00	Buildings	23, 772, 043	1	0	0	15. 00
16.00	Accumul ated depreciation	-16, 330, 968	1	0	0	16. 00
17. 00	Leasehold improvements	0	C	0	0	17. 00
18. 00	Accumulated depreciation	0	ı c	0	0	18. 00
19.00	Fixed equipment	0		0	0	19.00
20. 00 21. 00	Accumulated depreciation Automobiles and trucks	0	C		0	20. 00 21. 00
22. 00	Accumulated depreciation	0		0	0	•
23. 00	Major movable equipment	55, 618, 959	i c	0	0	23. 00
24. 00	Accumul ated depreciation	-40, 524, 856		0	0	24. 00
25. 00	Mi nor equipment depreciable	0	C	0	0	25. 00
26. 00	Accumul ated depreciation	0	C	0	0	26. 00
27. 00	HIT designated Assets	0		0	0	27. 00
28. 00 29. 00	Accumulated depreciation Minor equipment-nondepreciable	24, 796, 159		0	0	28. 00 29. 00
30.00	Total fixed assets (sum of lines 12-29)	48, 740, 732	l .		0	•
	OTHER ASSETS		,			
31. 00	Investments	43, 547, 024	C	0	0	31. 00
32. 00	Deposits on Leases	0	C C	0	0	32. 00
33.00	Due from owners/officers	0 104 (00		0	0	33.00
34. 00 35. 00	Other assets Total other assets (sum of lines 31-34)	3, 104, 608 46, 651, 632	1	0	0	34. 00 35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	113, 758, 019	1		0	
00.00	CURRENT LI ABI LI TI ES	110,700,017		· <u> </u>		00.00
37. 00	Accounts payable	16, 578, 357	C	0	0	37. 00
38. 00	Salaries, wages, and fees payable	0	C	0	0	•
39. 00	Payroll taxes payable	0	C	0	0	39. 00
40. 00 41. 00	Notes and Loans payable (short term) Deferred income	0			0	40. 00 41. 00
42. 00	Accel erated payments	0		,	U	42.00
43. 00	Due to other funds	Ö	l c	0	0	•
44.00	Other current liabilities	160, 933	c	0	0	44. 00
45. 00	Total current liabilities (sum of lines 37 thru 44)	16, 739, 290	C	0	0	45. 00
47.00	LONG TERM LIABILITIES		.I			1 47 00
46. 00 47. 00	Mortgage payable Notes payable	14 720 420		0	0	ł
48. 00	Unsecured Loans	16, 730, 638		0	0	ł
49. 00	Other long term liabilities	٥		o o	0	ı
50.00	Total long term liabilities (sum of lines 46 thru 49	16, 730, 638	c	0	0	1
51.00	Total liabilites (sum of lines 45 and 50)	33, 469, 928	C	0	0	51. 00
	CAPI TAL ACCOUNTS		1			
52.00	General fund balance	80, 288, 091	1			52.00
53. 00 54. 00	Specific purpose fund Donor created - endowment fund balance - restricted		C	, 		53. 00 54. 00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56. 00	Governing body created - endowment fund balance			0		56. 00
57.00	Plant fund balance - invested in plant				0	•
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
E0 00	replacement, and expansion	00 200 001		0	0	59. 00
59. 00 60. 00	Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and	80, 288, 091 113, 758, 019	l .	0	0	60.00
55. 55	[59]	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Ĭ	O .	55.00

Provider CCN: 140089

Peri od: Worksheet G-1 From 07/01/2014 To 06/30/2015 Date/Time Prepared:

					To 06/30/2015	Date/Time Prep 11/23/2015 5:0	
		General	Fund	Speci al	Purpose Fund	Endowment Fund	р
		1.00	2. 00	3. 00	4. 00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) CAPITAL GRANTS & GIFTS ROUNDING Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) TRANSFERS TO MDH FOUNDATION	22, 643 0 0 0 0 0 0 278, 585 0 0 0	76, 113, 753 4, 430, 280 80, 544, 033 22, 643 80, 566, 676	3.00	4.00 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)		278, 585 80, 288, 091		0		18. 00 19. 00
		Endowment Fund	PI ant	Fund			
	T	6.00	7. 00	8. 00			
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) CAPITAL GRANTS & GIFTS ROUNDING	0	0 0 0 0		0		1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) TRANSFERS TO MDH FOUNDATION Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0	0 0 0 0 0		0 0 0		10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00

Health Financial Systems MC STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 140089

			To 06/30/2015	Date/Time Pre 11/23/2015 5:	
	Cost Center Description	Inpatient	Outpati ent	Total	оо рііі
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES	<u> </u>			
	General Inpatient Routine Services				
1.00	Hospi tal	6, 082, 22	18	6, 082, 228	1.00
2.00	SUBPROVI DER - I PF				2.00
3.00	SUBPROVI DER - I RF				3.00
4.00	SUBPROVI DER				4.00
5.00	Swing bed - SNF	61, 88	80	61, 880	5. 00
6.00	Swing bed - NF		0	0	6.00
7.00	SKILLED NURSING FACILITY		0	0	7. 00
8.00	NURSING FACILITY				8. 00
9.00	OTHER LONG TERM CARE				9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	6, 144, 10	18	6, 144, 108	10.00
	Intensive Care Type Inpatient Hospital Services				
11. 00	INTENSIVE CARE UNIT	1, 745, 21	4	1, 745, 214	11. 00
12. 00	CORONARY CARE UNIT				12. 00
13. 00	BURN INTENSIVE CARE UNIT				13. 00
14. 00	SURGICAL INTENSIVE CARE UNIT				14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines	1, 745, 2	4	1, 745, 214	16. 00
17. 00	11-15) Total inpatient routine care services (sum of lines 10 and 16)	7 000 20	10	7 000 222	17 00
18.00	Ancillary services	7, 889, 32		7, 889, 322 141, 788, 028	17. 00 18. 00
19. 00	Outpatient services	24, 075, 07	76 117, 712, 952 0 0	141, 788, 028	19.00
20. 00	RURAL HEALTH CLINIC		0 887, 134	887, 134	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0 007, 134	007, 134	21. 00
22. 00	HOME HEALTH AGENCY		1, 165, 349	1, 165, 349	22. 00
23. 00	AMBULANCE SERVICES		0 3, 122, 292	3, 122, 292	23. 00
24. 00	CMHC		5, 122, 272	5, 122, 272	24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26. 00	HOSPI CE		0 1, 483, 848	1, 483, 848	26. 00
27. 00	MCDONOUGH MEDICAL GROUP		0 11, 432, 145	11, 432, 145	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst	31, 964, 39		167, 768, 118	28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES	<u> </u>			
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		71, 251, 857		29. 00
30.00	ADD (SPECIFY)		0		30.00
31.00			0		31.00
32.00			0		32. 00
33.00			0		33.00
34.00			0		34.00
35. 00			0		35. 00
36. 00	Total additions (sum of lines 30-35)		0		36. 00
37. 00	DEDUCTHOSPI TALI TY HOUSE	37, 78			37. 00
38. 00	MEDICAL ARTS BUILDING	110, 33			38. 00
39. 00	ORTHO BUILDING	77, 80			39. 00
40.00	HEALTH SERVICES BUILDING I & II	785, 17			40.00
41.00	MI SCELLANEOUS & I NTEREST EXPENSE	62, 73			41.00
41. 01	INTEREST EXPENSE		0 0		41. 01
41. 02 41. 03			0 0		41. 02 41. 03
41.03	Total deductions (sum of lines 27 41)		-		41.03
42.00	Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(trans	for	1, 073, 833 70, 178, 024		42. 00 43. 00
43.00	to Wkst. G-3, line 4)	DI 61	10, 170, 024		43.00
	122	ı	1		ı

Heal th	Financial Systems MCDONOUGH DISTRICT H	IOSPI TAL	In Lie	u of Form CMS-2	2552-10
		Provi der CCN: 140089	Peri od:	Worksheet G-3	
			From 07/01/2014		
			To 06/30/2015		
				11/23/2015 5:	Jo pili
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 2	8)		167, 768, 118	1. 00
2. 00	Less contractual allowances and discounts on patients' accounts	0)		95, 606, 748	
3. 00	Net patient revenues (line 1 minus line 2)			72, 161, 370	3. 00
4. 00	Less total operating expenses (from Wkst. G-2, Part II, line 43)			70, 178, 024	
5. 00	Net income from service to patients (line 3 minus line 4)			1, 983, 346	5. 00
0.00	OTHER I NCOME			17 7007 010	0.00
6.00	Contributions, donations, bequests, etc			199, 168	6. 00
7.00	Income from investments			794, 535	
8.00	Revenues from telephone and other miscellaneous communication se	rvi ces		1, 440	
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10.00
11. 00	Rebates and refunds of expenses			79, 851	11. 00
12.00	Parking Lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			90, 157	13.00
14.00	Revenue from meals sold to employees and guests			282, 751	14.00
15.00	Revenue from rental of living quarters			0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than	pati ents		2, 481	16.00
17. 00	Revenue from sale of drugs to other than patients			0	17.00
18.00	Revenue from sale of medical records and abstracts			10, 620	18. 00
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			110	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21. 00	Rental of vending machines			0	21.00
22. 00	Rental of hospital space			359, 372	
23. 00	Governmental appropriations			67, 056	
24. 00	CONSULTING			121, 921	24.00
24. 01	BILLING			114, 876	
24. 02	INCOME FROM FF			249, 463	
24. 03	MEANI NGFUL USE			937, 019	
24. 04	PATH & MMG SERVICES TO NOT OUR PAT			197, 974	
24. 05	AMBULANCE STANDBY, HSK SERV, OUTREAC			51, 216	
24. 06	OTHER			5, 909	
24. 07	FLU VACCINE & INJECTION			7, 890	
	Total other income (sum of lines 6-24)			3, 573, 809	
	Total (line 5 plus line 25)			5, 557, 155	
27. 00	PHYSICIAN OFFICE BUILDINGS			1, 022, 500	

16, 854 27. 01 53, 046 27. 02 34, 479 27. 03

1, 126, 875 28. 00 4, 430, 280 29. 00

-4 27.04

27. 01 INTEREST EXPENSE
27. 02 NET LOSS ON RETIREMENT OF ASSETS

28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

27. 03 MI SCELLANEOUS 27. 04 ROUNDI NG

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Col umn.	6 line 2	4 should	agree wit	n the	Worksheet	Α.	column 3	3 1	Line	101	or	subscript	as	appl	i cabl e	

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-19, 764

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18.00

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21.00

22.00

23.00

Clinic

Home Dialysis Aide Services

Health Promotion Activities

Home Delivered Meals Program

Respiratory Therapy

Private Duty Nursing

Day Care Program

Homemaker Service

All Others (specify)

24.00 Total (sum of lines 1-23)

						Agency I		
			Capital Rel	ated Costs				
		Net Expenses	Bl dgs &	Movabl e	PI ant	Transportati on		
		for Cost	Fixtures	Equi pment	Operation &		(cols. 0-4)	
		Allocation			Mai ntenance			
		(from Wkst. H,						
		col . 10) 0	1 00	2.00	2.00	4.00	4A. 00	
	GENERAL SERVICE COST CENTERS	0 1	1.00	2. 00	3. 00	4. 00	4A. 00	
1.00	Capital Related - Bldg. &	0	0		I		0	1.00
1.00	Fixtures							1.00
2.00	Capital Related - Movable	o		0			0	2. 00
	Equi pment							
3.00	Plant Operation & Maintenance	o	0	0) c		0	3. 00
4.00	Transportation	0	0	0) c	0		4. 00
5.00	Administrative and General	288, 781	0	0) C	0	288, 781	5. 00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	585, 113	0	0				ı
7.00	Physical Therapy	196, 316	0	0	1		,	1
8.00	Occupational Therapy	84, 466	0	0	1		,	
9.00	Speech Pathology	16, 036	0	0	C		16, 036	l
10.00	Medical Social Services Home Health Aide	8, 575	0	0			8, 575	1
11.00		22, 367	0	0			,	1
12. 00 13. 00	Supplies (see instructions) Drugs		0	0	1		0	13. 00
14. 00	DME		0	0				1
14.00	HHA NONREI MBURSABLE SERVI CES	<u> </u>	<u> </u>		,)	0	14.00
15. 00	Home Dialysis Aide Services	0	0	0) C	0	0	15. 00
16. 00	Respiratory Therapy		o	0				16. 00
17. 00	Private Duty Nursing	l ol	o	0			0	17. 00
18. 00	Clinic	o	O	0		0	0	18. 00
19.00	Health Promotion Activities	O	o	0) c	0	0	19. 00
20.00	Day Care Program	o	O	0) c	0	0	20. 00
21.00	Home Delivered Meals Program	o	0	0) c	0	0	21. 00
22. 00	Homemaker Service	0	0	0) c	0	0	22. 00
23.00	All Others (specify)	0	0	0				23. 00
24. 00	Total (sum of lines 1-23)	1, 201, 654	0	0) <u> </u>	0	1, 201, 654	24. 00
		Administrative						
		& General 5.00	4A + 5) 6.00					
	GENERAL SERVICE COST CENTERS	5.00	0.00					
1.00	Capital Related - Bldg. &							1.00
00	Fi xtures							
2.00	Capital Related - Movable							2. 00
	Equi pment							
3.00	Plant Operation & Maintenance							3. 00
4.00	Transportation							4. 00
5. 00	Administrative and General	288, 781						5. 00
,	HHA REIMBURSABLE SERVICES	105 05:1	770 05-1					,
6.00	Skilled Nursing Care	185, 096	770, 209					6.00
7.00	Physical Therapy	62, 103	258, 419					7.00
	Occupational Therapy Speech Pathology	26, 720 5, 073	111, 186 21, 109					8. 00 9. 00
9. 00 10. 00	Medical Social Services	2, 713	11, 288					10.00
11. 00	Home Heal th Aide	7, 076	29, 443					11.00
12. 00	Supplies (see instructions)	7,070	27, 443					12. 00
13. 00	Drugs		o					13. 00
14. 00	DME	l o	o					14. 00
	HHA NONREIMBURSABLE SERVICES		-,					
15.00	Home Dialysis Aide Services	0	0					15. 00
16. 00	Respiratory Therapy	0	О					16. 00
17. 00	Private Duty Nursing	0	o					17. 00
18. 00	Clinic	0	0					18. 00
19. 00	Health Promotion Activities	0	0					19. 00
20.00	Day Care Program	0	0					20. 00
21. 00	Home Delivered Meals Program	0	0					21. 00
22. 00	Homemaker Service	0	0					22. 00
	All Others (specify)	0	1 201 (54					23. 00
∠4. UU	Total (sum of lines 1-23)	I I	1, 201, 654					24. 00

Health Financial Systems		MCDONOUGH DISTI	RICT HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - HHA STATISTICAL BAS	SIS		Provi der		Peri od:	Worksheet H-1	
			HHA CCN:	147293	From 07/01/2014 To 06/30/2015	Part II Date/Time Prep 11/23/2015 5:0	
					Home Health	PPS	
					Agency I		
	Capital Re	ated Costs					
	BI dgs &	Movabl e	PI ant	Transportation	nReconciliation	Admi ni strati ve	
	Fi xtures	Equi pment	Operation &	(MI LEAGE)		& General	
	(SQUARE FEET)	(DOLLAR VALUE)	Mai ntenance			(ACCUM. COST)	
			(SQUARE FEET)				
	1.00	2.00	3.00	4. 00	5A. 00	5. 00	
GENERAL SERVICE COST CENTERS							1
4 00 0 11 1 0 1 1 1 0 1 1 0	_		I	1			4 00

Peri od: Worksheet H-2
From 07/01/2014 Part I
To 06/30/2015 Date/Ti me Prepared: 11/23/2015 5: 05 pm HHA CCN: 147293

							11/23/2015 5:	05 pm_
						Home Health	PPS	
			CAPI TAL			Agency I		
			RELATED COSTS					
	Cost Center Description	HHA Trial	NEW BLDG &	CAP REL	CAP REL	CAP REL	CAP REL	
		Bal ance (1)	FLXT	COSTS-HOSPITAL	COSTS-HSB I	COSTS-HSB II	COSTS-REHAB	
		0	1 00	1 01	1.02	1.02	CNT	
1.00	Administrative and General	0 0	1.00	1. 01	1. 02	0 1.03	1.04	1. 00
2. 00	Skilled Nursing Care	770, 209	0	0	•	o o	0	2. 00
3.00	Physical Therapy	258, 419	0	0		0 0	0	3.00
4.00	Occupational Therapy	111, 186	0	0		0 0	0	4.00
5.00	Speech Pathology	21, 109	0	0		0	0	5.00
6.00	Medical Social Services	11, 288	0	0	1	0	0	6. 00
7.00	Home Heal th Aide	29, 443	0	0	1	0	0	7. 00
8. 00 9. 00	Supplies (see instructions) Drugs	0	0	0	•	0 0	0	8. 00 9. 00
10. 00	DME	0	0	0		0 0	0	10. 00
11. 00	Home Dialysis Aide Services	0	0	0		0 0	0	11.00
12.00	Respiratory Therapy	0	0	0		0 0	0	12.00
13.00	Private Duty Nursing	0	0	0		0	0	13.00
14.00	Clinic	0	0	0		0	0	14.00
15. 00 16. 00	Health Promotion Activities Day Care Program	0	0	0	1	0 0	0	15. 00 16. 00
17. 00	Home Delivered Meals Program	0	0	0	1	0 0	0	17. 00
18. 00	Homemaker Service	0	0	0		o o	Ö	18. 00
19. 00	All Others (specify)	0	0	0		0 0	0	19.00
20.00	Total (sum of lines 1-19) (2)	1, 201, 654	0	0		0	0	20.00
21. 00	Unit Cost Multiplier: column							21. 00
	26, line 1 divided by the sum of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.							
		CAPI TAL						
		DELATED COCTO						
	Cost Center Description	RELATED COSTS	CAP REI	CAP REI	CAP REI	CONVENI ENCE	RUSHNELL	
	Cost Center Description	CAP REL	CAP REL COSTS-HOSPI TAL	CAP REL COSTS-MAB	CAP REL COSTS-ORTHO	CONVENI ENCE CARE CLINI	BUSHNELL OFFICE BLDG	
	Cost Center Description	CAP REL COSTS-DI AYSI S	COSTS-HOSPITAL ITY HOUSE	COSTS-MAB	COSTS-ORTHO BLDG	CARE CLINI	OFFICE BLDG	
1.00		CAP REL COSTS-DI AYSI S	COSTS-HOSPITAL ITY HOUSE 1.06	COSTS-MAB 1.07	COSTS-ORTHO BLDG 1. 08	CARE CLINI 1.09	OFFICE BLDG 1.10	
1.00	Administrative and General	CAP REL COSTS-DI AYSI S 1. 05	COSTS-HOSPITAL ITY HOUSE	COSTS-MAB 1.07 18,722	COSTS-ORTHO BLDG 1.08	1. 09 0	OFFI CE BLDG 1. 10 0	1.00
2.00	Administrative and General Skilled Nursing Care	CAP REL COSTS-DI AYSI S	COSTS-HOSPITAL ITY HOUSE 1.06	COSTS-MAB 1.07	COSTS-ORTHO BLDG 1.08	CARE CLINI 1.09	0FFI CE BLDG 1.10 0	2. 00
2. 00 3. 00	Administrative and General Skilled Nursing Care Physical Therapy	CAP REL COSTS-DI AYSI S 1. 05	COSTS-HOSPITAL ITY HOUSE 1.06	COSTS-MAB 1.07 18,722	COSTS-ORTHO BLDG 1.08	1. 09 0	OFFI CE BLDG 1. 10 0	2. 00 3. 00
2.00	Administrative and General Skilled Nursing Care	CAP REL COSTS-DI AYSI S 1. 05	COSTS-HOSPITAL ITY HOUSE 1.06	COSTS-MAB 1.07 18,722	COSTS-ORTHO BLDG 1.08	1. 09 0	0FFI CE BLDG 1. 10 0 0 0	2. 00
2. 00 3. 00 4. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	CAP REL COSTS-DI AYSI S 1. 05	COSTS-HOSPITAL ITY HOUSE 1.06	COSTS-MAB 1.07 18,722	COSTS-ORTHO BLDG 1. 08	1. 09 0	1. 10 0 0 0 0	2. 00 3. 00 4. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	CAP REL COSTS-DI AYSI S 1. 05	COSTS-HOSPITAL ITY HOUSE 1.06	1. 07 18, 722 0 0 0 0 0 0	COSTS-ORTHO BLDG 1. 08	1. 09 0	0FFICE BLDG 1. 10 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions)	CAP REL COSTS-DI AYSI S 1. 05	COSTS-HOSPITAL ITY HOUSE 1.06	1. 07 18, 722 0 0 0 0 0 0 0	COSTS-ORTHO BLDG 1.08	1. 09 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 10 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs	CAP REL COSTS-DI AYSI S 1. 05	COSTS-HOSPITAL ITY HOUSE 1.06	1. 07 18, 722 0 0 0 0 0 0 0 0	COSTS-ORTHO BLDG 1.08	1. 09 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0FFICE BLDG 1.10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME	CAP REL COSTS-DI AYSI S 1. 05	COSTS-HOSPITAL ITY HOUSE 1.06	1. 07 18, 722 0 0 0 0 0 0 0	COSTS-ORTHO BLDG 1.08	1. 09 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0FFICE BLDG 1. 10 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs	CAP REL COSTS-DI AYSI S 1. 05	COSTS-HOSPITAL ITY HOUSE 1.06	1. 07 18, 722 0 0 0 0 0 0 0 0	COSTS-ORTHO BLDG 1. 08	1. 09 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0FFICE BLDG 1.10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services	CAP REL COSTS-DI AYSI S 1. 05	COSTS-HOSPITAL ITY HOUSE 1.06	1. 07 18, 722 0 0 0 0 0 0 0 0 0	COSTS-ORTHO BLDG 1. 08	1. 09 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0FFICE BLDG 1.10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic	CAP REL COSTS-DI AYSI S 1. 05 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	COSTS-HOSPITAL ITY HOUSE 1.06	1. 07 18, 722 0 0 0 0 0 0 0 0 0 0	COSTS-ORTHO BLDG 1. 08	CARE CLINI 1. 09 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0FFICE BLDG 1. 10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities	CAP REL COSTS-DI AYSI S 1. 05 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	COSTS-HOSPITAL ITY HOUSE 1.06	1. 07 18, 722 0 0 0 0 0 0 0 0 0 0	COSTS-ORTHO BLDG 1. 08	CARE CLINI 1. 09 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0FFICE BLDG 1. 10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program	CAP REL COSTS-DI AYSI S 1. 05 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	COSTS-HOSPITAL ITY HOUSE 1.06	1. 07 18, 722 0 0 0 0 0 0 0 0 0 0	COSTS-ORTHO BLDG 1. 08	CARE CLINI 1. 09 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1.10 1.10 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program	CAP REL COSTS-DI AYSI S 1. 05 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	COSTS-HOSPITAL ITY HOUSE 1.06	1. 07 18, 722 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	COSTS-ORTHO BLDG 1. 08	1. 09 1. 09 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0FFICE BLDG 1.10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program	CAP REL COSTS-DI AYSI S 1. 05 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	COSTS-HOSPITAL ITY HOUSE 1.06	1. 07 18, 722 0 0 0 0 0 0 0 0 0 0	COSTS-ORTHO BLDG 1. 08	CARE CLINI 1. 09 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1.10 1.10 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 20. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) (2)	CAP REL COSTS-DI AYSI S 1. 05 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	COSTS-HOSPITAL ITY HOUSE 1.06	1. 07 18, 722 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	COSTS-ORTHO BLDG 1. 08	1. 09 1. 09 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0FFICE BLDG 1.10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 20. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) (2) Unit Cost Multiplier: column	CAP REL COSTS-DI AYSI S 1. 05 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	COSTS-HOSPITAL ITY HOUSE 1.06	1. 07 18, 722 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	COSTS-ORTHO BLDG 1. 08	1. 09 1. 09 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0FFICE BLDG 1.10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 20. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum	CAP REL COSTS-DI AYSI S 1. 05 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	COSTS-HOSPITAL ITY HOUSE 1.06	1. 07 18, 722 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	COSTS-ORTHO BLDG 1. 08	1. 09 1. 09 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0FFICE BLDG 1.10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 20. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 20. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus	CAP REL COSTS-DI AYSI S 1. 05 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	COSTS-HOSPITAL ITY HOUSE 1.06	1. 07 18, 722 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	COSTS-ORTHO BLDG 1. 08	1. 09 1. 09 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0FFICE BLDG 1.10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 20. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 20. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum	CAP REL COSTS-DI AYSI S 1. 05 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	COSTS-HOSPITAL ITY HOUSE 1.06	1. 07 18, 722 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	COSTS-ORTHO BLDG 1. 08	1. 09 1. 09 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0FFICE BLDG 1.10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 20. 00

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

Worksheet H-2 Part I Date/Time Prepared: 11/23/2015 5:05 pm Provi der CCN: 140089 Peri od: From 07/01/2014 To 06/30/2015 HHA CCN: 147293 Home Health

						Home Health	PPS	
	Cost Contor Doscription	EMPLOYEE	Subtotal	ADMI NI STRATI VE	MAINTENANCE S	Agency I MAINTENANCE &	MAINTENANCE &	
	Cost Center Description	BENEFITS	Subtotal	& GENERAL	REPAIRS	REPAIRS-HSB I	REPAIRS-HSB II	
				α GENERAL	REPAIRS	KEPAIKS-HSD I	KEPAIKS-NOD II	
		DEPARTMENT 4.00	4A	5.00	6. 00	6. 01	6. 02	
1. 00	Administrative and General		· · · · · · · · · · · · · · · · · · ·			0.01		1. 00
		58, 391	77, 113			0 0		
2.00	Skilled Nursing Care	122, 238	892, 447	157, 732	1	-	1	2.00
3.00	Physi cal Therapy	41, 763	300, 182			0 0		3. 00
4.00	Occupational Therapy	19, 026	130, 212			0 0	0	4. 00
5.00	Speech Pathology	3, 389	24, 498		•	0 0	0	5. 00
6.00	Medical Social Services	1, 887	13, 175		1	0 0	0	6. 00
7.00	Home Health Aide	4, 564	34, 007	6, 010	1	0 0	0	7. 00
8.00	Supplies (see instructions)	0	0	0	1	0 0	0	8. 00
9.00	Drugs	0	0		1	0 0	0	9. 00
10.00	DME	0	0	0	1	0 0	0	10.00
11. 00	Home Dialysis Aide Services	0	0	0	1	0 0	0	11.00
12.00	Respiratory Therapy	0	0	0	•	0 0		12.00
13.00	Private Duty Nursing	0	0	0		0 0		13.00
14.00	Clinic	0	0			0 0	0	14.00
15. 00	Health Promotion Activities	0	0	0		0 0	0	15. 00
16. 00	Day Care Program	0	0	0	1	0 0	0	16. 00
17. 00	Home Delivered Meals Program	0	0	0	1	0 0	0	17. 00
18. 00	Homemaker Servi ce	0	0	0	1	0 0	0	18. 00
19. 00	All Others (specify)	0	0	0	1	0 0	0	19. 00
20. 00	Total (sum of lines 1-19) (2)	251, 258		260, 098	3	0 0	0	20. 00
21. 00	Unit Cost Multiplier: column		0. 000000					21. 00
	26, line 1 divided by the sum							
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.							
	Cost Center Description	MAINTENANCE &	MAINTENANCE &	MAINTENANCE &	MAINTENANCE 8	L ALINDRY &	HOUSEKEEDING	
	Cost Center Description	MAINTENANCE & REPAIRS-REHAB		MAINTENANCE & REPAIRS-ORTHO			HOUSEKEEPI NG	
	Cost Center Description	MAI NTENANCE & REPAI RS-REHAB CLI NI C	MAINTENANCE & REPAIRS-MAB			LAUNDRY & ELINEN SERVICE	HOUSEKEEPI NG	
	Cost Center Description	REPAI RS-REHAB		REPAI RS-ORTHO	REPAIRS-BUSHN		HOUSEKEEPI NG 9. 00	
1. 00	Cost Center Description Administrative and General	REPAI RS-REHAB CLI NI C	REPAIRS-MAB	REPAI RS-ORTHO BLDG 6. 05	REPAI RS-BUSHN LL 6.06	E LINEN SERVICE	9. 00	1. 00
1. 00 2. 00		REPAI RS-REHAB CLI NI C 6. 03	REPAI RS-MAB 6. 04	REPAI RS-ORTHO BLDG 6. 05	REPAI RS-BUSHN LL 6.06	E LINEN SERVICE 8.00	9.00	1. 00 2. 00
	Administrative and General	REPAI RS-REHAB CLI NI C 6. 03	6. 04 5, 215	REPAI RS-ORTHO BLDG 6. 05	REPAI RS-BUSHN LL 6. 06	E LINEN SERVICE 8.00 C	9.00	
2.00	Administrative and General Skilled Nursing Care	REPAI RS-REHAB CLI NI C 6. 03 0	6. 04 5, 215	REPAI RS-ORTHO BLDG 6. 05	REPAI RS-BUSHN LL 6. 06	E LINEN SERVICE 8.00 0 C	9.00	2. 00
2. 00 3. 00	Administrative and General Skilled Nursing Care Physical Therapy	REPAI RS-REHAB CLI NI C 6. 03 0 0	6. 04 5, 215 0	REPAI RS-ORTHO BLDG 6. 05	REPAI RS-BUSHN LL 6. 06	8. 00 0 0 0 0	9.00	2. 00 3. 00
2. 00 3. 00 4. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy	REPAI RS-REHAB	6. 04 5, 215 0	REPAIRS-ORTHO BLDG 6. 05	REPAI RS-BUSHN LL 6. 06	8. 00 0 CO 0 CO 0 CO 0 CO	9.00	2. 00 3. 00 4. 00
2. 00 3. 00 4. 00 5. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	REPAI RS-REHAB	6. 04 5, 215 0 0	REPAIRS-ORTHO BLDG 6.05 C C C C C C C C C C C C C C C C C C C	REPAI RS-BUSHN LL 6. 06	8. 00 CO	9.00 0 0 0 0	2. 00 3. 00 4. 00 5. 00
2. 00 3. 00 4. 00 5. 00 6. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	REPAI RS-REHAB	6. 04 5, 215 0 0 0 0	REPAIRS-ORTHO BLDG 6.05 C C C C C C C C C C C C C C C C C C C	REPAI RS-BUSHN LL 6. 06	SERVICE	9.00 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	REPAI RS-REHAB	6. 04 5, 215 0 0 0 0	REPAI RS-ORTHO BLDG 6. 05 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	REPAI RS-BUSHN LL 6. 06	E LINEN SERVICE	9.00 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions)	REPAI RS-REHAB	6. 04 5, 215 0 0 0 0 0	REPAI RS-ORTHO BLDG 6. 05 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	REPAI RS-BUSHN LL 6. 06	E LINEN SERVICE	9.00 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs	REPAI RS-REHAB	6. 04 5, 215 0 0 0 0 0	REPAI RS-ORTHO BLDG 6. 05 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	REPAI RS-BUSHN LL 6. 06	8.00 0 0 0 0 0 0 0 0 0	9.00 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME	REPAI RS-REHAB CLI NI C 6. 03 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	6. 04 5, 215 0 0 0 0 0 0	REPAI RS-ORTHO BLDG 6. 05 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	REPAI RS-BUSHN LL 6. 06	8. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services	REPAI RS-REHAB CLI NI C 6. 03 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	6. 04 5, 215 0 0 0 0 0 0 0	REPAI RS-ORTHO BLDG 6. 05 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	REPAI RS-BUSHN LL 6. 06	8. 00 0	9.00	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy	REPAI RS-REHAB CLI NI C 6. 03 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	6. 04 5, 215 0 0 0 0 0 0 0 0	REPAI RS-ORTHO BLDG 6. 05 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	REPAI RS-BUSHN LL 6. 06	S. 00 C C C C C C C C C	9.00	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing	REPAI RS-REHAB CLI NI C 6. 03 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	6. 04 5, 215 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	REPAIRS-ORTHO BLDG 6. 05 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	REPAI RS-BUSHN LL 6. 06	B. 00 C C C C C C C C C	9.00	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities	REPAI RS-REHAB CLI NI C 6. 03 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	6. 04 5, 215 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	REPAIRS-ORTHO BLDG 6. 05 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	REPAI RS-BUSHN LL 6. 06	E LINEN SERVICE 8.00 0.00 0.00 0.00 0.00 0.00 0.00 0	9.00	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic	REPAI RS-REHAB CLI NI C 6. 03 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	6. 04 5, 215 0 0 0 0 0 0 0 0 0 0 0 0	REPAI RS-ORTHO BLDG 6. 05 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	REPAIRS-BUSHN LL 6.06	8. 00 0	9.00	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program	REPAI RS-REHAB CLI NI C 6. 03 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	6. 04 5, 215 0 0 0 0 0 0 0 0 0 0 0	REPAI RS-ORTHO BLDG 6. 05 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	REPAI RS-BUSHN LL 6. 06	S	9.00	2. 00 3. 00 4. 00 5. 00 6. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Heal th Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service	REPAI RS-REHAB CLI NI C 6. 03 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	6. 04 5, 215 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	REPAIRS-ORTHO BLDG 6.05 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	REPAI RS-BUSHN LL 6. 06	S. 00 C C C C C C C C C	9.00	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program	REPAI RS-REHAB CLI NI C 6. 03 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	6. 04 5, 215 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	REPAIRS-ORTHO BLDG 6. 05 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	REPAI RS-BUSHN LL 6. 06	S. 00 C C C C C C C C C	9.00	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify)	REPAI RS-REHAB CLI NI C 6. 03 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	6. 04 5, 215 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	REPAIRS-ORTHO BLDG 6. 05 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	REPAI RS-BUSHN LL 6. 06	S. 00 C C C C C C C C C	9.00	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 20. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) (2)	REPAI RS-REHAB CLI NI C 6. 03 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	6. 04 5, 215 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	REPAIRS-ORTHO BLDG 6. 05 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	REPAI RS-BUSHN LL 6. 06	S. 00 C C C C C C C C C	9.00	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 20. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) (2) Unit Cost Multiplier: column	REPAI RS-REHAB CLI NI C 6. 03 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	6. 04 5, 215 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	REPAIRS-ORTHO BLDG 6. 05 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	REPAI RS-BUSHN LL 6. 06	S. 00 C C C C C C C C C	9.00	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 20. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum	REPAI RS-REHAB CLI NI C 6. 03 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	6. 04 5, 215 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	REPAIRS-ORTHO BLDG 6. 05 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	REPAI RS-BUSHN LL 6. 06	S. 00 C C C C C C C C C	9.00	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 20. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus	REPAI RS-REHAB CLI NI C 6. 03 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	6. 04 5, 215 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	REPAIRS-ORTHO BLDG 6. 05 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	REPAI RS-BUSHN LL 6. 06	S. 00 C C C C C C C C C	9.00	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 20. 00

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

140089 | Peri od: | Worksheet H-2 | Part I | 147293 | To | 06/30/2015 | Date/Time Prepared:

				HHA CCN:	147293	06/30/2015	Date/lime Pre 11/23/2015 5:	
						Home Health Agency I	PPS	
	Cost Center Description	HOUSEKEEPI NG-H SB	SB II	HOUSEKEEPI NG-(RTHO	AB	DI ETARY	CAFETERI A	
		9. 01	9. 02	9. 03	9. 04	10.00	11. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 20. 00 21. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to	000000000000000000000000000000000000000	000000000000000000000000000000000000000		1, 86.		8, 400 16, 349 4, 049 1, 917 345 258 1, 314 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 20. 00 21. 00
	6 decimal places. Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE		
		ADMI NI STRATI ON	SERVICES & SUPPLY	15.00	RECORDS & LI BRARY	17.00	ANESTHETI STS	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 9. 00 10. 00 11. 00 12. 00 13. 00 15. 00 16. 00 17. 00 18. 00 20. 00 21. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	13. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	14. 00 1, 540 6, 794 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			17. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00 20. 00 21. 00

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

Worksheet H-2 Part I Date/Time Prepared: 11/23/2015 5:05 pm Provi der CCN: 140089 Peri od: From 07/01/2014 To 06/30/2015 HHA CCN: 147293

						Home Health	PPS	
						Agency I		
	Cost Center Description	PARAMED ED	Subtotal	Intern &	Subtotal	Allocated HHA	Total HHA	
		PRGM		Residents Cost		A&G (see Part	Costs	
				& Post		11)		
				Stepdown				
				Adjustments				
		23. 00	24. 00	25. 00	26. 00	27. 00	28. 00	
1.00	Administrative and General	0	107, 759	0	107, 759			1. 00
2.00	Skilled Nursing Care	0	1, 073, 322	0	1, 073, 322	69, 173	1, 142, 495	2. 00
3.00	Physical Therapy	0	357, 285	0	357, 285		380, 312	3. 00
4.00	Occupational Therapy	0	155, 143	0	155, 143	9, 999	165, 142	4. 00
5.00	Speech Pathology	0	29, 173	0	29, 173	1, 880	31, 053	5. 00
6.00	Medical Social Services	0	15, 762	0	15, 762	1, 016	16, 778	6. 00
7.00	Home Health Aide	0	41, 331	0	41, 331	2, 664	43, 995	7. 00
8.00	Supplies (see instructions)	0	0	0	C	0	0	8. 00
9.00	Drugs	o	0	0	C	o	0	9. 00
10.00	DME	o	0	0	C	o	0	10.00
11. 00	Home Dialysis Aide Services	o	o	0	C	o	0	11. 00
12.00	Respiratory Therapy	o	0	0	C	o	0	12.00
13.00	Private Duty Nursing	o	0	0	C	o	0	13.00
14.00	Clinic	o	0	0	C	o	0	14. 00
15.00	Health Promotion Activities	O	0	0	C	o	0	15. 00
16.00	Day Care Program	o	o	0	C	o	0	16. 00
17. 00	Home Delivered Meals Program	o	o	0	C	o	0	17. 00
18.00	Homemaker Service	o	o	0	C	o	0	18. 00
19.00	All Others (specify)	o	o	0	C	ol	0	19. 00
20.00	Total (sum of lines 1-19) (2)	o	1, 779, 775	0	1, 779, 775	107, 759	1, 779, 775	20.00
21.00	Unit Cost Multiplier: column					0.064449		21. 00
	26, line 1 divided by the sum							
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.							
	•			'	•			•

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

Health Financial Systems	MCDONOUGH DISTRICT	HOSPI TAL	In Lie	u of Form CMS-2552-10
ALLOCATION OF GENERAL SERVICE COSTS TO HH BASIS	IA COST CENTERS STATISTICAL	Provi der CCN: 140089 HHA CCN: 147293	Peri od: From 07/01/2014 To 06/30/2015	Worksheet H-2 Part II Date/Time Prepared: 11/23/2015 5:05 pm
			Home Health	PPS

						Home Health Agency I	PPS	<u>00 piii</u>
		CAPI TAL RELATED COSTS				rigerie y		
	Cost Center Description	NEW BLDG & FIXT (SQUARE FEET)	CAP REL COSTS-HOSPI TAL (SQUARE FEET)	CAP REL COSTS-HSB I (SQUARE FEET)	CAP REL COSTS-HSB II (SQUARE FEET)	CAP REL COSTS-REHAB CNT (PER CENT)	CAP REL COSTS-DI AYSI S (PER CENT)	
		1.00	1. 01	1. 02	1. 03	1. 04	1. 05	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) Total cost to be allocated	000000000000000000000000000000000000000		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00
22. 00	Unit cost multiplier	0. 000000		0. 000000 TAL RELATED CO		0.000000	0. 000000	22. 00
	Cost Center Description	CAP REL COSTS-HOSPITAL ITY HOUSE (PER CENT) 1.06	CAP REL	CAP REL COSTS-ORTHO BLDG (SQUARE FEET) 1.08	CONVENI ENCE CARE CLI NI (PER CENT)	BUSHNELL OFFICE BLDG (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES) 4.00	
14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) Total cost to be allocated Unit cost multiplier	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 735 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			250, 623 524, 662 179, 252 81, 661 14, 545 8, 099 19, 589 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00

Health Financial Systems	MCDONOUGH DISTRICT HOSE	SPI TAL	In Lie	u of Form CMS-2552-10
ALLOCATION OF GENERAL SERVICE COSTS TO HH. BASIS			Peri od: From 07/01/2014	
	HHA	HA CUN: 147293	Home Health	Date/Time Prepared: 11/23/2015 5:05 pm PPS

						Home Health	PPS	
						Agency I		
	Cost Center Description	Reconciliation				MAINTENANCE &	MAINTENANCE &	
			& GENERAL	REPAI RS		REPAIRS-HSB II	REPAI RS-REHAB	
			(ACCUM.	(SQUARE	(SQUARE		CLINIC	
			COST)	FEET)	FEET)	(SQUARE	(PER	
						FEET)	CENT)	
1.00		5A	5.00	6.00	6. 01	6. 02	6. 03	4 00
1.00	Administrative and General	0	77, 113	0	1	0	· -	
2.00	Skilled Nursing Care	0	892, 447	0		0	· -	2. 00
3.00	Physi cal Therapy	0	300, 182	0)	0	· -	3. 00
4.00	Occupational Therapy	0	130, 212	0)	0	0	4. 00
5.00	Speech Pathology	0	24, 498) (0	0	5. 00
6.00	Medical Social Services	0	13, 175	0) (0	0	6. 00
7.00	Home Health Aide	0	34, 007	0) (0	0	7. 00
8.00	Supplies (see instructions)	0	0	0) (0	0	8. 00
9.00	Drugs	0	0	0)	0	0	9. 00
10.00	DME	0	0	0)	0	0	10.00
11. 00	Home Dialysis Aide Services	0	0	0)	0	0	11. 00
12.00	Respiratory Therapy	0	0	0) (0	0	12. 00
13.00	Private Duty Nursing	0	0	0)	0	0	13. 00
14.00	Clinic	0	0	0) (0	0	14. 00
15.00	Health Promotion Activities	0	0	0) (0	0	15. 00
16.00	Day Care Program	0	0	0) (0	0	16. 00
17.00	Home Delivered Meals Program	0	0	0) (0	0	17. 00
18.00	Homemaker Service	0	0	0) (0	0	18. 00
19.00	All Others (specify)	0	0	0) (0	0	19. 00
20.00	Total (sum of lines 1-19)		1, 471, 634	0) (0	0	20.00
21.00	Total cost to be allocated		260, 098	0) (0	0	21. 00
	The same and asset some							
22. 00	Unit cost multiplier		0. 176741	0.000000	0.000000	0. 000000	0. 000000	22. 00
22. 00	Cost Center Description	MAINTENANCE &	0. 176741 MAI NTENANCE &		0. 000000 LAUNDRY &	0. 000000 HOUSEKEEPI NG	O. 000000 HOUSEKEEPI NG-H	22. 00
22. 00		MAI NTENANCE & REPAI RS-MAB	MAINTENANCE &		LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	HOUSEKEEPI NG-H SB	22. 00
22. 00		REPAIRS-MAB (SQUARE	MAI NTENANCE & REPAI RS-ORTHO BLDG	MAINTENANCE & REPAIRS-BUSHNE LL	LAUNDRY & LINEN SERVICE (POUNDS OF	HOUSEKEEPI NG (TI ME	HOUSEKEEPI NG-H SB (SQUARE	22. 00
22. 00		REPAIRS-MAB	MAI NTENANCE & REPAI RS-ORTHO BLDG (SQUARE	MAINTENANCE & REPAIRS-BUSHNE LL (SQUARE	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG (TI ME	HOUSEKEEPI NG-H SB	22. 00
22. 00		REPAIRS-MAB (SQUARE FEET)	MAI NTENANCE & REPAI RS-ORTHO BLDG (SQUARE FEET)	MAI NTENANCE & REPAI RS-BUSHNE LL (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LINEN)	HOUSEKEEPI NG (TI ME SPENT)	HOUSEKEEPI NG-H SB (SQUARE FEET)	22. 00
	Cost Center Description	REPAIRS-MAB (SQUARE FEET)	MAI NTENANCE & REPAI RS-ORTHO BLDG (SQUARE FEET) 6.05	MAI NTENANCE & REPAI RS-BUSHNE LL (SQUARE FEET) 6.06	LAUNDRY & LI NEN SERVI CE (POUNDS OF LI NEN) 8.00	HOUSEKEEPING (TIME SPENT) 9.00	HOUSEKEEPI NG-H SB (SQUARE FEET) 9. 01	
1.00	Cost Center Description Administrative and General	REPAI RS-MAB (SQUARE FEET) 6. 04	MAI NTENANCE & REPAI RS-ORTHO BLDG (SQUARE FEET) 6.05	MAI NTENANCE & REPAI RS-BUSHNE LL (SQUARE FEET) 6.06	LAUNDRY & LI NEN SERVI CE (POUNDS OF LI NEN) 8.00	HOUSEKEEPI NG (TI ME SPENT) 9.00	HOUSEKEEPI NG-H SB (SOUARE FEET) 9. 01	1.00
1. 00 2. 00	Cost Center Description Administrative and General Skilled Nursing Care	REPAIRS-MAB (SQUARE FEET)	MAI NTENANCE & REPAI RS-ORTHO BLDG (SQUARE FEET) 6. 05	MAI NTENANCE & REPAI RS-BUSHNE LL (SQUARE FEET) 6.06	LAUNDRY & LI NEN SERVI CE (POUNDS OF LI NEN) 8.00	HOUSEKEEPI NG (TI ME SPENT) 9.00 0 0	HOUSEKEEPI NG-H SB (SQUARE FEET) 9. 01 0	1. 00 2. 00
1. 00 2. 00 3. 00	Cost Center Description Administrative and General Skilled Nursing Care Physical Therapy	REPAI RS-MAB (SQUARE FEET) 6. 04	MAI NTENANCE & REPAI RS-ORTHO BLDG (SQUARE FEET) 6. 05	MAI NTENANCE & REPAI RS-BUSHNE LL (SQUARE FEET) 6.06	LAUNDRY & LI NEN SERVI CE (POUNDS OF LI NEN) 8.00	HOUSEKEEPI NG (TI ME SPENT) 9.00 0 0	HOUSEKEEPI NG-H SB (SQUARE FEET) 9. 01 0	1. 00 2. 00 3. 00
1. 00 2. 00 3. 00 4. 00	Cost Center Description Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy	REPAI RS-MAB (SQUARE FEET) 6. 04	MAI NTENANCE & REPAI RS-ORTHO BLDG (SQUARE FEET) 6. 05	MAI NTENANCE & REPAI RS-BUSHNE LL (SQUARE FEET) 6.06	LAUNDRY & LI NEN SERVI CE (POUNDS OF LI NEN) 8.00	HOUSEKEEPI NG (TI ME SPENT) 9.00 0 0	HOUSEKEEPI NG-H SB (SOUARE FEET) 9. 01 0 0	1. 00 2. 00 3. 00 4. 00
1. 00 2. 00 3. 00 4. 00 5. 00	Cost Center Description Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	REPAI RS-MAB (SQUARE FEET) 6. 04	MAI NTENANCE & REPAI RS-ORTHO BLDG (SOUARE FEET) 6.05	MAI NTENANCE & REPAI RS-BUSHNE LL (SQUARE FEET) 6.06	LAUNDRY & LI NEN SERVI CE (POUNDS OF LI NEN) 8.00	9. 00 0 0 0 0 0 0 0 0 0	HOUSEKEEPI NG-H SB (SQUARE FEET) 9. 01 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	REPAI RS-MAB (SQUARE FEET) 6. 04	MAI NTENANCE & REPAI RS-ORTHO BLDG (SQUARE FEET) 6. 05 0 0 0 0 0	MAI NTENANCE & REPAI RS-BUSHNE LL (SQUARE FEET) 6.06	LAUNDRY & LI NEN SERVI CE (POUNDS OF LI NEN) 8.00	9. 00 0 0 0 0 0 0 0 0 0	HOUSEKEEPI NG-H SB (SQUARE FEET) 9. 01 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	REPAI RS-MAB (SQUARE FEET) 6. 04	MAI NTENANCE & REPAI RS-ORTHO BLDG (SQUARE FEET) 6. 05 0 0 0 0 0 0	MAI NTENANCE & REPAI RS-BUSHNE LL (SQUARE FEET) 6.06	LAUNDRY & LI NEN SERVI CE (POUNDS OF LI NEN) 8. 00	9. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	HOUSEKEEPI NG-H SB (SOUARE FEET) 9.01 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions)	REPAI RS-MAB (SQUARE FEET) 6. 04	MAI NTENANCE & REPAI RS-ORTHO BLDG (SQUARE FEET) 6. 05 0 0 0 0 0 0 0	MAI NTENANCE & REPAI RS-BUSHNE LL (SQUARE FEET) 6.06	LAUNDRY & LI NEN SERVI CE (POUNDS OF LI NEN) 8.00	9. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	HOUSEKEEPING-H SB (SOUARE FEET) 9. 01 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs	REPAI RS-MAB (SQUARE FEET) 6. 04	MAI NTENANCE & REPAI RS-ORTHO BLDG (SQUARE FEET) 6. 05 0 0 0 0 0 0 0 0 0 0	MAI NTENANCE & REPAI RS-BUSHNE LL (SQUARE FEET) 6.06	LAUNDRY & LI NEN SERVI CE (POUNDS OF LI NEN) 8. 00	9. 00 9. 00 0 0 0 0	HOUSEKEEPI NG-H SB (SQUARE FEET) 9. 01 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME	REPAI RS-MAB (SQUARE FEET) 6. 04	MAI NTENANCE & REPAI RS-ORTHO BLDG (SQUARE FEET) 6. 05 0 0 0 0 0 0 0 0 0 0 0 0 0	MAI NTENANCE & REPAI RS-BUSHNE LL (SQUARE FEET) 6.06	LAUNDRY & LI NEN SERVI CE (POUNDS OF LI NEN) 8.00	9. 00 9. 00 0 0 0 0	HOUSEKEEPING-H SB (SOUARE FEET) 9. 01 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services	REPAI RS-MAB (SQUARE FEET) 6. 04	MAI NTENANCE & REPAI RS-ORTHO BLDG (SQUARE FEET) 6. 05 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	MAI NTENANCE & REPAI RS-BUSHNE LL (SQUARE FEET) 6.06	LAUNDRY & LI NEN SERVI CE (POUNDS OF LI NEN) 8.00	9. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	HOUSEKEEPI NG-H SB (SQUARE FEET) 9. 01 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy	REPAI RS-MAB (SQUARE FEET) 6. 04	MAI NTENANCE & REPAI RS-ORTHO BLDG (SQUARE FEET) 6. 05 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	MAI NTENANCE & REPAI RS-BUSHNE LL (SQUARE FEET) 6.06	LAUNDRY & LI NEN SERVI CE (POUNDS OF LI NEN) 8.00	9. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9. 01 9. 01 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing	REPAI RS-MAB (SQUARE FEET) 6. 04	MAI NTENANCE & REPAI RS-ORTHO BLDG (SQUARE FEET) 6. 05 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	MAI NTENANCE & REPAI RS-BUSHNE LL (SQUARE FEET) 6.06	LAUNDRY & LI NEN SERVI CE (POUNDS OF LI NEN) 8.00	9. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	HOUSEKEEPI NG-H	1. 00 2. 00 3. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic	REPAI RS-MAB (SQUARE FEET) 6. 04	MAI NTENANCE & REPAI RS-ORTHO BLDG (SQUARE FEET) 6. 05 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	MAI NTENANCE & REPAI RS-BUSHNE LL (SQUARE FEET) 6.06	LAUNDRY & LI NEN SERVI CE (POUNDS OF LI NEN) 8.00	9. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9. 01 9. 01 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities	REPAI RS-MAB (SQUARE FEET) 6. 04	MAI NTENANCE & REPAI RS-ORTHO BLDG (SQUARE FEET) 6. 05 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	MAI NTENANCE & REPAI RS-BUSHNE LL (SQUARE FEET) 6.06	LAUNDRY & LI NEN SERVI CE (POUNDS OF LI NEN) 8.00	9. 00 9. 00 0 0 0 0	HOUSEKEEPI NG-H	1. 00 2. 00 3. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program	REPAI RS-MAB (SQUARE FEET) 6. 04	MAI NTENANCE & REPAI RS-ORTHO BLDG (SQUARE FEET) 6. 05 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	MAI NTENANCE & REPAI RS-BUSHNE LL (SQUARE FEET) 6.06	LAUNDRY & LI NEN SERVI CE (POUNDS OF LI NEN) 8.00	9. 00 9. 00 0 0 0 0	HOUSEKEEPI NG-H SB (SOUARE FEET) 9. 01 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program	REPAI RS-MAB (SQUARE FEET) 6. 04	MAI NTENANCE & REPAI RS-ORTHO BLDG (SQUARE FEET) 6. 05 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	MAI NTENANCE & REPAI RS-BUSHNE LL (SQUARE FEET) 6.06	LAUNDRY & LI NEN SERVI CE (POUNDS OF LI NEN) 8.00	9. 00 9. 00 0 0 0 0	9. 01 9. 01 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service	REPAI RS-MAB (SQUARE FEET) 6. 04	MAI NTENANCE & REPAI RS-ORTHO BLDG (SQUARE FEET) 6. 05 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	MAI NTENANCE & REPAI RS-BUSHNE LL (SQUARE FEET) 6.06	LAUNDRY & LI NEN SERVI CE (POUNDS OF LI NEN) 8.00	9. 00 9. 00 0 0 0 0	HOUSEKEEPI NG-H SB (SOUARE FEET) 9. 01 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify)	REPAI RS-MAB (SQUARE FEET) 6. 04 1, 735 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	MAI NTENANCE & REPAI RS-ORTHO BLDG (SQUARE FEET) 6. 05 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	MAI NTENANCE & REPAI RS-BUSHNE LL (SQUARE FEET) 6.06	LAUNDRY & LI NEN SERVI CE (POUNDS OF LI NEN) 8.00	9. 00 9. 00 0 0 0 0	9. 01 9. 01 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19)	REPAI RS-MAB (SQUARE FEET) 6. 04 1, 735 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 1, 735	MAI NTENANCE & REPAI RS-ORTHO BLDG (SQUARE FEET) 6. 05 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	MAI NTENANCE & REPAI RS-BUSHNE LL (SQUARE FEET) 6.06	LAUNDRY & LI NEN SERVI CE (POUNDS OF LI NEN) 8.00	9. 00 9. 00 0 0 0 0	HOUSEKEEPI NG-H SB (SOUARE FEET) 9.01 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify)	REPAI RS-MAB (SQUARE FEET) 6. 04 1, 735 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	MAI NTENANCE & REPAI RS-ORTHO BLDG (SQUARE FEET) 6. 05 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	MAINTENANCE & REPAIRS-BUSHNE LL (SQUARE FEET) 6.06 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LI NEN) 8. 00	9. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9. 01 9. 01 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 20. 00 21. 00

Health Financial Systems	MCDONOUGH DISTRICT	HOSPI TAL	In Lie	u of Form CMS-2552-10
ALLOCATION OF GENERAL SERVICE COSTS TO I BASIS	HHA COST CENTERS STATISTICAL	Provi der CCN: 140089 HHA CCN: 147293	Peri od: From 07/01/2014 To 06/30/2015	Worksheet H-2 Part II Date/Time Prepared: 11/23/2015 5:05 pm
				•

						Home Health Agency I	PPS	p
	Cost Center Description	HOUSEKEEPI NG-H				CAFETERI A	NURSI NG	
		SB II (SQUARE	RTHO (SQUARE	AB (SQUARE	(MEALS SERVED)	(FTE' S)	ADMI NI STRATI ON	
		FEET)	FEET)	FEET)	SERVED)		(DI RECT	
			,				NRSING HRS)	
1 00	Administrative and Consumb	9. 02	9. 03	9. 04	10.00	11.00	13.00	1.00
1. 00 2. 00	Administrative and General Skilled Nursing Care	0	0	1, 735 0		0 39 0 75		
3.00	Physical Therapy	l ő	o	0		0 18	•	3.00
4.00	Occupational Therapy	0	0	0		0 8	9 0	4. 00
5.00	Speech Pathology	0	0	0		0 1		5. 00
6. 00 7. 00	Medical Social Services Home Health Aide	0	0	0		0 1	l e	
8. 00	Supplies (see instructions)	0	0	0		٥		8.00
9. 00	Drugs	Ö	Ö	0		-	o o	9. 00
10. 00	DME	0	0	0		0	0 0	
11.00	Home Dialysis Aide Services	0	0	0		0	0 0	11.00
12. 00 13. 00	Respiratory Therapy Private Duty Nursing	0	0	0		0	0 0 0 0	
14. 00	Clinic	Ö	o	0		0	ol o	
15. 00	Health Promotion Activities	0	0	0		0	0 0	15. 00
16.00	Day Care Program	0	0	0		0	0	16.00
17. 00 18. 00	Home Delivered Meals Program Homemaker Service	0	0	0		0	0 0	17. 00 18. 00
19. 00	All Others (specify)	0	0	0		0		19.00
20. 00	Total (sum of lines 1-19)	O	0	1, 735		0 1, 51	5 0	20. 00
21. 00	Total cost to be allocated	0	0	1, 862		0 32, 63	1	21. 00
22. 00	Unit cost multiplier Cost Center Description	0. 000000 CENTRAL	0. 000000 PHARMACY	1. 073199 MEDI CAL	0.00000 SOCIAL SERVIO	_		22. 00
	cost center bescription	SERVICES &	(COSTED	RECORDS &	SOCIAL SERVIN	ANESTHETI STS		
		SUPPLY	REQUIS.)	LI BRARY	(TIME	(ASSI GNED	(ASSI GNED	
		(COSTED		(TIME	SPENT)	TI ME)	TIME)	
		REQUI S.) 14. 00	15. 00	SPENT) 16. 00	17. 00	19. 00	23. 00	
1.00	Administrative and General	4, 736	0	0		0	0 0	1. 00
2.00	Skilled Nursing Care	20, 897	0	0		0	0 0	
3.00	Physical Therapy	0	0	0		0	0 0	1 0.00
4. 00 5. 00	Occupational Therapy Speech Pathology	0	0	0		0	0 0	4. 00 5. 00
6. 00	Medical Social Services	ő	Ö	0		o	o o	ı
7.00	Home Health Aide	0	0	0		0	0 0	7. 00
8.00	Supplies (see instructions)	0	0	0		0	0	
9. 00 10. 00	Drugs DME	0	0	0		0	0 0	9. 00 10. 00
11. 00	Home Dialysis Aide Services		0	0		0		
12.00	Respiratory Therapy	0	0	0		0	o o	12. 00
13. 00	Private Duty Nursing	0	0	0		0	0 0	
14. 00 15. 00	Clinic Health Promotion Activities	0	0	0		0	0 0	14. 00 15. 00
16. 00	Day Care Program		0	0		0		ı
17. 00	Home Delivered Meals Program	O	0	0		0	o o	1
18. 00	Homemaker Service	0	o	0		0	0 0	
19.00	All Others (specify)	0	0	0		0	0 0	
20. 00 21. 00	Total (sum of lines 1-19) Total cost to be allocated	25, 633 8, 334	0	0		0	0 0	20. 00 21. 00
	Unit cost multiplier	0. 325128	0. 000000	0. 000000	0. 00000	0. 00000	9	•
	•	•						

	Financial Systems		MCDONOUGH DISTE		00N 440000		u of Form CMS-2	
APPORI	IONMENT OF PATIENT SERVICE COST	S		HHA CCN:	CCN: 140089 147293	Peri od: From 07/01/2014 To 06/30/2015	Worksheet H-3 Part I Date/Time Prep 11/23/2015 5:0	pared:
				Ti tl	e XVIII	Home Health Agency I	PPS	
	Cost Center Description		Facility Costs		Total HHA	Total Visits	Average Cost	
		H-2, Part I, col. 28, line	(from Wkst.	Ancillary Costs (from	Costs (cols. + 2)	1	Per Visit (col. 3 ÷ col.	
		COI . 20, TTHE	11-2, Fait 1)	Part II)	+ 2)		4)	
	T	0	1.00	2.00	3. 00	4. 00	5. 00	
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION	OF AGGREGATE F	PROGRAM COST, A	GGREGATE OF TH	IE PROGRAM LIN	MITATION COST, OF	₹	
	Cost Per Visit Computation							1
1.00	Skilled Nursing Care	2. 00			1, 142, 49		279. 34	
2.00	Physical Therapy	3.00				· ·	230. 49	
3. 00 4. 00	Occupational Therapy Speech Pathology	4. 00 5. 00			1,		220. 78 235. 25	
5.00	Medical Social Services	6. 00			16, 7		578. 55	
6.00	Home Health Aide	7. 00			43, 99			
7.00	Total (sum of lines 1-6)		1, 779, 775	0	., ., , .			7. 00
			l		Program Visi	ts art B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject			
	·		, ,		Deducti bl es			
		0	1.00	2.00	Coi nsurance 3.00	4.00	5. 00	
	Limitation Cost Computation	0	1.00	2.00	3.00	4.00	5.00	
8.00	Skilled Nursing Care		99914	0				8. 00
9.00	Physical Therapy		99914	0				9. 00
10. 00 11. 00	Occupational Therapy Speech Pathology	•	99914 99914	0	1	94 41		10.00
12. 00	Medical Social Services		99914	0	•	22		12. 00
13.00	Home Health Aide		99914	0	18	39		13. 00
14. 00	Total (sum of lines 8-13)	- 111		0			5 11 (1 0	14. 00
	Cost Center Description	From Wkst. H-2 Part I, col.	Facility Costs (from Wkst.	Shared Ancillary	Total HHA Costs (cols.		Ratio (col. 3 ÷ col. 4)	
		28, line	H-2, Part I)	Costs (from	+ 2)	Record)	. (01. 4)	
			1.00	Part II)				
	Supplies and Drugs Cost Comput	ations	1.00	2.00	3. 00	4. 00	5. 00	
15. 00		8. 00	0	0		0 28, 688	0. 000000	15. 00
16. 00	Cost of Drugs	9. 00		0		0 0	0. 000000	16. 00
			Program Visits		Cost of Services			
			Par	t B	J Sel VI Ces	Part B		
	Cost Center Description	Part A	Not Subject to		Part A	Not Subject to		
			Deductibles &			Deductibles &		
		6. 00	Coi nsurance 7.00	Coi nsurance 8.00	9. 00	Coi nsurance 10.00	Coi nsurance 11.00	
	PART I - COMPUTATION OF LESSER							
	BENEFICIARY COST LIMITATION							_
1. 00	Cost Per Visit Computation Skilled Nursing Care	1 0	2, 150			0 600, 581		1.00
2. 00	Physical Therapy	l ő				0 236, 944		2. 00
3.00	Occupational Therapy	0	394			0 86, 987		3. 00
4.00	Speech Pathology	0	41			0 9, 645		4. 00
5. 00 6. 00	Medical Social Services Home Health Aide	0	22 189		-	0 12, 728 0 26, 398		5. 00 6. 00
7. 00	Total (sum of lines 1-6)	Ö				0 973, 283		7. 00
	Cost Center Description							
	Limitation Cost Computation	6. 00	7. 00	8. 00	9. 00	10. 00	11. 00	
8. 00	Skilled Nursing Care				1			8.00
9.00	Physi cal Therapy							9. 00
	Occupational Therapy							10.00
								11. 00
10. 00 11. 00	Speech Pathology							
	Speech Pathology Medical Social Services Home Health Aide							12. 00 13. 00

APPORT	PORTIONMENT OF PATIENT SERVICE COSTS				CCN: 140089	Peri od: From 07/01/2014	Worksheet H-3 Part I	
				HHA CCN:	147293		Date/Time Pre 11/23/2015 5:	
				Ti tl	e XVIII	Home Health Agency I	PPS	
		Prog	ram Covered Char	ges	Cost of	Agency		
				•	Servi ces			
			Part			Part B		
	Cost Center Description	Part A	Not Subject to		Part A	Not Subject to	Subject to	
			Deductibles & D			Deductibles &	Deductibles &	
		6. 00	Coi nsurance 7.00	Coi nsurance 8. 00	9.00	Coi nsurance 10.00	Coi nsurance 11.00	-
	Supplies and Drugs Cost Computa		7.00	8.00	9.00	10.00	11.00	
15. 00	Cost of Medical Supplies	0	17, 697	0	1	0 0	0	15. 0
	Cost of Drugs	Ĭ	17,077	0	1	ő	0	1
	Cost Center Description	Total Program	- '	_	'			
	·	Cost (sum of						
		col s. 9-10)						
	DADT I COMPUTATION OF LECCED	12.00	DOODAH OOST AG	DECATE OF TH	IE DDOODAM III	MI TATION OCCT. OF		
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION	OF AGGREGATE I	PROGRAM COST, AG	REGATE OF TH	IE PROGRAM LI	MITATION COST, OR	•	
	Cost Per Visit Computation							1
1. 00	Skilled Nursing Care	600, 581						1 1.00
2.00	Physical Therapy	236, 944						2. 0
3.00	Occupational Therapy	86, 987						3. 0
4. 00	Speech Pathology	9, 645						4. 0
5. 00	Medical Social Services	12, 728						5. 0
6.00	Home Heal th Aide	26, 398						6.0
7. 00	Total (sum of lines 1-6) Cost Center Description	973, 283						7. 00
	cost center bescription	12. 00						1
	Limitation Cost Computation	12.00						
3. 00	Skilled Nursing Care							8.0
9. 00	Physical Therapy							9. 0
10.00	Occupational Therapy							10.0
11. 00	Speech Pathology							11.0
12.00	Medical Social Services							12. 0
13.00	Home Health Aide							13. 0
14.00	Total (sum of lines 8-13)		1					14.0

Heal th	Financial Systems		MCDONOUGH DISTE	RICT HOS	SPI TAL			In Lie	u of Form CMS-2	2552-10
APPORT	TIONMENT OF PATIENT SERVICE COST	S		Pr	rovi der	CCN: 140089		i od:	Worksheet H-3	
				HF	HA CCN:	147293	From 07/01/2014 Part II 3 To 06/30/2015 Date/Time Pre 11/23/2015 5:			
					Ti tl	e XVIII	Н	Home Health	PPS	
								Agency I		
	Cost Center Description	From Wkst. C,	Cost to Charge		I HHA	HHA Shared	·	Transfer to		
		Part I, col.	Rati o	Charge	(from	Ancillary		Part I as		
		9, line		provi der		Costs (col.	1	Indi cated		
				reco	rds)	x col. 2)				
		0	1. 00	2.	00	3.00		4. 00		
	PART II - APPORTIONMENT OF COST	T OF HHA SERVIO	CES FURNI SHED B	Y SHARE	D HOSPI	TAL DEPARTMEN	NTS			
1.00	Physical Therapy	66. 00	0. 456634		0		0 cc	ol. 2, line 2.	. 00	1.00
2.00	Occupational Therapy	67. 00	0. 000000		0		0 cc	ol. 2, line 3.	. 00	2.00
3.00	Speech Pathology	68. 00	0. 458569		0		0 cc	ol. 2, line 4.	.00	3.00
4.00	Cost of Medical Supplies	71.00	0. 192805		0		0 cc	ol. 2, line 15	5. 00	4. 00
5.00	Cost of Drugs	73. 00	0. 436599		0		0 cc	ol. 2, line 16	5. 00	5. 00

1LCUL <i>F</i>	Financial Systems MCDONOUGH DISTRICT I		CCN: 140089	Peri od:	eu of Form CMS-2 Worksheet H-4	
.2002		HHA CCN:	147293	From 07/01/2014	Part I-II	par
		Ti tl	e XVIII	Home Health Agency I	PPS	-
			_		t B	
			Part A	Not Subject to Deductibles &	Deductibles &	
			1. 00	Coi nsurance 2. 00	Coi nsurance 3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMA	ARY CHARGE		2.00	3.00	
	Reasonable Cost of Part A & Part B Services	0.11.11.02	<u> </u>			
	Reasonable cost of services (see instructions)			0 0	0	
	Total charges			0 613, 970	0	
	Customary Charges				ı	
0	Amount actually collected from patients liable for payment for s	servi ces		0	0	
00	on a charge basis (from your records)			o	0	
	Amount that would have been realized from patients liable for pa for services on a charge basis had such payment been made in acc with 42 CFR §413.13(b)				U	
	Ratio of line 3 to line 4 (not to exceed 1.000000)		0. 0000	0. 000000	0. 000000	
	Total customary charges (see instructions)			0 613, 970		
	Excess of total customary charges over total reasonable cost (coonly if line 6 exceeds line 1)	omplete		0 613, 970	0	
0	Excess of reasonable cost over customary charges (complete only 1 exceeds line 6)	ifline		0 0	0	
0	Primary payer amounts			0 0		
				Part A Services 1.00	Part B Services	L
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			1.00	2.00	
	Total reasonable cost (see instructions)			0	0	1
00	Total PPS Reimbursement - Full Episodes without Outliers			0	595, 680	1
	Total PPS Reimbursement - Full Episodes with Outliers			0	1, 303	
	Total PPS Reimbursement - LUPA Episodes			0	12, 686	
- 1	Total PPS Reimbursement - PEP Episodes			0	2, 585	
- 1	Total PPS Outlier Reimbursement - Full Episodes with Outliers			0	0	
1	Total PPS Outlier Reimbursement - PEP Episodes			0	0	
	Total Other Payments DME Payments				37	
	Oxygen Payments				0	
- 1	Prosthetic and Orthotic Payments			0	ő	
	Part B deductibles billed to Medicare patients (exclude coinsura	ance)			0	
	Subtotal (sum of lines 10 thru 20 minus line 21)	,		0	612, 291	2
00	Excess reasonable cost (from line 8)			0	0	
00	Subtotal (line 22 minus line 23)			0	612, 291	2
	Coinsurance billed to program patients (from your records)				0	
	Net cost (line 24 minus line 25)			0	612, 291	
	Reimbursable bad debts (from your records)					2
	Reimbursable bad debts for dual eligible beneficiaries (see inst				(40.004	2
	Total costs - current cost reporting period (line 26 plus line 2	27)		0		
- 1	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)			0	0	1 .
- 1	Pioneer ACO demonstration payment adjustment (see instructions) Subtotal (see instructions)					
1	Sequestration adjustment (see instructions)					
()1	Interim payments (see instructions)					
. 00	, ,			0		
. 00 . 00	Tentative settlement (for contractor use only) Balance due provider/program (line 31 minus lines 31.01, 32, and	d 33)		0	0	3

PROGRAM BENEFICIARIES

147293 HHA CCN:

Peri od: From 07/01/2014 To 06/30/2015

Date/Time Prepared: 11/23/2015 5:05 pm

Home Health

PPS

				Agency I	PPS	
		Inpatien	t Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		C)	600, 046	1. 00
2.00	Interim payments payable on individual bills, either		C)	0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none, write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider	T	T	. [1	
3. 01			C		0	3. 01
3. 02 3. 03					0 0	3. 02 3. 03
3. 03						3. 03
3. 05						3. 05
0.00	Provider to Program	1		1	0	0.00
3.50	<u> </u>		C)	0	3. 50
3. 51			C		0	3. 51
3. 52			C		0	3. 52
3. 53			C		0	3. 53
3. 54	Cultural (0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		_)	0	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99)				600, 046	4. 00
00	(transfer to Wkst. H-4, Part II, column as appropriate,				000,010	00
	line 32)					
	TO BE COMPLETED BY CONTRACTOR			_		
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	1 ogram to 11 ovi dei		C		0	5. 01
5. 02			ĺ		0	5. 02
5.03			C		0	5. 03
	Provider to Program	,				
5. 50			C		0	5. 50
5. 51			C		0	5. 51
5. 52 5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines				0 0	5. 52 5. 99
5. 99	5. 50-5. 98)			,		5. 99
6.00	Determined net settlement amount (balance due) based on					6. 00
00	the cost report. (1)					00
6. 01	SETTLEMENT TO PROVIDER		C		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		C		1	6. 02
7.00	Total Medicare program liability (see instructions)		C		600, 045	7. 00
				Contractor	NPR Date	
)	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor		,	1.00	2.00	8. 00
3. 00	1	ı		1	1	0.00

Health Financial Systems	MCDONOUGH DISTRICT HOSPITAL		In Lie	u of Form CMS-2552-10
ANALYSIS OF PROVIDER-BASED HOSPICE COSTS	Provi der CC	N: 140089	Period: From 07/01/2014	Worksheet K
	Hospi ce CCN	l: 141524		Date/Time Prepared:

			Hospi ce (CCN: 141524	To 06/30/2015		
					Hospi ce I	11/23/2015 5:	05 pm
		Salaries (from	Employee	Transportatio		Other	
			Benefits (from		Services (from	Other	
		WKSL. K-I)	Wkst. K-2)	(See Hist.)	Wkst. K-3)		
		1.00	2.00	3.00	4.00	5. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
1.00	Capital Related Costs-Bldg and Fixt.					0	1.00
2. 00	Capital Related Costs-Movable Equip.				o l	0	
3.00	Plant Operation and Maintenance		0			0	
4. 00	Transportation - Staff		0			0	4.00
5. 00	Volunteer Service Coordination		0			0	
6. 00	Administrative and General	57, 848	0		0 3, 062	11, 640	
0.00	I NPATI ENT CARE SERVI CE	37,040		1	0, 002	11,040	0.00
7. 00	Inpatient - General Care	0	0	1	0 21, 937	0	7. 00
8. 00	Inpatient - Respite Care		0	1	0 21, 737	0	1
0.00	VISITING SERVICES	<u> </u>		1	9 9		0.00
9.00	Physi ci an Servi ces	69, 969	0	ı	0 43, 403	0	9.00
10.00	Nursing Care	323, 759	0	1	0 10, 100	0	10.00
11. 00	Nursing Care-Continuous Home Care	020,707	0			0	11. 00
12. 00	Physical Therapy	0	0			0	12. 00
13. 00	Occupational Therapy	0	0			0	13.00
14. 00	Speech/ Language Pathology	0	0			0	14. 00
15. 00	Medical Social Services	45, 062	0			0	15. 00
16. 00	Spiritual Counseling	13,002	0			0	16.00
17. 00	Dietary Counseling		0			0	17. 00
18. 00	Counseling - Other		0			0	18. 00
19. 00	Home Health Aide and Homemaker	51, 928	0			0	19. 00
20. 00	HH Aide & Homemaker - Cont. Home Care	31, 720	0			0	20.00
21. 00	Other		0			0	21.00
21.00	OTHER HOSPICE SERVICE COSTS	<u> </u>		1	9		21.00
22. 00	Drugs, Biological and Infusion Therapy	0	0		ol ol	139, 707	22. 00
23. 00	Anal gesi cs	0	0			0	23. 00
24. 00	Sedatives / Hypnotics	0	0			0	24. 00
	Other - Specify	0	0			0	25. 00
26. 00	Durable Medical Equipment/Oxygen	0	0			66, 137	26. 00
27. 00	Patient Transportation	0	0	30, 53	1 954	0	1
28. 00	Imaging Services	0	0]	0	0	28. 00
29. 00	Labs and Diagnostics	0	0			0	29. 00
30. 00	Medical Supplies	0	0			15, 022	
31. 00	Outpatient Services (including E/R Dept.)	0	0		0 37, 374	0,022	31.00
32. 00	Radi ati on Therapy	0	0		0	0	32. 00
33. 00	Chemotherapy	0	0			0	33. 00
34. 00	Other	0	0	,	ol ol	3, 121	1
	HOSPICE NONREIMBURSABLE SERVICE		-		-1	<u> </u>	
35. 00	Bereavement Program Costs	8, 079	0		0 50	0	35. 00
36. 00	Volunteer Program Costs	O	0	,	ol ol	0	36. 00
37. 00	Fundrai si ng		0	,	ol ol	0	37. 00
38. 00	Other Program Costs	o	0		0 126, 877	0	38. 00
39. 00	Total (sum of lines 1 thru 38)	556, 645	0	30, 53	1 233, 657	235, 627	39. 00

Heal th	Financial Systems	MCDONOUGH DIST	RICT HOSPITAL		In Lie	eu of Form CMS-2	2552-10
ANALYSIS OF PROVIDER-BASED HOSPICE COSTS			Provi der	CCN: 140089	Peri od: From 07/01/2014	Worksheet K	
			Hospi ce	CCN: 141524	To 06/30/2015	Date/Time Prep 11/23/2015 5:0	pared: 05 pm_
					Hospi ce I		
		Total (cols.	Recl assi fi cati	Subtotal (co	I. Adjustments	Total (col. 8	
		1-5)	on	6 ± col. 7)		± col. 9)	
		6.00	7. 00	8. 00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	C) (0 0	0	1. 00
2.00	Capital Related Costs-Movable Equip.	C) (0 0	0	2. 00
3.00	Plant Operation and Maintenance	C) (0 0	0	3. 00
4 00	Transpartation Ctoff		d c	N.		i 0'	1 00

		1-5)	on	$6 \pm \text{col}$. 7)	Auj us tillerits	± col. 9)	
		6.00	7.00	8.00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS	0.00	7.00	0.00	7. 00	10.00	
1.00	Capital Related Costs-Bldg and Fixt.	0	ol	0	0	0	1.00
2. 00	Capital Related Costs-Movable Equip.	0	ol	0	0	0	2. 00
3. 00	Plant Operation and Maintenance	0	ol	0	0	0	3. 00
4. 00	Transportation - Staff	0	أم	0	0	0	4. 00
5. 00	Volunteer Service Coordination	0	l o	0	0	0	5. 00
6. 00	Administrative and General	72, 550	21, 086	93, 636	0	93, 636	6. 00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	21, 937	0	21, 937	0	21, 937	7. 00
8.00	Inpatient - Respite Care	0	o	0	0	0	8. 00
	VI SI TI NG SERVI CES						
9.00	Physi ci an Servi ces	113, 372	0	113, 372	0	113, 372	9. 00
10.00	Nursing Care	323, 759	0	323, 759	0	323, 759	10.00
11. 00	Nursing Care-Continuous Home Care	0	o	0	0	0	11. 00
12.00	Physical Therapy	0	o	0	0	0	12. 00
13.00	Occupational Therapy	0	o	0	0	0	13. 00
14.00	Speech/ Language Pathology	0	o	0	0	0	14. 00
15. 00	Medical Social Services	45, 062	o	45, 062	0	45, 062	15. 00
16.00	Spiritual Counseling	0	o	0	0	0	16. 00
17. 00	Di etary Counseling	0	o	0	0	0	17. 00
18.00	Counseling - Other	0	o	0	0	0	18. 00
19.00	Home Health Aide and Homemaker	51, 928	o	51, 928	0	51, 928	19. 00
20.00	HH Aide & Homemaker - Cont. Home Care	0	o	0	0	0	20. 00
21. 00	Other	0	o	0	0	0	21. 00
	OTHER HOSPICE SERVICE COSTS						
22. 00	Drugs, Biological and Infusion Therapy	139, 707	0	139, 707	0	139, 707	22. 00
23. 00	Anal gesi cs	0	0	0	0	0	23. 00
24. 00	Sedatives / Hypnotics	0	0	0	0	0	24. 00
25.00	Other - Specify	0	0	0	0	0	25. 00
26.00	Durable Medical Equipment/Oxygen	66, 137	0	66, 137	0	66, 137	26. 00
27. 00	Patient Transportation	31, 485	0	31, 485	0	31, 485	27. 00
28. 00	I maging Services	0	0	0	0	0	28. 00
29. 00	Labs and Diagnostics	0	0	0	0	0	29. 00
30.00	Medi cal Supplies	15, 022	0	15, 022	0	15, 022	30.00
31.00	Outpatient Services (including E/R Dept.)	37, 374	0	37, 374	0	37, 374	31.00
32.00	Radi ati on Therapy	0	o	0	0	0	32. 00
33.00	Chemotherapy	0	o	0	0	0	33. 00
34.00	Other	3, 121	o	3, 121	0	3, 121	34. 00
	HOSPICE NONREIMBURSABLE SERVICE						
35. 00	Bereavement Program Costs	8, 129	1, 845	9, 974	0	9, 974	35. 00
36. 00	Volunteer Program Costs	0	0	0	0	0	36. 00
37. 00		0	0	0	0	0	37. 00
38. 00	Other Program Costs	126, 877		128, 028	0	128, 028	
39. 00	Total (sum of lines 1 thru 38)	1, 056, 460	24, 082	1, 080, 542	0	1, 080, 542	39. 00

Health Financial Systems	MCDONOUGH DISTRICT HOSE	SPI TAL		In Lieu	ı of Form CMS-2552-10
HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES	Pro	rovi der CCN:	140089	Peri od:	Worksheet K-1
				From 07/01/2014	
					D I /T' D I

Hospi ce CCN: 141524 To 06/30/2015 Date/Time Prepared: 11/23/2015 5:05 pm Hospi ce I Admi ni strator Di rector Soci al Nurses Supervi sors S<u>ervi ces</u> 1.00 2.00 5. 00 4. 00 3 00 GENERAL SERVICE COST CENTERS 1.00 Capital Related Costs-Bldg and Fixt. 1.00 Capital Related Costs-Movable Equip. 2.00 2.00 3.00 0 3.00 Plant Operation and Maintenance 0 0 0 0 4.00 Transportation - Staff C 0 0 4.00 5.00 Volunteer Service Coordination 0 0 0 5.00 0 6.00 Administrative and General 0 43, 518 0 14, 330 6.00 INPATIENT CARE SERVICE Inpatient - General Care Inpatient - Respite Care 7.00 0 0 0 0 7.00 8.00 0 0 0 0 0 8.00 VISITING SERVICES 9.00 Physi ci an Servi ces 0 0 0 0 Ω 9.00 0 10.00 Nursing Care 0 0 0 323, 759 10.00 Nursing Care-Continuous Home Care 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 11.00 0 11.00 0 12.00 Physical Therapy 0 0 12.00 13.00 Occupational Therapy 0 0 0 13.00 Speech/ Language Pathology 14.00 14.00 Medical Social Services 0 15.00 45, 062 15.00 0 16.00 Spiritual Counseling 0 0 0 16.00 17.00 Dietary Counseling 0 17.00 0 18.00 Counseling - Other 0 18.00 Home Heal th Aide and Homemaker 0 19.00 19.00 0 0 20.00 HH Aide & Homemaker - Cont. Home Care C 0 20.00 21.00 0 21.00 OTHER HOSPICE SERVICE COSTS 22.00 Drugs, Biological and Infusion Therapy 22.00 23.00 Anal gesi cs 23.00 Sedatives / Hypnotics 24.00 24.00 Other - Specify 25.00 25.00 Durable Medical Equipment/Oxygen 26.00 26.00 27.00 Patient Transportation 0 27.00 0 28. 00 Imaging Services 00000 0 0 0 0 0 28.00 0 29 00 Labs and Diagnostics 0 29.00 0 30.00 Medical Supplies 0 30.00 0 31.00 Outpatient Services (including E/R Dept.) 0 0 31.00 Radiation Therapy 0 32.00 0 0 32.00 0 0 33.00 Chemotherapy 0 33.00 34.00 0ther 0 0 34.00 HOSPICE NONREIMBURSABLE SERVICE 35 00 n O n 35.00 Bereavement Program Costs 0 0 0 0 0 0 36.00 Volunteer Program Costs 0 0 36.00 37.00 Fundrai si ng 0 0 0 37.00 0 38.00 Other Program Costs 0 0 38.00 338, 089 39.00 Total (sum of lines 1 thru 38) 43, 518 45, 062 39.00

Heal th	Financial Systems	MCDONOUGH DISTRI	CT HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPI (CE COMPENSATION ANALYSIS SALARIES AND WAGES		Provi der	CCN: 140089	Peri od:	Worksheet K-1	
				0.01 4.450.4	From 07/01/2014	D 1 (T' D	
			Hospi ce C	CCN: 141524	To 06/30/2015	Date/Time Prep 11/23/2015 5:0	oared: O5 nm
					Hospi ce I	1172072010 0.0	оо рііі
		Total	Ai des	All-Other	Total (1)		
		Therapi sts			, ,		
		6. 00	7. 00	8. 00	9. 00		
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1. 00
2.00	Capital Related Costs-Movable Equip.						2. 00
3.00	Plant Operation and Maintenance		0		0 0		3. 00
4. 00	Transportation - Staff		0		0 0		4. 00
5. 00	Volunteer Service Coordination		0		0 0		5. 00
6. 00	Administrative and General		0		0 57, 848		6. 00
7.00	I NPATI ENT CARE SERVI CE						7 00
7.00	Inpatient - General Care		0		0 0		7. 00
8. 00	Inpatient - Respite Care		0		0 0		8. 00
9. 00	VISITING SERVICES Physician Services		0	69, 9	69 69, 969		9. 00
10.00	Nursing Care		0	09, 9	0 323, 759		10. 00
11. 00	Nursing Care-Continuous Home Care		0		0 323, 759		11. 00
12. 00	Physical Therapy	0	0				12. 00
13. 00	Occupational Therapy		0				13. 00
14. 00	Speech/ Language Pathology		0				14. 00
15. 00	Medical Social Services	٥	0		0 45, 062		15. 00
16. 00	Spiritual Counseling		0		0 43,002		16. 00
17. 00	Di etary Counsel i ng		0				17. 00
18. 00	Counseling - Other		0				18. 00
19. 00	Home Health Aide and Homemaker		51, 928		0 51, 928		19. 00
20. 00	HH Aide & Homemaker - Cont. Home Care		01, 720		0 0		20. 00
21. 00	Other		0		0 0		21. 00
	OTHER HOSPICE SERVICE COSTS	- \			-		
22. 00	Drugs, Biological and Infusion Therapy						22. 00
23.00	Anal gesi cs						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27. 00	Pati ent Transportation		0		0 0		27. 00
28. 00	I maging Services		0		0		28. 00
29. 00	Labs and Diagnostics		0		0 0		29. 00
30. 00	Medical Supplies		0		0 0		30. 00
31. 00	Outpatient Services (including E/R Dept.)		0		0 0		31. 00
32. 00	Radi ati on Therapy		0		0 0		32. 00
33. 00	Chemotherapy		0		0 0		33. 00
34.00	Other		0		0 0		34.00

8, 079

60, 007

0 0 0

69, 969

8, 079

556, 645

0

35.00

36.00

37. 00

38.00

39. 00

35.00

36.00

HOSPICE NONREIMBURSABLE SERVICE Bereavement Program Costs

Volunteer Program Costs

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

37.00 Fundrai si ng

Heal th Financial Systems MCDONOUGH DISTRICT HOSPITAL In Lieu of Form CMS-2552-100 HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES Provider CCN: 140089 Period: From 07/01/2014 Hospice CCN: 141524 To 06/30/2015 Prepared: 1402/0045 From 1402/0045 Prepared: 1402/0045

			nospi ce c	JON. 141324	10 00/30/2013	11/23/2015 5:	
					Hospi ce I	==, ==	<u> </u>
		Admi ni strator	Director	Soci al	Supervi sors	Nurses	
				Servi ces			
		1.00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS			ı			
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capi tal Related Costs-Movable Equip.	_	_			_	2. 00
3. 00	Plant Operation and Maintenance	0	0		0 0	0	1
4.00	Transportation - Staff	0	0		0 0	0	
5.00	Volunteer Service Coordination	0	0		0	0	
6.00	Administrative and General	0	0		0 0	0	6. 00
7.00	I NPATI ENT CARE SERVI CE			1		^	7.00
7.00	Inpatient - General Care	0	0		0 0		
8. 00	Inpatient - Respite Care	0	0		0 0	0	8. 00
0.00	VI SI TI NG SERVI CES	0		1		0	0.00
9.00	Physician Services	0	0		0 0	0	1
10.00	Nursing Care	0	0			0	
11. 00	Nursing Care-Continuous Home Care	0	0		0 0	0	
12. 00	Physical Therapy		0		0 0	0	
13. 00 14. 00	Occupational Therapy Speech/ Language Pathology		0		0 0	0	
15. 00	Medical Social Services		0		0 0	0	
16. 00	Spiritual Counseling		0		0 0	0	
17. 00	Dietary Counseling		0		0 0	0	
18. 00	Counseling - Other		0		0 0	0	
19. 00	Home Health Aide and Homemaker		0		0 0	0	
20. 00	HH Ai de & Homemaker - Cont. Home Care		0		0 0	0	1
21. 00	Other		0		0 0	0	
21.00	OTHER HOSPICE SERVICE COSTS	9			0 0		21.00
22. 00	Drugs, Biological and Infusion Therapy						22. 00
23. 00	Anal gesi cs						23. 00
24. 00	Sedatives / Hypnotics						24. 00
25. 00	Other - Specify						25. 00
26. 00	Durable Medical Equipment/Oxygen						26. 00
27.00	Patient Transportation	0	0		0 0	0	27. 00
28.00	I maging Services	0	0		0 0	0	28. 00
29.00	Labs and Diagnostics	0	0		0 0	0	29. 00
30.00	Medical Supplies	0	0		0 0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0		0 0	0	31. 00
32.00	Radi ati on Therapy	0	0		0 0	0	32. 00
33.00	Chemotherapy	0	0		0 0	0	33. 00
34.00	Other	0	0		0 0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35. 00	Bereavement Program Costs	0	0		0 0	0	
36. 00	Volunteer Program Costs	0	0		0 0	0	
37.00	Fundrai si ng	0	0		0 0	0	
38. 00	Other Program Costs	0	0		0 0	0	
39. 00	Total (sum of lines 1 thru 38)	0	0	1	0 0	0	39. 00

Health Financial Systems	MCDONOUGH	H DISTRICT	HOSPI TAL		In Lie	u of Form CMS-2552-10
HOSPICE COMPENSATION ANALYSIS CONTRACTED	SERVI CES/PURCHASED	SERVI CES	Provi der C	CN: 140089		Worksheet K-3
			Hospi so CCI	N. 141504	From 07/01/2014	Data/Tima Dranarad

Total Heoptics Aides All-other Total (1)				Hospi ce C		From 07/01/2014 To 06/30/2015	Date/Time Prepared: 11/23/2015 5:05 pm
Therapists						Hospi ce I	
CENERAL SERVICE COST CENTERS				Ai des	All-Other	Total (1)	
1.00			6. 00	7. 00	8. 00	9. 00	
2.00		GENERAL SERVICE COST CENTERS					
3.00	1.00	Capital Related Costs-Bldg and Fixt.					1. 00
4 .00	2.00	Capital Related Costs-Movable Equip.					2.00
5.00 Volunteer Service Coordination 0 0 0 0 0 0 0 0 0	3.00	Plant Operation and Maintenance		0	(o o	3.00
Administrative and General 0 3,062 3,062 6.00	4.00	Transportation - Staff		0	(o o	4. 00
INPATIENT CARE SERVICE	5.00	Volunteer Service Coordination		0	(o o	5.00
7. 00 Inpatient - General Care 0 21,937 21,937 7. 00 8. 00 Inpatient - Respite Care 0 0 0 0 9. 00 Physician Services 0 43,403 43,403 9. 00 11. 00 Nursing Care-Continuous Home Care 0 0 0 0 11. 00 12. 00 Physical Therapy 0 0 0 0 0 12. 00 13. 00 Occupational Therapy 0 0 0 0 0 13. 00 14. 00 Speech/ Language Pathology 0 0 0 0 0 14. 00 15. 00 Medical Social Services 0 0 0 0 0 15. 00 17. 00 Dietary Counseling 0 0 0 0 0 17. 00 18. 00 Counseling - Other 0 0 0 0 18. 00 19. 00 Hid Aide & Homemaker 0 0 0 0 0 19. 00 19. 00 Hime Health Aide and Homemaker 0 0 0 0 0 0 10. 00 Other 0 0 0 0 0 0 10. 00 Other 0 0 0 0 0 0 10. 00 Other 0 0 0 0 0 0 10. 00 Other 0 0 0 0 0 0 10. 01 Other 0 0 0 0 0 0 10. 02. 00 Other - Specify 0 0 0 0 0 0 21. 00 Other - Specify 0 0 0 0 0 0 22. 00 Other - Specify 0 0 0 0 0 0 23. 00 Other - Specify 0 0 0 0 0 0 24. 00 Sedatives / Hypnotics 0 0 0 0 0 25. 00 Other - Specify 0 0 0 0 0 26. 00 Unable Medical Equipment/Oxygen 0 0 0 0 0 27. 00 Patient Transportation 0 954 954 27. 00 28. 00 Imaging Services 0 0 0 0 0 0 39. 00 Medical Supplies 0 0 0 0 0 31. 00 Other Other	6.00	Administrative and General		0	3, 062	3, 062	6.00
8. 00 Inpatient - Respite Care 0 0 0 0 8. 00 VI SITING SERVICES		INPATIENT CARE SERVICE					
VISITING SERVICES	7.00	Inpatient - General Care		0	21, 937	21, 937	7. 00
9.00 Physician Services 0 43, 403 43, 403 9, 00	8.00	Inpatient - Respite Care		0	(o	8. 00
10.00 Nursing Care 0		VISITING SERVICES					
11.00	9.00	Physi ci an Servi ces		0	43, 403	43, 403	9. 00
12.00	10.00	Nursing Care		0	(o	10.00
13. 00 0 0 0 0 0 0 13. 00 14. 00 59eech/ Language Pathology 0 0 0 0 0 0 14. 00 15. 00 Medical Social Services 0 0 0 0 0 15. 00 15. 00 Medical Social Services 0 0 0 0 0 15. 00 15. 00 0 0 0 15. 00 0 0 15. 00 0 0 0 15. 00 0 0 15. 00 0 0 0 15. 00 0 0 0 15. 00 0 0 0 0 15. 00 0 0 0 0 0 15. 00 0 0 0 0 0 0 0 0 0	11. 00	Nursing Care-Continuous Home Care		0	(o o	11. 00
14. 00 Speech / Language Pathology 0 0 0 0 0 14. 00	12.00	Physical Therapy	0	0	(o o	12. 00
15.00 Medical Social Services 0 0 0 0 0 0 15.00 16.00 Spiritual Counseling 0 0 0 0 0 0 17.00 17.00 Dietary Counseling 0 0 0 0 0 0 17.00 18.00 Counseling - Other 0 0 0 0 0 0 0 18.00 19.00 Home Heal th Aide and Homemaker 0 0 0 0 0 0 0 19.00 10.00 Hi Aide & Homemaker - Cont. Home Care 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	13.00	Occupational Therapy	0	0	(o o	13. 00
16.00 Spiritual Counseling 0 0 0 0 16.00 17.00 Dietary Counseling 0 0 0 0 18.00 Counseling 0 0 0 0 18.00 0 0 0 0 19.00 Home Heal th Ai de and Homemaker 0 0 0 0 19.00 Hill Ai de & Homemaker - Cont. Home Care 0 0 0 0 20.00 Hill Ai de & Homemaker - Cont. Home Care 0 0 0 0 21.00 Other 0 0 0 0 22.00 Drugs, Biological and Infusion Therapy 22.00 23.00 Anal gesics 24.00 25.00 Other - Specify 25.00 26.00 Other - Specify 26.00 Durable Medical Equipment/Oxygen 27.00 28.00 Patient Transportation 0 954 954 27.00 28.00 Labs and Diagnostics 0 0 0 28.00 29.00 Labs and Diagnostics 0 0 0 0 30.00 Medical Supplies 0 0 0 30.00 31.00 Outpatient Services (including E/R Dept.) 0 37,374 37,374 31.00 32.00 Radiation Therapy 0 0 0 32.00 33.00 Chemotherapy 0 0 0 0 33.00 34.00 Other 0 0 0 0 35.00 35.00 Bereavement Program Costs 0 0 0 0 36.00 37.00 Fundralsing 0 0 0 0 37.00 50.00 Fundralsing 0 0 0 0 0 37.00 Fundralsing 0 0 0 0 37.00 Fundralsing 0 0 0 0 37.00 Fundralsing 0 0 0 37.00 0	14.00	Speech/ Language Pathology	0	0	(o o	14. 00
17.00 Di etary Counseling 0 0 0 0 17.00 18.00 Counseling - Other 0 0 0 0 18.00 19.00 19.00 0 0 19.00 19.00 0 0 0 19.00 19.00 0 0 0 19.00 19.00 0 0 0 19.00 19.00 0 0 0 19.00 19.00 0 0 0 19.00 0 0 0 0 19.00 0 0 0 19.00 0 0 0 19.00 0 0 0 19.00 0 0 0 19.00 0 0 0 19.00 0 0 0 19.00 0 0 0 19.00 0 0 0 19.00 0 0 0 19.00 0 0 0 19.00 0 0	15. 00	Medical Social Services		0	(o o	15. 00
18.00 Counseling - Other 0 0 0 0 18.00 19.00 Home Heal th Aide and Homemaker 0 0 0 0 20.00 HIH Aide & Homemaker - Cont. Home Care 0 0 0 0 21.00 Other 0 0 0 0 22.00 Other Othe	16.00	Spiritual Counseling		0	(0	16. 00
19.00 Home Heal th Ai de and Homemaker 0	17. 00			0	(0	17. 00
20.00	18.00	Counseling - Other		0	(0	18. 00
21.00 Other Othe	19. 00	Home Health Aide and Homemaker		0	(0	19. 00
OTHER HOSPICE SERVICE COSTS 22.00	20.00	HH Aide & Homemaker - Cont. Home Care		0	(
Drugs, Biological and Infusion Therapy 22.00	21. 00			0	(0	21. 00
23.00 Anal gesics 23.00 24.00 Sedatives / Hypnotics 24.00 25.00 25.00 25.00 26.00 26.00 26.00 26.00 26.00 27.00 28.00 1 maging Services 0 0 0 0 0 0 28.00 29.00 28.00 29.00 28.00 29.00 28.00 29.00 28.00 29.00							
24.00 Sedatives / Hypnotics 24.00 25.00 Other - Specify 25.00 Other - Specify 26.00 Durable Medical Equipment/Oxygen 26.00 Patient Transportation 0 954 954 27.00 28.00 Imaging Services 0 0 0 0 0 28.00 29.00 Labs and Diagnostics 0 0 0 0 0 28.00 29.00 Labs and Diagnostics 0 0 0 0 0 29.00 30.00 Medical Supplies 0 0 0 0 0 0 30.00 31.00 Outpatient Services (including E/R Dept.) 0 37,374 37,374 31.00 32.00 Radiation Therapy 0 0 0 0 0 32.00 33.00 Other 0 0 0 0 0 33.00 Other 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		, , ,					
25. 00 Other - Specify 25. 00 26. 00 Durable Medical Equipment/Oxygen 26. 00 27. 00 Patient Transportation 0 954 954 27. 00 28. 00 Imaging Services 0 0 0 0 28. 00 29. 00 Labs and Diagnostics 0 0 0 0 29. 00 30. 00 Medical Supplies 0 0 0 0 30. 00 31. 00 Outpatient Services (including E/R Dept.) 0 37, 374 37, 374 31. 00 32. 00 Radiation Therapy 0 0 0 0 32. 00 33. 00 Other 0 0 0 0 34. 00 Other 0 0 0 0 0 34. 00 Other Sereavement Program Costs 0 50 50 35. 00 37. 00 Fundraising 0 0 0 0 37. 00 0 0 37. 00 0 0 0 0 0 0 0 0 0							
26. 00 Durable Medical Equipment/Oxygen 26. 00 27. 00 Patient Transportation 0 954 954 27. 00 28. 00 Imaging Services 0 0 0 0 28. 00 29. 00 Labs and Diagnostics 0 0 0 0 29. 00 30. 00 Medical Supplies 0 0 0 0 30. 00 31. 00 Outpatient Services (including E/R Dept.) 0 37. 374 37. 374 31. 00 32. 00 Radiation Therapy 0 0 0 0 32. 00 33. 00 Chemotherapy 0 0 0 0 33. 00 34. 00 Other 0 0 0 0 34. 00 HOSPICE NONREIMBURSABLE SERVICE 8 0 50 35. 00 36. 00 Volunteer Program Costs 0 0 0 36. 00 37. 00 Fundraising 0 0 0 0 37. 00							
27. 00 Patient Transportation 0 954 954 27. 00 28. 00 Imaging Services 0 0 0 28. 00 29. 00 Labs and Diagnostics 0 0 0 0 29. 00 30. 00 Medical Supplies 0 0 0 0 30. 00 31. 00 Outpatient Services (including E/R Dept.) 0 37, 374 37, 374 31. 00 32. 00 Radiation Therapy 0 0 0 0 32. 00 33. 00 Chemotherapy 0 0 0 33. 00 34. 00 HOSPICE NONREIMBURSABLE SERVICE 0 0 34. 00 40 Bereavement Program Costs 0 50 50 35. 00 36. 00 Volunteer Program Costs 0 0 0 0 36. 00 37. 00 Fundraising 0 0 0 0 37. 00							
28. 00 I maging Services 0 0 0 28. 00 29. 00 Labs and Diagnostics 0 0 0 29. 00 30. 00 Medical Supplies 0 0 0 0 30. 00 31. 00 Outpatient Services (including E/R Dept.) 0 37. 374 37. 374 31. 00 32. 00 Radiation Therapy 0 0 0 0 32. 00 33. 00 Other 0 0 0 0 33. 00 34. 00 Other 0 0 0 34. 00 HOSPICE NONREIMBURSABLE SERVICE 0 50 50 35. 00 36. 00 Volunteer Program Costs 0 0 0 36. 00 37. 00 Fundrai sing 0 0 0 0 37. 00							
29. 00 Labs and Diagnostics 0 0 0 29. 00 30. 00 Medical Supplies 0 0 0 30. 00 31. 00 Outpatient Services (including E/R Dept.) 0 37, 374 37, 374 31. 00 32. 00 Radiation Therapy 0 0 0 0 32. 00 33. 00 Chemotherapy 0 0 0 0 33. 00 34. 00 Other 0 0 0 0 34. 00 HOSPICE NONREI MBURSABLE SERVI CE 8 0 50 50 35. 00 36. 00 Vol unteer Program Costs 0 0 0 0 36. 00 37. 00 Fundrai si ng 0 0 0 0 37. 00				0	954	954	
30.00 Medical Supplies 0 0 0 30.00		3 3		0	(0	
31.00 Outpatient Services (including E/R Dept.) 0 37,374 37,374 31.00 32.00 Radiation Therapy 0 0 0 0 32.00 33.00 Chemotherapy 0 0 0 0 33.00 34.00 Other O 0 0 0 34.00 Other O O O O O O O O O				0	(0	
32.00 Radiation Therapy 0 0 0 32.00				0	(0	
33.00 Chemotherapy 0 0 0 33.00 34.00		, , , , , , , , , , , , , , , , , , , ,		0	37, 374		
34. 00 Other 0 0 0 34. 00 HOSPICE NONREIMBURSABLE SERVICE 35. 00 Bereavement Program Costs 0 50 50 35. 00 36. 00 Volunteer Program Costs 0 0 0 0 36. 00 37. 00 Fundrai si ng 0 0 0 0 37. 00				0	(1	
HOSPICE NONREIMBURSABLE SERVICE		1		-			
35. 00 Bereavement Program Costs 0 50 50 35. 00 36. 00 Volunteer Program Costs 0 0 0 36. 00 37. 00 Fundrai si ng 0 0 0 37. 00	34. 00			0	(0	34.00
36. 00 Volunteer Program Costs 0 0 0 36. 00 37. 00 Fundrai si ng 0 0 0 37. 00							05.00
37. 00 Fundrai si ng 0 0 0 37. 00				0	50		
				0	(
				0	(0	
	38. 00	Other Program Costs		0	126, 87		38.00
39.00 Total (sum of lines 1 thru 38) 0 0 233,657 233,657 39.00	39.00	Tiotal (Sum of lines I thru 38)	١	O	233, 65	/ 233, 65/	39.00

			·			11/23/2015 5:	05 pm_
					Hospi ce I		
			CAPITAL RE	LATED COST			
		NET EXPENSES FOR COST ALLOCATION	BUI LDI NGS & FI XTURES	MOVABLE EQUI PMENT	PLANT OPERATION & MAINT.	TRANSPORTATI ON	
		0	1. 00	2.00	3. 00	4. 00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1. 00
2.00	Capital Related Costs-Movable Equip.	0			0		2. 00
3.00	Plant Operation and Maintenance	0	0		0		3. 00
4.00	Transportation - Staff	0	0		0	0	4. 00
5.00	Volunteer Service Coordination	0	0		0	0	5. 00
6.00	Administrative and General	93, 636	0		0 0	0	6. 00
	I NPATI ENT CARE SERVI CE						
7.00	Inpatient - General Care	21, 937	0		0		7. 00
8.00	Inpatient - Respite Care	0	0		0 0	0	8. 00
	VI SI TI NG SERVI CES					_	
9.00	Physi ci an Servi ces	113, 372	0		0 0		9.00
10. 00	Nursing Care	323, 759	0		0 0	_	10.00
11. 00	Nursing Care-Continuous Home Care	0	0		0	_	11. 00
12. 00	Physi cal Therapy	0	0		0	0	12.00
13.00	Occupational Therapy	0	0		0		13. 00
14.00	Speech/ Language Pathology	0	0		0 0	0	14. 00
15.00	Medical Social Services	45, 062	0		0	_	15.00
16.00	Spiritual Counseling	0	0		0 0	0	16.00
17. 00	, ,	0	0		0	0	17. 00
18. 00	Counseling - Other	F1 020	0		0	0	18. 00
19. 00	Home Health Aide and Homemaker	51, 928	0		0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0				20.00
21. 00	OTHER HOSPICE SERVICE COSTS	U U	U		0 0	l 0	21. 00
22. 00	Drugs, Biological and Infusion Therapy	139, 707	0		0 0	0	22. 00
23. 00	Anal gesi cs	134, 707	0		0 0		23. 00
24. 00	Sedatives / Hypnotics	0	0		0 0	0	24.00
25. 00	Other - Specify		0		0 0	0	25. 00
26. 00	Durable Medical Equipment/Oxygen	66, 137	0		0 0		26. 00
27. 00	Patient Transportation	31, 485	0		0 0		27. 00
28. 00	Imaging Services	0 0	0		0 0	Ö	28. 00
29. 00	Labs and Diagnostics		Ö		0 0	Ö	29. 00
30.00		15, 022	0		0 0	Ö	30.00
31. 00	Outpatient Services (including E/R Dept.)	37, 374	0		0 0	Ö	31. 00
32. 00	Radi ati on Therapy	0	0		0 0	Ö	32. 00
33. 00	Chemotherapy	0	Ö		0 0		33. 00
34. 00	Other	3, 121	0		o o		34. 00
	HOSPICE NONREIMBURSABLE SERVICE		-				
35.00	Bereavement Program Costs	9, 974	0		0 0	0	35. 00
36.00		o	0		0 0		36. 00
37.00	Fundrai si ng	o	0		0 0	0	37. 00
38. 00	Other Program Costs	128, 028	0		0 0	0	38. 00
39. 00	Total (sum of lines 1 thru 38)	1, 080, 542	0		0 0	0	39. 00
			·				

Health Financial Systems	MCDONOUGH DISTRICT HOSPITAL	In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPICE GENERAL SERVICE COST	Provi der CCN: 14	0089 Period: From 07/01/2014	Worksheet K-4 Part I

Hospi ce CCN: 141524 To 06/30/2015 Date/Time Prepared:

						11/23/2015 5:05 pm
					Hospi ce I	
	·	VOLUNTEER	SUBTOTAL	ADMI NI STRATI VE	TOTAL (col. 5A	
		SERVI CES	(col s. 0 - 5)	& GENERAL	± col . 6)	
		COORDI NATOR	,		,	
		5. 00	5A	6.00	7. 00	
	GENERAL SERVICE COST CENTERS					
1.00	Capital Related Costs-Bldg and Fixt.					1. 00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance					3.00
4.00	Transportation - Staff					4.00
5.00	Volunteer Service Coordination	0				5. 00
6.00	Administrative and General	0	93, 636	93, 636	,	6. 00
	I NPATI ENT CARE SERVI CE					
7.00	Inpatient - General Care	0	21, 937	2, 081	24, 018	7. 00
8.00	Inpatient - Respite Care	0			o	8.00
	VI SI TI NG SERVI CES	1			<u>'</u>	
9.00	Physi ci an Servi ces	0	113, 372	10, 757	124, 129	9. 00
10.00	Nursi ng Care	0	323, 759	30, 719	354, 478	10.00
11.00	Nursing Care-Continuous Home Care	0	O	l c	o	11.00
12.00	Physi cal Therapy	0	0	l c	ol	12.00
13.00	Occupational Therapy	0	0	l c	ol	13. 00
14.00	Speech/ Language Pathology	0	0		ol ol	14.00
15. 00	Medi cal Social Servi ces	0	45, 062	4, 275	49, 337	15. 00
16. 00	Spiritual Counseling	0	0	0		16. 00
17. 00	Di etary Counsel i ng	0	i o	i d	o	17. 00
18. 00		0	i o	i d	o	18. 00
19. 00	Home Health Aide and Homemaker	0	51, 928	4, 927	56, 855	19. 00
20. 00	HH Aide & Homemaker - Cont. Home Care	0	0.,0	,,	1	20.00
21. 00	Other			1		21. 00
	OTHER HOSPICE SERVICE COSTS				-1	
22. 00	Drugs, Biological and Infusion Therapy	0	139, 707	13, 255	152, 962	22. 00
23. 00		0	0	0		23. 00
24. 00	Sedatives / Hypnotics	0	i o	l d	o	24. 00
25. 00	7.	0	0		ام	25. 00
26. 00	Durable Medical Equipment/Oxygen	0	66, 137	6, 275	72, 412	26. 00
27. 00		0	31, 485			27. 00
28. 00	Imaging Services	0	0., .00	2,707		28. 00
29. 00		0			-	29. 00
30. 00	Medical Supplies		15, 022	1	1 4	30.00
31. 00	Outpatient Services (including E/R Dept.)		37, 374		1	31.00
32. 00	Radi ati on Therapy		37,374	3, 340		32.00
33. 00	Chemotherapy				_	33.00
34. 00	Other		3, 121		-	34.00
34.00	HOSPI CE NONREI MBURSABLE SERVI CE		J, 121	1 290	ا 3,417	34.00
35. 00	Bereavement Program Costs	0	9, 974	946	10, 920	35. 00
36. 00	Volunteer Program Costs		9, 9/4	1		36.00
37. 00	ů .					37.00
38. 00	Other Program Costs		128, 028	12, 147	140, 175	38.00
	Total (sum of lines 1 thru 38)		1, 080, 542		1, 080, 542	39. 00
37.00	Tiotal (Sam of Filles I till a so)	1	1,000,042	·I	1, 000, 542	1 34.00

CAPITAL RELATED COST							11/23/2015 5:	05 pm
BUILDINGS & FIXTURES (SO. COUI PRICTITY (SO. CONTROL CONTR						Hospi ce I		
FIXTURES (SQ. FIX.) VALUE FIX. VALUE VALU			CAPITAL RE	LATED COST		·		
CENERAL SERVICE COST CENTERS			FIXTURES (SQ.	EQUIPMENT (\$	OPERATION & MAINT. (SQ.		SERVI CES COORDI NATOR	
1.00			1.00	2.00	3.00	4. 00	5. 00	
2.00 Capit tal Real ated Costs-Movable Equip. 0 0 3.00 4.00 Transportation - Staff 0 0 0 0 0 5.00 Volunteer Service Coordination 0 0 0 0 0 5.00 Volunteer Service Coordination 0 0 0 0 0 5.00 Nontreer Service Coordination 0 0 0 0 0 Nontreer Service Service 0 0 0 0 0 Nontreer Service Service 0 0 0 0 0 0 Nontreer Service Service 0 0 0 0 0 0 Nontreer Service Service 0 0 0 0 0 0 0 Nontrieve Service 0 0 0 0 0 0 0 0 Nontrieve 0 0 0 0 0 0 0 0 0		GENERAL SERVICE COST CENTERS						
1.00	1.00	Capital Related Costs-Bldg and Fixt.	0					1.00
4.00	2.00	Capital Related Costs-Movable Equip.	0	0				2. 00
4.00	3.00	Plant Operation and Maintenance	0	0	l			3.00
5.00	4.00		0	0		ol		4.00
INPATIENT CARE SERVICE	5.00	·	0	0		ol	0	5. 00
Post	6.00	Administrative and General	0	0		ol	0	6.00
Post			_			- 1		
Injantient - Respite Care O O O O O O O O O O O O O O O O O O	7.00		0	0	C	ol	0	7.00
VISTING SERVICES	8.00	· ·	0	0		ol	0	8. 00
9.00 Physician Services				_	<u> </u>	-1	_	
10.00 Nursing Care 0	9.00		0	0	(ol	0	9.00
11.00 Nursing Care-Continuous Home Care 0 0 0 0 0 0 11.00 12.00 Physical Therapy 0 0 0 0 0 0 12.00 13.00 Occupational Therapy 0 0 0 0 0 0 13.00 14.00 Speech/ Language Pathology 0 0 0 0 0 0 0 14.00 15.00 Medical Social Services 0 0 0 0 0 0 15.00 16.00 Spiritual Counseling 0 0 0 0 0 0 0 16.00 17.00 Dietary Counseling 0 0 0 0 0 0 0 17.00 18.00 Counseling 0 0 0 0 0 0 18.00 19.00 Hald Haide And Homemaker 0 0 0 0 0 0 18.00 19.00 Hald Haide And Homemaker 0 0 0 0 0 0 0 18.00 19.00 Hald Haide And Homemaker 0 0 0 0 0 0 0 0 19.00 Other Health Aide and Home Care 0 0 0 0 0 0 0 19.00 Other Home Care 0 0 0 0 0 0 0 0 22.00 Other Home Care 0 0 0 0 0 0 0 23.00 Anal gesics 0 0 0 0 0 0 0 0 24.00 Sedatives / Hypnotics 0 0 0 0 0 0 0 0 25.00 Other - Specify 0 0 0 0 0 0 0 0 0 26.00 Durable Medical Equipment/Oxygen 0 0 0 0 0 0 0 0 26.00 Unable Medical Equipment/Oxygen 0 0 0 0 0 0 0 0 26.00 Labs and Diagnostics 0 0 0 0 0 0 0 0 29.00 Labs and Diagnostics 0 0 0 0 0 0 0 0 20.00 Other - Specify 0 0 0 0 0 0 0 0 20.00 Other - Specify 0 0 0 0 0 0 0 0 20.00 Diagnostics 0 0 0 0 0 0 0 0 0 20.00 Diagnostics 0 0 0 0 0 0 0 0 0 20.00 Diagnostics 0 0 0 0 0 0 0 0 0 20.00 Other - Orgama Costs 0 0 0 0 0 0 0 0 0 20.00 Other - Orgama Costs 0 0 0 0 0 0 0 0 0 20.00 Other - Orgama Costs 0 0 0 0 0 0 0 0 0 20.00 Other - Orgama Costs 0 0 0 0 0 0 0 0 0 20.00 Other - Orgama Costs 0 0 0 0 0 0 0 0		3		0			_	
12.00 Physical Therapy 0 0 0 0 0 0 12.00 13.00 Cocupational Therapy 0 0 0 0 0 0 0 14.00 Speech/ Language Pathology 0 0 0 0 0 0 15.00 Medical Social Services 0 0 0 0 0 0 15.00 Medical Social Services 0 0 0 0 0 15.00 Medical Social Services 0 0 0 0 0 15.00 Dietary Counseling 0 0 0 0 0 0 17.00 Dietary Counseling 0 0 0 0 0 0 18.00 Counseling 0 0 0 0 0 0 19.00 Home Heal th Aide and Homemaker 0 0 0 0 0 0 19.00 Hill Aide & Homemaker - Cont. Home Care 0 0 0 0 0 0 19.00 Other 0 0 0 0 0 0 0 19.00 Other 0 0 0 0 0 0 0 19.00 Other 0 0 0 0 0 0 0 19.00 Other 0 0 0 0 0 0 0 19.00 Other 0 0 0 0 0 0 0 19.00 Other 0 0 0 0 0 0 0 19.00 Other 0 0 0 0 0 0 0 0 20.00 Other 0 0 0 0 0 0 0 0 21.00 Other 0 0 0 0 0 0 0 0 22.00 Other 0 0 0 0 0 0 0 0 23.00 Analgesics 0 0 0 0 0 0 0 0 24.00 Sedatives / Hypnotics 0 0 0 0 0 0 0 25.00 Other - Specify 0 0 0 0 0 0 0 26.00 Other - Specify 0 0 0 0 0 0 0 26.00 Other - Specify 0 0 0 0 0 0 0 26.00 Other - Specify 0 0 0 0 0 0 27.00 Patient Transportation 0 0 0 0 0 0 28.00 Labs and Diagnostics 0 0 0 0 0 0 0 29.00 Labs and Diagnostics 0 0 0 0 0 0 0 29.00 Caddition Therapy 0 0 0 0 0 0 0 29.00 Other + Other 0 0 0 0 0 0 0 29.00 Other + Other 0 0 0 0 0 0 0 29.00 Other + Other 0 0 0 0 0 0 29.00 Other + Other 0 0 0 0 0 0 29.00 Other + Other 0 0 0 0 0 0 29.00 Other + Other 0 0 0 0 0 0 29.00 Other + Other 0			0	0	l d	ol ol	0	
13.00			0	0	l d	ol ol	0	
14.00 Speech Language Pathology		3	0	0	l d	ol ol	0	
15. 00 Medical Social Services 0 0 0 0 0 0 15. 00			0	0	l d	ol ol	0	
16.00 Spiritual Counseling 0 0 0 0 0 16.00 17.00 Dietary Counseling 0 0 0 0 0 17.00 18.00 Counseling - Other 0 0 0 0 0 17.00 19.00 Home Heal th Aide and Homemaker 0 0 0 0 0 19.00 20.00 HH Aide & Homemaker - Cont. Home Care 0 0 0 0 0 0 20.00 21.00 Other 0 0 0 0 0 0 21.00 22.00 Other 0 0 0 0 0 0 21.00 22.00 Drugs, Biological and Infusion Therapy 0 0 0 0 0 22.00 23.00 Anal gesics 0 0 0 0 0 22.00 24.00 Sedatives / Hypnotics 0 0 0 0 22.00 25.00 Other - Speci fy 0 0 0 0 22.00		,	0	0	l d	ol ol	0	
17. 00 Di etary Counseling			0	0	i c	ol ol	0	1
18.00 Counseling - Other		, · · · · · · · · · · · · · · · · · · ·	0	0	i c	ol ol	0	
19.00 Home Heal th Ai de and Homemaker			0	0		ol ol	0	1
20.00			0	0		ol ol	0	1
21.00 Other			0	0		ol ol	0	
22. 00 Drugs, Biological and Infusion Therapy 0 0 0 0 0 22. 00 23. 00 Anal gesics 0 0 0 0 0 0 23. 00 24. 00 Sedatives / Hypnotics 0 0 0 0 0 0 0 24. 00 25. 00 Other - Specify 0 0 0 0 0 0 0 25. 00 26. 00 Durable Medical Equipment/Oxygen 0 0 0 0 0 0 26. 00 27. 00 Patient Transportation 0 0 0 0 0 0 26. 00 27. 00 Patient Transportation 0 0 0 0 0 0 27. 00 28. 00 Imaging Services 0 0 0 0 0 28. 00 29. 00 Labs and Di agnostics 0 0 0 0 0 28. 00 30. 00 Medical Supplies 0 0 0 0 0 0 0 0 0 <t< td=""><td>21.00</td><td>Other</td><td>0</td><td>0</td><td>l</td><td>ol ol</td><td>0</td><td>21.00</td></t<>	21.00	Other	0	0	l	ol ol	0	21.00
22. 00 Drugs, Biological and Infusion Therapy 0 0 0 0 0 22. 00 23. 00 Anal gesics 0 0 0 0 0 0 23. 00 24. 00 Sedatives / Hypnotics 0 0 0 0 0 0 0 24. 00 25. 00 Other - Specify 0 0 0 0 0 0 0 25. 00 26. 00 Durable Medical Equipment/Oxygen 0 0 0 0 0 0 26. 00 27. 00 Patient Transportation 0 0 0 0 0 0 26. 00 27. 00 Patient Transportation 0 0 0 0 0 0 27. 00 28. 00 Imaging Services 0 0 0 0 0 28. 00 29. 00 Labs and Di agnostics 0 0 0 0 0 28. 00 30. 00 Medical Supplies 0 0 0 0 0 0 0 0 0 <t< td=""><td></td><td>OTHER HOSPICE SERVICE COSTS</td><td></td><td></td><td>•</td><td><u>'</u></td><td></td><td></td></t<>		OTHER HOSPICE SERVICE COSTS			•	<u>'</u>		
23. 00	22.00	Drugs, Biological and Infusion Therapy	0	0	C	0	0	22. 00
25.00 Other - Specify 0 0 0 0 0 0 0 25.00 26.00 Durable Medical Equipment/Oxygen 0 0 0 0 0 0 0 26.00 27.00 Patient Transportation 0 0 0 0 0 0 0 0 27.00 28.00 Imaging Services 0 0 0 0 0 0 0 0 28.00 29.00 Labs and Diagnostics 0 0 0 0 0 0 0 0 0 29.00 30.00 Medical Supplies 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0	l	ol	0	23. 00
26. 00 Durable Medical Equipment/Oxygen 0 0 0 0 0 0 26. 00 27. 00 Patient Transportation 0 0 0 0 0 0 0 0 27. 00 28. 00 Imaging Services 0 0 0 0 0 0 0 0 28. 00 29. 00 Labs and Diagnostics 0	24.00	Sedatives / Hypnotics	0	0	C	o	0	24. 00
27. 00 Pati ent Transportation 0 0 0 0 0 27. 00 28. 00 Imaging Services 0 0 0 0 0 0 0 0 28. 00 29. 00 Labs and Diagnostics 0 0 0 0 0 0 0 29. 00 30. 00 Medical Supplies 0 <td< td=""><td>25.00</td><td>Other - Specify</td><td>0</td><td>0</td><td>C</td><td>o</td><td>0</td><td>25. 00</td></td<>	25.00	Other - Specify	0	0	C	o	0	25. 00
28. 00 Imaging Services 0 0 0 0 0 28. 00 29. 00 Labs and Diagnostics 0 0 0 0 0 0 30. 00 Medical Supplies 0 0 0 0 0 31. 00 Outpatient Services (including E/R Dept.) 0 0 0 0 32. 00 Radiation Therapy 0 0 0 0 33. 00 Chemotherapy 0 0 0 0 34. 00 Other 0 0 0 0 HOSPICE NONREIMBURSABLE SERVICE 0 0 0 0 35. 00 Volunteer Program Costs 0 0 0 36. 00 Volunteer Program Costs 0 0 0 0 37. 00 Fundraising 0 0 0 0 38. 00 Other Program Costs 0 0 0 39. 00 Cost to be Allocated (per Wkst. K-4, Part I) 0 0 0 0 39. 00 Ocst to be Allocated (per Wkst. K-4, Part I) 0 0 0 0 30. 00 0 0 0 0 30. 00 0 0 0 0 30. 00 0 0 0 31. 00 0 0 0 32. 00 0 0 0 34. 00 0 0 35. 00 0 0 36. 00 0 0 37. 00 0 0 38. 00 0 0 39. 00 0 0 39. 00 0 0 39. 00 0 0 39. 00 0 0 39. 00 0 0 39. 00 0 0 30. 00 0 0 30. 00 0 0 30. 00 0 0 30. 00 0 30. 00 0 0 30. 00 0 30. 00 0 30. 00 0 30. 00 0 30. 00 0 30. 00 0 30. 00 0 30. 00 0 30. 00 0 30. 00 0 30. 00 30. 00 0 30. 00 0 30. 00 31. 00 0 32. 00 0 34. 00 35. 00 0 36. 00 37. 00 38. 00 39. 00 0 39. 00 0 39. 00 0 30. 00 0 30. 00 30	26.00	Durable Medical Equipment/Oxygen	0	0	C	o	0	26. 00
29. 00 Labs and Diagnostics 0 0 0 0 0 29. 00 30. 00 Medical Supplies 0 0 0 0 0 30. 00 31. 00 Outpatient Services (including E/R Dept.) 0 0 0 0 0 0 31. 00 32. 00 Radiation Therapy 0 0 0 0 0 0 32. 00 33. 00 Chemotherapy 0 0 0 0 0 0 33. 00 34. 00 Other 0 0 0 0 0 0 34. 00 HOSPICE NONREIMBURSABLE SERVICE 35. 00 Bereavement Program Costs 0 0 0 0 0 35. 00 36. 00 Vol unteer Program Costs 0 0 0 0 0 36. 00 37. 00 Fundrai si ng 0 0 0 0 0 0 37. 00 38. 00 Other Program Costs 0 0 0 0 0 0 0 0 <t< td=""><td>27.00</td><td>Patient Transportation</td><td>0</td><td>0</td><td>C</td><td>o</td><td>0</td><td>27. 00</td></t<>	27.00	Patient Transportation	0	0	C	o	0	27. 00
30.00 Medical Supplies 0 0 0 0 0 30.00 31.00 Outpatient Services (including E/R Dept.) 0 0 0 0 0 31.00 32.00 Radiation Therapy 0 0 0 0 0 32.00 33.00 Chemotherapy 0 0 0 0 0 0 33.00 34.00 Other 0 0 0 0 0 0 HOSPICE NONREIMBURSABLE SERVICE	28.00	I maging Services	0	0	l c	o	0	28. 00
31. 00 Outpati ent Servi ces (including E/R Dept.) 0 0 0 0 0 31. 00 32. 00 33. 00 Radi ati on Therapy 0 0 0 0 0 32. 00 33. 00 Chemotherapy 0 0 0 0 0 0 33. 00 34. 00 Other 0 0 0 0 0 0 0 34. 00 Other Other	29.00	Labs and Diagnostics	0	0	C	o	0	29. 00
32.00 Radiation Therapy 0 0 0 0 0 0 32.00 33.00 Chemotherapy 0 0 0 0 0 0 0 33.00 34.00 Other 0 0 0 0 0 0 0 34.00 HOSPICE NONREIMBURSABLE SERVICE 35.00 Bereavement Program Costs 0 0 0 0 0 0 35.00 36.00 Volunteer Program Costs 0 0 0 0 0 0 36.00 37.00 Fundraising 0 0 0 0 0 0 37.00 38.00 Other Program Costs 0 0 0 0 0 0 37.00 38.00 Other Program Costs 0 0 0 0 0 0 38.00 39.00 Cost to be Allocated (per Wkst. K-4, Part I) 0 0 0 0 0 0 0 39.00	30.00	Medical Supplies	0	0	l	ol	0	30.00
33. 00 Chemotherapy 0 0 0 0 0 0 33. 00 34. 00 Other 0 0 0 0 0 0 0 34. 00 HOSPICE NONREIMBURSABLE SERVICE 35. 00 Bereavement Program Costs 0 0 0 0 0 35. 00 36. 00 Volunteer Program Costs 0 0 0 0 0 0 36. 00 37. 00 Fundraising 0 0 0 0 0 0 0 37. 00 38. 00 Other Program Costs 0 0 0 0 0 0 38. 00 39. 00 Cost to be Allocated (per Wkst. K-4, Part I) 0 0 0 0 0 0 0 0 39. 00	31.00	Outpatient Services (including E/R Dept.)	0	0	l	ol	0	31.00
34. 00 Other 0 0 0 0 0 0 34. 00 HOSPICE NONREIMBURSABLE SERVICE 35. 00 Bereavement Program Costs 0 0 0 0 0 0 35. 00 0 36. 00 37. 00 Fundraising 0 0 0 0 0 0 0 37. 00 38. 00 0 0 0 0 0 0 0 38. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	32.00	Radiation Therapy	0	0	l	ol	0	32. 00
HOSPICE NONREIMBURSABLE SERVICE	33.00	Chemotherapy	0	0	l	ol	0	33. 00
35.00 Bereavement Program Costs 0 0 0 0 35.00 36.00 Volunteer Program Costs 0 0 0 0 0 36.00 37.00 Fundraising 0 0 0 0 0 37.00 38.00 Other Program Costs 0 0 0 0 0 38.00 39.00 Cost to be Allocated (per Wkst. K-4, Part I) 0 0 0 0 0 39.00	34.00	Other	0	0	l	ol	0	34.00
36.00 Volunteer Program Costs 0 0 0 0 0 36.00 37.00 Fundraising 0 0 0 0 0 0 37.00 38.00 Other Program Costs 0 0 0 0 0 0 38.00 39.00 Cost to be Allocated (per Wkst. K-4, Part I) 0 0 0 0 0 0 0 39.00		HOSPICE NONREIMBURSABLE SERVICE						
37.00 Fundraising 0 0 0 0 37.00 38.00 Other Program Costs 0 0 0 0 0 38.00 39.00 Cost to be Allocated (per Wkst. K-4, Part I) 0 0 0 0 0 39.00	35.00	Bereavement Program Costs	0	0	C	0	0	35. 00
37.00 Fundraising 0 0 0 0 37.00 38.00 Other Program Costs 0 0 0 0 0 38.00 39.00 Cost to be Allocated (per Wkst. K-4, Part I) 0 0 0 0 0 39.00			0	0	C	ol	0	36.00
39.00 Cost to be Allocated (per Wkst. K-4, Part I) 0 0 0 0 0 39.00	37.00		0	0	C	ol	0	37. 00
	38.00	Other Program Costs	0	0	C	ol	0	38. 00
40.00 Unit Cost Multiplier 0.000000 0.000000 0.000000 0.000000 40.00	39. 00	Cost to be Allocated (per Wkst. K-4, Part I)	0	0	[c	o	0	39. 00
	40.00	Unit Cost Multiplier	0. 000000	0. 000000	0.000000	0. 000000	0. 000000	40.00

11/23/2015 5:05 pm Hospi ce I RECONCI LI ATI ON ADMI NI STRATI VE & GENERAL (ACC. COST) 6A 6.00 GENERAL SERVICE COST CENTERS Capital Related Costs-Bldg and Fixt. 1.00 0 2.00 Capital Related Costs-Movable Equip. 2.00 3.00 Plant Operation and Maintenance 0 3.00 Transportation - Staff 0 4.00 4.00 5.00 Volunteer Service Coordination 5.00 Administrative and General -93, 636 6.00 986, 906 6.00 INPATIENT CARE SERVICE Inpatient - General Care Inpatient - Respite Care 7.00 0 21, 937 7.00 8.00 0 8.00 VISITING SERVICES 9.00 Physician Services 0 113, 372 9.00 10.00 Nursing Care 0 323, 759 10.00 Nursing Care-Continuous Home Care 0000000000 11.00 11.00 0 12.00 Physical Therapy 0 12.00 13.00 Occupational Therapy 13.00 Speech/ Language Pathology Medical Social Services 14.00 14.00 15.00 15.00 45, 062 16.00 Spiritual Counseling C 16.00 Dietary Counseling 17.00 17.00 0 Counseling - Other 18.00 18.00 Home Heal th Aide and Homemaker 19.00 51, 928 19.00 20.00 HH Aide & Homemaker - Cont. Home Care 0 20.00 0 21.00 0ther 0 21.00 OTHER HOSPICE SERVICE COSTS 0 22.00 Drugs, Biological and Infusion Therapy 139, 707 22.00 23.00 Anal gesi cs 0 23.00 24.00 Sedatives / Hypnotics 0000000000 0 24.00 Other - Specify 25.00 Ω 25.00 26.00 Durable Medical Equipment/Oxygen 66, 137 26.00 27.00 Patient Transportation 31, 485 27.00 28 00 Imaging Services 28 00 Ω Labs and Diagnostics 29.00 29.00 30.00 Medical Supplies 15, 022 30.00 31.00 Outpatient Services (including E/R Dept.) 37, 374 31.00 32. 00 Radiation Therapy 32.00 Ω 33.00 Chemotherapy Ω 33.00 34.00 3, 121 34.00 HOSPICE NONREIMBURSABLE SERVICE 35.00 Bereavement Program Costs 0 9, 974 35.00 0 36.00 Volunteer Program Costs 36.00 37.00 Fundrai si ng 0 0 37.00 38.00 Other Program Costs 0 128, 028 38.00

93, 636

0.094878

39.00

40.00

39.00 Cost to be Allocated (per Wkst. K-4, Part I)

40.00 Unit Cost Multiplier

Provi der CCN: 140089 Hospi ce CCN: 141524

	Date/ IT lie 1		
	11/23/2015	5: 05	pm
Jospi co I			

					Hospi ce I		
				CAPITAL REL	LATED COSTS		
	Cost Center Description	Hospi ce Tri al	NEW BLDG &	CAP REL	CAP REL	CAP REL	
		Bal ance (1)	FLXT	COSTS-HOSPI TAL	COSTS-HSB I	COSTS-HSB II	
		0	1.00	1. 01	1. 02	1. 03	
1.00	Administrative and General		0	0	0	0	1. 00
2.00	Inpatient - General Care	24, 018	0	0	0	0	2. 00
3.00	Inpatient - Respite Care	0	0	0	0	0	3. 00
4.00	Physi ci an Servi ces	124, 129	0	0	0	0	4. 00
5.00	Nursing Care	354, 478	0	0	0	0	5. 00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	o	0	o	0	0	7. 00
8.00	Occupational Therapy	o	0	o	0	0	8. 00
9.00	Speech/ Language Pathology	o	0	o	0	0	9. 00
10.00	Medical Social Services	49, 337	0	o	0	0	10.00
11. 00	Spiritual Counseling	o	O	o	0	0	11. 00
12.00	Di etary Counseling	o	O	o	0	0	12. 00
13.00	Counseling - Other	o	O	o	0	0	13. 00
14.00	Home Health Aide and Homemaker	56, 855	O	o	0	0	14. 00
15. 00	HH Aide & Homemaker - Cont. Home Care	o	O	o	0	0	15. 00
16. 00	Other	o	0	o	0	0	16.00
17. 00	Drugs, Biological and Infusion Therapy	152, 962	0	o	0	0	17. 00
18. 00		o	0	o	0	0	18. 00
19. 00		o	0	o	0	0	19. 00
20.00		o	0	o	0	0	20.00
21. 00	Durable Medical Equipment/Oxygen	72, 412	0	o	0	0	21. 00
	Patient Transportation	34, 472	0	ol	0	0	22. 00
	I maging Services	o	0	ol	0	0	1
24. 00		o	0	ol	0	0	24. 00
25. 00	9	16, 447	0	ol	0	0	25. 00
26. 00	1 ''	40, 920	0	ol	0	0	•
27. 00	Radiation Therapy	O	0	ol	0	0	•
28. 00		0	0	ol	0	0	28. 00
29. 00	Other	3, 417	0	ol	0	0	1
30. 00	Bereavement Program Costs	10, 920	0	ol	0	0	30.00
31. 00		0	0		0	0	1
32. 00			0	ol ol	0	0	1
	Other Program Costs	140, 175	n		0	Ő	1
	Total (sum of lines 1 thru 33) (2)	1, 080, 542	n		0	Ö	ł
	Unit Cost Multiplier (see instructions)	., 555, 612	Č	Ĭ	Ü	Ĭ	35. 00
55.50	[1	1 1		1		ı	, 55. 55

Peri od: Worksheet K-5 From 07/01/2014 Part I To 06/30/2015 Date/Time Prepared: 11/23/2015 5:05 pm Provi der CCN: 140089 Hospi ce CCN: 141524

						11/23/2013 3.	UJ PIII
					Hospi ce I		
			CAP	TTAL RELATED CO	OSTS		
	Cost Center Description	CAP REL	CAP REL	CAP REL	CAP REL	CAP REL	
		COSTS-REHAB	COSTS-DI AYSI S	COSTS-HOSPI TAL	COSTS-MAB	COSTS-ORTHO	
		CNT		ITY HOUSE		BLDG	
	T	1. 04	1. 05	1. 06	1. 07	1. 08	
1.00	Administrative and General	0	0	0	11, 374	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	
3.00	Inpatient - Respite Care	0	0	0	0	0	3. 00
4.00	Physi ci an Servi ces	0	0	0	0	0	
5.00	Nursing Care	0	0	0	0	0	5. 00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6. 00
7.00	Physi cal Therapy	0	0	0	0	0	7. 00
8.00	Occupational Therapy	0	0	0	0	0	8. 00
9.00	Speech/ Language Pathology	0	0	0	0	0	9. 00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11. 00
12.00	Di etary Counsel i ng	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15. 00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17. 00
18.00	Anal gesi cs	0	0	0	0	0	18. 00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19. 00
20.00	Other - Specify	0	l c	0	0	0	20. 00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21. 00
22. 00	Patient Transportation	0	l c	0	0	0	22. 00
23.00	I maging Services	0	l c	0	0	0	23. 00
24.00	Labs and Diagnostics	0	l c	0	0	0	24. 00
25.00	Medical Supplies	0	l c	0	0	0	25. 00
26. 00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26. 00
27. 00	Radi ati on Therapy	0	0	0	0	0	27. 00
28. 00	Chemotherapy	0	0	0	0	0	28. 00
29. 00	Other	0	0	0	0	0	29. 00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	o c	0	0	0	31.00
32. 00	Fundrai si ng		l o	0	0	0	32.00
33. 00	Other Program Costs		l o	o o	0	Ō	33. 00
34. 00	Total (sum of lines 1 thru 33) (2)		l o	o o	11, 374	Ō	34. 00
	Unit Cost Multiplier (see instructions)						35. 00
		1	•	•		•	

						11/23/2015 5:	05 pm
					Hospi ce I		
	·	CAPITAL REI	LATED COSTS				
	Cost Center Description	CONVENI ENCE	BUSHNELL	EMPLOYEE	Subtotal	ADMI NI STRATI VE	
		CARE CLINI	OFFICE BLDG	BENEFITS		& GENERAL	
				DEPARTMENT			
		1. 09	1. 10	4.00	4A	5. 00	
1.00	Administrative and General	0	(13, 47	78 24, 852	4, 392	1. 00
2.00	Inpatient - General Care	0	(0	0 24, 018	4, 245	2. 00
3.00	Inpatient - Respite Care	0	(0	0	0	3. 00
4.00	Physi ci an Servi ces	0	(26, 4	4 150, 543	26, 607	4. 00
5.00	Nursi ng Care	0	(75, 43	429, 909	75, 982	5. 00
6.00	Nursing Care-Continuous Home Care	0	(o	0	0	6. 00
7.00	Physi cal Therapy	0	(o	0 0	0	7. 00
8.00	Occupational Therapy	0	()	0 0	0	8. 00
9.00	Speech/ Language Pathology	0	(o l	0 0	0	9. 00
10.00	Medical Social Services	0	(10, 49	59, 836	10, 575	10.00
11.00	Spiritual Counseling	0	(o l	0 0	0	11. 00
12.00	Di etary Counsel i ng	0	(0 0	0	12. 00
13.00	Counseling - Other	0	(o	0 0	0	13.00
14.00	Home Health Aide and Homemaker	0	(12, 09	68, 953	12, 187	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0			0 0	0	15. 00
16.00	Other	0			0 0	0	16. 00
17.00	Drugs, Biological and Infusion Therapy	0		ol .	0 152, 962	27, 035	17. 00
18.00	Anal gesi cs	0		ol .	0 0	0	18. 00
19.00	Sedatives / Hypnotics	0		ol .	0 0	0	19. 00
20.00	Other - Specify	0	(o	0 0	0	20. 00
21.00	Durable Medical Equipment/Oxygen	0	(o	0 72, 412	12, 798	21. 00
22.00	Pati ent Transportation	0	(o	0 34, 472	6, 093	22. 00
23.00	I maging Services	0		ol .	0 0	0	23. 00
24.00	Labs and Diagnostics	0	(o	0 0	0	24. 00
25.00	Medical Supplies	0	(o	0 16, 447	2, 907	25. 00
26.00	Outpatient Services (including E/R Dept.)	0	(o	0 40, 920	7, 232	26. 00
27.00	Radi ati on Therapy	0	(o	0 0	0	27. 00
28.00	Chemotherapy	0	(o	0 0	0	28. 00
29.00	Other	0	(o	0 3, 417	604	29. 00
30.00	Bereavement Program Costs	0		1, 88	12, 802	2, 263	30. 00
31.00	Volunteer Program Costs	0	(o	0 0	0	31. 00
32.00	Fundrai si ng	0	(o	0 0	0	32. 00
33.00	Other Program Costs	0			0 140, 175	24, 775	33. 00
34.00	Total (sum of lines 1 thru 33) (2)	0	(139, 80	1, 231, 718	217, 695	34.00
35.00	Unit Cost Multiplier (see instructions)				0. 000000		35. 00

									11/23/2015 5: (05 pm_
								Hospi ce I		
	Cost Center Description							MAINTENANCE &	MAINTENANCE &	
		REPAI RS		REPAI RS-HSB	Т	REPAI RS-HSB	П	REPAI RS-REHAB	REPAIRS-MAB	
			\perp					CLI NI C		
		6.00	\perp	6. 01		6. 02		6. 03	6. 04	
1.00	Administrative and General		0		0		0	0	3, 168	1.00
2.00	Inpatient - General Care		0		0		0	0	0	2.00
3.00	Inpatient - Respite Care		0		0		0	0	0	3.00
4.00	Physi ci an Servi ces		0		0		0	0	0	4.00
5.00	Nursi ng Care		0		0		0	0	0	5.00
6.00	Nursing Care-Continuous Home Care		0		0		0	0	0	6.00
7.00	Physi cal Therapy		0		0		0	0	0	7.00
8.00	Occupational Therapy		0		0		0	0	0	8.00
9.00	Speech/ Language Pathology		0		0		0	0	0	9.00
10.00	Medical Social Services		0		0		0	0	0	10.00
11.00	Spiritual Counseling		0		0		0	0	0	11.00
12.00	Di etary Counsel i ng		0		0		0	0	0	12.00
13.00	Counseling - Other		0		0		0	0	0	13.00
14.00	Home Health Aide and Homemaker		0		0		0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care		0		0		0	0	0	15.00
16.00	Other		0		0		0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy		0		0		0	0	0	17.00
18. 00	Anal gesi cs		0		0		0	0	0	18.00
19.00	Sedatives / Hypnotics		0		0		0	0	0	19.00
20.00	Other - Specify		0		0		0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen		0		0		0	0	0	21.00
22. 00	Patient Transportation		0		0		0	0	0	22.00
23.00	I maging Services		0		0		0	0	0	23.00
24.00	Labs and Diagnostics		0		0		0	0	0	24.00
25.00	Medical Supplies		0		0		0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)		0		0		0	0	0	26.00
27.00	Radiation Therapy		0		0		0	0	0	27.00
28. 00	Chemotherapy		0		0		0	0	0	28.00
29.00	Other		0		o		0	0	0	29.00
30.00	Bereavement Program Costs		0		o		0	0	0	30.00
31.00	Volunteer Program Costs		0		o		0	0	0	31.00
32.00	Fundrai si ng		0		0		0	0	0	32.00
33.00	Other Program Costs		0		0		0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)		0		0		0	0	3, 168	34.00
35.00	Unit Cost Multiplier (see instructions)									35.00
		•							. '	

						11/23/2015 5:	05 pm
					Hospi ce I		<u> </u>
	Cost Center Description	MAINTENANCE &	MAINTENANCE &	LAUNDRY &	HOUSEKEEPI NG	HOUSEKEEPI NG-H	
		REPAIRS-ORTHO	REPAIRS-BUSHNE	LINEN SERVICE		SB	
		BLDG	LL				
		6. 05	6.06	8. 00	9. 00	9. 01	
1.00	Administrative and General	C	0) (0	0	1.00
2.00	Inpatient - General Care	C	0) (0	0	2.00
3.00	Inpatient - Respite Care	C	0) (0	0	3.00
4.00	Physi ci an Servi ces	C	0) (0	0	4. 00
5.00	Nursi ng Care	C	0	526	C	0	5. 00
6.00	Nursing Care-Continuous Home Care	C	0) (0	0	6.00
7.00	Physi cal Therapy	C	0) (0	0	7. 00
8.00	Occupational Therapy	C	0) (0	0	8. 00
9.00	Speech/ Language Pathology	C	0) (0	0	9. 00
10.00	Medical Social Services	C	0) (0	0	10.00
11.00	Spiritual Counseling	C	0) (0	0	11.00
12.00	Di etary Counsel i ng	C	0) (0	0	12.00
13.00	Counseling - Other	C	0) (0	0	13.00
14.00	Home Health Aide and Homemaker	C	0) (0	0	14.00
15. 00	HH Aide & Homemaker - Cont. Home Care	C	0) (C	0	15. 00
16.00	Other	C	0) (C	0	16.00
17. 00	Drugs, Biological and Infusion Therapy	C	0) (0	0	17.00
18. 00	Anal gesi cs	C	0) (0	0	18. 00
19. 00	Sedatives / Hypnotics	C	0) (0	0	19.00
20.00	Other - Specify	C	0) (0	0	20.00
	Durable Medical Equipment/Oxygen	C) 0) () C	0	21. 00
22. 00	Patient Transportation	C) 0) () C	0	22. 00
23. 00		C) 0) () C	0	23. 00
	Labs and Diagnostics	C) 0) () C	0	24.00
25. 00	Medical Supplies	C) 0) () C	0	25. 00
26. 00	Outpatient Services (including E/R Dept.)	C) 0) () C	0	26. 00
27. 00	Radiation Therapy	C) 0) () C	0	27. 00
28. 00	Chemotherapy	C) 0) () C	0	28. 00
29. 00	Other	C	0) (0	0	29. 00
	Bereavement Program Costs	C) 0) () C	0	30.00
31. 00	Volunteer Program Costs	C) 0) () C	0	31.00
32.00	Fundrai si ng	C	0) () C	0	32.00
33.00	Other Program Costs	C	0) () C	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	C) 0	526	C	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35. 00

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

						11/23/2015 5: 0	05 pm
					Hospi ce I		
	Cost Center Description	HOUSEKEEPI NG-H	HOUSEKEEPI NG-C	HOUSEKEEPI NG-M	DI ETARY	CAFETERI A	
		SB II	RTH0	AB			
		9. 02	9. 03	9. 04	10.00	11. 00	
1.00	Administrative and General	0	C	1, 131	0	1, 272	1. 00
2.00	Inpatient - General Care	0	C	0	0	0	2. 00
3.00	Inpatient - Respite Care	0	C	0	0	0	3. 00
4.00	Physician Services	0	C	0	0	690	4. 00
5.00	Nursing Care	0	C	0	0	9, 619	5. 00
6.00	Nursing Care-Continuous Home Care	0	C	0	0	0	6. 00
7.00	Physi cal Therapy	0	C	0	0	0	7. 00
8.00	Occupational Therapy	0	C	0	0	0	8. 00
9.00	Speech/ Language Pathology	0	C	0	0	0	9. 00
10.00	Medical Social Services	0	C	0	0	1, 682	10.00
11. 00	Spiritual Counseling	0	C	0	0	0	11. 00
12.00	Di etary Counseling	0	C	0	0	0	12.00
13.00	Counseling - Other	0	C	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	C	0	0	3, 731	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	C	0	0	0	15.00
16.00	Other	0	C	0	0	0	16.00
17. 00	Drugs, Biological and Infusion Therapy	0	C	0	0	0	17. 00
18.00	Anal gesi cs	0	C	0	0	0	18.00
19. 00	Sedatives / Hypnotics	0	C	0	0	0	19.00
20.00	Other - Specify	0	C	0	0	0	20.00
21. 00	Durable Medical Equipment/Oxygen	0	C	0	0	0	21. 00
22. 00	Patient Transportation	0	C	0	0	0	22. 00
23.00	I maging Services	0	C	0	0	0	23. 00
24.00	Labs and Diagnostics	0	C	0	0	0	24. 00
25.00	Medical Supplies	0	C	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	C	0	0	0	26. 00
27. 00	Radiation Therapy	0	C	0	0	0	27. 00
28. 00	Chemotherapy	0	C	0	0	0	28. 00
29. 00	Other	0	C	0	0	0	29. 00
30.00	Bereavement Program Costs	0	C	0	0	259	30.00
31. 00	Volunteer Program Costs	0	C	0	0	0	31. 00
32.00	Fundrai si ng	0	C	0	0	0	32.00
33. 00	Other Program Costs	0	C	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	C	1, 131	0	17, 253	34.00
35. 00	Unit Cost Multiplier (see instructions)						35. 00

 Heal th Financial
 Systems
 MCDONOUGH

 ALLOCATION OF GENERAL SERVICE
 COSTS TO HOSPICE
 COST CENTERS

						11/23/2015 5:	05 pm
					Hospi ce I		
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
		ADMI NI STRATI ON	SERVICES &		RECORDS &		
			SUPPLY		LI BRARY		
		13.00	14. 00	15. 00	16. 00	17. 00	
1.00	Administrative and General	0	0		0	0	1. 00
2.00	Inpatient - General Care	0	0		0	0	2. 00
3.00	Inpatient - Respite Care	0	0		0	0	3. 00
4.00	Physi ci an Servi ces	0	0		0 (0	4. 00
5.00	Nursing Care	0	4, 307		0 (0	5. 00
6.00	Nursing Care-Continuous Home Care	0	0		0 (0	6. 00
7.00	Physi cal Therapy	0	0		0 (0	7. 00
8.00	Occupational Therapy	0	0		0 (0	8. 00
9.00	Speech/ Language Pathology	0	0		0 (0	9. 00
10. 00	Medical Social Services	0	0		0	0	10.00
11. 00	Spiritual Counseling	0	0		0	0	11. 00
12.00	Di etary Counseling	0	0		0 (0	12. 00
13. 00	Counseling - Other	0	0		0	0	13.00
14. 00	Home Health Aide and Homemaker	0	0		0	0	14. 00
15. 00	HH Aide & Homemaker - Cont. Home Care	0	0		0	0	15. 00
16. 00	Other	0	0		0 (0	16. 00
17. 00	Drugs, Biological and Infusion Therapy	0	0		0	0	17. 00
18. 00	Anal gesi cs	0	0		0	0	18. 00
19. 00	Sedatives / Hypnotics	0	0		0	0	19. 00
	Other - Specify	0	0		0	0	20. 00
	Durable Medical Equipment/Oxygen	0	0		0	0	21. 00
	Patient Transportation	0	0		0	0	22. 00
	I maging Services	0	0		0 (0	23. 00
24. 00	Labs and Diagnostics	0	0		0	0	24. 00
25. 00	Medical Supplies	0	0		0	0	25. 00
26. 00	Outpatient Services (including E/R Dept.)	0	0		0	0	26. 00
27. 00	Radiation Therapy	0	0		0	0	27. 00
28. 00	Chemotherapy	0	0		0 (0	28. 00
29. 00	Other	0	0		0	0	29. 00
30.00	Bereavement Program Costs	0	0		0	0	30. 00
	Volunteer Program Costs	0	0		0	0	31. 00
	Fundrai si ng	0	0		0 (0	32. 00
33. 00	Other Program Costs	0	0		0 (0	33. 00
	Total (sum of lines 1 thru 33) (2)	0	4, 307		0 (0	34. 00
35. 00	Unit Cost Multiplier (see instructions)						35. 00

 Heal th Financial
 Systems
 MCDONOUGH

 ALLOCATION OF GENERAL SERVICE
 COSTS TO HOSPICE
 COST CENTERS

						11/23/2015 5:	05 pm
					Hospi ce I		
	Cost Center Description	NONPHYSI CI AN	PARAMED ED	Subtotal	Intern &	Subtotal	
		ANESTHETI STS	PRGM	(col s. 4A-23)	Residents Cost	(cols. 24 ±	
					& Post	25)	
					Stepdown		
					Adjustments		
		19. 00	23. 00	24.00	25.00	26. 00	
1.00	Administrative and General	0	0	34, 815			1. 00
2.00	Inpatient - General Care	0	0	28, 263	0	28, 263	2. 00
3.00	Inpatient - Respite Care	0	0	0	0	0	3. 00
4.00	Physi ci an Servi ces	0	0	177, 840	0	177, 840	4. 00
5.00	Nursi ng Care	0	0	520, 343	0	520, 343	5. 00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6. 00
7.00	Physi cal Therapy	0	0	0	0	0	7. 00
8.00	Occupational Therapy	0	0	0	0	0	8. 00
9.00	Speech/ Language Pathology	0	0	0	0	0	9. 00
10.00	Medical Social Services	0	0	72, 093	0	72, 093	10.00
11. 00	Spiritual Counseling	0	0	0	0	0	11. 00
12.00	Di etary Counseling	0	0	0	0	0	12. 00
13.00	Counseling - Other	0	0	0	0	0	13. 00
14.00	Home Health Aide and Homemaker	0	0	84, 871	0	84, 871	14. 00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15. 00
16.00	Other	0	0	0	0	0	16. 00
17. 00	Drugs, Biological and Infusion Therapy	0	0	179, 997	0	179, 997	17. 00
18. 00	Anal gesi cs	0	0	0	0	0	18. 00
19. 00	Sedatives / Hypnotics	0	0	0	0	0	19. 00
20.00	Other - Specify	0	0	0	0	0	
21. 00	Durable Medical Equipment/Oxygen	0	0	85, 210	0	85, 210	
22. 00	Pati ent Transportation	0	0	40, 565	0	40, 565	22. 00
23. 00	I maging Services	0	0	0	0	0	23. 00
24. 00	Labs and Diagnostics	0	0	0	0	0	
25. 00	Medical Supplies	0	0	19, 354		19, 354	1
26. 00	Outpatient Services (including E/R Dept.)	0	0	48, 152	0	48, 152	1
27. 00	Radiation Therapy	0	0	0	0	0	27. 00
28. 00	Chemotherapy	0	0	0	0	0	28. 00
29. 00	Other	0	0	4, 021		4, 021	29. 00
30.00	Bereavement Program Costs	0	0	15, 324	0	15, 324	
31. 00	Volunteer Program Costs	0	0	0	0	0	31. 00
32.00	Fundrai si ng	0	0	0	0	0	32. 00
33.00	Other Program Costs	0	0	164, 950		164, 950	1
34.00	Total (sum of lines 1 thru 33) (2)	0	0	1, 475, 798	0	1, 475, 798	
35. 00	Unit Cost Multiplier (see instructions)						35. 00

Hospi ce CCN:

						11/23/2015 5:	US PIII
	,				Hospi ce I		
	Cost Center Description	Allocated	Total Hospice				
		Hospi ce A&G	Costs (cols.				
		(See Part II)	26 ± 27)				
		27. 00	28. 00				
1.00	Administrative and General						1.00
2.00	Inpatient - General Care	683	28, 94	5			2. 00
3.00	Inpatient - Respite Care	0	()			3. 00
4.00	Physi ci an Servi ces	4, 297	182, 13	7			4. 00
5.00	Nursing Care	12, 571	532, 91	1			5. 00
6.00	Nursing Care-Continuous Home Care	0					6. 00
7.00	Physi cal Therapy	0					7. 00
8.00	Occupational Therapy	0	(8. 00
9.00	Speech/ Language Pathology	0	(9. 00
10.00	Medical Social Services	1, 742	73, 83	5			10.00
11. 00	Spiritual Counseling	0					11. 00
12.00	Di etary Counsel i ng	0					12. 00
13.00	Counseling - Other	0					13.00
14.00	Home Health Aide and Homemaker	2, 051	86, 92	2			14. 00
15.00	HH Aide & Homemaker - Cont. Home Care	0	(15. 00
16.00	Other	0					16.00
17.00	Drugs, Biological and Infusion Therapy	4, 349	184, 34	5			17. 00
18.00	Anal gesi cs	0					18. 00
19.00	Sedatives / Hypnotics	0					19. 00
20.00	Other - Specify	0					20.00
21. 00	Durable Medical Equipment/Oxygen	2,059	87, 269	9			21. 00
22. 00	Patient Transportation	980	41, 54	5			22. 00
23.00	I maging Services	0	l .				23. 00
24.00	Labs and Diagnostics	0					24. 00
25.00	Medical Supplies	468	19, 82	2			25. 00
26.00	Outpatient Services (including E/R Dept.)	1, 163	49, 31!	5			26. 00
27.00	Radi ati on Therapy	0					27. 00
28. 00	Chemotherapy	0					28. 00
29. 00	Other	97	4, 118	3			29. 00
30. 00	Bereavement Program Costs	370					30.00
31. 00	Volunteer Program Costs	0					31. 00
32. 00	Fundrai si ng						32. 00
33. 00	Other Program Costs	3, 985	168, 93!	5			33. 00
34. 00	Total (sum of lines 1 thru 33) (2)		1, 475, 798	1			34. 00
	Unit Cost Multiplier (see instructions)	0. 024161					35. 00
55.50	1 (000 (000)	3. 32 1101	1	1			, 50.00

Hospi ce CCN: 141524 Hospi ce I CAPITAL RELATED COSTS

	Cost Center Description	NEW BLDG &	CAP REL	CAP REL	CAP REL	CAP REL	
			COSTS-HOSPI TAL	COSTS-HSB I	COSTS-HSB II	COSTS-REHAB	
		(SQUARE		(SQUARE	(SQUARE	CNT	
		FEET)	(SQUARE	FEET)	FEET)	(PER	
			FEET)			CENT)	
	T	1. 00	1. 01	1. 02	1. 03	1. 04	
1.00	Administrative and General	0	0	0	0	0	1. 00
2.00	Inpatient - General Care	0	0	0	0	0	2. 00
3.00	Inpatient - Respite Care	0	0	0	0	0	3. 00
4.00	Physi ci an Servi ces	0	0	0	0	0	4. 00
5.00	Nursing Care	0	0	0	0	0	5. 00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6. 00
7.00	Physi cal Therapy	0	0	0	0	0	7. 00
8.00	Occupational Therapy	0	0	0	0	0	8. 00
9.00	Speech/ Language Pathology	0	0	0	0	0	9. 00
10.00	Medical Social Services	0	0	0	0	0	10.00
11. 00	Spiritual Counseling	0	0	0	0	0	11. 00
12.00	Di etary Counsel i ng	0	0	0	0	0	12. 00
13.00	Counseling - Other	0	0	0	0	0	13. 00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14. 00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15. 00
16.00	Other	0	0	0	0	0	16. 00
17. 00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17. 00
18. 00	Anal gesi cs	0	0	0	0	0	18. 00
19. 00	Sedatives / Hypnotics	0	0	0	0	0	19. 00
20.00	Other - Specify	0	0	0	0	0	20. 00
21. 00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21. 00
22. 00	Pati ent Transportation	0	0	0	0	0	22. 00
23. 00	I maging Services	0	0	0	0	0	23. 00
24. 00	Labs and Diagnostics	0	0	0	0	0	24. 00
25.00	Medical Supplies	0	0	0	0	0	25. 00
26. 00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26. 00
27. 00	Radiation Therapy	0	0	0	0	0	27. 00
28. 00	Chemotherapy	0	0	0	0	0	28. 00
29. 00	Other	0	0	0	0	0	29. 00
30.00	Bereavement Program Costs	0	0	0	0	0	30. 00
31.00	Volunteer Program Costs	0	0	0	0	0	31. 00
32.00	Fundrai si ng	0	0	0	0	0	32. 00
33.00	Other Program Costs	0	0	0	0	0	33. 00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	0	0	0	34.00
35.00	Total cost to be allocated	0	0	0	0	0	35. 00
36. 00	Unit Cost Multiplier (see instructions)	0. 000000	0. 000000	0. 000000	0. 000000	0. 000000	36. 00

Hospi ce CCN: 141524

					Hospi ce I		
	·		CAP	ITAL RELATED CO	OSTS		
	Cost Center Description	CAP REL	CAP REL	CAP REL	CAP REL	CONVENI ENCE	
		COSTS-DI AYSI S	COSTS-HOSPI TAL	COSTS-MAB	COSTS-ORTHO	CARE CLINI	
		(PER	ITY HOUSE	(SQUARE	BLDG	(PER	
		CENT)	(PER	FEET)	(SQUARE	CENT)	
			CENT)		FEET)		
		1. 05	1. 06	1. 07	1. 08	1. 09	
1.00	Administrative and General	0	0	1, 054	0	0	
2.00	Inpatient - General Care	0	0	0	0	0	
3.00	Inpatient - Respite Care	0	0	0	0	0	
4.00	Physici an Services	0	0	0	0	0	4. 00
5.00	Nursing Care	0	0	0	0	0	
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	
7.00	Physi cal Therapy	0	0	0	0	0	
8.00	Occupational Therapy	0	0	0	0	0	
9.00	Speech/ Language Pathology	0	0	0	0	0	
10.00	Medical Social Services	0	0	0	0	0	
11. 00	Spiritual Counseling	0	0	0	0	0	
12.00	Dietary Counseling	0	0	0	0	0	
13.00	Counseling - Other	0	0	0	0	0	
14. 00	Home Health Aide and Homemaker	0	0	0	0	0	
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	
16.00	0ther	0	0	0	0	0	
17. 00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	
18. 00	Anal gesi cs	0	0	0	0	0	1
19. 00	Sedatives / Hypnotics	0	0	0	0	0	
20. 00	Other - Specify	0	0	0	0	0	
21. 00	Durable Medical Equipment/Oxygen	0	0	0	0	0	
22. 00	Patient Transportation	0	0	0	0	0	
23. 00	I maging Services	0	0	0	0	0	
24.00	Labs and Diagnostics	0	0	0	0	0	
25. 00	Medical Supplies	0	0	0	0	0	
26. 00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	
27. 00	Radi ati on Therapy	0	0	0	0	0	•
28. 00	Chemotherapy	0	0	0	0	0	
29. 00	Other	0	0	0	0	0	
30.00	Bereavement Program Costs	0	0	0	0	0	
31.00	Volunteer Program Costs	0	0	0	0	0	
32. 00	Fundrai si ng	0	0	0	0	0	
33.00	Other Program Costs	0	0	0	0	0	33. 00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	1, 054		0	
35.00	Total cost to be allocated	0	0	11, 374		0	
36.00	Unit Cost Multiplier (see instructions)	0. 000000	0. 000000	10. 791271	0.000000	0. 000000	36. 00

						11/23/2015 5: (05 pm_
					Hospi ce I		
		CAPI TAL					
		RELATED COSTS					
	Cost Center Description	BUSHNELL	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	MAINTENANCE &	
		OFFICE BLDG	BENEFITS		& GENERAL	REPAI RS	
		(SQUARE	DEPARTMENT		(ACCUM.	(SQUARE	
		FEET)	(GROSS		COST)	FEET)	
			SALARI ES)				
		1. 10	4. 00	5A	5. 00	6. 00	
1. 00	Administrative and General	0	57, 848	3 C	2.,002		1. 00
2.00	Inpatient - General Care	0	C) C	24, 018		2. 00
3.00	Inpatient - Respite Care	0	C) C	0	0	3. 00
4.00	Physi ci an Servi ces	0	113, 372		150, 543		4. 00
5.00	Nursing Care	0	323, 759	P) C	429, 909		5. 00
6.00	Nursing Care-Continuous Home Care	0	C) C	0	0	6. 00
7.00	Physi cal Therapy	0	C) C	0	0	7. 00
8.00	Occupational Therapy	0	C) C	0	0	8. 00
9.00	Speech/ Language Pathology	0	C) C	0	0	9. 00
10.00	Medical Social Services	0	45, 062	2 C	59, 836		10.00
11. 00	Spiritual Counseling	0	C) C	0	0	11. 00
12. 00	Di etary Counseling	0	C) C	0	0	12. 00
13.00	Counseling - Other	0	C) c	0	0	13. 00
14. 00	Home Health Aide and Homemaker	0	51, 928	3 C	68, 953		14. 00
15. 00	HH Aide & Homemaker - Cont. Home Care	0	C) C	0	0	15. 00
16.00	Other	0	C) c	0	0	16. 00
17. 00	Drugs, Biological and Infusion Therapy	0	C) c	152, 962	0	17. 00
18.00	Anal gesi cs	0	C) c	0	0	18. 00
19. 00	Sedatives / Hypnotics	0	C) C	0	0	19. 00
20.00	Other - Specify	0	C) C	0	0	20. 00
21. 00	Durable Medical Equipment/Oxygen	0	C) C	72, 412		21. 00
22. 00	Patient Transportation	0	C) C	34, 472		22. 00
23. 00	I maging Services	0	C) c	0	0	23. 00
24.00	Labs and Diagnostics	0	C) C	0	0	24. 00
25. 00	Medical Supplies	0	C) C	16, 447		25. 00
26.00	Outpatient Services (including E/R Dept.)	0	C) c	40, 920	0	26. 00
27. 00	Radi ati on Therapy	0	C) c	0	0	27. 00
28. 00	Chemotherapy	0	C) c	0	0	28. 00
29. 00	0ther	0	C) c	3, 417	0	29. 00
30.00	Bereavement Program Costs	0	8, 079	ol c	12, 802	0	30. 00
31. 00	Volunteer Program Costs	0	C) C	0	0	31. 00
32.00	Fundrai si ng	0	C) c	0	0	32. 00
33.00	Other Program Costs	0	C) c	140, 175	0	33. 00
34.00	Total (sum of lines 1 thru 33) (2)	0	600, 048	3	1, 231, 718	0	34. 00
35.00	Total cost to be allocated	0	139, 802		217, 695		35. 00
36.00	Unit Cost Multiplier (see instructions)	0. 000000	0. 232985	5	0. 176741	0.000000	36. 00

								11/23/2015 5:	05 pm_
							Hospi ce I		
	Cost Center Description	MAINTENANCE &	MAIN	TENANCE	&	MAINTENANCE &	MAINTENANCE &	MAINTENANCE &	
	·	REPAIRS-HSB I	REPAI	RS-HSB	П	REPAIRS-REHAB	REPAI RS-MAB	REPAI RS-ORTHO	
		(SQUARE				CLINIC	(SQUARE	BLDG	
		FEET)		SQUARE		(PER	FEET)	(SQUARE	
				FEET)		CENT)		FEET)	
		6. 01		6. 02		6. 03	6. 04	6. 05	
1.00	Administrative and General	C			0	C	1, 054	0	1. 00
2.00	Inpatient - General Care	(c			0	C	0	0	2.00
3.00	Inpatient - Respite Care	(c			0	C	0	0	3.00
4.00	Physician Services	(c			0	C	0	0	4.00
5.00	Nursi ng Care	(c			0	C	0	0	5. 00
6.00	Nursing Care-Continuous Home Care	(c			0	C	0	0	6. 00
7.00	Physical Therapy				0	Ö	0	0	7. 00
8.00	Occupational Therapy				0	Ö	0	0	8. 00
9.00	Speech/ Language Pathology				0	Ö	0	0	9. 00
10.00	Medical Social Services				0	Ö	0	0	10.00
11. 00	Spiritual Counseling				0	Ö	0	0	11. 00
12.00	Di etary Counsel i ng		ol		0	C	0	0	12.00
13.00	Counseling - Other				0	C	0	0	13.00
14.00	Home Health Aide and Homemaker				0	Ö	0	0	14. 00
15. 00	HH Aide & Homemaker - Cont. Home Care		ol		0	C	0	0	15. 00
16. 00	Other		ol		0	C	0	0	16. 00
17. 00	Drugs, Biological and Infusion Therapy		ol		0	C	0	0	17. 00
18.00	Anal gesi cs				0	Ö	0	0	18. 00
19.00	Sedatives / Hypnotics				0	Ö	0	0	19. 00
20.00	Other - Specify	c			0	C	0	0	20.00
21. 00	Durable Medical Equipment/Oxygen	(c			0	C	0	0	21. 00
22. 00	Patient Transportation	(c			0	C	0	0	22. 00
23.00	I maging Services	(0	C	0	0	23. 00
24.00	Labs and Diagnostics	(c			0	C	0	0	24.00
25.00	Medical Supplies	(0	C	0	0	25. 00
26.00	Outpatient Services (including E/R Dept.)	(c			0	C	0	0	26.00
27.00	Radi ati on Therapy	(c			0	C	0	0	27. 00
28.00	Chemotherapy	(c			0	C	0	0	28. 00
29.00	Other	(c			0	C	0	0	29. 00
30.00	Bereavement Program Costs	(c			0	C	0	0	30.00
31.00	Volunteer Program Costs	(c			0	C	0	0	31.00
32.00	Fundrai si ng	(c			0	C	0	0	32.00
33.00	Other Program Costs				0	Ö	0	0	33. 00
34.00	Total (sum of lines 1 thru 33) (2)				0	C	1, 054	0	34.00
35.00	Total cost to be allocated	()		0	C	3, 168	0	35. 00
36.00	Unit Cost Multiplier (see instructions)	0. 000000	o	0. 0000	000	0.000000	3. 005693	0. 000000	36. 00

	11/23/2015 5: 05 pm
	Hospi ce I
Cost Center Description MAINTENANCE & LAUNDRY & HOUSEKEEPING HO	IOUSEKEEPI NG-H HOUSEKEEPI NG-H
REPAIRS-BUSHNE LINEN SERVICE (TIME	SB SB II
LL (POUNDS OF SPENT)	(SQUARE (SQUARE
(SQUARE LINEN)	FEET) FEET)
FEET)	
6.06 8.00 9.00	9. 01 9. 02
1.00 Administrative and General 0 0 0	0 0 1.00
2.00 Inpatient - General Care 0 0 0	0 0 2.00
3.00 Inpatient - Respite Care 0 0 0	0 0 3.00
4.00 Physician Services 0 0 0	0 0 4.00
5.00 Nursi ng Care 0 251 0	0 0 5.00
6.00 Nursing Care-Continuous Home Care 0 0 0	0 0 6.00
7.00 Physical Therapy 0 0 0	0 0 7.00
8.00 Occupational Therapy 0 0 0	0 0 8.00
9.00 Speech/ Language Pathology 0 0 0	0 9.00
10.00 Medical Social Services 0 0 0	0 0 10.00
11.00 Spiritual Counseling 0 0 0	0 0 11.00
12.00 Dietary Counseling 0 0 0	0 0 12.00
13. 00 Counseling - Other 0 0 0	0 0 13.00
14.00 Home Health Aide and Homemaker 0 0 0	0 0 14.00
15.00 HH Aide & Homemaker - Cont. Home Care 0 0 0	0 0 15.00
16.00 Other 0 0 0	0 0 16.00
17.00 Drugs, Biological and Infusion Therapy 0 0 0	0 0 17.00
18. 00 Anal gesi cs 0 0 0	0 0 18.00
19.00 Sedatives / Hypnotics 0 0 0	0 0 19.00
20. 00 Other - Specify 0 0 0	0 0 20.00
21.00 Durable Medical Equipment/Oxygen 0 0 0	0 0 21.00
22.00 Patient Transportation 0 0 0	0 0 22.00
23.00 Imaging Services 0 0 0	0 0 23.00
24.00 Labs and Diagnostics 0 0 0	0 0 24.00
25. 00 Medical Supplies 0 0	0 0 25.00
26.00 Outpatient Services (including E/R Dept.) 0 0 0	0 0 26.00
27.00 Radiation Therapy 0 0 0	0 0 27.00
28.00 Chemotherapy 0 0 0	0 28.00
29.00 Other 0 0 0	0 0 29.00
30.00 Bereavement Program Costs 0 0	0 0 30.00
31.00 Volunteer Program Costs 0 0	0 0 31.00
32.00 Fundrai si ng 0 0 0	0 0 32.00
33.00 Other Program Costs 0 0 0	0 0 33.00
34.00 Total (sum of lines 1 thru 33) (2) 0 251 0	0 0 34.00
35.00 Total cost to be allocated 0 526 0	0 0 35.00
36.00 Unit Cost Multiplier (see instructions) 0.000000 2.095618 0.000000	0.000000 0.000000 36.00

			1.000	70111		11/23/2015 5: 0	05 pm
					Hospi ce I		
	Cost Center Description	HOUSEKEEPI NG-OF	IOUSEKEEPI NG-M	DI ETARY	CAFETERI A	NURSI NG	
	·	RTH0	AB	(MEALS	(FTE' S)	ADMI NI STRATI ON	
		(SQUARE	(SQUARE	SERVED)			
		FEET)	FEET)	,		(DI RECT	
						NRSING HRS)	
		9. 03	9. 04	10.00	11.00	13.00	
1.00	Administrative and General	0	1, 054		0 59	0	1. 00
2.00	Inpatient - General Care	0	0)	0	0	2. 00
3.00	Inpatient - Respite Care	0	0)	0	0	3. 00
4.00	Physi ci an Servi ces	0	0)	0 32	. 0	4. 00
5.00	Nursing Care	0	0)	0 446	0	5. 00
6.00	Nursing Care-Continuous Home Care	O	0		0	0	6. 00
7.00	Physi cal Therapy	0	0)	0	0	7. 00
8.00	Occupational Therapy	0	0)	0	0	8. 00
9.00	Speech/ Language Pathology	0	0)	0	0	9. 00
10.00	Medical Social Services	0	0)	0 78	0	10.00
11.00	Spiritual Counseling	0	0)	0	0	11. 00
12.00	Di etary Counsel i ng	0	0)	0	0	12.00
13.00	Counseling - Other	0	0)	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0)	0 173	0	14. 00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0)	0	0	15. 00
16.00	Other	0	0)	0	0	16. 00
17. 00	Drugs, Biological and Infusion Therapy	0	0		0	0	17. 00
18. 00	Anal gesi cs	0	0)	0	0	18. 00
19.00	Sedatives / Hypnotics	0	0		0	0	19. 00
20.00	Other - Specify	0	0)	0	0	20. 00
21.00	Durable Medical Equipment/Oxygen	0	0)	0	0	21. 00
22. 00	Pati ent Transportation	0	0)	0	0	22. 00
23.00	I maging Services	0	0)	0	0	23. 00
24.00	Labs and Diagnostics	0	0)	0	0	24. 00
25.00	Medi cal Supplies	0	0	1	0	0	25. 00
26.00	Outpatient Services (including E/R Dept.)	0	0	1	0	0	26. 00
27.00	Radi ati on Therapy	0	0	1	0	0	27. 00
28. 00	Chemotherapy	0	0		0	0	28. 00
29. 00	0ther	0	0)	0	0	29. 00
30.00	Bereavement Program Costs	0	0)	0 12	0	30. 00
31.00	Volunteer Program Costs	0	0)	0	0	31. 00
32.00	Fundrai si ng	0	0		0	0	32. 00
33.00	Other Program Costs	0	0		0	0	33. 00
34.00	Total (sum of lines 1 thru 33) (2)	0	1, 054		0 800		34. 00
35.00	Total cost to be allocated	0	1, 131		0 17, 253	0	35. 00
36.00	Unit Cost Multiplier (see instructions)	0. 000000	1. 073055	0.00000	0 21. 566250	0.000000	36. 00

			·			11/23/2015 5:	05 pm
					Hospi ce I		
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	NONPHYSI CI AN	
		SERVICES &	(COSTED	RECORDS &		ANESTHETI STS	
		SUPPLY	REQUIS.)	LI BRARY	(TIME	(ASSI GNED	
		(COSTED		(TIME	SPENT)	TIME)	
		REQUIS.)		SPENT)			
		14.00	15. 00	16.00	17. 00	19. 00	
1.00	Administrative and General	0	0		0	0	1. 00
2.00	Inpatient - General Care	0	0)	0	0	2. 00
3.00	Inpatient - Respite Care	0	0		0	0	3. 00
4.00	Physi ci an Servi ces	0	0)	0	0	4. 00
5.00	Nursing Care	13, 248	0)	0	0	5. 00
6.00	Nursing Care-Continuous Home Care	O	0)	0	0	6. 00
7.00	Physical Therapy	o	0		0	0	7. 00
8.00	Occupational Therapy	o	0	1	0	0	8. 00
9.00	Speech/ Language Pathology	0	0)	0	0	9. 00
10.00	Medical Social Services	0	0)	0	0	10.00
11.00	Spiritual Counseling	0	0	,	0	0	11. 00
12.00	Di etary Counseling	o	0		0	0	12.00
13.00	Counseling - Other	o	0		0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	,	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	o	0	,	o o	0	15. 00
16. 00	Other	o	0	,	0	0	16. 00
17. 00	Drugs, Biological and Infusion Therapy	o	0	,	0	0	17. 00
18. 00	Anal gesi cs	o	0	,	0	0	18. 00
19.00	Sedatives / Hypnotics	o	0	,	0	0	19. 00
20.00	Other - Specify	o	0	,	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	o	0	,	0	0	21. 00
22. 00	Pati ent Transportation	o	0	,	0	0	22. 00
23.00	I maging Services	o	0	1	0	0	23. 00
24.00	Labs and Diagnostics	o	0	1	0	0	24. 00
25.00	Medical Supplies	o	0	1	0	0	25. 00
26.00	Outpatient Services (including E/R Dept.)	o	0	1	0	0	26. 00
27.00	Radiation Therapy	o	0	1	0	0	27. 00
28.00	Chemotherapy	o	0	1	0	0	28. 00
29.00	Other	o	0	1	0	0	29. 00
30.00	Bereavement Program Costs	o	0	1	0	0	30.00
31.00	Volunteer Program Costs	o	0	1	0	0	31.00
32.00	Fundrai si ng	0	0)	0	0	32. 00
33.00	Other Program Costs	0	0)	0	0	33. 00
34.00	Total (sum of lines 1 thru 33) (2)	13, 248	0		0	0	34. 00
35.00	Total cost to be allocated	4, 307	0		0	0	35. 00
36.00	Unit Cost Multiplier (see instructions)	0. 325106	0. 000000	0.00000	0. 000000	0. 000000	36. 00
24. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00	Labs and Diagnostics Medical Supplies Outpatient Services (including E/R Dept.) Radiation Therapy Chemotherapy Other Bereavement Program Costs Volunteer Program Costs Fundraising Other Program Costs Total (sum of lines 1 thru 33) (2) Total cost to be allocated	4, 307	0 0 0 0 0 0 0 0 0 0 0 0	0.00000		0 0 0 0 0 0 0 0	24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00

Health Financial Systems	MCDONOUGH DISTRICT	HOSPI TAL		In Lie	u of Form CMS-2552-10
ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COSTATISTICAL BASIS	OST CENTERS	Provider CCN:	140089 141524	From 07/01/2014	Worksheet K-5 Part II Date/Time Prepared:

Cost Center Description PARAMED ED PRGM (ASSIGNED TIME) Hospice I Hospice I	1.00
PRGM (ASSI GNED TI ME)	2. 00
(ASSI GNED TI ME)	2. 00
TIME)	2. 00
	2. 00
	2. 00
23.00	2. 00
1.00 Administrative and General 0	
2.00 Inpatient - General Care 0	
3.00 Inpatient - Respite Care 0	3.00
4.00 Physician Services 0	4.00
5.00 Nursing Care 0	5.00
6.00 Nursing Care-Continuous Home Care 0	6.00
	7.00
8.00 Occupational Therapy 0	8.00
9.00 Speech/ Language Pathology 0	9.00
10. 00 Medical Social Services 0	0.00
11. 00 Spi ri tual Counsel i ng 0	1.00
12.00 Dietary Counseling 0	2.00
	3.00
	4.00
	5.00
16. 00 Other 0	6.00
17. 00 Drugs, Biological and Infusion Therapy 0	7.00
	8. 00
19.00 Sedatives / Hypnotics 0	9.00
	20. 00
	21. 00
22.00 Patient Transportation 0	22. 00
	23. 00
	24. 00
	25. 00
	26. 00
	27. 00
	28. 00
	29. 00
30.00 Bereavement Program Costs 0	30. 00
	31. 00
	32. 00
	3. 00
	34. 00
	35. 00
36.00 Unit Cost Multiplier (see instructions) 0.000000 36	86. 00

Heal th	Financial Systems	MCDONOUGH DISTRICT	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUT	TATION OF TOTAL HOSPICE SHARED COSTS		Provi der	CCN: 140089	Peri od:	Worksheet K-5	
			Hospi ce (CCN: 141524	From 07/01/2014 To 06/30/2015	Part III Date/Time Pre	narod:
			nospi ce i	JCN. 141324	10 00/30/2013	11/23/2015 5:	
				_	Hospi ce I		
	Cost Center Description			Cost to Char		Hospi ce Shared	
		Ι,	col . 11	Ratio	Charges	Ancillary	
			line			Costs (cols. 1	
					Records)	x 2)	
			0	1.00	2. 00	3. 00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSI CAL THERAPY		66.00	•		0	1
2.00	OCCUPATI ONAL THERAPY		67. 00	•		0	
3.00	SPEECH PATHOLOGY		68. 00	•		0	
4.00	DRUGS CHARGED TO PATIENTS		73. 00	•	99 0	0	1
5.00	DURABLE MEDICAL EQUIP-RENTED		96.00	•			5. 00
6.00	LABORATORY		60.00	•	91 0	0	6. 00
6. 01	BLOOD LABORATORY		60. 01	•			6. 01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		71. 00	•	05 0	0	
8.00	OTHER OUTPATIENT SERVICE COST CENTER		93.00	•			8. 00
9.00	RADI OLOGY-THERAPEUTI C		55.00	•			9. 00
10.00	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		76.00	0. 8718	98 0	0	10. 00
10. 01	DI ABETES/WOUND CARE/COUMADIN CNTR		76. 01	1. 1330	48 0	0	10. 01
10. 02	FLU CLINIC		76. 02	3. 6152	90 0	0	10. 02
11. 00	Totals (sum of lines 1-10)			[0	11. 00

Health Financial Systems M	CDONOUGH DISTE	RICT HOSPITAL		In Lie	u of Form CMS-2	2552-10
CALCULATION OF HOSPICE PER DIEM COST		Provi der	CCN: 140089	Peri od:	Worksheet K-6	
		Hospi ce (CCN: 141524	From 07/01/2014 To 06/30/2015	Date/Time Prep 11/23/2015 5:0	
				Hospi ce I		
		Title XVIII	Title XIX	Other	Total	
		1.00	2. 00	3. 00	4. 00	
1.00 Total cost (see instructions)					1, 306, 863	1.00
2.00 Total Unduplicated Days (Worksheet S-9, column	n 6, line 5)				6, 515	2.00
3.00 Average cost per diem (line 1 divided by line	2)				200. 59	3.00
4.00 Upduplicated Medicare Days (Worksheet S-9, co	lumn 1, line	5, 955				4. 00
5.00 Aggregate Medicare cost (line 3 time line 4)		1, 194, 513				5. 00
6.00 Unduplicated Medicaid Days (Worksheet S-9, co 5)	lumn 2, line			0		6. 00
7.00 Aggregate Medicaid cost (line 3 time line 60)				0		7. 00
8.00 Upduplicated SNF Days (Worksheet S-9, column :	3, line 5)	0				8. 00
9.00 Aggregate SNF cost (line 3 time line 8)		0				9. 00
10.00 Unduplicated NF Days (Worksheet S-9, column 4	, line 5)			0		10.00
11.00 Aggregate NF cost (line 3 times line 10)				0		11.00
12.00 Other Unduplicated days (Worksheet S-9, column	n 5, line 5)			560		12.00
13.00 Aggregate cost for other days (line 3 times l	ine 12)			112, 330		13. 00

Heal th	Financial Systems MCDONOUGH DISTRICT	T HOSPITAL	In Lie	u of Form CMS-2	2552-10		
CALCUL	ATION OF CAPITAL PAYMENT	Provi der CCN: 140089	Peri od: From 07/01/2014 To 06/30/2015	Worksheet L Parts I-III Date/Time Pre 11/23/2015 5:0			
		Title XVIII	Hospi tal	PPS			
				1. 00			
	PART I - FULLY PROSPECTIVE METHOD			1.00			
	CAPITAL FEDERAL AMOUNT						
1.00	Capital DRG other than outlier			323, 899	1.00		
1.01	Model 4 BPCI Capital DRG other than outlier		0	1. 01			
2. 00 2. 01	Capital DRG outlier payments Model 4 BPCI Capital DRG outlier payments			20, 975 0	1		
3. 00	Total inpatient days divided by number of days in the cost rep	oorting period (see inst	ructions)	15. 05	3.00		
4. 00	Number of interns & residents (see instructions)	voi tring period (see riist	1 40 (1 0113)	0.00			
5.00	Indirect medical education percentage (see instructions)			0. 00	5. 00		
6.00	Indirect medical education adjustment (multiply line 5 by the	sum of lines 1 and 1.01	, columns 1 and	0	6. 00		
7. 00	1.01)(see instructions) Percentage of SSI recipient patient days to Medicare Part A pa 30) (see instructions)	itient days (Worksheet E	E, part A line	0.00	7. 00		
8.00	Percentage of Medicaid patient days to total days (see instruc	ctions)		0.00	8. 00		
9. 00	Sum of lines 7 and 8	,		0. 00			
10.00	Allowable disproportionate share percentage (see instructions)			0.00	10.00		
11.00	Disproportionate share adjustment (see instructions)			0 344, 874	11. 00 12. 00		
12.00	12.00 Total prospective capital payments (see instructions)						
	DADT II. DAVMENT INDED DEACONADIE COCT			1. 00			
1. 00	PART II - PAYMENT UNDER REASONABLE COST Program inpatient routine capital cost (see instructions)			0	1.00		
2. 00	Program inpatient ancillary capital cost (see instructions)			0	2.00		
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	3. 00		
4.00	Capital cost payment factor (see instructions)			0			
5.00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00		
				1. 00			
4 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS			-	4 00		
1. 00 2. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance	os (soo instructions)		0			
3.00	Net program inpatient capital costs for extraordinary circumstance	s (see Histractions)		0			
4. 00	Applicable exception percentage (see instructions)			0. 00			
5.00	Capital cost for comparison to payments (line 3 x line 4)			0			
6. 00	Percentage adjustment for extraordinary circumstances (see ins	,		0. 00	1		
7. 00 8. 00	Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7)	circumstances (line 2 >	(line 6)	0			
9. 00	Current year capital payments (from Part I, line 12, as applic	rahl e)		0			
10.00	Current year comparison of capital minimum payment level to ca		less line 9)	0			
11. 00	Carryover of accumulated capital minimum payment level over ca Worksheet L, Part III, line 14)	0	11. 00				
12. 00	Net comparison of capital minimum payment level to capital pay			0			
13.00	Current year exception payment (if line 12 is positive, enter	0					
14. 00	Carryover of accumulated capital minimum payment level over ca (if line 12 is negative, enter the amount on this line)	ipital payment for the f	orrowing period	0	14. 00		
15. 00	Current year allowable operating and capital payment (see inst	ructions)		0	15. 00		
	Current year operating and capital costs (see instructions)	,		0	16. 00 17. 00		
17.00	OU Current year operating and capital costs (see instructions) Ourrent year exception offset amount (see instructions)						

	Financial Systems IS OF HOSPITAL-BASED RURAL HEALTH CLINIC/FEDE	MCDONOUGH DISTE		CCN: 140089	Peri od:	eu of Form CMS-2 Worksheet M-1	
	CENTER COSTS	INCET CONCITTEE			From 07/01/2014 To 06/30/2015	Date/Time Pre	pared:
						11/23/2015 5:	05 pm_
					Rural Health Clinic (RHC) I	Cost	
		Compensation	Other Costs	Total (col	1 Reclassificati	Reclassi fi ed	
		Compensation	other dests	+ col . 2)	ons	Trial Balance	
				' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '		(col. 3 + col.	
						4)	
		1.00	2.00	3.00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	175, 141	C	175, 14	1 0	175, 141	1.00
2.00	Physician Assistant	0	C)	0 0	0	2. 00
3.00	Nurse Practitioner	87, 212	C	87, 21	2 0	87, 212	3. 00
4.00	Visiting Nurse	0	C)	0 0	0	4. 00
5.00	Other Nurse	671	C	67	'1 0	671	5. 00
6.00	Clinical Psychologist	0	C)	0	0	6. 00
7.00	Clinical Social Worker	0	C)	0	0	7. 00
8.00	Laboratory Techni ci an	0	C)	0 0	0	8. 00
9.00	Other Facility Health Care Staff Costs	104, 651	C	104, 65	51 0	104, 651	9. 00
10.00	Subtotal (sum of lines 1 through 9)	367, 675	C	367, 67	75 0	367, 675	10. 00
11. 00	Physician Services Under Agreement	0	C	1	0	0	11. 00
12.00	Physician Supervision Under Agreement	0	C		0	0	12. 00
13.00	Other Costs Under Agreement	0	12, 433			12, 433	
14.00	Subtotal (sum of lines 11 through 13)	0	12, 433			12, 433	1
15. 00	Medical Supplies	0	13, 847	1		13, 847	1
16. 00	Transportation (Health Care Staff)	0	C		0	0	16. 00
17. 00	Depreciation-Medical Equipment	0	C	1	0	0	17. 00
18. 00	Professional Liability Insurance	0	9, 516	1		9, 516	
19. 00	Other Health Care Costs	0	C	1	0	0	
20. 00	Allowable GME Costs	0	C		0	0	20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	23, 363			23, 363	21. 00
22. 00	Total Cost of Health Care Services (sum of	367, 675	35, 796	403, 47	[1] 0	403, 471	22. 00
	lines 10, 14, and 21)						
00.00	COSTS OTHER THAN RHC/FQHC SERVICS				07.040	07.040	00.00
23. 00	Pharmacy	0	C	1	0 27, 943		1
24. 00	Dental	0		1	0	0	24. 00
25. 00 26. 00	Optometry All other nonreimbursable costs	0			0 0		25. 00 26. 00
26.00	Nonallowable GME costs				0 0	0	26.00
28.00	Total Nonreimbursable Costs (sum of lines 23				0 27, 943	27, 943	
∠0. ∪∪	through 27)	١		Ί	21, 943	21,943	20.00

367, 675

25, 093

25, 093

60, 889

25, 093

25, 093

428, 564

27, 943

0

25, 093

25, 093

456, 507

29. 00 0

30.00

31.00

32.00

through 27) FACILITY OVERHEAD

30.00 Administrative Costs

29.00 Facility Costs

and 31)

Total Facility Overhead (sum of lines 29 and

Total facility costs (sum of lines 22, 28

31.00

32.00

Health Financial Systems	MCDONOUGH DISTRICT	HOSPI TAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CENTER COSTS	HEALTH CLINIC/FEDERALLY QUALIFIED	Provider CCN: 140089	Peri od: From 07/01/2014	Worksheet M-1
HEALTH CENTER COSTS		Component CCN: 148522		
			Rural Health	Cost

					Rural Health	Cost	
		Adiustmonts	Net Expens	00	Clinic (RHC) I		_
		Adjustments	for Allocat				
			(col. 5 + c				
			6)	01 .			
		6, 00	7.00				
	FACILITY HEALTH CARE STAFF COSTS	0.00	7.00				_
1.00	Physi ci an	0	175,	141		1, 00	Ω
2.00	Physician Assistant	0	173,	0		2.00	
3.00	Nurse Practitioner	0	87,	- 1		3.00	
4.00	Vi si ti ng Nurse	0	07,	0		4. 00	
5.00	Other Nurse	0		671		5. 00	
6. 00	Clinical Psychologist	0		0		6. 00	
7. 00	Clinical Social Worker	0		0		7.00	
	II .	0	(-1			
8.00	Laboratory Techni ci an	U	104	0		8. 00	
9.00	Other Facility Health Care Staff Costs	U	104,			9. 00	
10.00	Subtotal (sum of lines 1 through 9)	Ü	367,	1		10.00	
11.00	Physician Services Under Agreement	0)	0		11. 00	
12. 00	Physician Supervision Under Agreement	0)	0		12. 00	
13. 00	Other Costs Under Agreement	0	12,			13. 00	
14. 00	Subtotal (sum of lines 11 through 13)	0	12,			14. 00	
15. 00	Medical Supplies	0	13,	1		15. 00	-
16. 00	Transportation (Health Care Staff)	0)	0		16. 00	
17. 00	Depreciation-Medical Equipment	0)	0		17. 00	
18. 00	Professional Liability Insurance	0	9,	516		18. 00	
19. 00	Other Health Care Costs	0)	0		19. 00	
20.00	Allowable GME Costs	0)	0		20.00	0
21. 00	Subtotal (sum of lines 15 through 20)	0		363		21. 00	
22. 00	Total Cost of Health Care Services (sum of	0	403,	471		22. 00	0
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICS						
23. 00	Pharmacy	0	27,	943		23.00	
24. 00	Dental	0)	0		24. 00	
25. 00	Optometry	0)	0		25. 00	
26. 00	All other nonreimbursable costs	0)	0		26. 00	
27. 00	Nonallowable GME costs	0)	0		27. 00	0
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	27,	943		28. 00	0
	through 27)						
	FACILITY OVERHEAD						
29. 00	Facility Costs	0	I .	0		29. 00	
30.00	Administrative Costs	0		093		30.00	
31.00	Total Facility Overhead (sum of lines 29 and	0	25,	093		31.00	0
	30)						
32. 00	Total facility costs (sum of lines 22, 28	0	456,	507		32.00	0
	and 31)		1				

		MCDONOUGH DISTE					u of Form CMS-2	
ALLOCA	TION OF OVERHEAD TO RHC/FQHC SERVICES			Provi der	CCN: 140089	Peri od:	Worksheet M-2	
				Component	CCN: 148522	From 07/01/2014 To 06/30/2015	Date/Time Pre	narod:
				Component	CON. 140322	10 00/30/2013	11/23/2015 5:	
						Rural Health	Cost	
						Clinic (RHC) I		
		Number of FTE	Tota	Vi si ts		y Minimum Visits		
		Personnel			Standard (1	(col. 1 x col.		
		1.00		2. 00	3.00	3) 4. 00	4 5. 00	
	VISITS AND PRODUCTIVITY	1.00	L .	2.00	3.00	4.00	5.00	
	Posi ti ons							1
1.00	Physi ci an	0.74	1	3, 393	4, 20	3, 108		1.00
2.00	Physician Assistant	0.00		0	1			2. 00
3.00	Nurse Practitioner	0. 56		1, 009				3.00
4.00	Subtotal (sum of lines 1 through 3)	1. 30		4, 402		4, 284	4, 402	4. 00
5.00	Visiting Nurse	0.00		0			0	5. 00
6.00	Clinical Psychologist	0.00		0			0	6. 00
7.00	Clinical Social Worker	0. 00		0			0	7. 00
7.01	Medical Nutrition Therapist (FQHC only)	0. 00		0			0	
7.02	Diabetes Self Management Training (FQHC	0. 00		0			0	7. 02
	onl y)							
8. 00	Total FTEs and Visits (sum of lines 4	1. 30		4, 402			4, 402	8. 00
9. 00	through 7) Physician Services Under Agreements			0			0	9. 00
9.00	Prhysr chair Services Under Agreements						U	9.00
							1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO	RHC/FOHC SERV	/LCFS				1.00	
10.00	Total costs of health care services (from Wks			e 22)			403, 471	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,			,			27, 943	
12.00	Cost of all services (excluding overhead) (si	um of lines 10	and 1	1)			431, 414	12. 00
13.00	Ratio of RHC/FQHC services (line 10 divided	by line 12)					0. 935229	13.00
14.00								14. 00
15.00	Parent provider overhead allocated to facili	ty (see instruc	ctions)			330, 171	
16. 00	Total overhead (sum of lines 14 and 15)						355, 264	
17. 00	Allowable GME overhead (see instructions)						0	17. 00
	Subtotal (see instructions)	40 11 :-					355, 264	
	Overhead applicable to RHC/FQHC services (li			0)			332, 253	
∠0. 00	Total allowable cost of RHC/FQHC services (s	um of lines 10	and 1	9)			735, 724	J 20. 00

Heal th	Financial Systems MCDONOUGH DISTRICT	HOSPI TAI	Inlie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provi der CCN: 140089	Peri od:	Worksheet M-3	
		Component CCN: 148522	From 07/01/2014 To 06/30/2015	Date/Time Prepared: 11/23/2015 5:05 pm	
		Title XVIII	Rural Health Clinic (RHC) I	Cost	
				1. 00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES				
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line			735, 724	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line	15)		17, 116	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2) Total Visits (from Wkst. M-2, column 5, line 8)			718, 608 4, 402	3. 00 4. 00
4. 00 5. 00	Physicians visits under agreement (from Wkst. M-2, column 5, li	no (1)		4, 402	5.00
6. 00	Total adjusted visits (line 4 plus line 5)	116 9)		4, 402	6. 00
7. 00	Adjusted cost per visit (line 3 divided by line 6)			163. 25	7. 00
71.00	praguetta acceptor trait (trille a artifaca ay trille ay		Cal cul ati on		7.00
			Prior to	On on After	
			January 1	January 1	
			1. 00	2. 00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6	or your contractor)	79. 80	80. 44	8. 00
9. 00	Rate for Program covered visits (see instructions)		163. 25	163. 25	9. 00
10. 00	CALCULATION OF SETTLEMENT Program covered visits excluding mental health services (from co	ontractor records)	565	566	10. 00
11. 00	Program cost excluding costs for mental health services (line 9		92, 236	92, 400	
12. 00	Program covered visits for mental health services (from contract		92, 230	92, 400	12.00
13. 00	Program covered cost from mental health services (line 9 x line		o	0	13. 00
14. 00	Limit adjustment for mental health services (see instructions)	12)		0	14. 00
15. 00	Graduate Medical Education Pass Through Cost (see instructions)			0	15. 00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 a	nd 3) *		184, 636	16. 00
16. 01	Total program charges (see instructions)(from contractor's reco	rds)		147, 313	16. 01
16. 02	Total program preventive charges (see instructions)(from provide			1, 816	
16. 03	Total program preventive costs ((line 16.02/line 16.01) times I			2, 276	
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.03 at (Titles V and XIX see instructions.)	and 18) times .80)		126, 942	
16. 05	Total program cost (see instructions)			129, 218	
17. 00	Primary payer amounts			270	
18. 00	Less: Beneficiary deductible for RHC only (see instructions) (records)			23, 683	
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instructions records)) (from contractor		24, 363	
20.00	Net Medicare cost excluding vaccines (see instructions)			128, 948	
21. 00	Program cost of vaccines and their administration (from Wkst. M	-4, line 16)		9, 949	21. 00
22. 00 23. 00	Total reimbursable Program cost (line 20 plus line 21) Allowable bad debts (see instructions)			138, 897 0	22. 00 23. 00
23. 00	Adjusted reimbursable bad debts (see instructions)			0	
24. 00		ctions)		0	24. 00
25. 00	3				25. 00
25. 50	, , , , , ,				25. 50
26. 00					26. 00
26. 01					26. 01
27. 00	, , , , , , , , , , , , , , , , , , ,				27. 00
28. 00	Tentative settlement (for contractor use only)			0	28. 00
29. 00				81, 782	
30. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-II,		0	30. 00
	chapter I, §115.2				

Heal th	Financial Systems MCDONOUGH DISTRICT	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 140089	Peri od:	Worksheet M-4	
		Component CCN: 148522	From 07/01/2014 To 06/30/2015	Date/Time Prep 11/23/2015 5:0	
		Title XVIII	Rural Health	Cost	
			Clinic (RHC) I		
			Pneumococcal	I nfl uenza	
			1. 00	2. 00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		367, 675	367, 675	
2. 00	Ratio of pneumococcal and influenza vaccine staff time to total			0. 001854	2. 00
3.00	Pneumococcal and influenza vaccine health care staff cost (line		682	682	3. 00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from		1, 624	6, 114	4. 00
5. 00	Direct cost of pneumococcal and influenza vaccine (line 3 plus	,	2, 306	6, 796	5. 00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line	22)	403, 471	403, 471	6. 00
7.00	Total overhead (from Wkst. M-2, line 16)		355, 264	355, 264	7. 00
8. 00	Ratio of pneumococcal and influenza vaccine direct cost to tota divided by line 6)	direct cost (line 5	0. 005715	0. 016844	8. 00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x li	ne 8)	2, 030	5, 984	9. 00
10. 00	Total pneumococcal and influenza vaccine cost and its (their) allines 5 and 9)	dministration (sum of	4, 336	12, 780	10. 00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	84	186	11. 00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/	line 11)	51. 62	68. 71	12.00
13. 00	Number of pneumococcal and influenza vaccine injections adminis beneficiaries	tered to Program	41	114	13. 00
14. 00	Program cost of pneumococcal and influenza vaccine and its (the (line 12 x line 13)	ir) administration	2, 116	7, 833	14. 00
15. 00	Total cost of pneumococcal and influenza vaccine and its (their of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3,			17, 116	15. 00
16. 00	Total Program cost of pneumococcal and influenza vaccine and italiaministration (sum of cols. 1 and 2, line 14) (transfer this alline 21)	s (theír)		9, 949	16. 00

Health Financial Systems	MCDONOUGH DISTRICT	HOSPI TAL	In Lieu	u of Form CMS-2	2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RENDERED TO PROGRAM BENEFICIARIES	RHC/FQHC PROVIDER FOR SERVICES	Provi der CCN: 1	Period: From 07/01/2014	Worksheet M-5	
RENDERED TO FROGRAM BENEFICIARIES		Component CCN:	To 06/30/2015		
			Rural Health	Cost	
			Clinic (RHC) I		
			Part	t B	

			Rural Health Clinic (RHC) I	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
1.00	Total interim payments paid to provider		1.00	51, 405	1. C
2. 00	Interim payments payable on individual bills, either submit	ted or to be submitted to		0.7.00	2.0
	the contractor for services rendered in the cost reporting				
	"NONE" or enter a zero				
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent				3.0
	revision of the interim rate for the cost reporting period.	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
. 01			02/10/2015	1, 195	
3. 02			06/23/2015	1, 737	3.0
3. 03				0	
3. 04				0	3. (
. 05				0	3. (
	Provider to Program				
. 50				0	3. !
. 51				0	3.
. 52				0	3.
. 53				0	3.
. 54 . 99	Subtatal (sum of lines 2 01 2 40 minus sum of lines 2 50 2	00)		0	3.
		Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line		2, 932	
. 00	27)	ster to worksheet M-3, Time		54, 337	4. (
	TO BE COMPLETED BY CONTRACTOR				ł
. 00	List separately each tentative settlement payment after des	k review Also show date of	-		5.0
. 00	each payment. If none, write "NONE" or enter a zero. (1)] 5. \
	Program to Provider				
. 01				0	5.0
. 02				l ol	5.
. 03				0	5.0
	Provider to Program				
. 50				0	5.
. 51				0	5.
52				0	5.
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5.
00	Determined net settlement amount (balance due) based on the cost report. (1)				6.
. 01	SETTLEMENT TO PROVIDER			81, 782	6.
. 02	SETTLEMENT TO PROGRAM			0	6.
. 00	Total Medicare program liability (see instructions)			136, 119	7.
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
	To the second se	0	1. 00	2. 00	
3. 00	Name of Contractor				8.