Heal th	Financial Systems	COMMUNI TY HOSP	ITAL OF BREMEN		In Lie	u of Form CMS-2	2552-10
						FORM APPROVED	
	<u> </u>				0,		0050
		T REPORT CERTIFICATI	ON Provider				
AND SE	TTLEMENT SUMMARY						pared:
					01/00/2010		
	- COST REPORT STATUS						
Provi d					Date: 9/30/20	15 Time: 10	:33 am
use on							
	3. [U] IT THIS IS AN AMENDED F 4 [F] Medicare Utilization F	eport enter the humma nter "F" for full or	per of times the r "I" for low	e provider resu	omitted this c	ost report	
Contra			2 101 1011	10 NPR	Date		
use on	IV (1) As Submitted 7	Contractor No		11 Con	tractor's Vendo	or Code:	4
	(2) Settled without Audit 8.	[N] Initial Report	t for this Prov	ider CCN 12. [0]If line 5, cc	olumn 1 is 4: E	nter
	(3) Settled with Addit	[м] ғіпаг керогт і	FOR THIS PROVID	er con	number of tim	nes reopened =	0-9.
	(5) Amended						
PART I	I - CERTIFICATION			I			
MI SREP	RESENTATION OR FALSIFICATION OF ANY INF	ORMATION CONTAINED I	N THIS COST REF	PORT MAY BE PUNI	SHABLE BY CRIM	MINAL, CIVIL AN	D
			OF A KICKBACK OF	R WERE OTHERWISE	E ILLEGAL, CRIN	MINAL, CIVIL AN	D
ADMI NI	STRAILVE ACTION, FINES AND/OR IMPRISONM	ENI MAY RESULI.					
	CERTIFICATION BY OFFICER OR A	ADMINISTRATOR OF PRO	IVI DER(S)				
	I HEPERY CEPTLEY that I have read the	above certification	n statement and	that I have ex	amined the acc	ompanying	
	complete and prepared from the books	and records of the p	provider in acco	ordance with ap	olicable instru	uctions,	
		rvices identified ir	n this cost repo	ort were provid	ed in compliand	ce with such	
	laws and regulations.						
		(a)					
		(Si g					
			UTTIC	er or Administr	ator of Provid	ier(s)	
			Title				
			Date				
			-				
		Unred by Law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED et the beginning of the cost reporting geened overpayments (42 USC 1395g). OMB NO. 0938-0050 OMB NO. 0938-0050 TAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION MARY Provider CCN: 151300 Period: From 05/01/2011 Worksheet S Period: 10 04/30/2015 Worksheet S Period: 9/30/2015 Worksheet S Period: 9/30/2015 Time: 10: 33 am IRT STATUS Date: 9/30/2015 Time: 10: 33 am Time: 10: 33 am I Cost Report Status 6. Date Received: 11 Cost Report Status Time: 10: 33 am 2 Settled without Audit 8 [N] linit all Report for this Provider CCN 2 Settled without Audit 8 [N] linit all Report for this Provider CCN 3 Settled without Audit 8 [N] linit all Report for this Provider CCN 4 Reopend Cost Report Natus Column 1 is 4: Enter number of times reopened = 0-9. 7 Monded President Contractor No. 5 Mended I N FINIS REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND 10N, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHEMMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE ED TIROUGH MERCITV OR INDIRECITV OR NUMER FEDERAL LAW. FURTHEMMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE ED TIROUGH MERT SOMMENT MAY RESULT. ERTIFY that I have read the above certification statement and that I have examined the accompanying ally filed or manually subilited cost report and the Balance Sheet and Statement are freewene and repared by COMMINIT MOSPITAL OF BREMEN (151300) for the cost reporting period beginning 05/01/2014 04/30/2015 and to the best of my knowledge and belief, this repo					
	Cost Center Description						
		1.00	2.00	3.00	4.00	5.00	
1.00	PART III - SETTLEMENT SUMMARY Hospital	(_211_225	0	162 270	1 00
2.00	Subprovider - IPF			-211, 335	0	162, 270	2.00
2.00	Subprovider - IRF			0		0	2.00
5.00	Swing bed - SNF		٥ ١	0		0	5.00
6.00	Swing bed - NF	(0	6.00

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.

0

-59, 892

-211.335

162, 270 200. 00

200. 00 Total

	Financial Systems		/ HOSPITAL					In Lieu		rm CMS-2	
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DA	ТА	Prov	der CCN	: 151300	Period: From 05/01 To 04/30	/2014 /2015	Part I	eet S-2 ime Pre	
	1.00	2	00		2.00		10 04730			015 10:	
	1.00 Hospital and Hospital Health Care Co		00		3.00			4.00			-
1.00	Street: 1020 HIGH RD	P0 Box: 1			4/50/	0					1.00
2.00	City: BREMEN	State: I Component Na		CCN	e: 46506- CBSA	Provi de	r Date		ent Sys	tem (P,	2.00
				lumber	Number	Туре	Certified	IТ	, 0, or	N)	-
		1.00		2.00	3.00	4.00	5.00	V 6.00	XVIII 7.00	-	-
	Hospital and Hospital-Based Componen	t Identification:					1				
3.00	Hospi tal	COMMUNITY HOSPITA BREMEN	AL OF 1	51300	99915	1	07/01/196	6 N	0	0	3.00
4.00	Subprovi der - IPF										4.00
5.00 6.00	Subprovider - IRF Subprovider - (Other)										5.00
7.00	Swing Beds - SNF	COMMUNITY HOSPIT	AL 1	5Z300	99915		05/01/198	4 N	0	N	7.00
8.00	Swing Beds - NF	SWING BED									8.00
9.00	Hospital-Based SNF										9.00
10. 00 11. 00	Hospi tal -Based NF Hospi tal -Based OLTC										10.00
12.00	Hospi tal -Based HHA										12.00
	Separately Certified ASC										13.00
	Hospital-Based Hospice Hospital-Based Health Clinic - RHC										14.00
16.00	Hospital-Based Health Clinic - FQHC										16.00
17.00 18.00	Hospital-Based (CMHC) Renal Dialysis										17.00
19.00	5										19.00
							From				-
20.00	Cost Reporting Period (mm/dd/yyyy)						1.0			00 /2015	20.00
21.00	Type of Control (see instructions) Inpatient PPS Information							2			21.00
22.00	Does this facility qualify and is it	currently receiv	ing payme	nts for	di sprop	ortionate	e N		1	N	22.00
	share hospital adjustment, in accord										
	for yes or "N" for no. Is this facil amendment hospital?) In column 2, en				2.06(0)((2) (PI CKI (5				
22. 01	Did this hospital receive interim un						N		1	N	22.01
	period? Enter in column 1, "Y" for y reporting period occurring prior to										
	for no for the portion of the cost r										
22. 02	(see instructions) Is this a newly merged hospital that	requires final u	Incompensa	ted car	e paymer	nts to be	N		1	N	22.02
22.02	determined at cost report settlement	? (see instructio	ons) Enter	in col	umn 1, "	'Y" for ye					22.02
	or "N" for no, for the portion of th in column 2, "Y" for yes or "N" for						n				
	or after October 1.	no, foi the point		CUSET	eportruç	j periou (
22.03	Did this hospital receive a geograph								1	N	22.03
	of the OMB standards for delineating in column 1, "Y" for yes or "N" for										
	prior to October 1. Enter in column	2, "Y" for yes or	"N" for	no for	the port	tion of th	ne				
	cost reporting period occurring on o hospital contain at least 100 but no						th				
	42 CFR 412.105)? Enter in column 3,	"Y" for yes or "N	l" for no.					_	_		
23.00	Which method is used to determine Me 1, enter 1 if date of admission, 2 i						1	3	ſ	N	23.00
	method of identifying the days in th	is cost reporting	, period d	i fferen	t from t	the method					
	used in the prior cost reporting per	iod? In column 2	2, enter " In-State			<u>'N" for n</u> Out-of		Medi ca	id ()ther	
			Medi cai d	Medi	cai d	State	State	HMO da		di cai d	
			paid days	eligi		edicaid id days	Medicaid eligible			days	
				da			unpai d				
24.00	If this provides is an IDDS have it	optor the	1.00	2.0	00	3.00	4.00	5.00		6.00	24.00
24.00	If this provider is an IPPS hospital in-state Medicaid paid days in colum			0	0	0	0		0	0	24.00
	Medicaid eligible unpaid days in col	umn 2,									
	out-of-state Medicaid paid days in c out-of-state Medicaid eligible unpai										
	4, Medicaid HMO paid and eligible bu	t unpaid days in									
25 00	column 5, and other Medicaid days in			0	0	0	0		0		25 00
∠ວ.∪∪	If this provider is an IRF, enter th Medicaid paid days in column 1, the					U	U				25.00
	Medicaid eligible unpaid days in col	umn 2,									
	out-of-state Medicaid days in column Medicaid eligible unpaid days in col										
	HMO paid and eligible but unpaid day										

			TAL OF BREMEN		1	n Lieu	u of For	m CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provi der	F	eriod: rom 05/01/ o 04/30/		Workshe Part I Date/Ti 9/30/20	me Pre	pared:
					Urban/Rur 1.00		Date of 2.0	U	
26.00	Enter your standard geographic classification (not wa			ginning of the	1.00	2	2.0		26.00
27.00	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or	nge) sta "2" fo	atus at the end or rural. If ap			2			27.00
35.00	enter the effective date of the geographic reclassifi If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			CH status in		0			35.00
					Begi nni 1. 00	<u> </u>	Endi 2. (
36.00	Enter applicable beginning and ending dates of SCH st		Subscript line	36 for number	1.00	,	2.0	0	36.00
37.00	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter in effect in the cost reporting period.		umber of period	ds MDH status		О			37.00
38.00	Enter applicable beginning and ending dates of MDH st		Subscript line	38 for number					38.00
	of periods in excess of one and enter subsequent date	:5.			Y/N		Υ/		
39.00	Does this facility qualify for the inpatient hospital	paymer	nt adjustment f	for low volume	1.00 N)	2.0 N		39.00
	hospitals in accordance with 42 CFR §412.101(b)(2)(ii or "N" for no. Does the facility meet the mileage rec CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes Is this hospital subject to the HAC program reduction)? Ente juiremen or "N"	er in column 1 nts in accordar for no. (see i	"Y" for yes nce with 42 nstructions)	N		N		40.00
40.00	"N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	per 1. I	Enter "Y" for y		N				40.00
						V 1.00	XVIII 2.00	XI X 3.00	
45.00	Prospective Payment System (PPS)-Capital			. <u>.</u> .			_		45.00
	Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce					N N	N N	N N	45.00 46.00
47.00	pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.				0				47.00
	Is this a new hospital under 42 CFR §412.300 PPS capi Is the facility electing full federal capital payment Teaching Hospitals					N N	N	N N	47.00 48.00
56.00	Is this a hospital involved in training residents in	approve	ed GME programs	s? Enter "Y"	for yes	N			56.00
57.00	or "N" for no. If line 56 is yes, is this the first cost reporting p 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 "N", complete Wkst. D, Parts III & IV and D-2, Pt. II	yes or h of th' (", comp	r "N" for no ir his cost report plete Worksheet	n column 1. If ting period?	column 1 Enter "Y"				57.00
58.00	If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15–1, § 2148? If yes, complete Wk			ans' services a	as				58.00
	Are costs claimed on line 100 of Worksheet A? If yes	s, compl	lete Wkst. D-2,			N			59.00
60.00	Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y"					N			60.00
		Y/N	IME	Direct GME	IME		Direct	t GME	
		1.00	2.00	3.00	4.00		5. (
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N				0.00		0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see		0.00	0.0	o				61. 01
61. 02	instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of		0.00	0.0	o				61. 02
61. 03	ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see		0.00	0.0	o				61.03
61.04	instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the		0.00	0.0	o				61.04
61.05	current cost reporting period. (see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line		0.00	0.0	o				61.05
61.06	61.04 minus line 61.03). (see instructions) Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.0	o				61.06

OSPITAL AND HOSPITAL HEALTH CARE CO	MPLEX IDENTIFICATION DA	TA Provi		Period: From 05/01/2014	Worksheet S-2 Part I	
				o 04/30/2015	9/30/2015 10:	pared: <u>33 am</u>
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
 1.10 Of the FTEs in line 61.05, special ty, if any, and the num for each new program. (see ins col umn 1, the program name, er program code, enter in col umn unweighted count and enter in FTE unweighted count. 1.20 Of the FTEs in line 61.05, spe program special ty, if any, and residents for each expanded pr instructions) Enter in col umn enter in col umn 2, the program 3, the IME FTE unweighted cour 4, direct GME FTE unweighted cour 	ber of FTE residents tructions) Enter in ter in column 2, the 3, the IME FTE column 4, direct GME cify each expanded the number of FTE ogram. (see 1, the program name, code, enter in column t and enter in column			0.00		61. 1
		·				
	and the Decourage and C				1.00	
ACA Provisions Affecting the H 2.00 Enter the number of FTE reside				iod for which	0.00	62.0
your hospital received HRSA PC	RE funding (see instruc	ctions)			0.00	02.0
2.01 Enter the number of FTE reside during in this cost reporting Teaching Hospitals that Claim	period of HRSA THC proc	gram. (see instruc		your hospital	0.00	62.0
3.00 Has your facility trained resi "Y" for yes or "N" for no in c	dents in nonprovider se	ettings during thi		period? Enter	N	63. C
	· · ·		Unwei ghted		Ratio (col. 1/	
			FTEs Nonprovider	FTEs in Hospital	(col. 1 + col. 2))	
			Si te	nospi tai	2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Base N period that begins on or after			gsThis base year	is your cost r	eporting	
4.00 Enter in column 1, if line 63 in the base year period, the r resident FTEs attributable to settings. Enter in column 2 t resident FTEs that trained in of (column 1 divided by (colum	is yes, or your facilit umber of unweighted nor rotations occurring in he number of unweightec your hospital. Enter ir	ty trained resider n-primary care all nonprovider d non-primary care n column 3 the rat	9	0.00	0. 000000	64. C
	Program Name	Program Code	Unweighted	Unweighted	Ratio (col. 3/	
			FTĔs Nonprovider Site	FTES in Hospital	(col. 3 + col. 4))	
5.00 Enter in column 1, if line 63	1.00	2.00	3.00	4.00 0.00	5.00 0.000000	
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 i						

Heal th	Financial Systems	COMMUNIT	Y HOSPITAL OF	BREMEN		I	n Lieu	u of For	n CMS-2	2552-10
	AL AND HOSPITAL HEALTH CARE COMPI	LEX IDENTIFICATION DA	TA	Provi der	F	Period: From 05/01/ To 04/30/		Workshe Part I Date/Ti 9/30/20	me Pre	pared:
					Unweighted FTEs Nonprovider Site 1.00	Unwei gh FTEs i Hospi t 2.00	n al	Ratio (c (col. 1 2))	ol. 1/ + col.)	
	Section 5504 of the ACA Current		n Nonprovider	- Setting						
66.00	beginning on or after July 1, 20 Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-primar ccurring in all nonpr unweighted non-primar al. Enter in column 3 column 2)). (see ins	rovider setti ry care resid 3 the ratio c	ngs. lent	0. 0		0. 00			66. 00
		Program Name	Program	Code	Unwei ghted FTEs Nonprovi der Si te	Unwei gh FTEs i Hospi t	n	Ratio (c (col. 3 4))	+ col .	
		1.00	2.00)	3.00	4.00)	5.0		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)				0.0	0	0.00	0.	000000	67.00
							1.00	2.00	3.00	
70.00	Inpatient Psychiatric Facility P			: + + -		a manufi al a mO	N			70.00
	Is this facility an Inpatient Ps Enter "Y" for yes or "N" for no If line 70 yes: Column 1: Did th						N		0	70.00 71.00
	recent cost report filed on or b 42 CFR 412.424(d)(1)(iii)(c)) Co program in accordance with 42 CF Column 3: If column 2 is Y, ente reporting period covers the begi or subsequent academic years of instructions) For cost reporting reporting period covers the begi teaching program in existence, e Inpatient Rehabilitation Facilit Is this facility an Inpatient Re	efore November 15, 20 lumn 2: Did this faci R 412.424 (d)(1)(iii) r 1, 2, or 3, in colu nning of the fourth the new teaching proc periods beginning or nning of the sixth or nter 6 in column 3. (y PPS habilitation Facility	004? Enter " lity train r (D)? Enter " year, enter 4 gram in exist n or after Oc any subsequ (see instruct	Y" for ye residents Y" for ye nstructic in colur rence, ent ctober 1, rent acade ions)	es or "N" for in a new teac es or "N" for ons) If this c mn 3, or if th ter 5. (see 2012, if this emic year of t	no. (see hing no. ost e fifth cost	N			75.00
	subprovider? Enter "Y" for yes If line 75 yes: Column 1: Did th recent cost reporting period end no. Column 2: Did this facility CFR 412.424 (d)(1)(iii)(D)? Ente 1, 2, or 3, in column 3. (see in of the fourth year, enter 4 in c teaching program in existence, e on or after October 1, 2012, if any subsequent academic year of instructions)	and "N" for no. e facility have an ap ing on or before Nove train residents in a r "Y" for yes or "N" structions) If this c olumn 3, or if the fi nter 5. (see instruct this cost reporting p	pproved GME t ember 15, 200 new teaching for no. Colu cost reportin fth or subse tions) For co period covers	eaching p 4? Enter program mn 3: If g period quent aca st report the begi	brogram in the "Y" for yes o in accordance column 2 is Y covers the be ademic years o ting periods b nning of the	r "N" for with 42 , enter ginning f the new eginning sixth or			0	76.00
								1.0	0	
	Long Term Care Hospital PPS									
	Is this a long term care hospita Is this a LTCH co-located within "Y" for yes and "N" for no. TEFRA Providers					period? E	nter	N N		80. 00 81. 00
	Is this a new hospital under 42 Did this facility establish a ne \$413.40(f)(1)(ii)? Enter "Y" fo	w Other subprovider (excluded uni				no.	N		85. 00 86. 00

Health Financial Systems COMMUNITY HOSPI HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA			eriod: rom 05/01/2014	u of Form CMS- Worksheet S-2 Part I Date/Time Pre	2
			V	9/30/2015 10: XI X	
Title V and XIX Services			1.00	2.00	
90.00 Does this facility have title V and/or XIX inpatient hospit yes or "N" for no in the applicable column.	al services? Er	nter "Y" for	N	Y	90.00
91.00 Is this hospital reimbursed for title V and/or XIX through full or in part? Enter "Y" for yes or "N" for no in the app			N	Y	91.00
92.00 Are title XIX NF patients occupying title XVIII SNF beds (d instructions) Enter "Y" for yes or "N" for no in the applic	ual certificati			Ν	92.00
93.00 Does this facility operate an ICF/MR facility for purposes "Y" for yes or "N" for no in the applicable column.		XIX? Enter	N	Ν	93.00
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, applicable column.	and "N" for no	o in the	N	Ν	94.00
95.00 If line 94 is "Y", enter the reduction percentage in the ap 96.00 Does title V or XIX reduce operating cost? Enter "Y" for ye			0.00 N	0. 00 N	95.00 96.00
applicable column. 97.00 <u>If line 96 is "Y", enter the reduction percentage in the ap</u>	plicable columr	٦.	0.00	0.00	97.00
Rural Providers 105.00Does this hospital qualify as a Critical Access Hospital (C	AH)?		Y		105.00
106.00 If this facility qualifies as a CAH, has it elected the all for outpatient services? (see instructions)	-inclusive meth	nod of payment	N	-	106.00
107.00 Column 1: If this facility qualifies as a CAH, is it eligi for I &R training programs? Enter "Y" for yes or "N" for n instructions) If yes, the GME elimination would not be on W the program would be cost reimbursed. If yes complete Wkst. this facility is a CAH, do I&Rs in an approved medical educ CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or	o in column 1. kst. B, Pt. I, D-2, Pt. II. (ation program 1	(see col. 25 and Column 2: If train in the	N		107.00
instructions) 108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee schee	dule? See 42	N		108.00
	Physi cal 1.00	Occupational 2.00	Speech 3.00	Respi ratory 4.00	
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.		Y	Y	N	109.00
				1.00	_
110.00 Did this hospital participate in the Rural Community Hospit the current cost reporting period? Enter "Y" for yes or "N"		on project (410)A Demo)for	N	110.00
			1.00) 2.00 3.00	
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes o is yes, enter the method used (A, B, or E only) in column 2 3 either "93" percent for short term hospital or "98" perce psychiatric, rehabilitation and long term hospitals provide Pub. 15-1, §2208.1. 114 Olio this facility algorified as a pefercel center? Enter "Y"	. If column 2 i nt for long ter rs) based on th	is "E", enter i rm care (includ ne definition i	n column des	0	115.00
116.00 Is this facility classified as a referral center? Enter "Y" 117.00 Is this facility legally-required to carry malpractice insu no.					116. 00 117. 00
118.00 Is the malpractice insurance a claims-made or occurrence po claim-made. Enter 2 if the policy is occurrence.	licy? Enter 1 i	. ,			118.00
		Premi ums	Losses	Insurance	
		1.00	2.00	3.00	110.01
118.01 List amounts of malpractice premiums and paid losses:		126, 360			0118.01
118.02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sche and amounts contained therein.			1.00 N	2.00	118.02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that q Hold Harmless provision in ACA §3121 and applicable amendme	n column 1, "Y ualifies for th	' for yes or ne Outpatient	N	Ν	119. 00 120. 00
Enter in column 2, "Y" for yes or "N" for no. 121.00Did this facility incur and report costs for high cost impl patients? Enter "Y" for yes or "N" for no. Transplant Center Information	antable devices	s charged to	Y		121.00
125.00 Does this facility operate a transplant center? Enter "Y" f	or yes and "N"	for no. If	N		125. 00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, e		fication date			126. 00
in column 1 and termination date, if applicable, in column	/		1		1

SPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provi der	CCN: 151300		~iod: om 05/01/2014	Worksheet S- Part	-2
				To	04/30/2015		
				-	1.00	2.00	_
8.00 If this is a Medicare certified li	ver transplant center, en	ter the certifi	cation dat	e		2.00	128. 0
in column 1 and termination date, 9.00 f this is a Medicare certified lu	ing transplant center, ent		cation date	in			129. 0
column 1 and termination date, if 0.001f this is a Medicare certified pa		enter the cert	ification				130. (
date in column 1 and termination of 1.00 If this is a Medicare certified in	late, if applicable, in co	lumn 2.		n			131. (
date in column 1 and termination o	late, if applicable, in co	lumn 2.					131. (
2.00 If this is a Medicare certified is in column 1 and termination date,	if applicable, in column	2.					
3.00 f this is a Medicare certified of in column 1 and termination date,			cation dat	e			133. (
4.00 If this is an organ procurement or and termination date, if applicabl		he OPO number i	n column 1				134. (
All Providers 0.00Are there any related organization	or home office costs as	dofined in CMS	Dub 15 1		N		140. (
chapter 10? Enter "Y" for yes or '	N" for no in column 1. If	yes, and home	office cos		IN		140.0
are claimed, enter in column 2 the 1.00	home office chain number 2.0		i ons)		3.00		
If this facility is part of a chai home office and enter the home off	5		5	e name	e and address	of the	
1.00Name:	Contractor's Name:			ctor'	s Number:		141. 0
2.00 Street: 3.00 City:	PO Box: State:		Zip Co	de:			142. (143. (
						1.00	_
4.00 Are provider based physicians' cos						Y	144.
5.00 f costs for renal services are cl	aimed on Workshoot A lin	a 71 and the c	costs for i	nnati	ent services	N	145.0
only? Enter "Y" for yes or "N" for				npati	ent services		
							_
only? Enter "Y" for yes or "N" for 6.00 Has the cost allocation methodolog	no. gy changed from the previo	usly filed cost	report?	-	1.00 N	2.00	146. (
only? Enter "Y" for yes or "N" for	no. gy changed from the previo n column 1. (See CMS Pub.	usly filed cost	report?	-	1.00		146. (
only? Enter "Y" for yes or "N" for 6.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no ir the approval date (mm/dd/yyyy) in 7.00 Was there a change in the statisti	no. y changed from the previo column 1. (See CMS Pub. column 2. cal basis? Enter "Y" for	usly filed cost 15-2, § 4020) l yes or "N" for	: report? f yes, ent no.	-	1.00 N		147.
 only? Enter "Y" for yes or "N" for 6.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no ir the approval date (mm/dd/yyyy) in 7.00 Was there a change in the statisti 8.00 Was there a change to the simplifi 	no. y changed from the previo i column 1. (See CMS Pub. column 2. cal basis? Enter "Y" for allocation? Enter "Y" fo	usly filed cost 15-2, § 4020) I yes or "N" for r yes or "N" for	report? fyes, ent no. or no.	er	1.00 N		147. (148. (
 only? Enter "Y" for yes or "N" for 6.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in the approval date (mm/dd/yyyy) in 7.00 Was there a change in the statisti 8.00 Was there a change in the order of 	no. y changed from the previo i column 1. (See CMS Pub. column 2. cal basis? Enter "Y" for allocation? Enter "Y" fo	usly filed cost 15-2, § 4020) I yes or "N" for r yes or "N" for	report? fyes, ent no. or no.	er For	1.00 N N N		147. (148. (149. (
only? Enter "Y" for yes or "N" for 6.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in the approval date (mm/dd/yyyy) in 7.00 Was there a change in the statisti 8.00 Was there a change in the order of 9.00 Was there a change to the simplifi no.	no. y changed from the previo column 1. (See CMS Pub. column 2. cal basis? Enter "Y" for allocation? Enter "Y" fo ed cost finding method? E	usly filed cost 15-2, § 4020) yes or "N" for r yes or "N" fo nter "Y" for ye Part A 1.00	report? fyes, ent no. or no. es or "N" f Part B 2.00	er	1.00 N N N Title V 3.00	2.00 Title XIX 4.00	147. (148. (149. (
only? Enter "Y" for yes or "N" for 6.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no ir the approval date (mm/dd/yyyy) in 7.00 Was there a change in the statisti 8.00 Was there a change in the order of 9.00 Was there a change to the simplifi no. Does this facility contain a provi or charges? Enter "Y" for yes or	no. y changed from the previo column 1. (See CMS Pub. column 2. cal basis? Enter "Y" for allocation? Enter "Y" fo ed cost finding method? E der that qualifies for an	usly filed cost 15-2, § 4020) yes or "N" for r yes or "N" fo nter "Y" for ye Part A 1.00 n exemption from pent for Part A	report? fyes, ent no. or no. es or "N" f Part B 2.00 n the appli and Part E	er	1.00 N N N TitleV 3.00 Dn of the low De 42 CFR §41	2.00 Title XIX 4.00 er of costs 3.13)	147. (148. (149. (
only? Enter "Y" for yes or "N" for 6.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no ir the approval date (mm/dd/yyyy) in 7.00 Was there a change in the statisti 8.00 Was there a change in the order of 9.00 Was there a change to the simplifind no. Does this facility contain a provious or charges? Enter "Y" for yes or " 5.00 Hospital	no. y changed from the previo column 1. (See CMS Pub. column 2. cal basis? Enter "Y" for allocation? Enter "Y" fo ed cost finding method? E der that qualifies for an	usly filed cost 15-2, § 4020) I yes or "N" for r yes or "N" for nter "Y" for ye Part A 1.00 exemption fror ent for Part A N	report? fyes, ent no. or no. es or "N" f Part B 2.00 m the appli and Part B N	er	1.00 N N N Title V 3.00 Dn of the low De 42 CFR §41 N	2.00 Title XIX 4.00 er of costs 3.13) N	147. (148. (149. (
only? Enter "Y" for yes or "N" for 6.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no ir the approval date (mm/dd/yyyy) in 7.00 Was there a change in the statisti 8.00 Was there a change in the order of 9.00 Was there a change to the simplifind no. Does this facility contain a provious or charges? Enter "Y" for yes or " 5.00 Hospital 6.00 Subprovider - IPF	no. y changed from the previo column 1. (See CMS Pub. column 2. cal basis? Enter "Y" for allocation? Enter "Y" fo ed cost finding method? E der that qualifies for an	usly filed cost 15-2, § 4020) yes or "N" for r yes or "N" fo nter "Y" for ye Part A 1.00 n exemption from pent for Part A	report? fyes, ent no. or no. es or "N" f Part B 2.00 n the appli and Part E	er	1.00 N N N TitleV 3.00 Dn of the low De 42 CFR §41	2.00 Title XIX 4.00 er of costs 3.13)	147. (148. (149. (155. (156. (
only? Enter "Y" for yes or "N" for 6.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in the approval date (mm/dd/yyyy) in 7.00 Was there a change in the statisti 8.00 Was there a change in the order of 9.00 Was there a change to the simplifin no. Does this facility contain a provious or charges? Enter "Y" for yes or ' 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER	no. y changed from the previo column 1. (See CMS Pub. column 2. cal basis? Enter "Y" for allocation? Enter "Y" fo ed cost finding method? E der that qualifies for an	usly filed cost 15-2, § 4020) I yes or "N" for r yes or "N" for nter "Y" for ye Part A 1.00 n exemption fror ent for Part A N N N	report? fyes, ent no. or no. es or "N" f Part B 2.00 m the appli and Part E N N N	er	1.00 N N N N Title V 3.00 on of the low se 42 CFR §41 N N N	2.00 Title XIX 4.00 er of costs 3.13) N N N	155. (156. (157. (158. (
onl y? Enter "Y" for yes or "N" for 5.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no ir the approval date (mm/dd/yyyy) in 7.00 Was there a change in the statisti 3.00 Was there a change in the order of 9.00 Was there a change to the simplifind 10.00 Subprovider - IPF 10.00 Subprovider - IRF 10.00 SNF	no. y changed from the previo column 1. (See CMS Pub. column 2. cal basis? Enter "Y" for allocation? Enter "Y" fo ed cost finding method? E der that qualifies for an	usly filed cost 15-2, § 4020) yes or "N" for r yes or "N" for nter "Y" for ye Part A 1.00 n exemption from ent for Part A N N N	report? fyes, ent no. or no. es or "N" f Part B 2.00 m the appli and Part E N N N	er	1.00 N N N N Title V 3.00 Dn of the low Dn of the low DN of the low DN N N N	2.00 Title XIX 4.00 ver of costs 3.13) N N N N	147. (148. (149. (149. (155. (156. (157. (158. (159. (
onl y? Enter "Y" for yes or "N" for 5.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no ir the approval date (mm/dd/yyyy) in 7.00 Was there a change in the statisti 8.00 Was there a change in the order of 9.00 Was there a change to the simplifind 10.00 Subprovider - IPF 10.00 Subprovider - IPF 10.00 SNF 10.00 HOME HEALTH AGENCY	no. y changed from the previo column 1. (See CMS Pub. column 2. cal basis? Enter "Y" for allocation? Enter "Y" fo ed cost finding method? E der that qualifies for an	usly filed cost 15-2, § 4020) I yes or "N" for r yes or "N" for nter "Y" for ye Part A 1.00 n exemption fror ent for Part A N N N	report? fyes, ent no. or no. es or "N" f Part B 2.00 m the appli and Part E N N N	er	1.00 N N N N Title V 3.00 on of the low se 42 CFR §41 N N N	2.00 Title XIX 4.00 er of costs 3.13) N N N	147. (148. (149. (155. (155. (157. (157. (158. (159. (159. (159. (
onl y? Enter "Y" for yes or "N" for 6.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no ir the approval date (mm/dd/yyyy) in 7.00 Was there a change in the statisti 8.00 Was there a change in the order of 9.00 Was there a change to the simplifino. Does this facility contain a provion or charges? Enter "Y" for yes or ' 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IPF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY	no. y changed from the previo column 1. (See CMS Pub. column 2. cal basis? Enter "Y" for allocation? Enter "Y" fo ed cost finding method? E der that qualifies for an	usly filed cost 15-2, § 4020) yes or "N" for r yes or "N" for nter "Y" for ye Part A 1.00 n exemption from ent for Part A N N N	report? fyes, ent no. or no. so or "N" f Part B 2.00 n the appli and Part E N N N N	er	1.00 N N N Title V 3.00 Dn of the low De 42 CFR §41 N N N N N	2.00 Title XIX 4.00 ter of costs 3.13) N N N N N N	147. (148. (149. (155. (155. (157. (157. (158. (159. (159. (159. (
only? Enter "Y" for yes or "N" for 6.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in the approval date (mm/dd/yyyy) in 7.00 Was there a change in the statisti 8.00 Was there a change in the order of 9.00 Was there a change to the simplifin no. Does this facility contain a provious or charges? Enter "Y" for yes or ' 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC Multicampus	no. y changed from the previon column 1. (See CMS Pub. column 2. cal basis? Enter "Y" for allocation? Enter "Y" for ed cost finding method? E der that qualifies for an <u>N</u> " for no for each compon	usly filed cost 15-2, § 4020) yes or "N" for r yes or "N" for nter "Y" for ye Part A 1.00 n exemption from ent for Part A N N N N	report? fyes, ent no. or no. es or "N" f Part B 2.00 m the appli and Part E N N N N N	er for catic 3. (Se	1.00 N N N N Title V 3.00 on of the low be 42 CFR §41 N N N N N N N	2.00 Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N	147. (148. (149. (155. (156. (157. (158. (159. (160. (161. (
only? Enter "Y" for yes or "N" for 6.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in the approval date (mm/dd/yyyy) in 7.00 Was there a change in the statisti 8.00 Was there a change in the order of 9.00 Was there a change to the simplifin no. Does this facility contain a provious or charges? Enter "Y" for yes or ' 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC Multicampus	no. y changed from the previon column 1. (See CMS Pub. column 2. cal basis? Enter "Y" for allocation? Enter "Y" for ed cost finding method? E der that qualifies for an 'N" for no for each compon 'N" for no for each compon	usly filed cost 15-2, § 4020) yes or "N" for r yes or "N" for nter "Y" for yet Part A 1.00 n exemption from ent for Part A N N N N N N	report? fyes, ent no. or no. so or "N" f Part B 2.00 n the appli and Part E N N N N N N	er For catic 3. (Se	1.00 N N N N Title V 3.00 on of the low ee 42 CFR §41 N N N N N N N N N	2.00 Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N	147. (148. (149. (155. (156. (157. (158. (159. (160. (161. (161. (165. (
onl y? Enter "Y" for yes or "N" for 5.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no ir the approval date (mm/dd/yyyy) in 7.00 Was there a change in the statisti 3.00 Was there a change in the order of 9.00 Was there a change to the simplifin no. Does this facility contain a provious or charges? Enter "Y" for yes or " 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC Multicampus 5.00 Is this hospital part of a Multication 5.00 Is this hospital part of a Multication 1.00 Is this hospital p	no. y changed from the previon column 1. (See CMS Pub. column 2. cal basis? Enter "Y" for allocation? Enter "Y" for ed cost finding method? E der that qualifies for an <u>N</u> " for no for each compon	usly filed cost 15-2, § 4020) yes or "N" for r yes or "N" for nter "Y" for ye Part A 1.00 n exemption from ent for Part A N N N N	report? fyes, ent no. or no. so or "N" f Part B 2.00 n the appli and Part E N N N N N N	er for catic 3. (Se	1.00 N N N N Title V 3.00 On of the low 20 42 CFR §41 N N N N N N N N N N N N O CESAS? Ode CESA	2.00 Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N	147. 148. 149. 155. 156. 157. 158. 159. 160. 161. 161. 161. 161.
only? Enter "Y" for yes or "N" for 6.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in the approval date (mm/dd/yyyy) in 7.00 Was there a change in the statisti 8.00 Was there a change in the order of 9.00 Was there a change to the simplifin no. Does this facility contain a provious or charges? Enter "Y" for yes or " 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IPF 7.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC Multicampus 5.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	no. y changed from the previon column 1. (See CMS Pub. column 2. cal basis? Enter "Y" for allocation? Enter "Y" for ed cost finding method? E der that qualifies for an 'N" for no for each compon mpus hospital that has on Name	usly filed cost 15-2, § 4020) I yes or "N" for r yes or "N" for nter "Y" for ye Part A 1.00 exemption from ent for Part A N N N N N N N N N N O County	report? fyes, ent no. or no. es or "N" f Part B 2.00 n the appli and Part E N N N N N N N N N S State	er For Catic	1.00 N N N N Title V 3.00 On of the low 20 42 CFR §41 N N N N N N N N N N N N O CESAS? Ode CESA	2.00 Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N	147. (148. (149. (149. (155. (156. (157. (158. (159. (160. (161. (161. (165. (16
onl y? Enter "Y" for yes or "N" for 6.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no ir the approval date (mm/dd/yyyy) in 7.00 Was there a change in the statisti 8.00 Was there a change in the order of 9.00 Was there a change to the simplifin no. Does this facility contain a provious or charges? Enter "Y" for yes or " 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC Multicampus 5.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no. 6.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in	no. y changed from the previon column 1. (See CMS Pub. column 2. cal basis? Enter "Y" for allocation? Enter "Y" for ed cost finding method? E der that qualifies for an 'N" for no for each compon mpus hospital that has on Name	usly filed cost 15-2, § 4020) I yes or "N" for r yes or "N" for nter "Y" for ye Part A 1.00 exemption from ent for Part A N N N N N N N N N N O County	report? fyes, ent no. or no. es or "N" f Part B 2.00 n the appli and Part E N N N N N N N N N S State	er For Catic	1.00 N N N N Title V 3.00 On of the low 20 42 CFR §41 N N N N N N N N N N N N O CESAS? Ode CESA	2.00 Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N	147. (148. (149. (149. (155. (156. (157. (158. (157. (158. (159. (160. (161. (165. (165. (165. (
only? Enter "Y" for yes or "N" for 6.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in the approval date (mm/dd/yyyy) in 7.00 Was there a change in the statisti 8.00 Was there a change in the order of 9.00 Was there a change to the simplifin no. Does this facility contain a provion or charges? Enter "Y" for yes or " 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC Multicampus 5.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no. 6.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in	no.	usly filed cost 15-2, § 4020) yes or "N" for r yes or "N" for nter "Y" for ye Part A 1.00 n exemption from ent for Part A N N N N N N N N N N N N N N N N N N N	report? fyes, ent no. or no. es or "N" f Part B 2.00 m the appli and Part E N N N N N N State 2.00 ises in dif	er for catic 3. (Se feren Zip C 3. 0	1.00 N N N N N N Title V 3.00 on of the low ve 42 CFR §41 N	2.00 Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N	147. (148. (149. (155. (156. (157. (158. (159. (160. (161. (161. (165. (
only? Enter "Y" for yes or "N" for 6.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in the approval date (mm/dd/yyyy) in 7.00 Was there a change in the statisti 8.00 Was there a change in the order of 9.00 Was there a change to the simplifin no. Does this facility contain a provious or charges? Enter "Y" for yes or " 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC Multicampus 5.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no. 6.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)	The section \$1886(n)?	usly filed cost 15-2, § 4020) I yes or "N" for r yes or "N" for nter "Y" for ye Part A 1.00 exemption from ent for Part A N N N N N N N N N N N N N N N N N N N	report? fyes, ent no. or no. es or "N" f Part B 2.00 m the appli and Part B N N N N N N N N State 2.00 State 2.00 d Reinvestm yes or "N"	er for catic 3. (Se feren Zip C 3. 0	1.00 N N N N N N Title V 3.00 on of the low e 42 CFR §41 N <	2.00 Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N	147. (148. (149. (149. (155. (156. (157. (158. (159. (160. (161. (161. (165. (16

Health Financial Systems	COMMUNITY HOSPITAL	OF BREMEN	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ID	ENTIFICATION DATA	Provider CCN: 151300	Period:	Worksheet S-2	2
			From 05/01/2014 To 04/30/2015		parod
			10 047 307 2013	9/30/2015 10:	33 am
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR begin period respectively (mm/dd/yyyy)	nning date and ending date	for the reporting	05/01/2014	04/30/2015	170.00
				1.00	
171.00 If line 167 is "Y", does this provider Medicare cost plans reported on Wkst.				N	171.00
(see instructions)				l .	

	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE	Provi der		Period: From 05/01/2014	Worksheet S-2 Part II	2
					To 04/30/2015	Date/Time Pre	
					Y/N	9/30/2015 10: Date	:33 an
					1.00	2.00	
	General Instruction: Enter Y for all YES resp	onses. Enter N for	all NO re	esponses. Ente			
	mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS						_
	Provider Organization and Operation						-
00	Has the provider changed ownership immediatel				N		1.
	reporting period? If yes, enter the date of t	the change in colum	nn 2. (see			N/ /1	
				Y/N 1.00	Date 2.00	V/I 3.00	
00	Has the provider terminated participation in	the Medicare Progr	am?lf	N 1.00	2.00	3.00	2.
	yes, enter in column 2 the date of termination						
	voluntary or "I" for involuntary.	tiono including ma	nagement	N			1
00	Is the provider involved in business transact contracts, with individuals or entities (e.g.			N			3.
	or medical supply companies) that are related						
	officers, medical staff, management personnel						
	of directors through ownership, control, or 1 relationships? (see instructions)	family and other si	milar				
				Y/N	Туре	Date	
				1.00	2.00	3.00	
	Financial Data and Reports	anad by a 0 11 C	Dubl'	N N	•	07/00/0045	
0	Column 1: Were the financial statements prep Accountant? Column 2: If yes, enter "A" for			Y	A	07/22/2015	4.
	or "R" for Reviewed. Submit complete copy or						
	column 3. (see instructions) If no, see instr						
0	Are the cost report total expenses and total			N			5.
	those on the filed financial statements? If y	es, submit reconci	Tration.		Y/N	Legal Oper.	
					1.00	2.00	
	Approved Educational Activities				· · ·	1	
0	Column 1: Are costs claimed for nursing scho the legal operator of the program?	ool? Column 2: If	yes, is th	ne provider is	N		6.
0	Are costs claimed for Allied Health Programs	?lf"Y" see instru	uctions.		N		7.
0	Were nursing school and/or allied health prog	grams approved and/		d during the	N		8.
	cost reporting period? If yes, see instruction						
0	Are costs claimed for Intern-Resident program yes, see instructions.	ns claimed on the c	current cos	st report? If	N		9.
00	Was an Intern-Resident program been initiated	d or renewed in the	e current d	cost reporting	N		10.
	period? If yes, see instructions.						
00	Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see		lin an App	broved	N		11.
	reaching rrogram on worksheet A: Tr yes, see					Y/N	
						1.00	
	Bad Debts					1	- 10
00	Is the provider seeking reimbursement for bac				st reporting	Y	
00	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad det				st reporting	1	
00 00 00	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad det period? If yes, submit copy. If line 12 is yes, were patient deductibles a	ot collection polic	cy change o	during this co	1 5	Y	13.
00 00 00	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad det period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement	ot collection polic and/or co-payments	cy change o	during this co fyes, see ins	tructions.	Y N N	13. 14.
00 00 00	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad det period? If yes, submit copy. If line 12 is yes, were patient deductibles a	ot collection polic and/or co-payments	cy change o	during this co F yes, see ins yes, see inst	tructions.	Y N N	12. 13. 14. 15.
00 00 00	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad det period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement	ot collection polic and/or co-payments	waived? In	during this co F yes, see ins yes, see inst	tructions.	Y N N	13. 14.
00 00 00 00	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad det period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the pric	ot collection polic and/or co-payments or cost reporting p	waived? In	during this co Fyes, see ins yes, see inst Pa	tructions.	Y N N Y Part B	13. 14.
00 00 00 00 00 00 00 00 00 00 00 00 00	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad det period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prio	ot collection polic and/or co-payments or cost reporting p Descriptic	waived? In	during this co f yes, see inst yes, see inst Pa Y/N 1.00	ructions. ructions. rt A Date 2.00	Y N N Part B Y/N 3.00	13. 14. 15.
00 00 00 00	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad det period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the pric	ot collection polic and/or co-payments or cost reporting p Descriptic	waived? 11	during this co F yes, see ins yes, see inst Pa Y/N	tructions. ructions. rt A Date	Y N N Part B Y/N	13. 14. 15.
00 00 00 00 00 00 00 00 00 00 00 00 00	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad det period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prio PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R	ot collection polic and/or co-payments or cost reporting p Descriptic	waived? 11	during this co f yes, see inst yes, see inst Pa Y/N 1.00	ructions. ructions. rt A Date 2.00	Y N N Part B Y/N 3.00	13. 14. 15.
00 00 00 00	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad det period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prio PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see	ot collection polic and/or co-payments or cost reporting p Descriptic	waived? 11	during this co f yes, see inst yes, see inst Pa Y/N 1.00	ructions. ructions. rt A Date 2.00	Y N N Part B Y/N 3.00	13. 14. 15.
00 00 00 00	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad det period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prio PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions)	ot collection polic and/or co-payments or cost reporting p Descriptic	waived? 11	during this co F yes, see inst yes, see inst Pa Y/N 1.00 Y	ructions. ructions. rt A Date 2.00	Y N N Part B Y/N 3.00	13. 14. 15. 16.
00 00 00 00 00 00 00 00 00 00 00 00 00	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad det period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prio PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see	ot collection polic and/or co-payments or cost reporting p Descriptic	waived? 11	during this co f yes, see inst yes, see inst Pa Y/N 1.00	ructions. ructions. rt A Date 2.00	Y N N Part B Y/N 3.00	13. 14. 15. 16.
00 00 00 00 00 00 00 00 00 00 00 00 00	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad det period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prio PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through 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	ot collection polic and/or co-payments or cost reporting p Descriptic	waived? 11	during this co F yes, see inst yes, see inst Pa Y/N 1.00 Y	ructions. ructions. rt A Date 2.00	Y N N Part B Y/N 3.00	13. 14. 15. 16.
00 00 00 00 00 00 00 00 00 00 00 00 00	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad det period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prio PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through 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	ot collection polic and/or co-payments or cost reporting p Descriptic	waived? 11	during this co F yes, see inst yes, see inst Pa Y/N 1.00 Y	ructions. ructions. rt A Date 2.00	Y N N Part B Y/N 3.00	13. 14. 15. 16.
00 00 00 00 00	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad det period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prio PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through 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)	ot collection polic and/or co-payments or cost reporting p Descriptic	waived? 11	during this co <u>f yes, see inst</u> <u>yes, see inst</u> <u>Y/N</u> <u>1.00</u> Y N	ructions. ructions. rt A Date 2.00	Y N N Part B Y/N 3.00 Y	13. 14. 15. 16.
	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad det period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prio PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through 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	ot collection polic and/or co-payments or cost reporting p Descriptic	waived? 11	during this co F yes, see inst yes, see inst Pa Y/N 1.00 Y	ructions. ructions. rt A Date 2.00	Y N N Part B Y/N 3.00	13. 14. 15. 16.
00 00 00 00 00	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad det period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prio PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through 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	ot collection polic and/or co-payments or cost reporting p Descriptic	waived? 11	during this co <u>f yes, see inst</u> <u>yes, see inst</u> <u>Y/N</u> <u>1.00</u> Y N	ructions. ructions. rt A Date 2.00	Y N N Part B Y/N 3.00 Y	13. 14. 15. 16.
	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad det period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prio PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through 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	ot collection polic and/or co-payments or cost reporting p Descriptic	waived? 11	during this co <u>f yes, see inst</u> <u>yes, see inst</u> <u>Y/N</u> <u>1.00</u> Y N	ructions. ructions. rt A Date 2.00	Y N N Part B Y/N 3.00 Y	13. 14. 15. 16.
	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad det period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prio PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through 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.	ot collection polic and/or co-payments or cost reporting p Descriptic	waived? 11	during this co <u>f yes, see inst</u> <u>yes, see inst</u> <u>Pa</u> <u>Y/N</u> <u>1.00</u> <u>Y</u> N N	ructions. ructions. rt A Date 2.00	Y N N Part B Y/N 3.00 Y N	13. 14. 15. 16. 17.
	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad det period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prio PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through 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	ot collection polic and/or co-payments or cost reporting p Descriptic	waived? In	during this co <u>f yes, see inst</u> <u>yes, see inst</u> <u>Y/N</u> <u>1.00</u> Y	ructions. ructions. rt A Date 2.00	Y N N Part B Y/N 3.00 Y	13. 14. 15. 16. 17.
	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad det period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prio PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through 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	ot collection polic and/or co-payments or cost reporting p Descriptic	waived? In	during this co <u>f yes, see inst</u> <u>yes, see inst</u> <u>Pa</u> <u>Y/N</u> <u>1.00</u> <u>Y</u> N N	ructions. ructions. rt A Date 2.00	Y N N Part B Y/N 3.00 Y N	13. 14. 15. 16. 17.
	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad det period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prio PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through 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.	ot collection polic and/or co-payments or cost reporting p Descriptic	waived? In	during this co f yes, see inst yes, see inst Pa Y/N 1.00 Y N N N	ructions. ructions. rt A Date 2.00	Y N N Part B Y/N 3.00 Y N N	13. 14. 15. 16. 17. 18. 19.
	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad det period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prio PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through 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	ot collection polic and/or co-payments or cost reporting p Descriptic	waived? In	during this co <u>f yes, see inst</u> <u>yes, see inst</u> <u>Pa</u> <u>Y/N</u> <u>1.00</u> <u>Y</u> N N	ructions. ructions. rt A Date 2.00	Y N N Part B Y/N 3.00 Y N	13. 14. 15. 16. 17.

Heal th	Financial Systems 0	COMMUNITY HOSPI	TAL OF E	BREMEN		In Lie	eu of Form CMS-	2552-10
						Period:	Worksheet S-2	
							Part II Date/Time Pre	nared.
							Part B	
21 00	Was the sect was at an and solve weight the	(0			2.00		21.00
21.00					N		N	21.00
							1.00	
		ALS ONLY (EXCE	EPT CHILE	DRENS H	IOSPI TALS)			
					alo mada duri.	a the east		
23.00		ation expense	due to a	apprars	ars made durin	ig the cost	IN	23.00
24.00		n Leases entere	ed into d	duri na	this cost rep	ortina period?	N	24.00
	If yes, see instructions	·····						
25.00	Have there been new capitalized leases entere	ed into during	the cost	t repor	ting period?	f yes, see	N	25.00
	instructions.							
26.00		uired during th	ne cost r	reporti	ng period? If	yes, see	N	26.00
27.00		and during the	a cost re	portin	a poriod? If	voc cubmit	N	27 00
27.00		iged dui ring the	e cost re	eportri		yes, subili t	IN IN	27.00
	Interest Expense							
28.00	Were new loans, mortgage agreements or letter	rs of credit er	ntered in	nto dur	ing the cost i	reporting	N	28.00
	period? If yes, see instructions.							
29.00				nds (De	ebt Service Res	serve Fund)	N	29.00
30.00				th now	dobt2 If yos	500	N	20.00
30.00		Schedul ed liatt	unity wi		debt? IT yes,	366	IN IN	30.00
31.00		rity without is	ssuance o	of new	debt? If yes,	see	N	31.00
	instructions.	5			3			
	Purchased Services							
32.00				urni she	ed through con	tractual	N	32.00
33.00				stainin	a to compotiti	vo bidding2 lf	N	22 00
33.00		bec. 2135.2 app	bireu pei	tarmin	ig to competiti	ve bruurny: Ti	IN IN	33.00
		ty under an ar	rrangemer	nt with	n provi der-base	ed physi ci ans?	Y	34.00
	If yes, see instructions.							
35.00					its with the p	rovi der-based	N	35.00
	physicians during the cost reporting period?	If yes, see in	nstructio	ons.		V /N	Data	
	Home Office Costs					1.00	2.00	
		eport?				N		36.00
37.00	If line 36 is yes, has a home office cost sta	atement been pr	repared b	by the	home office?	N		37.00
	lf yes, see instructions.							
38.00						N		38.00
20 00	Description V/N Date V/N 0 1.00 2.00 3.00 Was the cost report prepared only using the provider's records? If yes, see instructions. N N 21.00 COMPLETED BY COST RELINDURSED AND TERA HOSPITALS ONLY (EXCEPT CHLIDRENS HOSPITALS) 1.00 22.00 N 23.00 Completing period? If yes, see instructions N 23.00 N 23.00 Nere new leases and/or amendments to existing leases entered into during this cost reporting period? N 24.00 If yes, see instructions. N 24.00 N 24.00 If yes, see instructions N 24.00 N 25.00 Instructions N 27.00 N 26.00 N 26.00 N 26.00 N<		20.00					
37.00				compon	ients: in yes,	IN		37.00
40.00		ervices to the	home off	fi ce?	lf ves, see	N		40.00
	instructions.				J			
				1.	00	2.	00	
		/naci +i	MICHAE					41 00
41.00						ALESSANDKINI		41.00
		i, ∠, anu s,						
42.00		report	BLUE & C	0., LL	.C			42.00
	preparer.			-				
43.00			317-713-	7959		MALESSANDRI NI @	BLUEANDCO. COM	43.00
	report preparer in columns 1 and 2, respectiv	vel y.						

alth Financial Systems SPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	COMMUNITY HOSPIT		CCN: 151300	Peri od:	u of Form CMS- Worksheet S-2	
STITLE AND HOSTITLE HEALTH OAKE KEIMBOKSEMENT 200	STIONNAINE	TTOVIGET	0011. 101000	From 05/01/2014	Part II	2
				To 04/30/2015		
				L	9/30/2015 10:	:33 am
	Part B					
	Date					
	4.00					
PS&R Data						
.00 Was the cost report prepared using the PS&R	08/16/2015					16.0
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)						
.00 Was the cost report prepared using the PS&R						17. (
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)						
.00 If line 16 or 17 is yes, were adjustments						18.
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.						
.00 If line 16 or 17 is yes, were adjustments						19.
made to PS&R Report data for corrections of						
other PS&R Report information? If yes, see						
instructions.						
.00 If line 16 or 17 is yes, were adjustments	1					20.
made to PS&R Report data for Other? Describe						
the other adjustments:						
.00 Was the cost report prepared only using the						21.
provider's records? If yes, see						
instructions.						
		3.	00			
Cost Report Preparer Contact Information						
.00 Enter the first name, last name and the titl		ENI OR MANAGER	2			41.
held by the cost report preparer in columns	1, 2, and 3,					
respecti vel y.						
.00 Enter the employer/company name of the cost	report					42.
preparer.						
.00 Enter the telephone number and email address	of the cost					43.
report preparer in columns 1 and 2, respecti	vel v.					

	Financial Systems C TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	COMMUNITY HOSPI			CCN: 151300	Pe	eriod:	u of Form CM Worksheet S		.002 10
							rom 05/01/2014	Part I Date/Time P 9/30/2015 1	Pre	
								I/P Days / O Visits / Tri		
	Component	Worksheet A Line Number	No.	of Beds	Bed Days Avai I abl e		CAH Hours	Title V		
		1.00		2.00	3.00		4.00	5.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30. 00		24	8, 7	60	17, 112. 00		0	1.00
2.00 3.00	HMO and other (see instructions) HMO IPF Subprovider									2.00 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			24	0.7		17 110 00		0	6.00
7.00 8.00	Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT			24	8, 70	60	17, 112. 00		0	7.00 8.00
8.00 9.00	CORONARY CARE UNIT									8.00 9.00
10.00	BURN INTENSIVE CARE UNIT									10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T									11.00
12.00	OTHER SPECIAL CARE (SPECIFY)									12.00
13.00	NURSERY	43.00							0	13.00
14.00	Total (see instructions)	10.00		24	8.7	60	17, 112. 00		0	14.00
15.00	CAH visits			2.	0,,,		,		0	15.00
16.00	SUBPROVIDER - IPF								-	16.00
17.00	SUBPROVIDER - IRF									17.00
18.00	SUBPROVI DER									18.00
19.00	SKILLED NURSING FACILITY									19.00
20.00	NURSING FACILITY				1					20.00
21.00	OTHER LONG TERM CARE									21.00
22.00	HOME HEALTH AGENCY									22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)									23.00
24.00	HOSPI CE									24.00
24. 10	HOSPICE (non-distinct part)	30.00								24.10
25.00	CMHC - CMHC									25.00
26.00	RURAL HEALTH CLINIC									26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER									26.25
27.00	Total (sum of lines 14-26)			24					~	27.00
28.00	Observation Bed Days								0	28.00
29.00	Ambulance Trips									29.00
30.00 31.00	Employee discount days (see instruction) Employee discount days - IRF									30.00 31.00
31.00	Labor & delivery days (see instructions)			0		0				31.00
32.00	Total ancillary labor & delivery room			0		U				32.00
JZ. UI	outpatient days (see instructions)									JZ. UI
22.00	LTCH non-covered days									33.00

OSPI 1	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provi der		Period: From 05/01/2014 To 04/30/2015		pared
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	387	13	71	3		1. (
. 00	HMO and other (see instructions)	o	93				2.0
. 00	HMO IPF Subprovider	0	0				3.1
. 00	HMO IRF Subprovider	o	0				4.
. 00	Hospital Adults & Peds. Swing Bed SNF	346	0	37.	2		5.
. 00	Hospital Adults & Peds. Swing Bed NF		0	8	6		6.
. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	733	13	1, 17	1		7.
. 00	INTENSIVE CARE UNIT						8.
00	CORONARY CARE UNIT						9.
0. 00	BURN INTENSIVE CARE UNIT						10.
1.00	SURGI CAL I NTENSI VE CARE UNI T						11.
2.00	OTHER SPECIAL CARE (SPECIFY)						12.
3.00	NURSERY		10				13.
4.00	Total (see instructions)	733	23		6 0.00	121.17	
5.00	CAH visits	0	0		C		15.
5.00	SUBPROVIDER - IPF						16.
7.00	SUBPROVIDER - IRF						17.
3. 00	SUBPROVI DER						18.
9.00	SKILLED NURSING FACILITY						19.
0.00	NURSING FACILITY						20.
1.00	OTHER LONG TERM CARE						21.
2.00	HOME HEALTH AGENCY						22.
3.00	AMBULATORY SURGICAL CENTER (D. P.)						23.
4.00	HOSPICE	0	0		0		24. 24.
4.10	HOSPICE (non-distinct part) CMHC - CMHC	0	0		J		24.
5.00 5.00							25.
6.25	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER						26.
7.00	Total (sum of lines 14-26)				0.00	121.17	
3.00	Observation Bed Days		0	51		121.17	27.
9.00	Ambulance Trips	0	0	51			20.
9.00 D.00	Employee discount days (see instruction)	0			0		30.
1.00	Employee discount days (see first detroit)				0		31.
2.00	Labor & delivery days (see instructions)	0	0				32.
2.00	Total ancillary labor & delivery room	0	0				32.
2.01	outpatient days (see instructions)						32.
2 00	LTCH non-covered days	0					33.

HOSPI	TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provi der	CCN: 151300	Period: From 05/01/2014 To 04/30/2015	Worksheet S-3 Part I Date/Time Pre 9/30/2015 10:	pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT		0		0 45	287	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	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY	0. 00	0	1.	27 11	287	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
23.00 24.00 24.10 25.00 26.25 27.00 28.00 29.00 30.00 31.00 32.00	AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days	0. 00					23. 00 24. 00 24. 10 25. 00 26. 00 26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 01 33. 00

Heal th	Financial Systems COMMUNITY HOSPITAL OF	BREMEN		In Lie	eu of Form CMS	-2552-10
			CCN: 151300	Period:	Worksheet S-	
				From 05/01/2014		
			-	Fo 04/30/2015		
					9/30/2015 10	:33 am
					1.00	
	Uncompensated and indigent care cost computation				1.00	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divid	ded by lir	ne 202 column	8)	0. 45842	5 1.00
1.00	Medicaid (see instructions for each line)			0)	0.43042	1.00
2.00	Net revenue from Medicaid				363, 94	5 2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				N N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental j	navments f	from Medicaid	>		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from 1					5.00
6.00	Medi cai d charges	liour our u			2, 458, 89	
7.00	Medicaid cost (line 1 times line 6)				1, 127, 22	
8.00	Difference between net revenue and costs for Medicaid program (1)	ine 7 minu	us sum of line	es 2 and 5 if	763, 27	
	< zero then enter zero)					
	State Children's Health Insurance Program (SCHIP) (see instruction	ons for ea	ach line)			
9.00	Net revenue from stand-alone SCHIP		,			9.00
10.00	Stand-alone SCHIP charges					10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)					0 11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 mi	nus line 9; i	f < zero then		12.00
	enter zero)					
	Other state or local government indigent care program (see instru	uctions fo	or each line)			
13.00	Net revenue from state or local indigent care program (Not inclu	ded on lir	nes 2, 5 or 9)			0 13.00
14.00	Charges for patients covered under state or local indigent care	program (N	Not included i	n lines 6 or		0 14.00
	10)					
15.00	State or local indigent care program cost (line 1 times line 14)					0 15.00
16.00	Difference between net revenue and costs for state or local indig	gent care	program (line	e 15 minus line		16.00
	13; if < zero then enter zero)					-
47.00	Uncompensated care (see instructions for each line)				-	17.00
17.00	Private grants, donations, or endowment income restricted to fund					0 17.00 0 18.00
18.00	Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid , SCHIP and state and local			(
19.00	8, 12 and 16)	i nai gent	care programs	s (sum or lines	763, 27	/ 19.00
			Uni nsured	Insured	Total (col. 1	
			patients	patients	+ col. 2	
		F	1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (a	at full	1,079,62			1 20.00
	charges excluding non-reimbursable cost centers) for the entire					
21.00	Cost of initial obligation of patients approved for charity care	(line 1	494, 92	5 0	494, 92	5 21.00
	times line 20)					
22.00	Partial payment by patients approved for charity care		(0 0		22.00
23.00	Cost of charity care (line 21 minus line 22)		494, 92	6 0	494, 92	5 23.00
					1.00	
24.00	Does the amount in line 20 column 2 include charges for patient (nd a length of	⁼stay limit	N	24.00
	imposed on patients covered by Medicaid or other indigent care p			<u> </u>		
25.00	If line 24 is "yes," charges for patient days beyond an indigen		ogram's length	n of stay limit		25.00
	Total bad debt expense for the entire hospital complex (see inst				321, 71	
27.00	Medicare bad debts for the entire hospital complex (see instruction)				114, 88	
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line			20)	206, 82	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expendent	nse (line	i times line	∠ŏ)	94, 81	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	o 20)			589, 74	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line	e 30)			1, 353, 01	J J . UU

		COMMUNITY HOSPITAL	OF BREMEN		In Lie	u of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der	CCN: 151300	Peri od:	Worksheet A	
					From 05/01/2014 To 04/30/2015	Date/Time Pre	nared
				_		9/30/2015 10:	
	Cost Center Description	Sal ari es	0ther	Total (col. '	1 Reclassificati		
				+ col. 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
						col. 4)	
		1.00	2.00	3.00	4.00	5.00	
1 00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT		1 001 001	1 021 22	1 0	1 021 221	1 1 00
1.00 2.00	00200 NEW CAP REL COSTS-BLDG & FIXT		1, 831, 221	1, 831, 22	0 0	1, 831, 221 0	1.00 2.00
2.00 3.00	00300 OTHER CAPITAL RELATED COSTS		0		0 0		
3.00 4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	84, 633	1, 709, 068			1, 793, 701	4.00
4.00 5.00	00500 ADMI NI STRATI VE & GENERAL	1, 252, 635	1, 439, 227				5.00
7.00	00700 OPERATI ON OF PLANT	177, 554	513, 853				•
8.00	00800 LAUNDRY & LINEN SERVICE	0	118, 425				
9.00	00900 HOUSEKEEPING	140, 029	21, 051			161, 078	
10.00	01000 DI ETARY	214, 827	251, 468				•
11.00	01100 CAFETERI A	0	201, 100		0 365, 058	365, 058	•
13.00	01300 NURSI NG ADMI NI STRATI ON	138, 424	7,027			145, 451	•
16.00	01600 MEDI CAL RECORDS & LI BRARY	247, 327	110, 784				
	INPATIENT ROUTINE SERVICE COST CENTERS				-		1
30.00	03000 ADULTS & PEDIATRICS	756, 205	170, 862	927, 06	7 -117, 284	809, 783	30.00
43.00	04300 NURSERY	0	0		0 42, 875	42, 875	43.00
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATING ROOM	710, 271	1, 286, 891	1, 997, 16	2 -438, 717	1, 558, 445	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 55, 675	55, 675	
54.00	05400 RADI OLOGY-DI AGNOSTI C	422, 240	367, 159				
57.00	05700 CT SCAN	51, 563	289, 959				
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	59, 725	306, 438				
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	
60.00	06000 LABORATORY	708, 300	880, 921	1, 589, 22		1, 589, 119	
60. 01	06001 BLOOD LABORATORY	0	0		0 0	0	
64.00	06400 I NTRAVENOUS THERAPY	0	8, 243			8, 243	•
65.00	06500 RESPI RATORY THERAPY	0	10, 444			10, 444	
66.00	06600 PHYSI CAL THERAPY	268, 919	12, 542				
67.00	06700 OCCUPATIONAL THERAPY	0	0		0 0	0	
68.00	06800 SPEECH PATHOLOGY	0	-		0	-	
69. 00 69. 02	06900 ELECTROCARDI OLOGY 06902 SLEEP LAB	0	2, 883 29, 960			2, 883 29, 960	
70.02	07000 ELECTROENCEPHALOGRAPHY	0	29,900	29,90		29,900	
70.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	105, 659	1, 540	107, 19	0		•
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	105, 059	1, 540	107, 13	0 169, 394	169, 394	
73.00	07300 DRUGS CHARGED TO PATIENTS	216, 920	384, 059	600, 97			•
75.00	OUTPATIENT SERVICE COST CENTERS	210, 720	304, 039	000, 77	-203	000,770	/ 3.00
90.00	09000 CLINIC	0	0		0 0	0	90.00
91.00	09100 EMERGENCY	746, 612	1,027,972				
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	6, 301, 843	10, 781, 997	17, 083, 84	0 3, 666	17, 087, 506	118.00
	NONREIMBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		0 0		190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	129, 043	116, 969				
200.00	TOTAL (SUM OF LINES 118-199)	6, 430, 886	10, 898, 966	17, 329, 85	2 0	17, 329, 852	200. 00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES Provider CCN: 151300 Peride: To 04/30/2015 Morksheet A to 04/30/2015 Cost Center Description Adjustments (See A.8) Met Expenses For All caction 1 0		Financial Systems	COMMUNI TY HOSPI	TAL OF BREMEN		In Lie	u of Form CM	IS-2552-10
To Date/11me Prepared: See A-8) To Det/30/2015 Date/11me Prepared: 9/30/2015 Date/2015 Date/201	RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der	CCN: 151300		Worksheet A	A
Cost Center Description Adjustments (See A.B) Net Expenses for Allocation 9/30/2015 10. 33.am 1.00 ENERAL SERVICE COST CENTERS 6.00 7.00							Date/Time P	Prenared
Cise A-B) For All (cation 0 00000 EVERAL SERVICE COST CENTERS 1.00 1.00 000000 EVERAL COSTS-MUBLE COUP 0 0 0.00 000000 DHE CAP REL COSTS-MUBLE COUP 0 0 3.00 0.00 000000 DHER CAP REL COSTS-MUBLE COUP 0 0 3.00 0.00 DONOGO DHER CAP REL COSTS-MUBLE COUP 0 0 3.00 3.00 0.00 DONOGO DHER CAPT RELA REATED COSTS -26.885 1.766.816 4.00 5.00 0.00 DONOGO OPERATION OF PLANT -3.317 688.040 7.00 8.00 0.00 DONOGO DIETARY -9.066 92.104 10.00 10.00 10.00 10.00 13.00						10 04/ 30/ 2013		
EENERAL SERVICE COST CENTERS - 1.00 Q0100 NEW CAP REL COSTS-BLOG & FLXT -477,567 1,353,654 1.00 2.00 Q0200 NEW CAP REL COSTS-BLOG & FLXT -477,567 1,353,654 2.00 3.00 Q0300 OTHER CAPITAL RELATED COSTS 0 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 4.00 3.00 4.00 4.00 4.00 4.00 5.00 5.00 5.00 5.00 5.00 5.00 7.00 0.0700 OPERATI ON PLANT -3.371 6.88,640 5.00 7.00 9.00 0.00		Cost Center Description	Adjustments	Net Expenses				
CENERAL SERVICE COST CENTERS 1 1.00 OUTON RW CAP REL COSTS-BLOG & FIXT -477, 567 1, 353, 654 1, 00 2.00 002000 NEW CAP REL COSTS-SUDG & FIXT -26, 885 1, 766, 816 4, 00 3.00 002000 DTHER CAPT REL RELATE COSTS 0 0 3, 00 3.00 00200 DTHER CAPT REL RELATE COSTS 0 0 3, 00 3.00 00200 DTHER CAPT REAL -434, 552 2, 6646 5, 00 3.00 000000 DUNNEN SERVEEPING 0 116, 425 8, 00 8, 00 9, 00 000000 DUNEN SERVEEPING -9, 066 92, 104 10, 00 10, 00 11, 00 01100 CAFETERIA -144, 096 220, 962 11, 00 13, 00 13, 00 13, 00 13, 00 13, 00 13, 00 13, 00 14, 425 43, 00 43, 00 43, 00 14, 006 13, 283 30, 00 14, 006 14, 007 14, 007 14, 007 14, 007 14, 007 14, 007 14, 007 14, 007 14, 007 14, 007 14, 007 14,					<u>n</u>			
1.00 00100 NEW CAP REL COSTS-BLOG & FLXT -477, 567 1, 353, 654 1.00 2.00 00200 NEW CAP REL COSTS-BLOG & FLXT -477, 567 1, 353, 654 2.00 3.00 00300 OTHER CAPITAL RELATED COSTS 0 0 3.00 3.00 0.00 00500 ADMIN STRATIVE & GENERAL -434, 565 2, 260, 466 5.00 0.00 00500 ADMIN STRATIVE & GENERAL -434, 565 2, 260, 466 5.00 0.00 00500 ADMIN STRATIVE & GENERAL -434, 565 2, 260, 466 5.00 0.00 00500 ADMIN STRATIVE & GENERAL -444, 096 220, 962 11.00 11.00 01000 DIETARY -144, 096 220, 962 11.00 13.00 01300 NUESING ADMIN STRATION 0 145, 451 13.00 0.00 03000 ADMLETA & PEDATRICS -26, 500 783, 283 30.00 43.00 04300 NUESICAR PEDATRICS -26, 500 783, 283 30.00 50.00 05500 DIELIVERY ROM & LABOR ROM -518, 530 1, 039, 915 50.00 50.00 05500 DIELIVERY ROM & L			6.00	7.00				
2.00 00200 NEW CAP REL COSTS 0 0 3.00 3.00 00200 OTHER CAPTAL RELATE COSTS 0 0 3.00 0.00 00200 OTHER CAPTAL RELATE COSTS 0 0 3.00 0.00 00200 OTHER CAPTAL RELATE COSTS 0 0 3.00 0.00 00200 OTHER CAPTAL RELATE COSTS -26.885 1.766.816 4.00 0.00 00200 OPERATION OF PLANT -3.317 688.040 7.00 0.00 00200 OPERATION OF PLANT -3.317 688.040 7.00 0.00 00200 OPERATION OF PLANT -9.06 9.00 10.00 10.00 0.00 0100 OPERATION OF PLANT -144.096 220.962 11.00 11.00 13.00 01100 OPERATINE SERVICE -144.096 220.962 11.00 10.00 10.00 0100 OPERATINE SERVICE COST CENTERS -3.737 354.374 16.00 10.00 003000 ANUESTRY -2.64,500 783.283 51.00 52.00 50.00 05200 OFENTINE ROM -518.530 1								
3.00 00300 OTHER CAPITAL, RELATED COSTS 0 0 3.00 4.00 004000 IMPORE DERPTTS DEPRATINENT -26.885 1.766.816 4.00 5.00 00500 ADMINISTRATIVE & GENERAL -434,565 2.260.466 5.00 7.00 00700								
4. 00 00400 [EMPLOYEE BENEFITS DEPARTMENT] -26,885 1,766,816 4.00 5.00 00500 ADMINI STRATI VE & GENERAL -434,565 2,260,466 7,00 6.00 00500 LAUNDRY & LINEN SERVICE 0 118,425 9,00 0.00 00500 LAUNDRY & LINEN SERVICE 0 161,078 9,00 0.00 0100 CAPTERIA -144,096 220,962 11.00 0.00 0100 OUNDO ILETARY -9,066 92,104 10.00 10.00 0100 OUNDICAL RECORDS & LIBRARY -3,737 354,374 16.00 11.00 0.0100 OUNDICAL RECORDS & LIBRARY -3,737 354,374 16.00 10.00 0.000 OUNDESING ROM -518,550 70.00 70.00 0.00 0.000 OPERATI NG ROM -518,550 70.00 52.00 0.00 0.000 OPERATI NG ROM -518,550 70.00 52.00 0.00 0.000 OPERATI NG ROM -518,550 70.02 52.00 0.00 0.000 OPERATI NG ROM -518,550 52.00 52.00 0.00 0.000 OPERATI NG ROM -518,550 52.00 52.00 52								
5.00 00500 ADMINISTRATIVE & GENERAL -434,565 2,260,466 5.00 7.00 0700 OPERATION OF PLANT -3,317 688,040 7.00 8.00 0000 ILMUNRY & LINEN SERVICE 0 118,425 8.00 9.00 0000 INUSEXEEPING 0 161,078 9.00 10.00 0100 CAFETERIA -9,066 92,104 10.00 10.00 0100 CAFETERIA -144,096 220,962 11.00 11.00 01000 NUEDI CAL RECORDS & LI BRAY -3,737 354,374 16.00 10.00 01000 OPERATINE SERVICE COST CENTERS 0 42,875 30.00 30.00 30.00 03000 AUBULTS & PEDIATRICS -518,530 1,039,915 50.00 52.00 52.00 52.00 55.075 52.00 55.00 59.			-		-			
7. 00 00700 (DEPERATION OF PLANT -3.317 668.00 7. 00 8. 00 00800 (LAINDRY & LINEN SERVICE 0 118, 425 8. 00 9. 00 00900 (LAINDRY & LINEN SERVICE 0 118, 425 9. 00 10. 00 01000 (DEFEREPING 0 118, 425 9. 00 11. 00 01100 (CAFETERIA -144, 096 22.0, 962 11. 00 13. 00 01300 (NURSI NG ADMINISTRATION 0 145, 451 13. 00 16. 00 16000 (MOUCS & PEDIATRICS -20, 737 354, 374 16. 00 10. 00 0000 ADULTS & PEDIATRICS -20, 500 783, 283 30. 00 43. 00 04300 (NURSERY 0 42, 875 50. 00 50. 00 05000 OPERATING ROOM 0 55, 675 52. 00 50. 00 05000 DELIVERY NOMS & LABOR ROOM 0 364, 999 54. 00 51. 00 0 0 364, 908 57. 00 50. 00 52. 00 05000 CARDIAC CATHETER TATION 0 0 0 60. 01 <tr< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr<>								
8. 00 00800 [LAUNDRY & LINEN SERVICE 0 118, 425 8. 00 9.00 00900 [HOUSEKEEPING 0 161, 078 9. 00 10.00 01000 [LETARY -9, 066 92, 104 10. 00 11.00 0100 (AFETERI A -144, 096 220, 962 13. 00 11.00 0100 (AFETERI A -3, 737 35. 374 16. 00 10.00 03000 (MED) CAL RECROS & LIBARY -2, 737 35. 374 16. 00 10.00 03000 (MED) CAL RECORDS & LIBARY -26, 500 783, 283 30. 00 30.00 03000 (MRSECAL RECORDS & LIBARY 0 42, 875 43. 00 30.00 03000 (OPERATI NG ROOM -518, 530 1, 039, 915 50. 00 52.00 05200 (DELUVERY NOOM & LABOR ROOM 0 56, 55 52. 00 54.00 0500 (CRADI LAC CATHETERI ZATI ON 0 360, 188 58. 00 59.00 05900 (LABORATORY 0 0 59. 00 60. 01 60.01 164.020 (INTRAVENDUS THERAPY 0 0 60. 01 6								
9.00 00900 H0USEKEEPI NG 0 101,078 9.00 10.00 01000 DIETAY -9.066 92,104 10.00 11.00 01100 CAFETERIA -144,096 220,962 11.00 13.00 01300 NURSING ADMINISTRATION 0 145,451 13.00 16.00 Di600 MEDICAL RECORDS & LIBRARY -3,737 354,374 16.00 10.00 0300 ADULTS & PEDIATRI CS -26,500 783,283 30.00 43.00 04300 NURSIERY 0 42,875 30.00 AKICILLARY SERVICE COST CENTERS -0 42,975 50.00 50.00 05000 DELIVERY NOOM & LABOR ROOM 0 55,675 52.00 50.00 OS000 DELIVERY NOOM & LABOR ROOM 0 334,908 57.00 57.00 50.00 OS000 CARDIA CATHETERIZATION 0 0 0 60.01 60.01 64.00 OS000 CARDIA CATHETERIZATION 0 0 0 60.01 60.01 64.00 OS000 CARDIA CATHETERIZATION 0 0 0 60.01 60.01 64.00 OS								
10.00 01000 DIETARY -9,066 92,04 10.00 11.00 0100 CAFETERIA -144,096 220,962 11.00 13.00 01300 NURSING ADMINISTRATION 0 145,451 13.00 16.00 01600/MEDICAL, RECORDS & LIBRARY -3,737 334,374 16.00 NIMPIT ENT ROUTINE SERVICE COST CENTERS -20,500 783,283 30.00 0.00 03000 ADUITS & PEDIATRICS -20,650 786,3283 30.00 ANCILLARY SERVICE COST CENTERS -20,067 786,929 54.00 50.00 052000 DELIVERY ROMA & LABOR ROM -518,530 1,039,915 52.00 51.00 05700 CT SCAN 0 334,908 57.00 52.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 0 58.00 50.00 05000 CARDIAC CATHETERIZATION 0 0 60.01 60.01 05000 CARDIAC CATHETERIZATION 0 0 60.01 60.01 05000 CARDIAC CATHETERIZATION 0 0 60.01 60.00 05000 CARDIAC CATHETERIZATION 0 0 60.01			-					
11.00 01100 CAFETERIA -144,096 220,962 11.00 13.00 01300 NURSI NG ADMINI STRATION 0 145,451 15.00 16.00 D1600 MEDI CAL, RECORDS & LIBRARY -3,737 354,374 16.00 INPATI ENT ROUTINE SERVICE COST CENTERS -3,737 354,374 354,374 30.00 0.00 03000 ADULTS & PEDI ATRICS -26,500 783,283 30.00 43.00 04300 NURSERY 0 42,875 43.00 50.00 05000 DELIVERY ROM & LABOR ROM 0 55,675 50.00 52.00 05000 MADULTS & SENVICE -2,096 786,929 54.00 50.00 05000 CADULTS & SENVICE -2,096 786,929 54.00 50.00 05000 CADULTS & SENVICE -2,096 786,929 54.00 50.00 05000 CADULT C & SENVICE IMAGI NG (MRI) 0 30.01 59.00 50.00 05000 CADULT C & SENVICE IMAGI NG (MRI) 0 0 60.00 60.00 06000 LABORATORY 0 1.599,119 60.00 60.00 06000 LABORATORY 0 0			-					
13.00 01300 NURSING ADMINISTRATION 0 145, 451 13.00 16.00 1000 NURSING ADMINISTRATION -3, 737 354, 374 16.00 INPATIENT ROUTINE SERVICE COST CENTERS -20, 500 783, 283 30.00 0.0000 00000 (NURSERY 0 42, 875 30.00 ANCILLARY SERVICE COST CENTERS -00 42, 875 50.00 0.0000 (DPERATING ROOM -518, 530 1.039, 915 50.00 52.00 05200 (DELIVERY ROOM & LABOR ROOM 0 55, 675 52.00 64.00 6A00 RADI CLOCY-DI AGNOSTIC -2, 096 786, 929 54.00 65.00 05900 CARDI AC CATHETERI ZATION 0 360, 188 58.00 65.00 05900 CARDI AC CATHETERI ZATION 0 1.589, 119 60.00 66.00 06000 IBLODO LABORATORY 0 0 0 60.00 66.00 06000 RESPIR ATORY THERAPY 0 1.444 65.00 66.00 66.00 06000 RESPIR ATORY THERAPY 0 0 0 66.00 67.00 66.00 06000 RESPIR ATORY THERAPY 0 0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
16.00 10400 MPATI ENT ROUTINE SERVICE COST CENTERS 16.00 30.00 03000 AULLTS & PEDIATRICS -26,500 783,283 30.00 43.00 04300 NURSERY 0 42,875 30.00 60.00 05000 PERVICE COST CENTERS 50.00 55.675 52.00 50.00 05000 PERVIEW ROM & LABOR ROM -518,530 1.039,915 50.00 50.00 05000 OPERATING ROM -518,630 1.039,915 50.00 50.00 05000 OPERATING ROM -20,096 786,929 54.00 51.00 05300 AGNETIC RESONANCE IMAGING (MRI) 0 349,098 58.00 50.00 05900 MAGNETIC RESONANCE IMAGING (MRI) 0 349,098 58.00 50.00 05900 AGNIC CATHERI ZATION 0 1,589,119 60.00 60.01 BLODU LABORATORY 0 1,589,119 60.00 61.00 06000 RENDOU LABORATORY 0 10.444 65.00 62.00 06500 RESPI RATORY THERAPY 0 10.444 65.00 63.00 06000 SPECH PATHORATINERAPY								
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30000 ADULTS & PEDIATRICS -26,500 783,283 30.00 30.00 4300 NURSERY 0 42,875 43.00 ANCILLARY SERVICE COST CENTERS -26,500 783,283 43.00 ANCILLARY SERVICE COST CENTERS -518,530 1,039,915 50.00 50.00 505000 (PERATI NG ROOM -518,530 1,039,915 52.00 54.00 55000 ROLOGY-DIAGNOSTI C -2,096 786,929 54.00 57.00 5500 CARDIA CATHER NAGUNANCE I MAGI NG (MRI) 0 360,188 58.00 59.00 5900 CORDIA CATHER CATHERAPY 0 1,589,119 60.00 60.01 60001 BLODD LABORATORY 0 0 0 64.00 64.00 06400 INTRAVENOUS THERAPY 0 8,243 64.00 65.00 65.00 06500 OSECH PATHERAPY 0 0 0 66.00 66.00 06600 PHYSICAL THERAPY 0 0 66.00 66.00 66.00 0 0 0 0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
30.00 00 00 00 00 726, 500 783, 283 30.00 43.00 04300 NURSERY 0 42, 875 43.00 50.00 05000 DEPRATING ROOM -518, 530 1.039, 915 50.00 52.00 050200 DELVERY ROOM & LABOR ROOM 0 55, 675 52.00 50.00 05400 RADI OLOGY-DI AGNOSTIC -2.096 786, 929 54.00 50.00 05300 MARGNETI C RESONANCE I MAGI NG (MRI) 0 360, 188 58.00 50.00 05900 CATHAETRI ZATION 0 360, 188 58.00 50.00 05000 CARDI AC CATHETERI ZATION 0 0 0 60.01 06000 LABORATORY 0 1, 589, 119 60.00 61.00 06000 LABORATORY 0 8, 243 64.00 62.00 06500 RESPI RATORY THERAPY 0 10, 444 65.00 63.00 06500 SPECH PATHOLOGY 0 2, 883 69.00 64.00 0 0 2, 883 69.00 65.00 0 0	10.00		-3,737	554, 57	4			10.00
43.00 04300 NURSERY 0 42,875 43.00 ANCLLARY SERVICE COST CENTERS -5000 05000 OPERATING ROM -518,530 1,039,915 50.00 52.00 05200 DELIVERY ROM & LABOR ROM 0 55,675 52.00 54.00 05400 RADICLORY-DI AGNOSTIC -2,096 786,929 54.00 55.00 05500 CASDIA CATHETERIZATION 0 360,188 58.00 59.00 05900 CARDIA CATHETERIZATION 0 0 0 60.01 D6000 LABORATORY 0 1,589,119 60.00 61.01 D6000 RESPIRATORY THERAPY 0 8,243 64.00 64.00 06400 INTRAVENUS THERAPY 0 278,403 65.00 65.00 06500 RESPIRATORY THERAPY 0 0 0 65.00 64.00 06600 PHYSICAL THERAPY 0 0 66.00 67.00 67.00 69.00 06500 SECENTRAPY 0 0 0 70.00 71.00 71.00 71.00 71.00 <td>30 00</td> <td></td> <td>- 26 500</td> <td>783.28</td> <td>3</td> <td></td> <td></td> <td>30.00</td>	30 00		- 26 500	783.28	3			30.00
ANCILLARY SERVICE COST CENTERS 50.00 OPERATING ROOM -518,530 1,039,915 50.00 52.00 55.075 52.00 52.00 52.00 55.075 52.00 52.00 52.00 54.00 54.00 55.675 52.00 54.00 54.00 53.00 55.070 57.00 58.00 58.00 58.00 58.00 58.00 59.00 60.00								
50.00 05000 0PERATI NG ROOM -518, 530 1, 039, 915 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 55, 675 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C -2, 096 786, 929 54.00 57.00 05700 CT SCAN 0 334, 908 58.00 58.00 05800 05900 CARDI AC CATHETRI ZATI ON 0 0 60.00 06000 LABORATORY 0 1, 589, 119 60.00 60.01 0.0001 BLODO LABORATORY 0 1, 589, 119 60.00 60.01 0.0001 BLODO LABORATORY 0 1, 589, 119 60.00 60.01 0.0000 LABORATORY 0 1, 444 65.00 60.00 0.0500 RESPI RATORY THERAPY 0 1, 444 65.00 60.00 0.0500 RESPI RATORY THERAPY 0 0 66.00 61.00 0.0500 RESPI RATORY THERAPY 0 0 67.00 62.00 0.0500 RESPI RATORY THERAPY 0 0 67.00 63.00 0.0000 SPECH PATHOLOGY 0 0 69.00 64.00 0.0000 SPECH AL THERAPY 0	43.00		0	42,07	5			43.00
52.00 05200 DELIVERY ROM & LABOR ROOM 0 55, 675 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C -2,096 786,929 54.00 57.00 05700 05800 MACNETI C RESONANCE I MAGI NG (MRI) 0 360,188 58.00 59.00 05900 CARDIAC CATHETERI ZATI ON 0 0 0 60.00 60.00 06000 LABORATORY 0 0 0 60.01 06000 LABORATORY 0 0 0 61.00 06000 LABORATORY 0 0 0 62.00 06000 LABORATORY 0 0 0 64.00 06400 INTRAVENUSI THERAPY 0 8,243 64.00 65.00 06500 06500 RESPI RATORY THERAPY 0 278,403 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 66.00 67.00 06700 0CUPATI ONAL THERAPY 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 2,833 69.00 69.00 0000 ELECTROEARDI OLOGY 0 2,833 71.00 70.00 07000 <td< td=""><td>50 00</td><td></td><td>-518 530</td><td>1 039 91</td><td>5</td><td></td><td></td><td>50.00</td></td<>	50 00		-518 530	1 039 91	5			50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C -2,096 786,929 54.00 57.00 57.00 05700 CT SCAN 0 334,908 57.00 58.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 60.00 LABORATORY 0 1,589,119 60.00 60.00 64.00 06400 LABORATORY 0 0 60.00 64.00 06400 INTRAVENOUS THERAPY 0 8,243 64.00 65.00 06500 RESPI RATORY THERAPY 0 10,444 65.00 66.00 06000 PHESPI RATORY THERAPY 0 278,403 66.00 67.00 06000 SPECI PATHOLOGY 0 0 68.00 69.00 68.00 069002 ELECTROCARDI OLOGY 0 2,883 69.00 69.00 06900 ELECTROCARDI OLOGY 0 169,394 72.00 71.00 71.00 MEDI CAL SUPPLIES CHARGED TO PATI ENTS -24,228 <								
57.00 05700 CT SCAN 0 334,908 57.00 58.00 05800 MAGNETI C RESONANCE IMAGING (MRI) 0 360,188 58.00 59.00 CARDIAC CATHETERIZATION 0 0 0 0 60.00 06000 LABORATORY 0 1,589,119 60.00 60.01 06001 LABORATORY 0 82.243 64.00 65.00 06500 RESPI RATORY THERAPY 0 82.243 66.00 66.00 06600 PHYSI CAL THERAPY 0 10,444 65.00 66.00 06000 SPEECH PATHOLOGY 0 0 0 66.00 69.00 06902 SELECT ROCARDIOLOGY 0 0 68.00 69.00 06902 SELECT ROCARDIOLOGY 0 0 69.00 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 169.394 72.00 72.00 07200 INPLES CHARGED TO PATIENTS -24.228 576.548 73.00 73.00 07300 DRUGS CHARGED TO PATIENTS -24.228 576.548 73.00 <td></td> <td></td> <td>-</td> <td></td> <td></td> <td></td> <td></td> <td></td>			-					
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 360, 188 58.00 59.00 05900 CARDIAC CATHETERIZATION 0 0 59.00 60.00 LABORATORY 0 1, 589, 119 60.01 64.00 06400 LABORATORY 0 8, 243 64.00 65.00 06500 RESPIRATORY THERAPY 0 10, 444 65.00 66.00 06000 LABORATORY 0 278, 403 66.00 67.00 06000 LABORATORY 0 0 66.00 66.00 06600 PHYSI CAL THERAPY 0 278, 403 66.00 67.00 06000 LECTROCARDI OLOGY 0 0 68.00 69.00 06902 SLEEP LAB 0 29, 960 69.02 00.00 07000 ELECTROCARDI OLOGY 0 0 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 169, 394 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS -24, 228 576, 548 73.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>								
59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 60.00 LABORATORY 0 1,589,119 60.00 60.01 06000 LABORATORY 0 0 0 64.00 06400 INTRAVENOUS THERAPY 0 8,243 64.00 65.00 06500 RESPI RATORY THERAPY 0 10,444 65.00 66.00 06600 PKISI CAL THERAPY 0 278,403 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 68.00 06800 SPEECH PATHOLOGY 0 0 67.00 69.00 06690 ELECTROCARDI OLOGY 0 2,883 69.00 69.02 06902 ELECTROCARDI OLOGY 0 29,960 69.02 70.00 07000 ELECTROCARCEPHALOGRAPHY 0 0 72.00 71.00 OT100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 169,394 72.00 72.00 07300 DRUGS CHARGED TO PATI ENTS -24,228 576,548 73.00 090.00 <			-					
60.00 06000 LABORATORY 0 1,589,119 60.00 60.01 06001 BLOOD LABORATORY 0 0 64.00 0 INTRAVENOUS THERAPY 0 8,243 64.00 65.00 06500 RESPI RATORY THERAPY 0 10,444 65.00 66.00 06600 PHYSI CAL THERAPY 0 278,403 66.00 67.00 06700 0CUPATI ONAL THERAPY 0 0 68.00 68.00 68.00 68.00 68.00 69.00 68.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.02 69.02 10.044 70.00 70.00 ELECTROCARDI OLOGY 0 0 0 70.00 70.00 FLECTROENCEPHALOGRAPHY 0 0 0 70.00 70.00 71.00 71.00 72.00 73.00 72.00 73.00 72.00 73.00 0 0 0 0 90.00 91.00 90.00 91			-					
60.01 06001 BLOOD LABORATORY 0 0 0 64.00 06400 INTRAVENOUS THERAPY 0 8,243 64.00 65.00 06500 RESPIRATORY THERAPY 0 10,444 65.00 66.00 06600 PHYSI CAL THERAPY 0 278,403 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 0 67.00 68.00 SPEECH PATHOLOGY 0 0 69.00 69.00 69.00 06900 ELECTROCARDI OLOGY 0 2,883 69.00 69.01 07000 ELECTROCARDI OLOGY 0 0 0 69.02 70.00 07000 ELECTROCARDI OLOGY 0 0 0 0 0 71.00 07100 MEDL CAL SUPPLIES CHARGED TO PATI ENTS 0 169,394 72.00 73.00 73.00 07300 DRUSC CHARGED TO PATI ENTS -24,228 576,548 73.00 91.00 92.00 90.00 O92000 OBERVATI ON BEDS (NON-DI STI NCT PART) -621,564 1, 138,347 91.00 92.00 92.00			0		-			
64.00 06400 INTRAVENOUS THERAPY 0 8,243 64.00 65.00 06500 RESPI RATORY THERAPY 0 10,444 65.00 66.00 06600 PHYSI CAL THERAPY 0 278,403 66.00 67.00 0CCUPATI ONAL THERAPY 0 0 0 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 68.00 69.02 69.02 59.02 69.02 59.02 69.02 51.67 69.02 69.02 69.02 69.02 51.67 69.02 69.02 69.02 69.02 69.02 69.02 69.02 69.02 69.02 69.02 69.02 69.02 69.02 69.02 69.02 69.02 69.02 69.02 69.02 70.00 70.00 70.00 70.00 70.00 70.00 70.00 71.00 70.00 71.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 90.00 91.00 92.00 99200 0BERVATI ON BEDS (NON-DI STINCT PART) -621, 564			0	1,007,11	0			
65.00 06500 RESPI RATORY THERAPY 0 10,444 65.00 66.00 06600 PHYSI CAL THERAPY 0 278,403 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 0 66.00 68.00 06800 SPEECH PATHOLOGY 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 2,883 69.02 70.00 07000 ELECTROCARDI OLOGY 0 0 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 426,871 71.00 72.00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0 169,394 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS -24,228 576,548 73.00 90.00 09000 CLI NI C 0 0 90.00 91.00 09100 EMEGENCY -621,564 1, 138, 347 92.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 92.00 92.00 92.00 SUBTOTALS (SUM OF LINES 1-117) -2,292,151 14, 795, 355 <t< td=""><td></td><td></td><td>0</td><td>8.24</td><td>3</td><td></td><td></td><td></td></t<>			0	8.24	3			
66.00 06600 PHYSI CAL THERAPY 0 278, 403 66.00 67.00 0CCUPATI ONAL THERAPY 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 67.00 69.00 06900 ELECTROCARDI OLOGY 0 2, 883 69.00 69.02 06902 SLEEP LAB 0 29, 960 69.02 70.00 07000 ELECTROCARDI OLOGY 0 0 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 426, 871 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS -24, 228 576, 548 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS -24, 228 576, 548 73.00 90.00 O92000 DISREVATI ON BEDS (NON-DI STI NCT PART) -22, 292, 151 14, 795, 355 91.00 92.00 092000 OBSERVATI ON BEDS (NON-DI STI NCT PART) -2, 292, 151 14, 795, 355 118.00 INNREI MBURSABLE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117) -2, 292, 151 14, 795, 355 190.00			0					
67.00 06700 0CCUPATI ONAL THERAPY 0 0 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 2,883 69.00 69.02 06902 SLEEP LAB 0 29,960 69.02 07.00 ELECTROCREPHALOGRAPHY 0 0 70.00 071.00 O7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 426,871 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 169,394 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS -24,228 576,548 73.00 001PATI ENT SERVICE COST CENTERS -621,564 1,138,347 90.00 90.00 90.00 O9200 OBSERVATI ON BEDS (NON-DI STI NCT PART) -2,292,151 14,795,355 92.00 90.00 O9200 OBSERVATI ON BEDS (COST CENTERS 118.00 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 242,346 190.00 192.00			0					
68.00 06800 SPEECH PATHOLOGY 0 0 68.00 69.00 06900 ELECTROCARDIOLOGY 0 2,883 69.00 69.02 06902 SLEEP LAB 0 29,960 69.02 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 426,871 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 169,394 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS -24,228 576,548 73.00 01.00 09000 CLINIC 0 0 90.00 091.00 09000 CLINIC -621,564 1,138,347 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 92.00 92.00 92.00 SPECI AL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117) -2,292,151 14,795,355 118.00 NONREL MBURSABLE COST CENTERS 118.00 118.00 0 0 0<			0					
69.00 06900 ELECTROCARDI OLOGY 0 2,883 69.00 69.02 06902 SLEEP LAB 0 29,960 69.02 70.00 OTOOD ELECTROENCEPHALOGRAPHY 0 0 70.00 71.00 OT100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 426,871 71.00 72.00 O7200 IMPL. DEV. CHARGED TO PATI ENTS 0 169,394 72.00 73.00 O7300 DRUGS CHARGED TO PATI ENTS -24,228 576,548 73.00 00TPATI ENT SERVICE COST CENTERS 0 0 0 90.00 90.00 90.00 09000 CLINIC 0 0 90.00 90.00 91.00 09100 EMERGENCY -621,564 1,138,347 91.00 92.00 92.00 OSERVATI ON BEDS (NON-DI STINCT PART) -22,292,151 14,795,355 118.00 118.00 INONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 190.00 190.00 192.00 242,346 192.00	68.00		0		0			68.00
69. 02 06902 SLEEP LAB 0 29, 960 69. 02 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 70. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 426, 871 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 169, 394 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS -24, 228 576, 548 73. 00 0000 OUTPATI ENT SERVICE COST CENTERS -24, 228 576, 548 79. 00 90. 00 90. 00 09000 CLI NI C 0 0 91. 00 91. 00 92. 00 92. 00 09200 DBERVATI ON BEDS (NON-DI STI NCT PART) -22, 292, 151 14, 795, 355 91. 00 92. 00 SPECIAL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1-117) -2, 292, 151 14, 795, 355 118. 00 190. 00 19000 GI FT, FLOWER, COFFEE SHOP, & CANTEEN 0 0 190. 00 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 242, 346	69.00		0	2, 88	3			69.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 426, 871 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 169, 394 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS -24, 228 576, 548 73. 00 00TPATI ENT SERVICE COST CENTERS 0 0 0 90. 00 900.00 900.00 900.00 91. 00 91. 00 91. 00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 92. 00 92.	69.02		0	29, 96	0			69.02
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 426, 871 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 169, 394 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS -24, 228 576, 548 73. 00 00TPATI ENT SERVICE COST CENTERS 0 0 0 90. 00 900.00 900.00 900.00 91. 00 91. 00 91. 00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 92. 00 92.	70.00	07000 ELECTROENCEPHALOGRAPHY	0		0			70.00
73.00 07300 DRUGS CHARGED TO PATIENTS -24,228 576,548 73.00 0UTPATIENT SERVICE COST CENTERS 0 0 90.00 90.00 90.00 91.00 09000 CLINIC 0 0 90.00 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) -621,564 1,138,347 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 SPECIAL PURPOSE COST CENTERS 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP, & CANTEEN 0 0 192.00 19200 PHYSICI ANS' PRIVATE OFFICES 0 242,346 192.00	71.00		0	426, 87	1			71.00
OUTPATI ENT SERVICE COST CENTERS 90. 00 09000 CLINIC 0 0 90. 00 91. 00 09100 EMERGENCY -621, 564 1, 138, 347 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) -621, 564 1, 138, 347 92. 00 SPECIAL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1-117) -2, 292, 151 14, 795, 355 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP, & CANTEEN 190. 00 190. 00 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 242, 346 192. 00 192. 00	72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	169, 39	4			72.00
90. 00 09000 CLINIC 0 0 90. 00 91. 00 09100 EMERGENCY -621, 564 1, 138, 347 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 92. 00 92. 00 SPECI AL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1-117) -2, 292, 151 14, 795, 355 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP, & CANTEEN 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 242, 346 192. 00	73.00	07300 DRUGS CHARGED TO PATIENTS	-24, 228	576, 54	8			73.00
91. 00 09100 EMERGENCY -621, 564 1, 138, 347 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 92. 00 SPECIAL PURPOSE COST CENTERS 118. 00 NONREL IMBURSABLE COST CENTERS 190. 00 190.00 192. 00 PHYSI CLANS' PRI VATE OFFICES 0 0 192. 00 19200 PHYSI CLANS' PRI VATE OFFICES 0 242, 346 192. 00		OUTPATIENT SERVICE COST CENTERS						
92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 92.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117) -2,292,151 14,795,355 118.00 NONREI MBURSABLE COST CENTERS 1190.00 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 0 0 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 242,346 192.00	90.00	09000 CLI NI C	0		0			90.00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117) -2, 292, 151 14, 795, 355 118.00 NONREI MBURSABLE COST CENTERS 1190.00 GI FT, FLOWER, COFFEE SHOP, & CANTEEN 0 0 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 242, 346 192.00	91.00	09100 EMERGENCY	-621, 564	1, 138, 34	7			91.00
Substant	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
NONREI MBURSABLE COST CENTERS 190.00 GI FT, FLOWER, COFFEE SHOP, & CANTEEN 0 0 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 242, 346 192.00		SPECIAL PURPOSE COST CENTERS						
190.00 GI FT, FLOWER, COFFEE SHOP, & CANTEEN 0 0 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 242, 346 192.00	118.00		-2, 292, 151	14, 795, 35	5			118.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 242, 346 192.00								
200.00 TOTAL (SUM OF LINES 118-199) -2, 292, 151 15, 037, 701 200.00			-	/ ~ .				
	200.00	TOTAL (SUM OF LINES 118-199)	-2, 292, 151	15, 037, 70	1			200.00

	Financial Systems SIFICATIONS	0	OMMUNITY HOSPIT		CCN: 151300	Peri od:	Worksheet	CMS-2552-10
RECLAS	STFTCATIONS			Provider	CCN: 151300	From 05/01/2014	worksneet	A-0
						To 04/30/2015	Date/Time	Prepared:
							9/30/2015	<u>10:33 am</u>
	Cast Castas	Increases	Calarry	0+6-5-5				
	Cost Center 2.00	Line # 3.00	Salary 4.00	0ther 5.00				
	A - IMPLANTABLE DEVICES	3.00	4.00	5.00				
1.00	IMPL. DEV. CHARGED TO	72.00	0	169, 394				1.00
1.00	PATIENTS	72.00	U	109, 394				1.00
	TOTALS	+		169, 394				
	B - CHARGABLE SUPPLIES	I	-1					
1.00	MEDI CAL SUPPLI ES CHARGED TO	71.00	0	489, 066				1.00
	PATI ENTS							
2.00		0.00	0	0				2.00
3.00		0.00	0	0				3.00
4.00		0.00	0	0				4.00
5.00		0.00	0	0				5.00
6.00		0.00	0	0				6.00
7.00		0.00	0	0				7.00
8.00		0.00	0	0				8.00
9.00		0.00	0	0				9.00
10.00		0.00	0	0				10.00
11.00		0.00	0	0				11.00
12.00		0.00	0	0				12.00
13.00		0.00	0	0				13.00
14.00			0	0				14.00
			0	489, 066				
1.00	C - OB/NURSING RECLASS DELIVERY ROOM & LABOR ROOM	52.00	35, 772	19, 903				1.00
2.00	NURSERY	52.00 43.00	35, 772 27, 548					1.00
2.00				15, 327				2.00
	D - CAFETERIA RECLASS		63, 320	35, 230				
1.00	CAFETERIA	11.00	168, 186	196, 872				1.00
1.00			168, 186	19 <u>6, 872</u>				1.00
	E - YELLOW PAGES		100, 100	170,072				
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	3, 173				1.00
			— — — o	<u>3, 173</u>				
500 00	Grand Total: Increases		231, 506	893, 735				500.00

Heal th	Financial Systems	C	OMMUNITY HOSPITA	AL OF BREMEN		In Lie	u of Form CMS-2552-1
RECLAS	SI FI CATI ONS			Provi der	CCN: 151300	Period: From 05/01/2014 To 04/30/2015	Worksheet A-6 Date/Time Prepared: 9/30/2015 10:33 am
		Decreases					
	Cost Center	Line #	Sal ary	Other	Wkst. A-7 Ref	°.	
	6.00	7.00	8.00	9.00	10.00		
	A - IMPLANTABLE DEVICES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	169, 394		0	1.0
	TOTALS			169, 394		1	
	B - CHARGABLE SUPPLIES		· · · ·				
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	4		0	1.0
2.00	OPERATION OF PLANT	7.00	0	50		0	2.0
3.00	HOUSEKEEPI NG	9.00	0	2		0	3. 0
4.00	DI ETARY	10.00	0	67		0	4.0
5.00	ADULTS & PEDIATRICS	30.00	0	18, 734		0	5.0
6.00	OPERATING ROOM	50.00	0	438, 717		0	6.0
7.00	RADI OLOGY-DI AGNOSTI C	54.00	0	374		0	7.0
8.00	CT SCAN	57.00	0	6, 614		0	8.0
9.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	5, 975		0	9.0
10.00	LABORATORY	60.00	0	102		0	10.0
11.00	PHYSI CAL THERAPY	66.00	0	3, 058		0	11.0
12.00	DRUGS CHARGED TO PATIENTS	73.00	0	203		0	12.0
13.00	EMERGENCY	91.00	0	14, 673		0	13.0
14.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	493		0	14.0
			o	489,066		1	
	C - OB/NURSING RECLASS	· · · ·	· · · · · · · · · · · · · · · · · · ·				
1.00	ADULTS & PEDIATRICS	30.00	63, 320	35, 230		0	1.0
2.00		0.00	0	0		0	2.0
	0	T	63, 320	35, 230		1	
	D - CAFETERIA RECLASS	· · · · ·		· · ·			
1.00	DI ETARY	10.00	168, 186	196, 872		0	1.0
			168, 186	196, 872		1	
	E - YELLOW PAGES	i	i	· · ·			
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	3, 173		0	1.0
				3, 173		1	
500.00	Grand Total: Decreases		231, 506	893, 735		1	500. 0

RECONCI	LIATION OF CAPITAL COSTS CENTERS					eu of Form CMS-2	2002-10
			Provi der		Peri od:	Worksheet A-7	
					From 05/01/2014 To 04/30/2015	Part I	narod
					10 04/ 30/ 2015	Date/Time Pre 9/30/2015 10:	33 am
				Acqui si ti ons	6		
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2.00	3.00	4.00	5.00	
[PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES				_	
1.00	Land	440, 039	0		0 0	0	1.00
2.00	Land Improvements	0	0		0 0	0	2.00
3.00	Buildings and Fixtures	0	0		0 0	0	3.00
4.00	Building Improvements	17, 872, 912	219, 441		0 219, 441	273, 532	4.00
5.00	Fixed Equipment	0	0		0 0	0	5.00
6.00	Movable Equipment	5, 588, 967	333, 838		0 333, 838	0	6.00
7.00	HIT designated Assets	1, 289, 248	0		0 0	0	7.00
8.00	Subtotal (sum of lines 1-7)	25, 191, 166	553, 279		0 553, 279	273, 532	8.00
9.00	Reconciling Items	0	0		0 0	0	9.00
10.00	Total (line 8 minus line 9)	25, 191, 166	553, 279		0 553, 279	273, 532	10.00
		Endi ng Bal ance	Fully				
		U U	Depreciated				
			Assets				
		6.00	7.00			-	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
	Land	440, 039	0				1.00
	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	0	0				3.00
4.00	Building Improvements	17, 818, 821	0				4.00
5.00	Fixed Equipment	0	0				5.00
	Movable Equipment	5, 922, 805	0				6.00
7.00	HIT designated Assets	1, 289, 248	0				7.00
8.00	Subtotal (sum of lines 1-7)	25, 470, 913	0				8.00
	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	25, 470, 913	0				10.00

Heal th	Financial Systems	COMMUNITY HOSPI	TAL OF BREMEN		In Lie	eu of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 151300	Period:	Worksheet A-7	
					From 05/01/2014 To 04/30/2015		pared:
	· · · · · · · · · · · · · · · · · · ·					9/30/2015 10:	33 am
			SL	JMMARY OF CAPI	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
			10.00	11.00		instructions)	
	DADT LL DECONCLULATION OF ANOUNTS FROM WOR	9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR				a .	00.175	
1.00	NEW CAP REL COSTS-BLDG & FIXT	1, 174, 106	0	618, 64	0 0	38, 475	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	1, 174, 106		618, 64	0 0	38, 475	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	0ther	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1, 831, 221				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	1, 831, 221				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CN: 151300 Period: Prom 05/01/2014 To 0/30/2015 Porcheck Pate/Time Prepared: 0/30/2015 Pate/Time Prepared: 0/30/2015 <th>Heal th</th> <th>n Financial Systems</th> <th>COMMUNITY HOSPI</th> <th>TAL OF BREMEN</th> <th></th> <th>In Lie</th> <th>u of Form CMS-2</th> <th>2552-10</th>	Heal th	n Financial Systems	COMMUNITY HOSPI	TAL OF BREMEN		In Lie	u of Form CMS-2	2552-10
Cost Center Description Gross Assets Capitalized Leases Gross Assets for Ratio (col. 1 - col. 2) Ratio (see instructions) Insurance 1.00 2.00 3.00 4.00 5.00 1.00 2.00 3.00 4.00 5.00 1.00 2.00 3.00 4.00 5.00 1.00 NEW CAP REL COSTS-BLDG & FIXT 0 0 0 0.00000 0 2.00 3.00 Total (sum of lines 1-2) 0 0 0 0 0.00000 0 2.00 1.00 Cost Center Description Taxes Other cols. 5 Total (sum of cols. 5 Depreciation Lease 3.00 1.00 2.00 NEW CAP REL COSTS-BLDG & FIXT 0 0 0 0 0.00 0 2.00 1.00 Taxes Other claid and atel atel d Costs Total (sum of cols. 5 Depreciation Lease 1.00 2.00 0 0 0 0 2.00 2.00 2.00 2.00 0 0 0	RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der		From 05/01/2014	Part III Date/Time Prep	pared: 33 am
PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS orgon bit instructions instructions instructions 1.00 2.00 3.00 4.00 5.00 1.00 NEW CAP REL COSTS-BLDG & FLXT 0 0 0 1.000000 0 1.00 2.00 NEW CAP REL COSTS-BLDG & FLXT 0			COMI	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPI TAL	
PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 0 <t< td=""><td></td><td>Cost Center Description</td><td>Gross Assets</td><td></td><td>for Ratio (col. 1 - col</td><td>instructions)</td><td>Insurance</td><td></td></t<>		Cost Center Description	Gross Assets		for Ratio (col. 1 - col	instructions)	Insurance	
1.00 NEW CAP REL COSTS-BLDG & FIXT 0 0 0 1.000000 0 2.00 3.00 Total (sum of lines 1-2) 0				2.00	3.00	4.00	5.00	
2.00 NEW CAP REL COSTS-MVBLE EQUIP 0 <			ENTERS		1			
3.00 Total (sum of lines 1-2) 0 0 0 0 1.000000 0 3.00 Cost Center Description ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL Cost Center Description Taxes Other Capital -Relate d Costs Total (sum of cols. 5 through 7) Depreciation Lease 1.00 NEW CAP REL COSTS-BLDG & FIXT 0 0 0 0 10.00 2.00 NEW CAP REL COSTS-BLDG & FIXT 0 0 0 0 2.00 10.00 2.00 SUMMARY OF CAPITAL Cost Center Description 1.00 0 0 0 0 2.00 1.00 SUMMARY OF CAPITAL Cost Center Description 1 1 0 0 0 0 2.00 2.00 810, 520 -84, 600 3.00 2.00 0 0 0 0 0 0 2.00 2.00 0 0 0 0 0 0 0 2.00 11.00			0	0				
ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL Cost Center Description Taxes Other Capital -Relate d Costs Total (sum of cols. 5 through 7) Depreciation Lease 1.00 PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 6.00 7.00 8.00 9.00 10.00 1.00 NEW CAP REL COSTS-BLDG & FIXT 0 0 0 8.00 9.00 10.00 2.00 NEW CAP REL COSTS-MVBLE EQUIP 0 0 0 0 0 0 2.00 3.00 Total (sum of lines 1-2) 0 0 0 0 0 2.00 SUMMARY OF CAPITAL Cost Center Description Interest Insurance (see instructions) Total (2) (sum of cols. 9 through 14) 111.00 12.00 13.00 14.00 15.00 11.00 12.00 13.00 14.00 15.00 NEW CAP REL COSTS-BLDG & FIXT Cost Center Description 11.00 12.00 13.00 14.00 15.00 NEW CAP REL COSTS-BLDG & FIXT 589,259 0 3			0	0				
Cost Center Description Taxes Other Capital-Relate d Costs Total (sum of cols. 5 through 7) Depreciation Lease PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 NEW CAP REL COSTS-BLDG & FIXT 0 0 0 810,520 -84,600 1.00 2.00 NEW CAP REL COSTS-MVBLE EQUIP 0 0 0 0 810,520 -84,600 1.00 3.00 Total (sum of lines 1-2) 0 0 0 0 810,520 -84,600 3.00 SUMMARY OF CAPITAL Cost Center Description Interest Insurance (see instructions) Taxes (see instructions) Total (2) (sum of cols. 9 through 14) PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS I.00 1.00 12.00 13.00 14.00 1.00 NEW CAP REL COSTS-BLDG & FIXT 589,259 0 38,475 0 1.00 NEW CAP REL COSTS-BLDG & FIXT 589,259 0 38,475 <t< td=""><td>3.00</td><td>lotal (sum of lines 1-2)</td><td>0</td><td></td><td></td><td></td><td></td><td>3.00</td></t<>	3.00	lotal (sum of lines 1-2)	0					3.00
PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS Col s. 5 through 7) Col s. 5 through 7) Col s. 5 through 7) Col s. 5 through 7) 1.00 PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 6.00 7.00 8.00 9.00 10.00 2.00 NEW CAP REL COSTS-BLOG & FIXT 0 0 0 8.00 9.00 10.00 2.00 NEW CAP REL COSTS-MVBLE EQUIP 0 0 0 0 0 2.00 3.00 Total (sum of lines 1-2) 0 0 0 0 8.00 9.00 1.00 Cost Center Description Interest Insurance (see instructions) Taxes (see instructions) Total (2) (sum of cols. 9 through 14) NEW CAP REL COSTS-BLOG & FIXT NEW CAP REL COSTS-BLOG & FIXT Summary of through 14.00 1.00 NEW CAP REL COSTS-BLOG & FIXT Summary of through 14.00 1.00 1.00 NEW CAP REL COSTS-BLOG & FIXT 1.00 13.00 <td< td=""><td></td><td></td><td>ALLOCA</td><td>IION OF OTHER (</td><td>CAPITAL</td><td>SUMMARY C</td><td>F CAPITAL</td><td></td></td<>			ALLOCA	IION OF OTHER (CAPITAL	SUMMARY C	F CAPITAL	
PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 0 0 8.00 9.00 10.00 1.00 NEW CAP REL COSTS-BLDG & FIXT 0 0 0 810,520 -84,600 1.00 2.00 NEW CAP REL COSTS-MVBLE EQUIP 0 0 0 0 0 2.00 3.00 Total (sum of lines 1-2) 0 0 0 0 2.00 SUMMARY OF CAPITAL Cost Center Description Interest Insurance (see instructions) Taxes (see instructions) Other capital -Relate d Costs (see instructions) Total (2) (sum of cols. 9 through 14) PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 12.00 13.00 14.00 15.00 NEW CAP REL COSTS-BLDG & FIXT 589,259 0 38,475 0 1,353,654 1.00 2.00 NEW CAP REL COSTS-MVBLE EQUIP 0 0 0 0 0 0 2.00		Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
BART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 6.00 7.00 8.00 9.00 10.00 1.00 PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 0 0 0 810,520 -84,600 1.00 2.00 NEW CAP REL COSTS-BLDG & FIXT 0 0 0 0 0 2.00 3.00 Total (sum of lines 1-2) 0 0 0 0 0 2.00 SUMMARY OF CAPITAL Cost Center Description Interest Insurance (see instructions) Taxes (see instructions) 0 <t< td=""><td></td><td></td><td></td><td>Capi tal -Rel ate</td><td>cols. 5</td><td></td><td></td><td></td></t<>				Capi tal -Rel ate	cols. 5			
PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 NEW CAP REL COSTS-BLDG & FIXT 0 0 0 0 0 0 2.00 3.00 Total (sum of lines 1-2) 0 0 0 0 0 0 0 2.00 SUMMARY OF CAPI TAL Cost Center Description Interest Insurance (see instructions) Instructions) 11.00 12.00 13.00 14.00 15.00 PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 12.00 13.00 14.00 15.00 PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 NEW CAP REL COSTS-BLDG & FIXT 589, 259 0 38, 475 0 1, 353, 654 1.00 2.00 NEW CAP REL COSTS-MVBLE EQUIP 0 0 0 0 2.00					through 7)			
1.00 NEW CAP REL COSTS-BLDG & FIXT 0 0 0 810, 520 84, 600 1.00 2.00 NEW CAP REL COSTS-MVBLE EQUIP 0 0 0 0 0 0 2.00 3.00 Total (sum of lines 1-2) 0 0 0 0 0 0 3.00 SUMMARY OF CAPI TAL Cost Center Description Interest Insurance (see instructions) Taxes (see instructions) Other d Costs (see instructions) Total (2) (sum of cols. 9 through 14) 11.00 12.00 13.00 14.00 15.00 PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 NEW CAP REL COSTS-BLDG & FIXT 589, 259 0 38, 475 0 1, 353, 654 1.00 2.00 NEW CAP REL COSTS-MVBLE EQUIP 0 0 0 0 0 2.00				7.00	8.00	9.00	10.00	
2.00 NEW CAP REL COSTS-MVBLE EQUIP 0 0 0 0 0 0 0 0 0 0 2.00 3.00 Total (sum of lines 1-2) 0 0 0 0 0 0 0 0 0 0 0 2.00 3.00			ENTERS	. <u></u>	1			
3.00 Total (sum of lines 1-2) 0 0 0 810, 520 -84, 600 3.00 SUMMARY OF CAPITAL Cost Center Description Interest Insurance (see instructions) Taxes (see instructions) Other Capital -Relate d Costs (see instructions) Total (2) (sum of cols. 9 through 14) 11.00 12.00 13.00 14.00 15.00 PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 NEW CAP REL COSTS-BLDG & FIXT 589, 259 0 38, 475 0 1, 353, 654 1.00 2.00 NEW CAP REL COSTS-MVBLE EQUIP 0 0 0 0 0 2.00			0	0		0 810, 520	-84, 600	
SUMMARY OF CAPITAL SUMMARY OF CAPITAL Cost Center Description Interest Insurance (see instructions) Taxes (see Other Total (2) (sum of cols. 9 d Costs (see Instructions) Interest Insurance (see Instructions) Total -Relate of cols. 9 through 14) Interest Insurance (see Instructions) Total (2) (sum of cols. 9 through 14) Int. 00 12.00 13.00 14.00 15.00 PART III - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 NEW CAP REL COSTS-BLDG & FIXT 589, 259 0 38, 475 0 1, 353, 654 1.00 2.00 NEW CAP REL COSTS-MVBLE EQUIP 0 0 0 0 0 2.00			0	0		0 0	Ű	
Cost Center Description Interest Insurance (see instructions) Taxes (see instructions) Other Capital -Relate d Costs (see instructions) Total (2) (sum of col s. 9 through 14) 11.00 12.00 13.00 14.00 15.00 PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 NEW CAP REL COSTS-BLDG & FIXT 589, 259 0 38, 475 0 1, 353, 654 1.00 2.00 NEW CAP REL COSTS-MVBLE EQUIP 0 0 0 0 0 2.00	3.00	Total (sum of lines 1-2)	0	0			-84, 600	3.00
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS 11.00 12.00 13.00 14.00 15.00 1.00 NEW CAP REL COSTS-BLDG & FIXT 589,259 0 38,475 0 1,353,654 1.00 2.00 NEW CAP REL COSTS-MVBLE EQUIP 0 0 0 0 0 2.00				SL	JMMARY OF CAPI	TAL		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS d Costs (see instructions) through 14) 1.00 12.00 13.00 14.00 15.00 2.00 NEW CAP REL COSTS-BLDG & FIXT 589, 259 0 38, 475 0 1, 353, 654 1.00 2.00 NEW CAP REL COSTS-MVBLE EQUIP 0 0 0 0 0 2.00		Cost Center Description	Interest	Insurance (see	Taxes (see	0ther		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS 11.00 12.00 13.00 14.00 15.00 1.00 NEW CAP REL COSTS-BLDG & FIXT 589, 259 0 38, 475 0 1, 353, 654 1.00 2.00 NEW CAP REL COSTS-MVBLE EQUIP 0 0 0 0 0 2.00				instructions)	instructions)			
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 12.00 13.00 14.00 15.00 1.00 NEW CAP REL COSTS-BLDG & FIXT 589, 259 0 38, 475 0 1, 353, 654 1.00 2.00 NEW CAP REL COSTS-MVBLE EQUIP 0 0 0 0 2.00							through 14)	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 NEW CAP REL COSTS-BLDG & FIXT 589, 259 0 38, 475 0 1, 353, 654 1.00 2.00 NEW CAP REL COSTS-MVBLE EQUIP 0 0 0 0 2.00								
1.00 NEW CAP REL COSTS-BLDG & FIXT 589, 259 0 38, 475 0 1, 353, 654 1.00 2.00 NEW CAP REL COSTS-MVBLE EQUIP 0 0 0 0 2.00				12.00	13.00	14.00	15.00	
2.00 NEW CAP REL COSTS-MVBLE EQUI P 0 0 0 0 2.00				1		_1		
			589, 259	0	38, 47	5 0		
3.00 lotal (sum of lines 1-2) 589, 259 0 38, 475 0 1, 353, 654 3.00			0	0		0 0	-	
	3.00	lotal (sum of lines 1-2)	589, 259	0	38, 47	5 0	1, 353, 654	3.00

	Financial Systems MENTS TO EXPENSES			TAL OF BREMEN Provider CCN: 151300	Period [.]	u of Form CMS-2 Worksheet A-8	
					From 05/01/2014 To 04/30/2015		
				Expense Classification or		9/30/2015 10: 3	<u>33 an</u>
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Line # 4.00	Wkst. A-7 Ref. 5.00	
. 00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter	В		NEW CAP REL COSTS-BLDG & FIXT	1.00	<u> </u>	1. (
. 00	2) Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter		C	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.
00	2) Investment income - other		C		0.00	0	3.
00	(chapter 2) Trade, quantity, and time		C		0.00	0	4.
	discounts (chapter 8)		C			-	
00	Refunds and rebates of expenses (chapter 8)	В	-11, 443	ADMI NI STRATI VE & GENERAL	5.00	0	5.
00	Rental of provider space by suppliers (chapter 8)		C		0.00	0	6.
00	Telephone services (pay stations excluded) (chapter		C		0.00	0	7.
00	21) Tel evision and radio service		C		0.00	0	8.
. 00	(chapter 21) Parking lot (chapter 21)		C		0.00	0	
0. 00	Provider-based physician adjustment	A-8-2	-1, 063, 737			0	10.
1.00	Sale of scrap, waste, etc. (chapter 23)	В	-2, 096	RADI OLOGY-DI AGNOSTI C	54.00	0	11.
2. 00	Related organization transactions (chapter 10)	A-8-1	C			0	12.
3. 00	Laundry and linen service	_	C)	0.00	0	
. 00 5. 00	Cafeteria-employees and guests Rental of quarters to employee and others	В	-144, 096 C	CAFETERI A	11.00 0.00	0 0	
5. 00	Sale of medical and surgical supplies to other than patients		C)	0.00	0	16.
7.00	Sale of drugs to other than	В	-24, 228	DRUGS CHARGED TO PATIENTS	73.00	0	17.
3. 00	patients Sale of medical records and abstracts	В	-3, 737	MEDI CAL RECORDS & LI BRARY	16.00	0	18.
. 00	Nursing school (tuition, fees, books, etc.)		C		0.00	0	19
	Vending machines		C		0.00		20
. 00	Income from imposition of interest, finance or penalty charges (chapter 21)	В	-3, 951	ADMI NI STRATI VE & GENERAL	5.00	0	21
. 00	Interest expense on Medicare overpayments and borrowings to		C		0.00	0	22
3. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	C	RESPI RATORY THERAPY	65.00		23.
1. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	C	PHYSI CAL THERAPY	66.00		24.
. 00	limitation (chapter 14) Utilization review - physicians' compensation		C	*** Cost Center Deleted ***	114.00		25
. 00	(chapter 21) Depreciation - NEW CAP REL		C	NEW CAP REL COSTS-BLDG &	1.00	0	26
. 00	COSTS-BLDG & FIXT Depreciation - NEW CAP REL		C	FIXT NEW CAP REL COSTS-MVBLE	2.00	0	27
. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		C	EQUIP *** Cost Center Deleted ***	19.00		28
. 00 . 00	Physicians' assistant Adjustment for occupational therapy costs in excess of	A-8-3	C	OCCUPATI ONAL THERAPY	0.00 67.00	0	29 30
. 99	limitation (chapter 14) Hospice (non-distinct) (see		C	ADULTS & PEDIATRICS	30.00		30
. 00	instructions) Adjustment for speech pathology costs in excess of	A-8-3	C	SPEECH PATHOLOGY	68.00		31.
2. 00	limitation (chapter 14) CAH HIT Adjustment for	А	_2/7 /01	NEW CAP REL COSTS-BLDG &	1.00	9	32
00	Depreciation and Interest	~		FIXT	1.00	9	32

Health Financial Systems	C	OMMUNITY HOSPI	TAL OF BREMEN	In Lie	eu of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES			Provider CCN: 151300	Peri od:	Worksheet A-8	
				From 05/01/2014 To 04/30/2015		narod
				10 04/ 30/ 2013	9/30/2015 10:	
			Expense Classification o			
			To/From Which the Amount is	to be Adjusted		
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
33.00 MEALS ON WHEELS	В		DIETARY	10.00		
34.00 HAF PROVIDER ASSESSMENT	A		ADMI NI STRATI VE & GENERAL	5.00		
35. 00 I NVOI CE PENALTI ES	A		ADMI NI STRATI VE & GENERAL	5.00		
36. 00 RECRUI TI NG/MD_SUPPORT	A		ADMI NI STRATI VE & GENERAL	5.00		
37.00 LOBBYING EXP IN DUES 38.00 PLYMOUTH ST CLINIC DEPR	A		ADMINISTRATIVE & GENERAL NEW CAP REL COSTS-BLDG &	5.00		
38.00 PETMOUTH SI CEINIC DEPR	A	- 10, 095	FIXT	1.00	9	30.00
39.00 MISC INCOME	В	-1 046	ADMI NI STRATI VE & GENERAL	5.00	0	39.00
40. 00 PLYMOUTH ST MAINTENANCE	B		OPERATION OF PLANT	7.00		
41.00 SALES TAX	В		ADMI NI STRATI VE & GENERAL	5.00		
42.00 LUNCH FUND	В		DI ETARY	10.00		42.00
43.00 DI ETARY PURCHASES	В	-270	DI ETARY	10.00	0	43.00
44.00 VENDING PURCHASES	В	-9	DI ETARY	10.00	0	44.00
45.00 OTHER OPER REV-COMMUNITY GR	В	-60	ADMINISTRATIVE & GENERAL	5.00	0	45.00
45.01 RENTAL REVENUE-SPECIALISTS	В	-84,600	NEW CAP REL COSTS-BLDG &	1.00	10	45.01
			FLXT			
45.02 RENTAL REVENUE CLINIC SUITE	В	-30	ADMI NI STRATI VE & GENERAL	5.00	0	45.02
REN CALADISC		400.057		50.00		45 00
45. 03 CRNA SALARI ES 45. 04 CRNA BENEFI TS	A		OPERATING ROOM EMPLOYEE BENEFITS DEPARTMEN	50.00 T 4.00		
45.04 CRNA BENEFITS 45.05 OTHER ADJUSTMENTS (SPECIFY)	A	-20, 885 0		0.00		1
(3)		0		0.00	0	45.05
45.06 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	45.06
(3)		0		0.00	, °	10.00
45.07 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	45.07
(3)						
45.08 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	45.08
(3)						
45.09 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	45.09
$\begin{pmatrix} (3) \\ (3$		0		0.00		45 10
45. 10 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.10
50.00 TOTAL (sum of lines 1 thru 49)		-2, 292, 151				50,00
(Transfer to Worksheet A,		-2, 272, 101				30.00
column 6, line 200.)						
(1) Description - all chapter refere		ump portain t	CMS Dub 15 1		•	•

(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.

Heal th	Financial Syste	ems	COMMUNITY HOSP	ITAL OF BREMEN	I	In Lie	eu of Form CMS-	2552-10
PROVI DE	ER BASED PHYSIC	I AN ADJUSTMENT		Provi de	r CCN: 151300	Period: From 05/01/2014 To 04/30/2015	Date/Time Pre	epared:
							9/30/2015 10:	<u>33 am</u>
	Wkst. A Line #		Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		ADULTS & PEDIATRICS	26, 500	26, 500) (0 0	0	1.00
2.00		OPERATING ROOM	415, 673	415, 673	3 (0 0	0	2.00
3.00	60.00	LABORATORY	21, 600	(21,60	0 0	0	3.00
4.00	91.00	EMERGENCY	1, 109, 935	621, 564	488, 37	1 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	(o o	0	8.00
9.00	0.00		0	(o o	0	9.00
10.00	0,00		0			0 0	0	
200.00			1, 573, 708	1,063,73	509, 97	1	0	
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er	Limit		Memberships &		of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		ADULTS & PEDIATRICS	0	(0 0	0	1.00
2.00	50.00	OPERATING ROOM	0	(o o	0	2.00
3.00		LABORATORY	0	(o o	0	3.00
4.00		EMERGENCY	0				0	
5.00	0,00		0	(0	0	5.00
6.00	0.00		0	(0	
7.00	0.00		0				0	
8.00	0.00		0				0	
9.00	0.00		0				0	
10.00	0.00		0				0	1.00
200.00	0.00		0			-	0	
200.00	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		200.00
		I denti fi er	Component	Limit	Di sal l owance			
		i dontri i or	Share of col.		Di Sai i Gilance			
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	(26, 500		1.00
2.00	50.00	OPERATING ROOM	0	(415, 673		2.00
3.00	60.00	LABORATORY	0	(3.00
4.00	91.00	EMERGENCY	0			621, 564		4,00
5.00	0.00		0	(5.00
6.00	0.00		0			-		6.00
7.00	0.00		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		0			1,063,737		200.00
200.00	I	1	. 0		1	1,000,707	I	200.00

REASON	Financial Systems (IABLE COST DETERMINATION FOR THERAPY SERVICES DE SUPPLIERS	:ommuni ty hospi t <i>i</i> Furni shed by	Provider CCN: 7	From O To O Occup			-3 pared:
						1.00	
1.00	PART I - GENERAL INFORMATION Total number of weeks worked (excluding aide:	s) (see instructi	ons)			3	1.00
2.00	Line 1 multiplied by 15 hours per week		0115)			45	
3.00	Number of unduplicated days in which supervis					11	3.00
4.00	Number of unduplicated days in which therapy nor therapist was on provider site (see inst		n provider site bu	t neither supe	rvi sor	0	4.00
5.00	Number of unduplicated offsite visits - super		oists (see instruc	tions)		0	5.00
6.00	Number of unduplicated offsite visits - there					0	6.00
	assistant and on which supervisor and/or the instructions)	rapist was not pi	resent during the	visit(s)) (see			
7.00	Standard travel expense rate					5.25	
8.00	Optional travel expense rate per mile	Supervi sors	Therapists Ass	istants	Ai des	0.00 Trai nees	8.00
		1.00			4. 00	5.00	
9.00	Total hours worked	0.00	20.67	0.00	0.00	0.00	
10.00 11.00	AHSEA (see instructions) Standard travel allowance (columns 1 and 2,	0. 00 38. 82	77.64 38.82	0.00 0.00	0.00	0.00	10.00 11.00
11.00	one-half of column 2, line 10; column 3,	50. 02	50.02	0.00			11.00
10.00	one-half of column 3, line 10)			0			10.00
12.00 12.01	Number of travel hours (provider site) Number of travel hours (offsite)	0	0	0			12.00 12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
11.00	Part II - SALARY EQUIVALENCY COMPUTATION	1: 40)					1 4 00
14.00 15.00	Supervisors (column 1, line 9 times column 1, Therapists (column 2, line 9 times column 2,					0 1, 605	
16.00	Assistants (column 3, line 9 times column 3,					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and	nd 15 for respira	atory therapy or I	ines 14-16 for	all	1, 605	17.00
18.00	others) Aides (column 4, line 9 times column 4, line	10)				0	18.00
19.00	Trainees (column 5, line 9 times column 5, li	ne 10)				0	19.00
20.00	Total allowance amount (sum of lines 17-19 for If the sum of columns 1 and 2 for respiratory					1,605	20.00
	occupational therapy, line 9, is greater than						
	the amount from line 20. Otherwise complete						
21.00	Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3,			columns 1 and	2, line 9	77.65	21.00
22.00	Weighted allowance excluding aides and train					3, 494	
23.00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW					3, 494	23.00
	Standard Travel Allowance	ANCE AND TRAVEL	EXPENSE COMPUTATIO	JN - PROVIDER	SITE		
24.00	Therapists (line 3 times column 2, line 11)					427	
25.00 26.00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or	sum of lines 24	and 2E for all at			0 427	
27.00	Standard travel expense (line 7 times line 3				for all	427 58	
~~ ~~	others)					105	
28.00	Total standard travel allowance and standard 27)	travel expense a	at the provider si	te (sum of lin	es 26 and	485	28.00
	Optional Travel Allowance and Optional Travel						
29.00	Therapists (column 2, line 10 times the sum of the sum		2, line 12)			0	
30.00 31.00	Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or		and 30 for all ot	hers)		0	30.00 31.00
32.00	Optional travel expense (line 8 times column				m of	0	32.00
22 00	columns 1-3, line 13 for all others)	ovnonco (lino '	00)			485	22 00
33.00 34.00	Standard travel allowance and standard trave Optional travel allowance and standard trave					485	
35.00	Optional travel allowance and optional trave	expense (sum of	lines 31 and 32)			0	
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense	ANCE AND TRAVEL E	XPENSE COMPUTATIO	N - SERVICES O	UISIDE PRO	DVIDER SITE	
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00 39.00	Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum	n of lines 5 and	6)			0	
27.00	Optional Travel Allowance and Optional Travel		-/				
40.00	Therapists (sum of columns 1 and 2, line 12.		2, line 10)			0	
41.00 42.00	Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41)	13, IIne 10)				0	41.00 42.00
42.00	Optional travel expense (line 8 times the sur	n of columns 1-3,	line 13.01)			0	42.00
	Total Travel Allowance and Travel Expense - (the following	three line	es 44, 45,	
	or 46, as appropriate.		Elines 20 and 20		ionc)	0	44.00
44.00	Standard travel allowance and standard trave	expense (sum o	11 nes 38 and 39		10115)	0	44.00

	ABLE COST DETERMINATION FOR THERAPY SERVICES I E SUPPLIERS	URNI SHED BY	Provi der		Period: From 05/01/2014 To 04/30/2015	Worksheet A-8 Parts I-VI Date/Time Pre 9/30/2015 10:	pared:
					Occupati onal Therapy	Cost	
						1.00	
15.00	Optional travel allowance and standard travel	expense (sum o	of lines 39 an	d 42 - see in	structions)	0	
6.00	Optional travel allowance and optional travel		of lines 42 an		,	0	46.00
		Therapists 1.00	Assistants 2.00	Ai des 3.00	Trai nees 4.00	<u>Total</u> 5.00	
	PART V - OVERTIME COMPUTATION						
7.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0. 00	0.00	0. C	0.00	0.00	47.00
8.00	Overtime rate (see instructions)	0.00	0.00				48.00
9.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.0	0.00		49.00
	CALCULATION OF LIMIT						
0. 00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0. C	0.00	0.00	50. OC
1.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	O. C	00 0.00	0.00	51.00
2.00	DETERMINATION OF OVERTIME ALLOWANCE Adjusted hourly salary equivalency amount	77.64	0.00	0.0	0.00		52.00
3. 00	(see instructions) Overtime cost limitation (line 51 times line	0	0.00		0 0		53.00
4. 00	52) Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0		0 0		54.00
5.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0		0 0		55.OC
6.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	O	0		0 0	0	56.00
		ND EVERS COST				1.00	
7 00	Part VI - COMPUTATION OF THERAPY LIMITATION A Salary equivalency amount (from line 23)	ND EXCESS CUST	ADJUSTMENT			3, 494	57.00
B. 00	Travel allowance and expense - provider site	(from lines 33,	, 34, or 35))			485	
9.00	Travel allowance and expense - Offsite servic	es (from lines	44, 45, or 46)		0	
0.00	Overtime allowance (from column 5, line 56) Equipment cost (see instructions)					0	
	Supplies (see instructions)					0	
	Total allowance (sum of lines 57-62)					3, 979	
	Total cost of outside supplier services (from	5				1, 281	
5.00	Excess over limitation (line 64 minus line 63	- if negative,	, enter zero)			0	65.00
00 00	LINE 33 CALCULATION Line 26 = line 24 for respiratory therapy or	sum of lines 2	4 and 25 for a	others		427	100. 00
	Line 27 = line 7 times line 3 for respiratory				others		100.01
00. 02	Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION					485	100. 02
1 00	Line 27 = line 7 times line 3 for respiratory				others		101.00
	Line 31 = line 29 for respiratory therapy or	sum of lines 29	9 and 30 for a	II others			101. 01 101. 02
01. 01	Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION						1
01.01 01.02	Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION Line 31 = line 29 for respiratory therapy or Line 32 = line 8 times columns 1 and 2, line	sum of lines 29	9 and 30 for a	II others		0	102. 00 102. 0'

	IABLE COST DETERMINATION FOR THERAPY SERVICES DE SUPPLIERS	Communi <u>Ty</u> hospi Furni Shed By		CCN: 151300	Period: From 05/01/2014 To 04/30/2015 Speech Pathology	5 Date/Time Pre 9/30/2015 10:	-3 pared:
	PART I – GENERAL INFORMATION					1.00	
1.00	Total number of weeks worked (excluding aides	s) (see instruc	tions)			8	1.00
2.00	Line 1 multiplied by 15 hours per week		· · · /			120	
3.00	Number of unduplicated days in which supervis					10	
4.00	Number of unduplicated days in which therapy		on provider si	te but neith	ier supervi sor	0	4.00
5.00	nor therapist was on provider site (see inst Number of unduplicated offsite visits - super		anists (see in	structions)		0	5.00
6.00	Number of unduplicated offsite visits - there				by therapy	0	6.00
	assistant and on which supervisor and/or the	apist was not	present during	the visit(s	s)) (see		
7 00	instructions)					F 05	7 00
7.00 8.00	Standard travel expense rate Optional travel expense rate per mile					5.25	7.00 8.00
0.00	optional travel expense rate per mine	Supervi sors	Therapi sts	Assi stants	Ai des	Trai nees	0.00
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	13.23		00 0.00		9.00
10.00	AHSEA (see instructions)	0.00	74.64		00 0.00	0.00	
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3,	37.32	37.32	0.	00		11.00
	one-half of column 3, line 10)						
12.00	Number of travel hours (provider site)	0	0		0		12.00
12.01	Number of travel hours (offsite)	0	0		0		12.01
13.00 13.01	Number of miles driven (provider site)	0	0		0		13.00
13.01	Number of miles driven (offsite)	0	U		U		13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION					1	
14.00 15.00	Supervisors (column 1, line 9 times column 1,					0 987	
16.00	Therapists (column 2, line 9 times column 2, Assistants (column 3, line 9 times column 3,	,				987	16.00
17.00	Subtotal allowance amount (sum of lines 14 ar		ratory therapy	or lines 14	-16 for all	987	17.00
	others)						
18.00	Aides (column 4, line 9 times column 4, line					0	18.00
19.00 20.00	Trainees (column 5, line 9 times column 5, li		thereasy on Lin	oc 17 and 10	for all athere)	987	19.00 20.00
20.00	Total allowance amount (sum of lines 17-19 for If the sum of columns 1 and 2 for respiratory	therapy or co	Lumns 1-3 for	es i/ anu ic	for all others)	907	20.00
		, therapy of co			ranv sneech nat	hology or	
	occupational therapy, line 9, is greater than	n line 2, make					
	the amount from line 20. Otherwise complete	lines 21-23.	no entries on	lines 21 and	22 and enter on	line 23	
21. 00	the amount from Line 20. Otherwise complete Weighted average rate excluding aides and tra	<u>lines 21-23.</u> ainees (line 17	no entries on divided by su	lines 21 and	22 and enter on	line 23	21.00
	the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3,	<u>lines 21-23.</u> ainees (line 17 line 9 for all	no entries on divided by su others)	lines 21 and	22 and enter on	line 23 74.60	
21.00 22.00 23.00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and trained	<u>lines 21-23.</u> ainees (line 17 line 9 for all	no entries on divided by su others)	lines 21 and	22 and enter on	line 23	22.00
22. 00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traino Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW	lines 21–23. ainees (line 17 line 9 for all ees (line 2 tim	no entries on divided by su others) es line 21)	lines 21 and	22 and enter on	line 23 74.60 8,952	22.00
22. 00 23. 00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance	lines 21–23. ainees (line 17 line 9 for all ees (line 2 tim	no entries on divided by su others) es line 21)	lines 21 and	22 and enter on	line 23 74.60 8,952 8,952	22. 00 23. 00
22. 00 23. 00 24. 00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11)	lines 21–23. ainees (line 17 line 9 for all ees (line 2 tim	no entries on divided by su others) es line 21)	lines 21 and	22 and enter on	line 23 74.60 8,952 8,952 373	22. 00 23. 00 24. 00
22. 00 23. 00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11)	lines 21-23. ainees (line 17 line 9 for all ees (line 2 tim MANCE AND TRAVE	no entries on divided by su others) es line 21) L EXPENSE COMP	lines 21 and m of columns UTATION - PR	22 and enter on	line 23 74.60 8,952 8,952	22.00 23.00 24.00 25.00
22. 00 23. 00 24. 00 25. 00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11)	lines 21-23. ainees (line 17 line 9 for all ees (line 2 tim MANCE AND TRAVE sum of lines 2	no entries on divided by su others) es line 21) L EXPENSE COMP 4 and 25 for a	lines 21 and m of columns UTATION - PR	22 and enter on 1 and 2, line 9 OVIDER SITE	line 23 74.60 8,952 8,952 	22. 00 23. 00 24. 00 25. 00 26. 00
22.00 23.00 24.00 25.00 26.00 27.00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traino Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others)	lines 21-23. ainees (line 17 line 9 for all ees (line 2 tim MANCE AND TRAVE sum of lines 2 for respirator	no entries on divided by su others) es line 21) L EXPENSE COMP 4 and 25 for a y therapy or s	lines 21 and m of columns UTATION - PR II others) um of lines	22 and enter on 1 and 2, line 9 OVIDER SITE 3 and 4 for all	line 23 74.60 8,952 8,952 373 0 373 53	22. 00 23. 00 24. 00 25. 00 26. 00 27. 00
22. 00 23. 00 24. 00 25. 00 26. 00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traino Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard	lines 21-23. ainees (line 17 line 9 for all ees (line 2 tim MANCE AND TRAVE sum of lines 2 for respirator	no entries on divided by su others) es line 21) L EXPENSE COMP 4 and 25 for a y therapy or s	lines 21 and m of columns UTATION - PR II others) um of lines	22 and enter on 1 and 2, line 9 OVIDER SITE 3 and 4 for all	line 23 74.60 8,952 8,952 373 0 373 53	22. 00 23. 00 24. 00 25. 00 26. 00 27. 00
22.00 23.00 24.00 25.00 26.00 27.00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traino Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others)	lines 21-23. ainees (line 17 line 9 for all ees (line 2 tim MANCE AND TRAVE sum of lines 2 for respirator travel expense	no entries on divided by su others) es line 21) L EXPENSE COMP 4 and 25 for a y therapy or s	lines 21 and m of columns UTATION - PR II others) um of lines	22 and enter on 1 and 2, line 9 OVIDER SITE 3 and 4 for all	line 23 74.60 8,952 8,952 373 0 373 53	22. 00 23. 00 24. 00 25. 00 26. 00 27. 00
22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of	lines 21-23. ainees (line 17 line 9 for all ees (line 2 tim MANCE AND TRAVE sum of lines 2 for respirator travel expense Expense of columns 1 an	no entries on divided by su others) es line 21) <u>L EXPENSE COMP</u> 4 and 25 for a y therapy or s at the provid	lines 21 and m of columns UTATION - PR II others) um of lines	22 and enter on 1 and 2, line 9 OVIDER SITE 3 and 4 for all	l i ne 23 74. 60 8, 952 8, 952 373 0 373 53 426 0	22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 28. 00
22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traino Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3,	lines 21-23. ainees (line 17 line 9 for all ees (line 2 tim VANCE AND TRAVE sum of lines 2 for respirator travel expense <u>Expense</u> of columns 1 an line 12)	no entries on divided by su others) es line 21) L EXPENSE COMP 4 and 25 for a y therapy or s at the provid d 2, line 12)	lines 21 and m of columns UTATION - PR II others) um of lines er site (sum	22 and enter on 1 and 2, line 9 OVIDER SITE 3 and 4 for all	l i ne 23 74. 60 8, 952 8, 952 373 0 373 53 426 0 0 0 0	22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 28. 00 30. 00
22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traino Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 2, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or	lines 21-23. ainees (line 17 line 9 for all ees (line 2 tim VANCE AND TRAVE sum of lines 2 for respirator travel expense Expense of columns 1 an line 12) sum of lines 2	no entries on divided by su others) es line 21) L EXPENSE COMP 4 and 25 for a y therapy or s at the provid d 2, line 12) 9 and 30 for a	lines 21 and m of columns UTATION - PR II others) um of lines er site (sum II others)	22 and enter on 1 and 2, line 9 OVIDER SITE 3 and 4 for all n of lines 26 and	l i ne 23 74. 60 8, 952 8, 952 373 0 0 373 53 426 0 0 0 0 0 0 0 0 0	22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00
22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traino Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum 0, Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns)	lines 21-23. ainees (line 17 line 9 for all ees (line 2 tim VANCE AND TRAVE sum of lines 2 for respirator travel expense Expense of columns 1 an line 12) sum of lines 2	no entries on divided by su others) es line 21) L EXPENSE COMP 4 and 25 for a y therapy or s at the provid d 2, line 12) 9 and 30 for a	lines 21 and m of columns UTATION - PR II others) um of lines er site (sum II others)	22 and enter on 1 and 2, line 9 OVIDER SITE 3 and 4 for all n of lines 26 and	l i ne 23 74. 60 8, 952 8, 952 373 0 373 53 426 0 0 0 0	22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 28. 00 30. 00
22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traino Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or	lines 21-23. ainees (line 17 line 9 for all ees (line 2 tim MANCE AND TRAVE sum of lines 2 for respirator travel expense <u>Expense</u> of columns 1 an line 12) sum of lines 2 s 1 and 2, line	no entries on divided by su others) es line 21) L EXPENSE COMP 4 and 25 for a y therapy or s at the provid d 2, line 12) 9 and 30 for a 13 for respir	lines 21 and m of columns UTATION - PR II others) um of lines er site (sum II others)	22 and enter on 1 and 2, line 9 OVIDER SITE 3 and 4 for all n of lines 26 and	l i ne 23 74. 60 8, 952 8, 952 373 0 0 373 53 426 0 0 0 0 0 0 0 0 0	22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00
22. 00 23. 00 25. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traino Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel	lines 21-23. ainees (line 17 line 9 for all ees (line 2 tim VANCE AND TRAVE sum of lines 2 for respirator travel expense <u>Expense</u> of columns 1 an line 12) sum of lines 2 s 1 and 2, line expense (line expense (sum	no entries on divided by su others) es line 21) L EXPENSE COMP 4 and 25 for a y therapy or s at the provid d 2, line 12) 9 and 30 for a 13 for respir 28) of lines 27 an	LI others) um of columns UTATION - PR UTATION - PR UN others) um of lines er site (sum ll others) atory therap d 31)	22 and enter on 1 and 2, line 9 OVIDER SITE 3 and 4 for all n of lines 26 and	l i ne 23 74. 60 8, 952 8, 952 373 0 373 53 426 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22. 00 23. 00 25. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00
22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traino Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column 3, Subtotal (line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel	lines 21-23. ainees (line 17 line 9 for all ees (line 2 tim VANCE AND TRAVE sum of lines 2 for respirator travel expense Expense of columns 1 an line 12) sum of lines 2 s 1 and 2, line expense (line expense (sum expense (sum	no entries on divided by su others) es line 21) L EXPENSE COMP 4 and 25 for a y therapy or s at the provid d 2, line 12) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an	LI others) UTATION - PR UTATION - PR UTATION - PR UN of Lines er site (sum LI others) atory therap d 31) d 32)	22 and enter on 1 and 2, line 9 OVIDER SITE 3 and 4 for all n of lines 26 and	l i ne 23 74. 60 8, 952 8, 952 373 373 373 373 426 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00
22. 00 23. 00 25. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traino Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 2, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and optional travel	lines 21-23. ainees (line 17 line 9 for all ees (line 2 tim VANCE AND TRAVE sum of lines 2 for respirator travel expense Expense of columns 1 an line 12) sum of lines 2 s 1 and 2, line expense (line expense (sum expense (sum	no entries on divided by su others) es line 21) L EXPENSE COMP 4 and 25 for a y therapy or s at the provid d 2, line 12) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an	LI others) UTATION - PR UTATION - PR UTATION - PR UN of Lines er site (sum LI others) atory therap d 31) d 32)	22 and enter on 1 and 2, line 9 OVIDER SITE 3 and 4 for all n of lines 26 and	l i ne 23 74. 60 8, 952 8, 952 373 373 373 373 426 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22. 00 23. 00 25. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00
22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traino Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum 0 Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column 3, Subtotal (line 29 for all others) Standard travel allowance and standard travel Optional travel allowance and optional travel Standard travel allowance and optional travel Optional travel allowance and optional travel Optional travel allowance and standard travel Optional travel allowance and optional travel	lines 21-23. ainees (line 17 line 9 for all ees (line 2 tim VANCE AND TRAVE sum of lines 2 for respirator travel expense Expense of columns 1 an line 12) sum of lines 2 s 1 and 2, line expense (line expense (sum expense (sum	no entries on divided by su others) es line 21) L EXPENSE COMP 4 and 25 for a y therapy or s at the provid d 2, line 12) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an	LI others) UTATION - PR UTATION - PR UTATION - PR UN of Lines er site (sum LI others) atory therap d 31) d 32)	22 and enter on 1 and 2, line 9 OVIDER SITE 3 and 4 for all n of lines 26 and	l i ne 23 74. 60 8, 952 8, 952 373 373 373 373 426 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22. 00 23. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00
22. 00 23. 00 25. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traino Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 2, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and optional travel	lines 21-23. ainees (line 17 line 9 for all ees (line 2 tim VANCE AND TRAVE sum of lines 2 for respirator travel expense Expense of columns 1 an line 12) sum of lines 2 s 1 and 2, line expense (line expense (sum expense (sum	no entries on divided by su others) es line 21) L EXPENSE COMP 4 and 25 for a y therapy or s at the provid d 2, line 12) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an	LI others) UTATION - PR UTATION - PR UTATION - PR UN of Lines er site (sum LI others) atory therap d 31) d 32)	22 and enter on 1 and 2, line 9 OVIDER SITE 3 and 4 for all n of lines 26 and	l i ne 23 74. 60 8, 952 8, 952 373 0 373 53 426 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22. 00 23. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00
22. 00 23. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traino Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column 3, Subtotal (line 13 for all others) Standard travel allowance and standard travel optional travel allowance and standard travel Option	lines 21-23. ainees (line 17 line 9 for all ees (line 2 tim VANCE AND TRAVE sum of lines 2 for respirator travel expense Expense of columns 1 an line 12) sum of lines 2 s 1 and 2, line expense (line expense (sum expense (sum NCE AND TRAVEL	no entries on divided by su others) es line 21) <u>L EXPENSE COMP</u> 4 and 25 for a y therapy or s at the provid d 2, line 12) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU	LI others) UTATION - PR UTATION - PR UTATION - PR UN of Lines er site (sum LI others) atory therap d 31) d 32)	22 and enter on 1 and 2, line 9 OVIDER SITE 3 and 4 for all n of lines 26 and	l i ne 23 74. 60 8, 952 8, 952 373 373 373 426 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22. 00 23. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00
22. 00 23. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traino Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column 3, Subtotal (line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum	lines 21-23. ainees (line 17 line 9 for all ees (line 2 tim VANCE AND TRAVE sum of lines 2 for respirator travel expense of columns 1 an line 12) sum of lines 2 s 1 and 2, line expense (line expense (sum expense (sum expense (sum mor lines 5 an	no entries on divided by su others) es line 21) <u>L EXPENSE COMP</u> 4 and 25 for a y therapy or s at the provid d 2, line 12) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU	LI others) UTATION - PR UTATION - PR UTATION - PR UN of Lines er site (sum LI others) atory therap d 31) d 32)	22 and enter on 1 and 2, line 9 OVIDER SITE 3 and 4 for all n of lines 26 and	1 i ne 23 74. 60 8, 952 8, 952 373 0 373 53 426 0	22. 00 23. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00
22. 00 23. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traino Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column 3, Subtotal (line 29 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel Ditional travel expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sur Optional Travel Allowance and Optional Travel	lines 21-23. ainees (line 17 line 9 for all ees (line 2 tim VANCE AND TRAVE sum of lines 2 for respirator travel expense Expense of columns 1 an line 12) sum of lines 2 s 1 and 2, line expense (line expense (sum expense (sum NCE AND TRAVEL n of lines 5 an Expense	no entries on divided by su others) es line 21) L EXPENSE COMP 4 and 25 for a y therapy or s at the provid d 2, line 12) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU d 6)	LI others) UTATION - PR UTATION - PR UTATION - PR UN of Lines er site (sum LI others) atory therap d 31) d 32)	22 and enter on 1 and 2, line 9 OVIDER SITE 3 and 4 for all n of lines 26 and	l i ne 23 74. 60 8, 952 8, 952 373 373 373 373 426 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22. 00 23. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00
22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traino Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel allowance and standard travel Optional travel allowance and standard travel Dptional travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel Dptional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sur Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.000000000000000000000000000000000000	lines 21-23. ainees (line 17 line 9 for all ees (line 2 tim VANCE AND TRAVE sum of lines 2 for respirator travel expense Expense of columns 1 an line 12) sum of lines 2 s 1 and 2, line expense (line expense (sum NACE AND TRAVEL m of lines 5 an Expense D1 times column	no entries on divided by su others) es line 21) L EXPENSE COMP 4 and 25 for a y therapy or s at the provid d 2, line 12) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU d 6)	LI others) UTATION - PR UTATION - PR UTATION - PR UN of Lines er site (sum LI others) atory therap d 31) d 32)	22 and enter on 1 and 2, line 9 OVIDER SITE 3 and 4 for all n of lines 26 and	l i ne 23 74. 60 8, 952 8, 952 373 373 373 426 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22. 00 23. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00
22. 00 23. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traino Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column 3, Subtotal (line 29 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel Ditional travel expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sur Optional Travel Allowance and Optional Travel	lines 21-23. ainees (line 17 line 9 for all ees (line 2 tim VANCE AND TRAVE sum of lines 2 for respirator travel expense Expense of columns 1 an line 12) sum of lines 2 s 1 and 2, line expense (line expense (sum NACE AND TRAVEL m of lines 5 an Expense D1 times column	no entries on divided by su others) es line 21) L EXPENSE COMP 4 and 25 for a y therapy or s at the provid d 2, line 12) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU d 6)	LI others) UTATION - PR UTATION - PR UTATION - PR UN of Lines er site (sum LI others) atory therap d 31) d 32)	22 and enter on 1 and 2, line 9 OVIDER SITE 3 and 4 for all n of lines 26 and	l i ne 23 74. 60 8, 952 8, 952 373 0 373 53 426 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22. 00 23. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00
22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traino Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel allowance and standard travel Optional travel allowance and standard travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 3, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sur Optional travel Allowance and Optional Travel Therapists (column 3, line 12.01 times column Subtotal (sum of columns 1 and 2, line 12.07 Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sur	lines 21-23. ainees (line 17 line 9 for all ees (line 2 tim VANCE AND TRAVE sum of lines 2 for respirator travel expense of columns 1 an line 12) sum of lines 2 s 1 and 2, line expense (line expense (sum expense (sum expense (sum MCE AND TRAVEL m of lines 5 an Expense D1 times column n 3, line 10) m of columns 1-	no entries on divided by su others) es line 21) L EXPENSE COMP 4 and 25 for a y therapy or s at the provid d 2, line 12) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU d 6) 2, line 10) 3, line 13.01)	lines 21 and m of columns UTATION - PR II others) um of lines er site (sum li others) atory therap d 31) d 32) TATION - SER	22 and enter on 1 and 2, line 9 OVIDER SITE 3 and 4 for all n of lines 26 and by or sum of VICES OUTSIDE PR	l i ne 23 74. 60 8, 952 8, 952 373 373 373 426 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22. 00 23. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00
22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 41. 00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traino Total salary equivalency (see instructions) PART 111 - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sur Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0 Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sur Total Travel Allowance and Travel Expense - 0	lines 21-23. ainees (line 17 line 9 for all ees (line 2 tim VANCE AND TRAVE sum of lines 2 for respirator travel expense of columns 1 an line 12) sum of lines 2 s 1 and 2, line expense (line expense (sum expense (sum expense (sum MCE AND TRAVEL m of lines 5 an Expense D1 times column n 3, line 10) m of columns 1-	no entries on divided by su others) es line 21) L EXPENSE COMP 4 and 25 for a y therapy or s at the provid d 2, line 12) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU d 6) 2, line 10) 3, line 13.01)	lines 21 and m of columns UTATION - PR II others) um of lines er site (sum li others) atory therap d 31) d 32) TATION - SER	22 and enter on 1 and 2, line 9 OVIDER SITE 3 and 4 for all n of lines 26 and by or sum of VICES OUTSIDE PR	l i ne 23 74. 60 8, 952 8, 952 373 373 373 426 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22. 00 23. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00
22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 41. 00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traino Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel allowance and standard travel Optional travel allowance and standard travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 3, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sur Optional travel Allowance and Optional Travel Therapists (column 3, line 12.01 times column Subtotal (sum of columns 1 and 2, line 12.07 Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sur	lines 21-23. ainees (line 17 line 9 for all ees (line 2 tim VANCE AND TRAVE sum of lines 2 for respirator travel expense Expense of columns 1 an line 12) sum of lines 2 s 1 and 2, line expense (line expense (sum expense (sum NCE AND TRAVEL n of lines 5 an Expense D1 times columns 1- Dffsite Service	no entries on divided by su others) es line 21) L EXPENSE COMP 4 and 25 for a y therapy or s at the provid d 2, line 12) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU d 6) 2, line 10) 3, line 13.01) s; Complete on	LI others) um of columns UTATION - PR II others) um of lines er site (sum II others) atory therap d 31) d 32) TATION - SER e of the fol	22 and enter on 1 and 2, line 9 OVIDER SITE 3 and 4 for all n of lines 26 and by or sum of VICES OUTSIDE PR Iowing three lin	I i ne 23 74.60 8,952 373 373 373 373 373 426 0	22. 00 23. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00

	ABLE COST DETERMINATION FOR THERAPY SERVICES I E SUPPLIERS	OMMUNI TY HOSPI T <i>F</i> FURNI SHED BY			Period: From 05/01/2014 To 04/30/2015 Speech Pathology	Date/Time Prep 9/30/2015 10:3	-3 pared:
						1.00	
16 00	Optional travel allowance and optional travel	expense (sum of	flines 42 an	d 43 - see in	structions)		46.00
10.00	optional travel arrowance and optional travel		Assi stants	Ai des	Trai nees	Total	10.00
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION		2100	0.00		0100	
7.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0. C	0 0.00	0.00	47.00
8.00	Overtime rate (see instructions)	0.00	0.00	0.0	0.00		48.00
	Total overtime (including base and overtime	0.00	0.00				49.00
	CALCULATION OF LIMIT	0.00	0.00	0.0	0.00		49.00
	Percentage of overtime hours by category	0.00	0.00	0.0	0 0.00	0.00	50.00
	(divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.0	0.00	0.00	50.00
	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0. 00	0.00	0.0	0 0.00	0.00	51.00
2.00	DETERMINATION OF OVERTIME ALLOWANCE Adjusted hourly salary equivalency amount	74.64	0.00	0.0	0 0.00		52.00
	(see instructions) Overtime cost limitation (line 51 times line	0	0		0 0		53.00
54.00	52) Maximum overtime cost (enter the lesser of	0	0		0 0		54.00
	line 49 or line 53) Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	О	0		0 0		55.00
	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for	0	0		0 0	0	56.00
	respiratory therapy and columns 1 through 3 for all others.)						
	respiratory therapy and columns 1 through 3 for all others.)					1.00	
	respiratory therapy and columns 1 through 3 for all others.) Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST #	ADJUSTMENT				
57.00	respiratory therapy and columns 1 through 3 for all others.) Part VI - COMPUTATION OF THERAPY LIMITATION A Salary equivalency amount (from line 23)					8, 952	
7. 00 8. 00	respiratory therapy and columns 1 through 3 for all others.) Part VI - COMPUTATION OF THERAPY LIMITATION A Salary equivalency amount (from line 23) Travel allowance and expense - provider site	(from lines 33,	34, or 35))			8, 952 426	58.0
7.00 8.00 9.00	respiratory therapy and columns 1 through 3 for all others.) Part VI - COMPUTATION OF THERAPY LIMITATION A Salary equivalency amount (from line 23) Travel allowance and expense - provider site Travel allowance and expense - Offsite servic	(from lines 33,	34, or 35)))		8, 952 426 0	58. 0 59. 0
7.00 8.00 9.00 0.00	respiratory therapy and columns 1 through 3 for all others.) Part VI - COMPUTATION OF THERAPY LIMITATION A Salary equivalency amount (from line 23) Travel allowance and expense - provider site Travel allowance and expense - Offsite servic Overtime allowance (from column 5, line 56)	(from lines 33,	34, or 35)))		8, 952 426 0 0	58.0 59.0 60.0
7.00 8.00 9.00 0.00 1.00	respiratory therapy and columns 1 through 3 for all others.) Part VI - COMPUTATION OF THERAPY LIMITATION A Salary equivalency amount (from line 23) Travel allowance and expense - provider site Travel allowance and expense - Offsite servic Overtime allowance (from column 5, line 56) Equipment cost (see instructions)	(from lines 33,	34, or 35)))		8, 952 426 0 0 0	58.0 59.0 60.0 61.0
7.00 8.00 9.00 0.00 1.00 2.00	respiratory therapy and columns 1 through 3 for all others.) Part VI - COMPUTATION OF THERAPY LIMITATION A Salary equivalency amount (from line 23) Travel allowance and expense - provider site Travel allowance and expense - Offsite servic Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions)	(from lines 33,	34, or 35)))		8, 952 426 0 0 0 0	58.0 59.0 60.0 61.0 62.0
7.00 8.00 9.00 0.00 1.00 2.00	respiratory therapy and columns 1 through 3 for all others.) Part VI - COMPUTATION OF THERAPY LIMITATION A Salary equivalency amount (from line 23) Travel allowance and expense - provider site Travel allowance and expense - Offsite servic Overtime allowance (from column 5, line 56) Equipment cost (see instructions)	(from lines 33,	34, or 35)))		8, 952 426 0 0 0	58.0 59.0 60.0 61.0
7.00 8.00 9.00 0.00 1.00 2.00 3.00	respiratory therapy and columns 1 through 3 for all others.) Part VI - COMPUTATION OF THERAPY LIMITATION A Salary equivalency amount (from line 23) Travel allowance and expense - provider site Travel allowance and expense - Offsite servic Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions)	(from lines 33, es (from lines 4	34, or 35)))		8, 952 426 0 0 0 0 0 9, 378	58.0 59.0 60.0 61.0 62.0 63.0
7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00	respiratory therapy and columns 1 through 3 for all others.) Part VI - COMPUTATION OF THERAPY LIMITATION A Salary equivalency amount (from line 23) Travel allowance and expense - provider site Travel allowance and expense - Offsite servic Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62)	(from lines 33, es (from lines 4 n your records)	34, or 35)) 44, 45, or 46)		8, 952 426 0 0 0 0 0 9, 378	58.0 59.0 60.0 61.0 62.0 63.0
7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00	respiratory therapy and columns 1 through 3 for all others.) Part VI - COMPUTATION OF THERAPY LIMITATION A Salary equivalency amount (from line 23) Travel allowance and expense - provider site Travel allowance and expense - Offsite servic Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63	(from lines 33, es (from lines 4 n your records) s - if negative,	34, or 35)) 44, 45, or 46 enter zero)			8, 952 426 0 0 0 9, 378 768 0	58.0 59.0 60.0 61.0 62.0 63.0 64.0 65.0
7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00	respiratory therapy and columns 1 through 3 for all others.) Part VI - COMPUTATION OF THERAPY LIMITATION A Salary equivalency amount (from line 23) Travel allowance and expense - provider site Travel allowance and expense - Offsite servic Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION Line 26 = line 24 for respiratory therapy or	(from lines 33, es (from lines 4 your records) - if negative, sum of lines 24	34, or 35)) 44, 45, or 46 enter zero) and 25 for a	II others	others	8, 952 426 0 0 0 9, 378 768 0 0 373	58. 0 59. 0 60. 0 61. 0 62. 0 63. 0 64. 0 65. 0
7. 00 8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 00. 00 00. 01 00. 02	respiratory therapy and columns 1 through 3 for all others.) Part VI - COMPUTATION OF THERAPY LIMITATION A Salary equivalency amount (from line 23) Travel allowance and expense - provider site Travel allowance and expense - Offsite servic Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 65 LINE 33 CALCULATION Line 26 = line 24 for respiratory therapy or Line 33 = line 28 = sum of lines 26 and 27	(from lines 33, es (from lines 4 your records) - if negative, sum of lines 24	34, or 35)) 44, 45, or 46 enter zero) and 25 for a	II others	others	8, 952 426 0 0 0 0 9, 378 768 0 768 0 373 53	58. 0 59. 0 60. 0 61. 0 62. 0 63. 0 64. 0 65. 0 100. 0 100. 0
7.00 8.00 9.00 1.00 2.00 3.00 4.00 5.00 5.00 00.00 00.01 00.02	respiratory therapy and columns 1 through 3 for all others.) Part VI - COMPUTATION OF THERAPY LIMITATION A Salary equivalency amount (from line 23) Travel allowance and expense - provider site Travel allowance and expense - offsite servic Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION Line 26 = line 24 for respiratory therapy or Line 23 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION	(from lines 33, es (from lines 4 your records) - if negative, sum of lines 24 therapy or sum	34, or 35)) 44, 45, or 46 enter zero) and 25 for a of lines 3 a	II others nd 4 for all		8, 952 426 0 0 0 9, 378 768 0 373 53 426	58. 0 59. 0 60. 0 61. 0 62. 0 63. 0 64. 0 65. 0 100. 0 100. 0
7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 00.01 00.01 00.02 01.00	respiratory therapy and columns 1 through 3 for all others.) Part VI - COMPUTATION OF THERAPY LIMITATION A Salary equivalency amount (from line 23) Travel allowance and expense - provider site Travel allowance and expense - Offsite servic Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION Line 26 = line 24 for respiratory therapy or Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory	(from lines 33, es (from lines 4 h your records) - if negative, sum of lines 24 h therapy or sum	34, or 35)) 44, 45, or 46 enter zero) and 25 for a of lines 3 a of lines 3 a	II others nd 4 for all nd 4 for all		8, 952 426 0 0 0 9, 378 768 0 768 0 373 53 426 53	58. 0 59. 0 60. 0 61. 0 62. 0 63. 0 64. 0 65. 0 100. 0 100. 0 100. 0
7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 00.01 00.01 00.02 01.00 01.01	respiratory therapy and columns 1 through 3 for all others.) Part VI - COMPUTATION OF THERAPY LIMITATION A Salary equivalency amount (from line 23) Travel allowance and expense - provider site Travel allowance and expense - offsite servic Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION Line 26 = line 24 for respiratory therapy or Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or	(from lines 33, es (from lines 4 h your records) - if negative, sum of lines 24 h therapy or sum	34, or 35)) 44, 45, or 46 enter zero) and 25 for a of lines 3 a of lines 3 a	II others nd 4 for all nd 4 for all		8, 952 426 0 0 0 0 9, 378 768 0 373 53 426 53 0	58. 0 59. 0 60. 0 61. 0 62. 0 63. 0 64. 0 65. 0 100. 0 100. 0 100. 0 101. 0
7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 00.00 00.01 00.02 01.00 01.01 01.01 01.02	respiratory therapy and columns 1 through 3 for all others.) Part VI - COMPUTATION OF THERAPY LIMITATION A Salary equivalency amount (from line 23) Travel allowance and expense - provider site Travel allowance and expense - Offsite servic Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION Line 26 = line 24 for respiratory therapy or Line 33 = line 7 times line 3 for respiratory Line 31 = line 7 times line 3 for respiratory Line 31 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31	(from lines 33, es (from lines 4 h your records) - if negative, sum of lines 24 h therapy or sum	34, or 35)) 44, 45, or 46 enter zero) and 25 for a of lines 3 a of lines 3 a	II others nd 4 for all nd 4 for all		8, 952 426 0 0 0 0 9, 378 768 0 373 53 426 53 0	58.0 59.0 60.0 61.0 62.0 63.0 64.0
7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 00.01 00.01 00.02 01.00 01.01 01.01	respiratory therapy and columns 1 through 3 for all others.) Part VI - COMPUTATION OF THERAPY LIMITATION A Salary equivalency amount (from line 23) Travel allowance and expense - provider site Travel allowance and expense - Offsite servic Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION Line 26 = line 24 for respiratory therapy or Line 31 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION	(from lines 33, es (from lines 4 your records) - if negative, sum of lines 24 therapy or sum sum of lines 29	34, or 35)) 44, 45, or 46 enter zero) and 25 for a of lines 3 a of lines 3 a and 30 for a	II others nd 4 for all nd 4 for all II others		8, 952 426 0 0 0 9, 378 768 0 9 373 53 426 53 0 53	58. 0 59. 0 60. 0 61. 0 62. 0 63. 0 64. 0 65. 0 100. 0 100. 0 100. 0 101. 0 101. 0
7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 00.01 00.01 00.02 01.01 01.01 01.02 01.02	respiratory therapy and columns 1 through 3 for all others.) Part VI - COMPUTATION OF THERAPY LIMITATION A Salary equivalency amount (from line 23) Travel allowance and expense - provider site Travel allowance and expense - Offsite service Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 65 LINE 33 CALCULATION Line 26 = line 24 for respiratory therapy or Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 31 = line 29 for respiratory therapy or Line 31 = line 29 for respiratory therapy or	(from lines 33, es (from lines 4) your records) - if negative, sum of lines 24 of therapy or sum sum of lines 29 sum of lines 29	34, or 35)) 44, 45, or 46 enter zero) and 25 for a of lines 3 a of lines 3 a and 30 for a and 30 for a	II others nd 4 for all nd 4 for all II others	others	8, 952 426 0 0 0 9, 378 768 0 9 373 53 426 53 426 53 0 53	58. 0 59. 0 60. 0 61. 0 62. 0 63. 0 64. 0 65. 0 100. 0 100. 0 100. 0 101. 0 101. 0 101. 0 101. 0
7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 00.01 00.01 00.02 01.01 01.01 01.02 01.02	respiratory therapy and columns 1 through 3 for all others.) Part VI - COMPUTATION OF THERAPY LIMITATION A Salary equivalency amount (from line 23) Travel allowance and expense - provider site Travel allowance and expense - Offsite servic Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION Line 26 = line 24 for respiratory therapy or Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION	(from lines 33, es (from lines 4 your records) - if negative, sum of lines 24 therapy or sum therapy or sum sum of lines 29 sum of lines 29	34, or 35)) 44, 45, or 46 enter zero) and 25 for a of lines 3 a of lines 3 a and 30 for a and 30 for a	II others nd 4 for all nd 4 for all II others	others	8, 952 426 0 0 0 9, 378 768 0 9 373 53 426 53 426 53 0 53	58. (59. (60. (61. (62. (63. (64. (65. (100. (100. (101. (101. (101. (

COST ALLOCATION - CENERAL SERVICE COSTS Provider CCN: 151300 Provider CN: 151300 Prov	Health Fi	nancial Systems	COMMUNITY HOSPI	TAL OF BREMEN		In Lie	u of Form CMS-:	2552-10
Cost Center Description Net Expenses (Process) (Process) (Process) Net Expenses (Process) Net (PSE) (Process) Net (PSE) (Process) Net (PSE) (Process) Subtorial (Process) Subtorial (Process) 0 0 0 0 0 0 4.00 4.00 4.00 1.00 0 0.00 0.00 0.00 4.00 4.00 4.00 0.00	COST ALL	OCATION - GENERAL SERVICE COSTS		Provi der	CCN: 151300	From 05/01/2014	Part I	pared:
Cost Center Description Net Expenses for Cost (from WSR A Net Expenses (from WSR A Net EVENUE EVENT EMPLOYEE EVENT Subtotal Image: Service Cost CentreRS 0 0 0.00 0.00 4.00 4.00 1 00 00000 Net Car PEL Cost SetUE 6 FIXT 1.353,654 0 0 0.00 2.00 00200 Net Car PEL Cost SetUE 6 FIXT 1.353,654 0 0 2.00 4.00 4.00 2.00 00200 Net Car PEL Cost SetUE 6 FIXT 1.766,186 5.06.2 0 1.771,875 4.00 3.00 00500 ADMINISTRATIVE & GENERAL 2.200,466 112,918 0.349,737 2.723,121 5.00 0.000000 DEPEATION OF PLANT 668,040 144,305 0.420,307,909,22,733 2.73,17,00 133,464 1.00,133,464 1.00,133,464 1.00,133,464 1.00,133,464 1.00,133,464 1.00,133,464 1.00,133,464 1.250,653 3.00 130,603,403,103,403,403,40 1.00,133,464 1.250,653 3.00 1.00,133,464 1.250,653,403,999 1.41,506 1.00,79,915 1.3,33,223 0 <td< td=""><td></td><td></td><td></td><td></td><td>ATED AGETC</td><td></td><td>9/30/2015 10:</td><td>33 am</td></td<>					ATED AGETC		9/30/2015 10:	33 am
FOR Cost (Fig. West A col. 7) FIXT (Col. 7) EQUIP BEMEITS DEPARTMENT 100 00000 2.00 4.00 4.0 100 00000 1000 2.00 4.00 4.0 100 00000 0000 4.00 4.00 4.00 200 00200 NEW CAP REL COSTS-BUDG & FIXT 1.353.654 0 1.771.878 2.00 200 00500 ADM INSTRATIVE & GENERAL 2.200.466 112.918 0.349,737 2.723.121 5.00 0.00 00500 ADMIN STRATIVE & GENERAL 2.200.466 124.918 0.349,737 2.723.121 5.00 0.00 00500 ADMIN STRATIVE & GENERAL 2.200.466 124.918 0.349,737 2.723.121 5.00 0.00 00500 ADMIN STRATIVE & GENERAL 2.200.466 12.918 0.349,737 2.723.121 5.00 10.00 01000 CHEATTENG TO PLANT 668.040 244.31 0.00 10.02 10.02 10.02 10.02 10.02 10.02 10.02 10.02 10.02 10.02 11.02				CAPITAL REL	LATED COSTS			
CENERAL SERVICE COST CENTERS 0 1.00 2.00 4.00 4.4 1.00 OOTOO NEW CAP REL COSTS-BLDG & FLXT 1.353,654 0 1.00 2.00 0.00		Cost Center Description	for Cost Allocation (from Wkst A			BENEFI TS	Subtotal	
CENERAL SERVICE COST CENTERS 1.353,654 1.353,				1.00	2.00	4.00	4A	
1.00 00100 NW CAP REL COSTS-BLOC & FLXT 1, 353, 654 1, 353, 654 0 0 20 0.00 00000 NW CAP REL COSTS-WBLE FOULP 1, 766, 816 5, 662 0 1, 771, 878 4, 00 0.00 00000 DEMALOYRE EBERTIS DEPARTMENT 1, 766, 816 5, 662 0 1, 771, 878 4, 00 0.00 00000 DEMALOYRE SERVICE 118, 425 4, 821 0 0123, 246 8, 00 0.00 00000 DETARY 921, 425 4, 821 0 0122, 324, 68, 00 118, 10, 0100 122, 133, 202 10, 00 1000 1000 1000 1000 1000, 0100 CAFETERIA 2200, 962 27, 523 0 46, 958 296, 443 11, 00 13.00 01300 AURSI MS ADMINISTRATION 145, 545 6, 743 0 38, 664 12, 284, 213, 00 0.00 00000 OPEARTING SERVICE COST CENTERS 0 0 1, 250, 059 30, 00 0 0, 420, 133, 4908 1, 421, 394 50, 00 0.00 05000 DELATRY SERVICE COST CENTERS 2, 279 0 17, 90 <t< td=""><td>GE</td><td>NERAL SERVICE COST CENTERS</td><td></td><td></td><td></td><td></td><td></td><td></td></t<>	GE	NERAL SERVICE COST CENTERS						
2.00 002200 KEU CAP REL COSTS-WALE EQUIP 0 0 2.00 4.00 00400 KEU CYE BERFITS DEPARTIMENT 1,766,816 5.062 1,771,878 2.02,121 5.00 5.00 00500 ADM INISTRATIVE & GENERAL 2,200,466 112,918 0 349,737 2.722,121 5.00 8.00 000800 LAUNDRY & LINEN SERVICE 118,425 4.821 0 0 122,246 8.00 9.00 00900 LOUSEKEEPING 161,078 8.283 0 39,096 2206,457 9.00 11.00 01000 LETARY 92,104 27,523 0 46,956 295,443 11.00 13.00 01300 NUESI NG ADMINISTRATION 145,451 8,733 38,645 129,8454 13.00 10.00 01300 NUESI SA PEDIATRICS 783,283 273,322 0 199,454 1.00,956 43.00 10.00 05000 OFEATIVICE COST CENTERS 1.039,915 183,717 0 199,454 1.20,059 30.00 13.00 05000 OFEATIVICE COST CENTERS 1.039,916 <t< td=""><td></td><td></td><td>1, 353, 654</td><td>1, 353, 654</td><td></td><td></td><td></td><td>1.00</td></t<>			1, 353, 654	1, 353, 654				1.00
5.00 00500 ADM IN STRATI VE & GENERAL 2.200.466 112,918 0 349,737 2.722,121 5.00 0.00 006800 LENDERY & LINEN SERVICE 118,425 4,821 0 0 7.00 7.00 0.00 00000 LOUSEKEPI MG 161,078 8,283 0 90,996 208,457 9.00 0.00 01000 DIETARY 92,104 27,523 0 46,958 295,443 11.00 11.00 01000 DIETCAR FCROSS & LIBRARY 344,374 14,506 0 69,054 437,934 16.00 0.00 0300 NUBEICAL FCROSS & LIBRARY 348,443 1.250,059 30.00 30.00 11.00 1102 OTINE SERVICE COST CENTERS 7.633,283 273,322 0 7.691 56,653 52.00 20.00 05000 DELIVERY ROM & LABOR ROM 55,575 0 0 9.988 65,663 52.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00	2.00 00	200 NEW CAP REL COSTS-MVBLE EQUIP	0			0		2.00
5.00 00500 ADM IN STRATI VE & GENERAL 2.200.466 112,918 0 349,737 2.722,121 5.00 0.00 006800 LENDERY & LINEN SERVICE 118,425 4,821 0 0 7.00 7.00 0.00 00000 LOUSEKEPI MG 161,078 8,283 0 90,996 208,457 9.00 0.00 01000 DIETARY 92,104 27,523 0 46,958 295,443 11.00 11.00 01000 DIETCAR FCROSS & LIBRARY 344,374 14,506 0 69,054 437,934 16.00 0.00 0300 NUBEICAL FCROSS & LIBRARY 348,443 1.250,059 30.00 30.00 11.00 1102 OTINE SERVICE COST CENTERS 7.633,283 273,322 0 7.691 56,653 52.00 20.00 05000 DELIVERY ROM & LABOR ROM 55,575 0 0 9.988 65,663 52.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00		2400 EMPLOYEE BENEFITS DEPARTMENT	1, 766, 816	5,062		0 1, 771, 878		
7. 00 00700 (PERATION OF PLANT 668, 040 244, 308 0 49, 573 981, 921 7. 00 9. 00 00900 (LAUNDRY & LINEN SERVICE 118, 425 4, 821 0 0 0 123, 246 8. 00 9. 00 00900 (LAUNDRY & LINEN SERVICE 118, 425 4, 821 0 39, 096 208, 457 9, 00 10. 00 01100 (AFETERIA 220, 962 27, 523 0 46, 958 295, 443 11, 00 10. 00 01600 (MEDICAL RECORDS & LIBRARY 354, 374 14, 506 0 69, 054 437, 934 16, 00 10. 00 0000 ADULTS & PEDI ATRI ON 142, 875 6, 399 0 7, 691 56, 965 30, 00 30, 00 30, 00 1, 029, 915 183, 171 0 198, 364, 45, 00 30, 30 30, 30 30, 30, 30 1, 421, 394 57, 00 99, 90 1, 729, 945, 729 0 17, 890, 992, 098 54, 00 54, 00 56, 663 52, 00 56, 663 52, 00 56, 00 56, 00 56, 00 56, 00 56, 66							2, 723, 121	
B. 00 000800 LAUNRY & LINEN SERVICE 118, 425 4, 821 0 0 172, 246 8, 00 0.00 01000 PLETARY 92, 104 27, 676 0 13, 022 132, 802 10, 00 11.00 01000 PLETARY 92, 104 27, 523 0 46, 958 295, 443 11, 00 11.00 01000 MEDICAL RECORDS & LIBRARY 354, 374 14, 506 0 69, 054 437, 934 66, 00 1NPATI ENT ROUTINE SERVICE COST CENTERS 783, 283 273, 322 0 193, 454 1, 250, 059 30, 00 30.00 033000 AURIST & PEDI ATRICS 783, 283 273, 322 0 193, 454 1, 250, 059 30, 00 30.00 033000 OPERATING ROOM 15, 675 0 0 9, 968 65, 663 52, 00 50.00 05000 CRIO LACONTHERY NOM 1, 589, 119 334, 908 0 14, 376 349, 304 57, 00 0 0 0 0 0 0 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>								
9.00 00900 HUSEKEEPING 161.078 8.283 0 39.096 208,457 9.00 10.00 01000 DIETRY 220.962 27.533 0 46.958 295,443 11.00 13.00 01300 NURSING ADM IN STRATION 145,451 8.743 0 38,648 192,842 13.00 14.00 01600 MEDI CAL RECORDS & LI BRARY 354,374 14,506 0 69,054 43.7,934 16.00 INPATI ENT ROUTINE SERVICE COST CENTERS 783,283 273,322 0 193,454 1,250,059 30.00 04300 NURSING KOMA 1,039,915 183,171 0 198,308 1,421,334 50.00 52.00 05000 DELIVERY NOM & LABOR ROOM 155,675 0 0 9.988 65,635 0.00 54.00 05400 RADI LOGY-DI AGNOSTI C 786,929 87,279 0 117,890 992,088 65,603 52.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.0								
10.00 01000 DITARY 92, 104 27, 573 0 13, 022 132, 022 132, 002 10.00 11.00 0100 CATTERN IS 220, 962 27, 573 0 46, 958 295, 443 11.00 16.00 DIGON MUSTING ARCORDS & LIBRARY 354, 374 14, 506 0 69, 054 437, 934 16.00 10.00 DIGON MUSTEAR FOOTS & LIBRARY 354, 374 14, 506 0 69, 054 437, 934 16.00 10.00 O3000 AURISS & PEDIATICS 783, 283 273, 322 0 193, 454 1, 250, 055 30.00 30.00 O3000 AURISS & PEDIATICS 76, 697 0 9, 988 65, 663 52.00 54.00 55.00 9, 988 65, 663 52.00 54.00 57.00 90, 988 65, 663 58.00 59.00 0 14, 396 349, 304 57.00 59, 900 60.01 16, 675 376, 683 58.00 59.00 65, 900 60.01 16, 675 376, 683 58.00 59.00 60.01 16, 675 376, 683 58.00 59.00 60.01 60.01 <t< td=""><td></td><td></td><td></td><td></td><td></td><td>0</td><td></td><td></td></t<>						0		
11.00 01100 CAFETERIA 220.962 27.523 0 46.958 295.443 11.00 13.00 01300 NURSING ADMINISTRATION 145.451 8,743 0 38.648 192.842 13.00 16.00 01600 MEDICAL RECORDS & LIBRARY 354.374 14.506 0 69.054 437.934 16.00 10.01 SOBOO ADULTS & APEDIATRICS 783.283 273.322 0 193.454 1,250.059 30.00 43.00 03000 AURISTS & APEDIATRICS 42.875 6.399 0 7.691 56.965 40.00 50.00 05000 DELIVERY NOOM & LABOR ROOM 155.675 0 99.988 65.635 52.00 52.00 05200 DELIVERY NOOM & LABOR ROOM 134.396 0 14.47.396 449.045 57.00 50.00 05000 CARDIAC CATHETERIZATION 0 0 0 0 0 0 0 58.00 59.00 59.00 59.00 59.00 59.00 59.00 50.00 59.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td>0,10,0</td><td></td><td></td></t<>						0,10,0		
13.00 01300 NURSING ADMI NI STRATI ON 145, 451 8, 743 0 38, 648 192, 842 13.00 16.00 01600 MEDICAL RECORDS & LIBRARY 354, 374 14, 506 0 69, 054 437, 934 16.00 10.00 03000 ADULTS & PEDIATRICS 783, 283 273, 322 0 193, 454 1, 250, 059 30.00 ANCILLARY SERVICE COST CENTERS 42, 875 6, 399 0 7, 691 56, 695 43.00 52.00 052000 OPERATING ROM 1, 039, 915 183, 171 0 198, 308 1, 421, 394 50.00 52.00 052000 DEUVERY ROM & LABOR ROM 55, 675 0 0 9, 988 65, 663 52.00 58.00 050000 ADOR ADULORSY CATHER ZATION 0 0 14, 396 349, 304 57.00 59.00 05000 AROU LARORATORY 1, 589, 119 52, 810 0 197, 758 18, 89, 687 60.00 60.01 60.01 60.01 60.00 60.00 60.01 60.00 60.01 60.01 60.01 60.01 60.01								
16:00 016:00 016:00 69:054 437.934 16:00 1NPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 AUULTS & PEDIATRICS 783.283 273.322 0 193.454 1,250.059 30.00 43:00 043001 NURSERY 42.375 6.399 0 7.691 56.055 43.00 ANCILLARY SERVICE COST CENTERS 50:00 05000 PERATING ROOM 1,039,915 183.171 0 198.308 1,421,394 50:00 50:00 05000 DELIVERY ROM & LABOR ROOM 55,675 0 0 9.986 65,663 52:00 50:00 05000 CARDI ALGROSTI C 786,929 87,279 0 117.890 992.98 54:00 59:00 05900 CARDI AL CATHETERI ZATI ON 0 0 0 0 59:00 16:675 376.83 58:00 60:01 BLOD LABORATORY 1,589,119 52:810 197.758 1,839,687 60:00 60:00 60:00 60:00 60:00 60:00 60:00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>								
INPATIENT ROUTINE SERVICE COST CENTERS 1 1 0.00 00000 ADULTS & PEDIATRICS 783, 283 273, 322 0 193, 454 1, 250, 059 30. 00 43.00 04300 NURSERY 42, 875 6, 399 0 7, 691 56, 965 43. 00 ANCILLARY SERVICE COST CENTERS 0 99, 988 65, 663 52. 00 09, 998 65, 663 52. 00 09, 998 65, 663 52. 00 00 5000 CARONCT L C 786, 299 87. 279 0 117, 890 992, 998 58. 00 58. 00 58. 00 59. 00 5900 CARDIAC CATHERER ZATION 0 0 16, 675 376, 863 58. 00 59. 00 5900 CARDIAC CATHERER ZATION 0 0 0 0 0 60. 01 660								1
30.00 Construction 783, 283 273, 322 0 193, 454 1, 250, 059 30, 00 43.00 O4300 NURSERY 42, 875 6, 399 0 7, 691 56, 965 43, 00 ANCILLARY SERVICE COST CENTERS 1, 039, 915 183, 171 0 198, 308 1, 421, 394 50, 00 50.00 05000 DELIVERY NOM & LABOR ROM 55, 675 0 0, 9, 988 65, 663 52, 00 52, 00 57, 00 0 14, 396 52, 00 52, 00 57, 00 0 14, 396 52, 00 57, 00 0 14, 396 52, 00 50, 00 50, 00 50, 00 50, 00 50, 00 54, 00 0 0 0 0 14, 396, 347, 364 52, 00 50,			354, 374	14, 506		0 69,054	437, 934	16.00
43.00 04300 NURSERY 42,875 6,399 0 7,691 56,965 43.00 ANCILLARY SERVICE COST CENTERS 0 05000 OPERATING ROOM 1,039,915 183,171 0 198,308 1,421,394 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 55,675 0 9,988 66,663 52.00 54.00 05700 CT SCAN 334,908 0 0 14,396 349,304 57.00 58.00 05900 CARDIAC CATHETERIZATION 0 0 0 0 59.00 60.01 06000 LABORATORY 1,589,119 52,810 0 197,758 18,839,687 60.00 60.01 06001 BLOOD LABORATORY 0 0 0 0 0 60.01 64.00 06400 INTRAVENOUS THERAPY 8,243 1,096 0 0 0 0 60.01 66.00 06600 PHYSICAL THERAPY 278,403 61,707 0 75,082 415,192 66.00 67.00 0 0 <td< td=""><td></td><td></td><td>702 202</td><td>272 222</td><td>1</td><td>0 102 454</td><td>1 250 050</td><td>20.00</td></td<>			702 202	272 222	1	0 102 454	1 250 050	20.00
ANCILLARY SERVICE COST CENTERS 50.00 OSDOOL OPERATING ROOM 1.039,915 183,171 0 198,308 1,421,394 50.00 52.00 05200 DELI VERY ROOM & LABOR ROOM 55,675 0 0 9,988 65,663 52.00 57.00 05700 CT SCAN 334,908 0 0 14,396 349,304 57.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 360,188 0 0 16,675 376,863 58.00 59.00 OS000 CARDIA C CATHETERI ZATION 0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
50.00 OS000 OPERATING ROOM 1,039,915 183,171 0 198,308 1,421,394 50.00 52.00 O5200 DELIVERY ROOM & LABOR ROOM 55,675 0 0 9,988 65,663 52.00 54.00 O5400 RADI OLGY-DI AGNOSTIC 786,929 87,279 0 117,890 992,098 54.00 55.00 OS500 CARDI AC CATHETERI ZATION 334,908 0 0 16,675 376,863 58.00 59.00 OS500 CARDI AC CATHETERI ZATION 0 0 0 0 0 59.00 0 60.01 <td></td> <td></td> <td>42,875</td> <td>0, 399</td> <td></td> <td>0 7,091</td> <td>50, 905</td> <td>43.00</td>			42,875	0, 399		0 7,091	50, 905	43.00
52.00 05200 DELIVERY ROOM & LABOR ROOM 55, 675 0 9, 988 65, 663 52.00 54.00 05400 RAUIOLOGY-DIAGNOSTIC 786, 929 87, 279 0 117, 890 992, 098 54.00 57.00 OSTOO (CT SCAN 334, 908 0 14, 396 344, 304 57.00 0 57.00 0 0 16, 675 376, 863 58.00 0			1 000 015	100 171	1	0 100 200	1 401 004	
54.00 RADI OLOGY-DI AGNOSTI C 786, 929 87, 279 0 117, 890 992, 098 54.00 57.00 05700 CT SCAN 334, 908 0 0 14, 396 349, 304 57.00 58.00 05800 ACMETI C RESONANCE I MAGI NG (MRI) 360, 188 0 0 16, 675 376, 863 58.00 59.00 05900 CARDI AL C CATHETERI ZATI ON 0								
57.00 05700 CT SCAN 334,908 0 14,396 349,304 57.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 360,188 0 0 16,675 376,863 58.00 59.00 05900 CARDI AC CATHETRI ZATI ON 0				-				
58.00 05800 MAGNETI C RESONANCE LANGI NG (MR1) 360, 188 0 16, 675 376, 863 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0								
59.00 05900 CARDIAC CATHETERIZATION 0 0 0 0 59.00 60.00 06000 LABORATORY 1,589,119 52,810 0 197,758 1,839,687 60.00 60.01 0.000 LABORATORY 0				-				
60.00 06000 LABORATORY 1,589,119 52,810 0 197,758 1,839,687 60.00 60.01 06000 BLOD LABORATORY 0 0 0 0 60.01 64.00 06400 INTRAVENOUS THERAPY 8,243 1,096 0 0 9,339 64.00 65.00 06500 RESPI RATORY THERAPY 10,444 0 0 0 10,444 65.00 66.00 06600 PHYSI CAL THERAPY 278,403 61,707 0 75,082 415,192 66.00 67.00 06700 0 0 0 0 0 67.00 67.00 67.00 68.00 68.00 68.00 68.00 68.00 68.00 69.02 06902 502 69.02 06902 9,839 0 0 39,799 69.02 69.02 69.02 69.02 69.02 69.02 502,958 71.00 71.00 72.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00			360, 188	0			376, 863	
60.01 06001 BLOOD LABORATORY 0				0		0 0	0	59.00
64.00 06400 INTRAVENOUS THERAPY 8,243 1,096 0 9,339 64.00 65.00 06500 RESPIRATORY THERAPY 10,444 0 0 0 10,444 65.00 66.00 PHYSI CAL THERAPY 278,403 61,707 0 75,082 415,192 66.00 67.00 0 0 0 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 2,883 1,578 0 0 4.61 69.02 69.02 06902 ELECTROCARDI OLOGY 2,883 1,578 0 0 4.69.00 69.02 70.00 07000 ELCTROCARDI OLOGY 2,883 1,578 0 0 70.00	60.00 06	5000 LABORATORY	1, 589, 119	52, 810		0 197, 758	1, 839, 687	60.00
65.00 06500 RESPI RATORY THERAPY 10,444 0 0 10,444 65.00 66.00 06600 PHYSI CAL THERAPY 278,403 61,707 0 75,082 415,192 66.00 67.00 0 0 0 0 0 0 67.00 67.00 0 0 0 0 67.00 67.00 67.00 0 0 0 0 67.00 67.00 0 0 0 0 0 0 67.00 66.00 67.00 66.00 0 0 0 0 0 0 0 0 0 0 67.00 68.00 0 64.00 69.02 SEECH PATHOLOGY 2,883 1,578 0 <t< td=""><td>60.01 06</td><td>5001 BLOOD LABORATORY</td><td>0</td><td>0</td><td></td><td>0 0</td><td>0</td><td>60. 01</td></t<>	60.01 06	5001 BLOOD LABORATORY	0	0		0 0	0	60. 01
66.00 06600 PHYSI CAL THERAPY 278, 403 61, 707 0 75, 082 415, 192 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 68.00 69.00 06900 ELECTROCARDIO LOGY 2,883 1,578 0 0 4.46 69.00 69.02 06902 SLEEP LAB 29,960 9,839 0 0 39,799 69.02 70.00 07000 ELECTROCARDIAGRAPHY 0 0 0 0 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 71.00 71.00 71.00 71.00 71.00 72.00 146,587 0 29,500 502,958 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 169,394 0 0 0 0 90.00 90000 CLAS 46,620 73.00 0 07300 DRUGS CHARGED TO PATI ENTS 576,548 17,508 00	64.00 06	5400 INTRAVENOUS THERAPY	8, 243	1, 096		0 0	9, 339	64.00
67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 2,883 1,578 0 0 4,461 69.02 69.02 06902 SLEEP LAB 29,960 9,839 0 0 39,799 69.02 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 70.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 426,871 46,587 0 29,500 502,958 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 169,394 0 0 0 159,394 72.00 73.00 D7300 DRUGS CHARGED TO PATI ENTS 576,548 17,508 0 60,564 654,620 73.00 90.00 09000 CLI NI C 0 0 0 0 0 90.00 90.00 91.00 09100 EMERGENCY 1, 138,347 149,315 0	65.00 06	500 RESPI RATORY THERAPY	10, 444	0		0 0	10, 444	65.00
68.00 06800 SPEECH PATHOLOGY 0 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 2,883 1,578 0 0 4,461 69.00 69.00 06902 SLEEP LAB 29,960 9,839 0 0 39,79 69.00 70.00 OTOOD ELECTRORCEPHALOGRAPHY 0 0 0 0 70.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 426,871 46,587 0 29,500 502,958 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 169,394 0 0 0 0 169,394 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 576,548 17,508 0 60,564 654,620 73.00 90.00 OPOOD CLI NI C 0 0 0 0 0 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00	66.00 06	600 PHYSI CAL THERAPY	278, 403	61, 707		0 75, 082	415, 192	66.00
68.00 06800 SPEECH PATHOLOGY 0 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 2,883 1,578 0 0 4,461 69.00 69.00 06902 SLEEP LAB 29,960 9,839 0 0 39,79 69.00 70.00 OTOOD ELECTRORCEPHALOGRAPHY 0 0 0 0 70.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 426,871 46,587 0 29,500 502,958 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 169,394 0 0 0 0 169,394 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 576,548 17,508 0 60,564 654,620 73.00 90.00 OPOOD CLI NI C 0 0 0 0 0 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00	67.00 06	5700 OCCUPATIONAL THERAPY	0	0		0 0	0	67.00
69.00 06900 ELECTROCARDIOLOGY 2,883 1,578 0 0 4,461 69.00 69.02 06902 SLEEP LAB 29,960 9,839 0 0 39,799 69.02 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 426,871 46,587 0 29,500 502,958 71.00 72.00 07200 INPL. DEV. CHARGED TO PATIENTS 169,394 0 0 0 169,394 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 576,548 17,508 0 60,564 654,620 73.00 001700 EMERGENCY 1,138,347 149,315 0 208,455 1,496,117 91.00 90.00 09200 DESERVATI ON BEDS (NON-DI STI NCT PART) 1,138,347 149,315 0 1,735,849 14,750,123 18.00 NONREL MBURSABLE COST CENTERS 18.00 190.00 19200 GI FT, FLOWER, COFFEE SHOP, & CANTEEN 0 9,203 <td< td=""><td></td><td></td><td>0</td><td>0</td><td></td><td>0 0</td><td>0</td><td></td></td<>			0	0		0 0	0	
69.02 06902 SLEEP LAB 29,960 9,839 0 0 39,799 69.02 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 70.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 426,871 46,587 0 29,500 502,958 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 169,394 0 0 0 169,394 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 576,548 17,508 0 60,564 654,620 73.00 00 09000 CLI NI C 0 0 0 0 90.00 90.00 09000 CLI NI C 0 0 0 0 90.00 91.00 09100 EMERGENCY 1,138,347 149,315 0 208,455 1,496,117 91.00 92.00 BSECI AL PURPOSE COST CENTERS 92.00 14,750,123 118.00 1,735,849 14,750,123 118.00 NONREL MBURSABLE COST CENTERS 92.00 92.03 0 0			2,883	1.578		0 0		
70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 70.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 426, 871 46, 587 0 29, 500 502, 958 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 169, 394 0 0 0 169, 394 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 576, 548 17, 508 0 60, 564 654, 620 73.00 00TPATI ENT SERVICE COST CENTERS 0 0 0 0 0 0 0 90.00 09000 CLI NI C 90.00 9000 0 0 0 0 90.00 90.00 0 0 0 0 90.00 90.00 9000 EMERGENCY 1, 138, 347 149, 315 0 208, 455 1, 496, 117 91.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00						-		
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 426, 871 46, 587 0 29, 500 502, 958 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 169, 394 0 0 0 169, 394 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 576, 548 17, 508 0 60, 564 654, 620 73. 00 0UTPATI ENT SERVICE COST CENTERS 0			27,700	,,,		0 0		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 169, 394 0 0 0 169, 394 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 576, 548 17, 508 0 60, 564 654, 620 73.00 00 09000 CLINIC 0 0 0 0 90.00 90.00 90.00 09100 EMERGENCY 1, 138, 347 149, 315 0 208, 455 1, 496, 117 91.00 92.00 OBSERVATI ON BEDS (NON-DI STINCT PART) 14, 795, 355 1, 344, 451 0 1, 735, 849 14, 750, 123 118.00 NONREL MBURSABLE COST CENTERS 190.00 19200 PHYSI CI ANS' PRI VATE OFFICES 242, 346 0 0 36, 029 278, 375 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 242, 346 0 0 36, 029 278, 375 190.00 192.00 Cross Foot Adjustments 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			426 871	46 587		0 29 500		
73.00 07300 DRUGS CHARGED TO PATIENTS 576,548 17,508 0 60,564 654,620 73.00 0UTPATIENT SERVICE COST CENTERS 0 <td></td> <td></td> <td></td> <td>40, 307</td> <td></td> <td></td> <td></td> <td></td>				40, 307				
OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 0 0 0 0 90.00 91.00 09100 EMERGENCY 1, 138, 347 149, 315 0 208, 455 1, 496, 117 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0 208, 455 1, 496, 117 91.00 92.00				17 509				
90. 00 09000 CLINIC 0 0 0 0 0 0 0 90. 00 91. 00 09100 EMERGENCY 1, 138, 347 149, 315 0 208, 455 1, 496, 117 91. 00 92. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 1 149, 315 0 208, 455 1, 496, 117 91. 00 92. 00 SPECIAL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1-117) 14, 795, 355 1, 344, 451 0 1, 735, 849 14, 750, 123 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP, & CANTEEN 0 9, 203 0 0 9, 203 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFICES 242, 346 0 0 36, 029 278, 375 192. 00 200. 00 Cross Foot Adjustments 0 0 0 0 0 0200. 00 201. 00 Negati ve Cost Centers 0 0 0 0 0 0 0 01. 00 <td></td> <td></td> <td>570, 540</td> <td>17, 500</td> <td></td> <td>0 00, 304</td> <td>034, 020</td> <td>/3.00</td>			570, 540	17, 500		0 00, 304	034, 020	/3.00
91. 00 09100 EMERGENCY 1, 138, 347 149, 315 0 208, 455 1, 496, 117 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 1 149, 315 0 208, 455 1, 496, 117 91. 00 SPECI AL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1-117) 14, 795, 355 1, 344, 451 0 1, 735, 849 14, 750, 123 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP, & CANTEEN 0 9, 203 0 0 9, 203 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFICES 242, 346 0 0 36, 029 278, 375 192. 00 200. 00 Cross Foot Adjustments 0 0 0 0 0 0 0 00 0 0 0 200. 00 201. 00 Negati ve Cost Centers 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 18. 00			0	0	1	0 0	0	00.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117) 14,795,355 1,344,451 0 1,735,849 14,750,123 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 0 9,203 0 0 9,203 190.00 192.00 192000 PHYSI CI ANS' PRI VATE OFFICES 242,346 0 0 36,029 278,375 192.00 200.00 Cross Foot Adjustments 0 0 0 0 0 0 00 0 0 0 200.00 201.00 Negative Cost Centers 0 <t< td=""><td></td><td></td><td></td><td>-</td><td></td><td></td><td></td><td></td></t<>				-				
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117) 14,795,355 1,344,451 0 1,735,849 14,750,123 118.00 NONREI MBURSABLE COST CENTERS 0 9,203 0 0 9,203 190.00 190.00 19200 PHYSI CI ANS' PRI VATE OFFICES 242,346 0 0 36,029 278,375 192.00 200.00 Cross Foot Adjustments 0 0 0 0 0 0 0 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0 0 0 0 201.00			1, 138, 347	149, 315		0 208, 455		
118.00 SUBTOTALS (SUM OF LINES 1-117) 14,795,355 1,344,451 0 1,735,849 14,750,123 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP, & CANTEEN 0 9,203 0 0 9,203 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 242,346 0 0 36,029 278,375 192.00 200.00 Cross Foot Adjustments 242,346 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 201.00					I		0	92.00
NONREI MBURSABLE COST CENTERS 190.00 GI FT, FLOWER, COFFEE SHOP, & CANTEEN 0 9, 203 0 0 9, 203 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 242, 346 0 0 36, 029 278, 375 192.00 200.00 Cross Foot Adj ustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 201.00			14 705 255	1 044 451	1	0 1 705 040	14 750 100	110 00
190.00 GI FT, FLOWER, COFFEE SHOP, & CANTEEN 0 9,203 0 0 9,203 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 242,346 0 0 36,029 278,375 192.00 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 201.00			14, 795, 355	1, 344, 451	I	U I, /35, 849	14, 750, 123	118.00
192.00 PHYSI CLANS' PRI VATE OFFICES 242, 346 0 0 36, 029 278, 375 192.00 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 201.00	100 00 10	NIKET MOUKSABLE CUST CENTERS		0.000	1	0	0.000	100.00
200.00 Cross Foot Adjustments 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0 201.00	190.0019	VUUU GIFT, FLUWER, CUFFEE SHUP, & CANTEEN	-	9, 203				
201.00 Negative Cost Centers 0 0 0 0 201.00			242, 346	0		U 36, 029		
202.00 101AL (sum lines 118-201) 15,037,701 1,353,654 0 1,771,878 15,037,701 202.00				0				
	202.00	101AL (sum lines 118-201)	15, 037, 701	1, 353, 654	I	U 1, 771, 878	15, 037, 701	202.00

Heal th	n Financial Systems	COMMUNITY HOSPI	TAL OF BREMEN		In Lie	u of Form CMS-	2552-10
COST /	ALLOCATION - GENERAL SERVICE COSTS		Provi der		Period:	Worksheet B	
					From 05/01/2014 To 04/30/2015	Part I Date/Time Pre	nored
					10 04/30/2015	9/30/2015 10:	
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	·	& GENERAL	PLANT	LINEN SERVICE			
		5.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS	- T	-	-			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL	2, 723, 121					5.00
7.00	00700 OPERATION OF PLANT	217, 132	1, 199, 053				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	27, 253					8.00
9.00	00900 HOUSEKEEPI NG	46, 096					9.00
10.00	01000 DI ETARY	29, 367	33, 474			203, 873	
11.00	01100 CAFETERI A	65, 331	33, 289			0	
13.00	01300 NURSI NG ADMI NI STRATI ON	42, 643			2, 472	0	
16.00	01600 MEDI CAL RECORDS & LI BRARY	96, 840	17, 545	(4, 102	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS	1		1			-
30.00	03000 ADULTS & PEDI ATRI CS	276, 426				203, 873	
43.00		12, 597	7, 739	23	3 1, 809	0	43.00
	ANCI LLARY SERVICE COST CENTERS	1	1	1			-
50.00	05000 OPERATI NG ROOM	314, 313				0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	14, 520				0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	219, 383				0	
57.00	05700 CT SCAN	77, 242			0 0	0	
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	83, 336			0 0	0	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	
60.00	06000 LABORATORY	406, 809	63, 874		14, 934	0	
60.01	06001 BLOOD LABORATORY	0	0		0 0	0	
64.00	06400 I NTRAVENOUS THERAPY	2,065	1, 325	1	310	0	
65.00	06500 RESPI RATORY THERAPY	2, 309	0		0 0	0	
66.00	06600 PHYSI CAL THERAPY	91, 811	74, 634			0	
67.00	06700 OCCUPATIONAL THERAPY	0	0		0 0	0	
68.00	06800 SPEECH PATHOLOGY	0	-		0 0	0	
69.00	06900 ELECTROCARDI OLOGY	986	1, 908			0	
69.02	06902 SLEEP LAB	8, 801	11, 900			0	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	U 5 (0 (7		0	0	
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	111, 219	56, 347		13, 174	0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	37, 458			0	0	
73.00		144, 756	21, 176	<u> </u> (0 4, 951	0	73.00
00.00		0				0	00.00
90.00		0				0	
91.00	09100 EMERGENCY	330, 836	180, 596	23, 38	3 42, 224	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
110 0	SPECIAL PURPOSE COST CENTERS	2 (50 520	1 107 001	154.00	1 274 025	202.072	1110 00
118.0		2, 659, 529	1, 187, 921	154, 29	4 274,035	203, 873	1118.00
100 0	NONREI MBURSABLE COST CENTERS	2.025	11 100		2 (02	0	100.00
	D 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN D 19200 PHYSICIANS' PRIVATE OFFICES	2,035			2,603		190.00
200.0		61, 557	C	2,03	6 0	0	192.00 200.00
		0				_	
201.0 202.0	5	2, 723, 121	1, 199, 053	156, 33	276,638		201.00
202.0	U TOTAL (SUIILITIES TIO-201)	2,723,121	1, 199, 003	1 100, 330	270,038	203, 8/3	1202.00

Heal th	Financial Systems	COMMUNITY HOSPI	TAL OF BREMEN		In Lie	eu of Form CMS-2	2552-10
	LLOCATION - GENERAL SERVICE COSTS				Period:	Worksheet B	
					From 05/01/2014		
					To 04/30/2015	Date/Time Pre 9/30/2015 10:	pared: 33 am
	Cost Center Description	CAFETERI A	NURSI NG	MEDI CAL	Subtotal	Intern &	
	bost bontor boschiption	ON ETERNA	ADMI NI STRATI ON		Subtotal	Residents Cost	
				LIBRARY		& Post	
						Stepdown	
						Adjustments	
		11.00	13.00	16.00	24.00	25.00	
	GENERAL SERVICE COST CENTERS	1	1	1		1	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING						9.00
10.00	01000 DI ETARY	402.200					10.00
11.00		402, 308	257 272				11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	7,831	256, 363	FO((4)			13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	30, 220	0	586, 64	I		16.00
30.00	03000 ADULTS & PEDIATRICS	58, 645	96, 692	55, 160	2, 393, 198	0	30.00
43.00	04300 NURSERY	2, 333	3, 846				43.00
43.00	ANCI LLARY SERVI CE COST CENTERS	2,333	5, 040	2,70	00,200	0	43.00
50.00	05000 OPERATI NG ROOM	45, 691	75, 333	107, 550	2, 284, 824	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	3, 027	4, 990	3, 184		0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	33, 588	0	47, 14		0	54.00
57.00	05700 CT SCAN	4,835	0	56, 120		0	57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	4, 725	0	22, 51		0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0			0 0	59.00
60.00	06000 LABORATORY	127, 457	0	173, 65	2, 626, 418	0 0	60.00
60.01	06001 BLOOD LABORATORY	0	0	(0	60.01
64.00	06400 I NTRAVENOUS THERAPY	0	0	84	4 13, 123	0	64.00
65.00	06500 RESPI RATORY THERAPY	0	0	610		0	65.00
66.00	06600 PHYSI CAL THERAPY	22,650	0	22, 11		0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	4	1 41	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0	7, 33	7 15, 701	0	69.00
69.02	06902 SLEEP LAB	0	0	2, 14	1 65, 762	0	69.02
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	(0 0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	12, 114	0	16, 78	5 712, 597	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	7, 76	5 214, 617	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	8, 470	13, 965	28, 243	3 876, 181	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0			0	90.00
91.00	09100 EMERGENCY	37, 323	61, 537	33, 420	2, 205, 436		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
	SPECIAL PURPOSE COST CENTERS	1					
118.00		398, 909	256, 363	586, 64	1 14, 667, 361	0	118.00
	NONREI MBURSABLE COST CENTERS	-	-			-	
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		24, 973		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	3, 399	0		0.0,007		192.00
200.00		_	_		0		200.00
201.00	5	402 200		E04 (44			201.00
202.00	TOTAL (sum lines 118-201)	402, 308	256, 363	586, 64	1 15, 037, 701	I 0	202.00

Heal th	Fi nanci al	Systems	

In Lieu of Form CMS-2552-10

Heal th F	inancial Systems	COMMUNITY HOSPITAL	OF BREMEN	In Lieu of Form CMS	-2552-10
COST ALL	LOCATION - GENERAL SERVICE COSTS		Provider CCN: 151300	Period: Worksheet B	
				From 05/01/2014 Part I	
				To 04/30/2015 Date/Time Pr	epared:
	Cast Castas Description	T-+-1		9/30/2015 10	<u>: 33 am</u>
	Cost Center Description	Total			
		26.00			
	ENERAL SERVICE COST CENTERS				
	0100 NEW CAP REL COSTS-BLDG & FIXT				1.00
	0200 NEW CAP REL COSTS-MVBLE EQUIP				2.00
	0400 EMPLOYEE BENEFITS DEPARTMENT				4.00
	0500 ADMINISTRATIVE & GENERAL				5.00
	0700 OPERATION OF PLANT				7.00
	0800 LAUNDRY & LINEN SERVICE				8.00
	0900 HOUSEKEEPI NG				9.00
	1000 DI ETARY				10.00
11.00 0	1100 CAFETERI A				11.00
13.00 0	1300 NURSI NG ADMI NI STRATI ON				13.00
16.00 0	1600 MEDICAL RECORDS & LIBRARY				16.00
1	NPATIENT ROUTINE SERVICE COST CENTERS				
30.00 0	3000 ADULTS & PEDIATRICS	2, 393, 198			30.00
43.00 0	4300 NURSERY	88, 288			43.00
A	NCILLARY SERVICE COST CENTERS				
50.00 0	5000 OPERATI NG ROOM	2, 284, 824			50.00
52.00 0	5200 DELIVERY ROOM & LABOR ROOM	91, 695			52.00
54.00 0	5400 RADI OLOGY-DI AGNOSTI C	1, 437, 772			54.00
	5700 CT SCAN	487, 501			57.00
	5800 MAGNETIC RESONANCE I MAGING (MRI)	487, 443			58.00
	5900 CARDI AC CATHETERI ZATI ON	0			59.00
	6000 LABORATORY	2, 626, 418			60.00
	6001 BLOOD LABORATORY	2,020,110			60.01
	6400 I NTRAVENOUS THERAPY	13, 123			64.00
	6500 RESPI RATORY THERAPY	13, 363			65.00
	6600 PHYSI CAL THERAPY	653, 401			66.00
	6700 OCCUPATI ONAL THERAPY	0000,401			67.00
	6800 SPEECH PATHOLOGY	41			68.00
	6900 ELECTROCARDI OLOGY	15, 701			69.00
	6902 SLEEP LAB				69.00
		65, 762			
	7000 ELECTROENCEPHALOGRAPHY	0			70.00
	7100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	712, 597			71.00
	7200 IMPL. DEV. CHARGED TO PATIENTS	214, 617			72.00
	7300 DRUGS CHARGED TO PATIENTS	876, 181			73.00
	UTPATIENT SERVICE COST CENTERS				
		0			90.00
	9100 EMERGENCY	2, 205, 436			91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
	PECIAL PURPOSE COST CENTERS				4
118.00	SUBTOTALS (SUM OF LINES 1-117)	14, 667, 361			118.00
	ONREI MBURSABLE COST CENTERS				
	9000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	24, 973			190. 00
	9200 PHYSI CLANS' PRI VATE OFFI CES	345, 367			192.00
200.00	Cross Foot Adjustments	0			200. 00
201.00	Negative Cost Centers	0			201.00
202.00	TOTAL (sum lines 118-201)	15, 037, 701			202.00

Heal th	Financial Systems	COMMUNITY HOSPI	TAL OF BREMEN		In Lie	u of Form CMS-	2552-10
	TION OF CAPITAL RELATED COSTS				Period: From 05/01/2014 To 04/30/2015	Worksheet B	
					10 04/30/2013	9/30/2015 10:	33 am
			CAPI TAL REI	LATED COSTS			
	Cost Center Description	Directly	NEW BLDG &	NEW MVBLE	Subtotal	EMPLOYEE	
		Assigned New Capital	FLXT	EQUI P		BENEFI TS DEPARTMENT	
		Related Costs				DEPARTMENT	
		0	1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS	3		2100	2.11		
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	5, 062		0 5, 062	5, 062	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	0	112, 918		0 112, 918	997	5.00
7.00	00700 OPERATION OF PLANT	0	244, 308		0 244, 308	142	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	4, 821		0 4, 821	0	8.00
9.00	00900 HOUSEKEEPI NG	0	8, 283		0 8, 283	112	9.00
10.00	01000 DI ETARY	0	27, 676		0 27, 676	37	10.00
11.00	01100 CAFETERI A	0	27, 523		0 27, 523	134	
13.00	01300 NURSI NG ADMI NI STRATI ON	0	8, 743		0 8, 743	110	
16.00	01600 MEDICAL RECORDS & LIBRARY	0	14, 506	•	0 14, 506	197	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS			1			
30.00	03000 ADULTS & PEDIATRICS	0	273, 322		0 273, 322	553	
43.00	04300 NURSERY	0	6, 399		0 6, 399	22	43.00
F0 00	ANCI LLARY SERVICE COST CENTERS		400.474	1	0 400 474	E / 7	50.00
50.00	05000 OPERATING ROOM	0	183, 171		0 183, 171	567	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	29	
54.00	05400 RADI OLOGY-DI AGNOSTI C 05700 CT SCAN	0	87, 279 0		0 87,279 0 0	337	54.00
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0 0 0	41	57.00 58.00
58.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	40	
60, 00	06000 LABORATORY	0	52, 810		0 52, 810	565	1
60.00	06001 BLOOD LABORATORY	0	52, 810		0 52,810	0	1
64.00	06400 I NTRAVENOUS THERAPY	0	1, 096		0 1,096	0	64.00
65.00	06500 RESPI RATORY THERAPY	0	1,070		0 0	0	
66.00	06600 PHYSI CAL THERAPY	0	61, 707		0 61, 707	215	
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	1
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	0	
69.00	06900 ELECTROCARDI OLOGY	0	1, 578		0 1, 578	0	69.00
69.02	06902 SLEEP LAB	0	9, 839		0 9, 839	0	69.02
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0)	0 0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	46, 587		0 46, 587	84	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	17, 508		0 17, 508	173	73.00
	OUTPATIENT SERVICE COST CENTERS			_			
90.00	09000 CLI NI C	0	0		0 0	0	90.00
91.00	09100 EMERGENCY	0	149, 315		0 149, 315	596	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
110.00	SPECIAL PURPOSE COST CENTERS	0	1 044 451	1	0 1. 344. 451	4.050	110.00
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	0	1, 344, 451		0 1, 344, 451	4, 959	118.00
100 00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	9, 203		0 9, 203	0	190.00
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	9, 203		0 9,203		190.00
200.00			0			103	200.00
200.00	5		Λ			Λ	200.00
201.00	U U U U U U U U U U U U U U U U U U U	0	1, 353, 654		0 1, 353, 654		202.00
202.00		, ч	1,000,004	1	1,000,004	5,002	1-02.00

Heal th	Financial Systems	COMMUNI TY HOSPI	TAL OF BREMEN		In Lie	u of Form CMS-	2552-10
ALLOCA	ATION OF CAPITAL RELATED COSTS		Provi der		Period: From 05/01/2014 Fo 04/30/2015	Worksheet B Part II Date/Time Pre 9/30/2015 10:	
	Cost Center Description	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
		5.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS			1			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	112 015					4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	113, 915					5.00
7.00	00700 OPERATION OF PLANT	9,083					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	1, 140					8.00
9.00	00900 HOUSEKEEPING	1, 928				24 404	9.00
10.00	01000 DI ETARY	1, 228				36, 406	
11.00		2,733				0	
13.00	01300 NURSING ADMINISTRATION	1, 784	2, 236		116	0	
16.00	01600 MEDI CAL RECORDS & LI BRARY	4, 051	3, 710	۱ <u> </u>	D 193	0	16.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	11 5/0	(0.000	2.04	2 (20	27.407	1 20 00
30.00	03000 ADULTS & PEDIATRICS	11, 563				36, 406	1
43.00	04300 NURSERY	527	1, 636	1	1 85	0	43.00
50.00	ANCI LLARY SERVI CE COST CENTERS	13, 148	14 011	2, 17	2 1 2 1 2 2	0	50.00
50.00	05200 DELIVERY ROOM & LABOR ROOM	607	46, 844			0	1
52.00 54.00	05400 RADI OLOGY-DI AGNOSTI C	9, 177	22, 321			0	
57.00	05700 CT SCAN	3, 231	22, 321	1	0	0	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	3, 486				0	
59.00	05900 CARDI AC CATHETERI ZATI ON	3,480				0	
60,00	06000 LABORATORY	17,023	13, 506		702	0	
60.00	06001 BLOOD LABORATORY	17,025	13, 300	1	0 0	0	
64.00	06400 I NTRAVENOUS THERAPY	86	280		15	0	
65.00	06500 RESPI RATORY THERAPY	97	200			0	
66,00	06600 PHYSI CAL THERAPY	3, 841	15, 781		-	0	
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	
68.00	06800 SPEECH PATHOLOGY	0			0 0	0	1
69.00	06900 ELECTROCARDI OLOGY	41	403		-	0	
69.02	06902 SLEEP LAB	368				0	
70.00	07000 ELECTROENCEPHALOGRAPHY	0				0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4,652	11, 914		619	0	1
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	1,567	0		0 0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	6,055	0		233	0	
70.00	OUTPATIENT SERVICE COST CENTERS	0,000	1, 170	1	200		/0.00
90.00	09000 CLINIC	0	0		0 0	0	90.00
91.00	09100 EMERGENCY	13, 839			-	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			.,	.,	-	92.00
/2:00	SPECIAL PURPOSE COST CENTERS			1			/2.00
118.00		111, 255	251, 179	7, 10	12, 874	36, 406	118.00
	NONREI MBURSABLE COST CENTERS						
190. 00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	85	2, 354) 122	0	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	2, 575		1			192.00
200.00			-			-	200.00
201.00		0	0)	0 0	0	201.00
202.00	5	113, 915	253, 533	7, 19	4 12, 996		202.00
				-			

Heal th F	inancial Systems	COMMUNITY HOSPI	TAL OF BREMEN		In Lie	eu of Form CMS-2	2552-10
	ON OF CAPITAL RELATED COSTS				Period:	Worksheet B	
					From 05/01/2014 To 04/30/2015		narod
					10 04/30/2015	9/30/2015 10:	33 am
	Cost Center Description	CAFETERI A	NURSI NG	MEDI CAL	Subtotal	Intern &	
	·		ADMI NI STRATI ON	RECORDS &		Residents Cost	
				LI BRARY		& Post	
						Stepdown	
		11.00	10.00	44.00		Adjustments	
		11.00	13.00	16.00	24.00	25.00	
	ENERAL SERVICE COST CENTERS 0100 NEW CAP REL COSTS-BLDG & FIXT	1	1	1			1.00
	0200 NEW CAP REL COSTS-BLDG & FIXT						2.00
	0400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	0500 ADMINI STRATI VE & GENERAL						5.00
	0700 OPERATION OF PLANT						7.00
	0800 LAUNDRY & LINEN SERVICE						8.00
	0900 HOUSEKEEPI NG						9.00
	1000 DI ETARY						10.00
	1100 CAFETERI A	37, 816					11.00
	1300 NURSING ADMINISTRATION	736					13.00
	1600 MEDI CAL RECORDS & LI BRARY	2,841	0		8		16.00
1	NPATIENT ROUTINE SERVICE COST CENTERS					•	1
30.00 0	3000 ADULTS & PEDIATRICS	5, 512	5, 176	2, 39	8 410, 505	0	30.00
	4300 NURSERY	219	206	12	0 9, 225	0	43.00
	NCILLARY SERVICE COST CENTERS						
	5000 OPERATING ROOM	4, 295	4, 033	4, 67	5 261, 338	0	50.00
	5200 DELIVERY ROOM & LABOR ROOM	285		13			52.00
	5400 RADI OLOGY-DI AGNOSTI C	3, 157	0	_,			54.00
	5700 CT SCAN	454	0			0	57.00
	5800 MAGNETIC RESONANCE I MAGING (MRI)	444	0			0	
	5900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
	6000 LABORATORY	11, 982	0			0	60.00
	6001 BLOOD LABORATORY	0	0		0 0	0	60.01
		0	-		4 1, 481	0	64.00
		0	0			0	65.00
	6600 PHYSI CAL THERAPY 6700 OCCUPATI ONAL THERAPY	2, 129			1 85, 893 0 0	0	66.00 67.00
	6800 SPEECH PATHOLOGY	0			2 2	0	68.00
	6900 ELECTROCARDI OLOGY	0				0	69.00
	6902 SLEEP LAB	0	0			0	69.02
	7000 ELECTROENCEPHALOGRAPHY	0	0		0 12, 703	0	
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 139		73		0	71.00
	7200 I MPL. DEV. CHARGED TO PATIENTS	0	0			0	
	7300 DRUGS CHARGED TO PATIENTS	796					
	UTPATIENT SERVICE COST CENTERS			.,==		-	
	9000 CLI NI C	0	0		0 0	0	90.00
	9100 EMERGENCY	3, 508	3, 295	1, 45	3 213, 252	0	91.00
92.00 0	9200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
	PECIAL PURPOSE COST CENTERS						1
118.00	SUBTOTALS (SUM OF LINES 1-117)	37, 497	13, 725	25, 49	8 1, 338, 799	0	118.00
N	ONREIMBURSABLE COST CENTERS					-	
	9000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0			0 11, 764		190.00
	9200 PHYSI CI ANS' PRI VATE OFFI CES	319	0		0 3, 091		192.00
200.00	Cross Foot Adjustments				0		200. 00
201.00	Negative Cost Centers	0	0		0 0		201.00
202.00	TOTAL (sum lines 118-201)	37, 816	13, 725	25, 49	8 1, 353, 654	0	202.00

Heal th Financial	Systems

Heal th	Financial Systems	COMMUNITY HOSPITAL	OF BREMEN	In Lieu	of Form CMS-	2552-10
	TION OF CAPITAL RELATED COSTS		Provider CCN: 151300	Peri od:	Worksheet B	
				From 05/01/2014	Part II	
				To 04/30/2015	Date/Time Pre 9/30/2015 10:	
	Cost Center Description	Total				
		26.00				
	GENERAL SERVICE COST CENTERS					
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500 ADMINISTRATIVE & GENERAL					5.00
7.00	00700 OPERATION OF PLANT					7.00
8.00	00800 LAUNDRY & LINEN SERVICE					8.00
9.00	00900 HOUSEKEEPING					9.00
10.00	01000 DI ETARY					10.00
11.00						11.00
13.00	01300 NURSING ADMINISTRATION					13.00
16.00	01600 MEDI CAL RECORDS & LI BRARY					16.00
	INPATIENT ROUTINE SERVICE COST CENTERS	410 505				
30.00	03000 ADULTS & PEDI ATRI CS	410, 505				30.00
43.00		9, 225				43.00
50.00	ANCI LLARY SERVI CE COST CENTERS	241 220				50.00
50.00 52.00	05200 DELIVERY ROOM & LABOR ROOM	261, 338 1, 340				52.00
52.00	05400 RADI OLOGY-DI AGNOSTI C	126, 184				52.00
57.00	05700 CT SCAN	6, 165				57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	4, 957				58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	4, 937				59.00
60.00	06000 LABORATORY	104, 133				60.00
60.00	06001 BLOOD LABORATORY	04, 133				60.00
64.00	06400 I NTRAVENOUS THERAPY	1, 481				64.00
65.00	06500 RESPI RATORY THERAPY	124				65.00
66.00	06600 PHYSI CAL THERAPY	85, 893				66.00
67.00	06700 OCCUPATI ONAL THERAPY	00,079				67.00
68.00	06800 SPEECH PATHOLOGY	2				68.00
69.00	06900 ELECTROCARDI OLOGY	2, 388				69.00
	06902 SLEEP LAB	12, 963				69.02
70.00	07000 ELECTROENCEPHALOGRAPHY	0				70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	65, 725				71.00
72.00	07200 I MPL. DEV. CHARGED TO PATI ENTS	1, 905				72.00
	07300 DRUGS CHARGED TO PATIENTS	31, 219				73.00
	OUTPATIENT SERVICE COST CENTERS	· · ·				1
90.00	09000 CLI NI C	0				90.00
91.00	09100 EMERGENCY	213, 252				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					92.00
	SPECIAL PURPOSE COST CENTERS					1
118.00		1, 338, 799				118.00
	NONREI MBURSABLE COST CENTERS					
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	11, 764				190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	3, 091				192.00
200.00		0				200. 00
201.00		0				201.00
202.00	TOTAL (sum lines 118-201)	1, 353, 654				202.00

Heal th	Financial Systems C	COMMUNITY HOSPI	TAL OF BREMEN		In Lie	eu of Form CMS-	2552-10
COST A	LLOCATION - STATISTICAL BASIS		Provi der		Period:	Worksheet B-1	
					rom 05/01/2014 o 04/30/2015	Data /Tima Dra	narod
					0 04/30/2015	Date/Time Pre 9/30/2015 10:	
		CAPITAL REL	ATED COSTS				
	Cost Center Description	NEW BLDG &	NEW MVBLE	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
		FLXT	EQUI P	BENEFITS		& GENERAL	
		(SQUARE	(SQUARE	DEPARTMENT		(ACCUM.	
		FOOTAGE)	FOOTAGE)	(GROSS		COST)	
		1.00		SALARIES)		5.00	
		1.00	2.00	4.00	5A	5.00	
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT	61, 774		1	1	1	1.00
2.00	00200 NEW CAP REL COSTS-BEDG & TTXT	01,774	61, 774				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	231	231	6, 346, 253	,		4.00
4.00 5.00	00500 ADMINI STRATI VE & GENERAL	5, 153	5, 153			12, 314, 580	
7.00	00700 OPERATION OF PLANT	11, 149	11, 149			981, 921	
8.00	00800 LAUNDRY & LINEN SERVICE	220	220			123, 246	
9.00	00900 HOUSEKEEPING	378	378		-	208, 457	1
10.00	01000 DI ETARY	1, 263	1, 263			132, 802	1
	01100 CAFETERI A	1, 256	1, 256				
	01300 NURSI NG ADMI NI STRATI ON	399	399				1
	01600 MEDICAL RECORDS & LIBRARY	662	662				
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	002	002	217,027		1 107,701	10.00
30.00	03000 ADULTS & PEDI ATRI CS	12, 473	12, 473	692, 885	5 0	1, 250, 059	30.00
	04300 NURSERY	292	292				
	ANCI LLARY SERVI CE COST CENTERS				1		
50.00	05000 OPERATI NG ROOM	8, 359	8, 359	710, 271	0	1, 421, 394	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0				
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 983	3, 983				
57.00	05700 CT SCAN	0	0			349, 304	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	59, 725	5 0	376, 863	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	(0 0	0	59.00
60.00	06000 LABORATORY	2, 410	2, 410	708, 300	0 0	1, 839, 687	60.00
60.01	06001 BLOOD LABORATORY	0	0	0 0	0 0	0	60.01
64.00	06400 I NTRAVENOUS THERAPY	50	50	0	0 0	9, 339	64.00
65.00	06500 RESPI RATORY THERAPY	0	0	0 0	0 0	10, 444	65.00
66.00	06600 PHYSI CAL THERAPY	2, 816	2, 816	268, 919	0	415, 192	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	(0 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	(0 0	0	68.00
	06900 ELECTROCARDI OLOGY	72	72		0 0		
	06902 SLEEP LAB	449	449	(0 0	39, 799	
	07000 ELECTROENCEPHALOGRAPHY	0	0	(0 0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 126	2, 126	105, 659			
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(0		
73.00	07300 DRUGS CHARGED TO PATIENTS	799	799	216, 920	0 0	654, 620	73.00
~~~~~	OUTPATIENT SERVICE COST CENTERS	a					00.00
90.00	09000 CLINIC	0	0		-		
91.00	09100 EMERGENCY	6, 814	6, 814	746, 612	2 0	1, 496, 117	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
110 00	SPECIAL PURPOSE COST CENTERS	(1.254	(1.254	( 217 210	2 722 121	12 027 002	1110 00
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	61, 354	61, 354	6, 217, 210	) -2, 723, 121	12, 027, 002	118.00
100 00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	420	420			0.202	190.00
	19000 PHYSICIANS' PRIVATE OFFICES	420	420	129, 043			1
200.00		U	0	127,04	0	270, 373	200.00
200.00	5						200.00
201.00		1, 353, 654	0	1, 771, 878	2	2, 723, 121	
202.00	Part 1)	1, 303, 004	0	, , , , , , , , , , , , , , , , , , , ,		2, 123, 121	202.00
203.00		21.913005	0. 000000	0. 279201		0. 221130	203 00
203.00		21.713003	0.00000	5, 062		113, 915	
207.00	Part II)			3,002	-	113, 713	
205.00				0. 000798	3	0.009250	205.00
		. I		1	1	1	1

	Financial Systems ( LLOCATION - STATISTICAL BASIS	SOMMUNITY HUSFT	TAL OF BREMEN	CCN: 151300	Peri od:	u of Form CMS-: Worksheet B-1	
0001 A				CON. 191900	From 05/01/2014 To 04/30/2015	Date/Time Pre	pared:
	Cost Center Description	OPERATION OF PLANT (SQUARE FOOTAGE)	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)	HOUSEKEEPI NO (SQUARE FOOTAGE)	G DI ETARY (MEALS SERVED)	9/30/2015 10: CAFETERI A (FTE HRS)	33 811
		7.00	8.00	9.00	10.00	11.00	
	GENERAL SERVICE COST CENTERS	1	1	I	- 1		
1.00 2.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00 16.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01600 MEDICAL RECORDS & LI BRARY	45, 241 220 378 1, 263 1, 256 399 662	1, 671 56 64	44, 64 1, 26 1, 25 39	53 100 56 0 99 0	168, 669 3, 283 12, 670	13.00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	12, 473	6, 157	12, 47	73 100	24, 587	30.00
43.00	04300 NURSERY	292	33			978	
	ANCI LLARY SERVI CE COST CENTERS				<u> </u>		-
50.00	05000 OPERATI NG ROOM	8, 359				19, 156	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	43		0 0	1, 269	
54.00 57.00	05400 RADI OLOGY-DI AGNOSTI C 05700 CT SCAN	3, 983	2, 121	3, 98	0 0	14, 082 2, 027	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	1, 981	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	
60.00	06000 LABORATORY	2, 410	0	2, 41	0 0	53, 437	60.00
60. 01	06001 BLOOD LABORATORY	0	0		0 0	0	
64.00	06400 I NTRAVENOUS THERAPY	50			50 0	0	
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	2, 816	0 1, 322	2, 8	0 0	0 9, 496	
67.00	06700 OCCUPATIONAL THERAPY	2,010	1, 322	2,0	0 0	9,490	67.0
68.00	06800 SPEECH PATHOLOGY	0	-		0 0	0	
69.00	06900 ELECTROCARDI OLOGY	72	78	-	0 0	0	
69. 02	06902 SLEEP LAB	449	47	44	19 0	0	69.0
	07000 ELECTROENCEPHALOGRAPHY	0	-		0 0	0	
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	2, 126				5, 079	
72.00 73.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0 799		79	-	0 3, 551	72.0
/0.00	OUTPATIENT SERVICE COST CENTERS	,,,,				0,001	/ 0. 0.
90.00	09000 CLI NI C	0	0		0 0	0	90.00
91.00	09100 EMERGENCY	6, 814	3, 238	6, 81	4 0	15, 648	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.0
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)	44, 821	21, 366	44, 22	23 100	167, 244	1110 0
	NONREI MBURSABLE COST CENTERS	44, 021	21, 300	44, 22	100	107, 244	1110. 0
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	420	0	42	20 0	0	190. 0
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	282		0 0	1, 425	192.0
200.00	5						200.0
201.00	0	1 100 050	454 000			100 000	201.0
202.00	Cost to be allocated (per Wkst. B, Part I)	1, 199, 053	156, 330	276, 63	38 203, 873	402, 308	202.0
203.00		26. 503680	7. 221452	6. 1966	2, 038. 730000	2. 385192	203 0
203.00 204.00		253, 533					
	Part II)			, , ,	22, 100	5.,510	
	i di c i i j						

		COMMUNITY HOSPIT		151200		u of Form Cl	
JUST A	LLOCATION - STATISTICAL BASIS		Provider CCN: 1		Period: From 05/01/2014	Worksheet	
					To 04/30/2015	Date/Time 9/30/2015	
	Cost Center Description	NURSI NG	MEDI CAL				<u></u>
		ADMI NI STRATI ON	RECORDS &				
		(DI RECT	LI BRARY (GROSS				
		NRSING HRS)	CHARGES)				
		13.00	16.00				
	GENERAL SERVICE COST CENTERS	TT					
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.0
2.00 4.00	00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.
5.00	00500 ADMI NI STRATI VE & GENERAL						5.0
7.00	00700 OPERATION OF PLANT						7.
3.00	00800 LAUNDRY & LINEN SERVICE						8.
9.00	00900 HOUSEKEEPI NG						9.0
	01000 DI ETARY						10.
	01100 CAFETERIA 01300 NURSING ADMINISTRATION	65, 189					11.
	01600 MEDICAL RECORDS & LIBRARY	05, 189	31, 995, 039				16.
0.00	INPATIENT ROUTINE SERVICE COST CENTERS		01, 770, 007				10.1
	03000 ADULTS & PEDIATRICS	24, 587	3, 008, 754				30. (
	04300 NURSERY	978	150, 585				43.
	ANCI LLARY SERVICE COST CENTERS	10.15/	5.045.045				
	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	19, 156 1, 269	5, 865, 845 173, 668				50. 52.
	05400 RADI OLOGY-DI AGNOSTI C	1, 209	2, 571, 094				52.
	05700 CT SCAN	0	3, 060, 817				57.
	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	1, 228, 206				58.
	05900 CARDI AC CATHETERI ZATI ON	0	0				59.
	06000 LABORATORY	0	9, 470, 661				60.
	06001 BLOOD LABORATORY	0					60.
	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	4, 585 33, 264				64. 65.
	06600 PHYSI CAL THERAPY	0	1, 206, 294				66.
	06700 OCCUPATI ONAL THERAPY	0	0				67.
58.00	06800 SPEECH PATHOLOGY	0	2, 243				68.
	06900 ELECTROCARDI OLOGY	0	400, 148				69.
	06902 SLEEP LAB	0	116, 770				69.
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0 915, 452				70.
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	423, 484				72.
	07300 DRUGS CHARGED TO PATIENTS	3, 551	1, 540, 413				73.
	OUTPATIENT SERVICE COST CENTERS	· · ·					
	09000 CLI NI C	0	0				90.
	09100 EMERGENCY	15, 648	1, 822, 756				91.
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)	65, 189	31, 995, 039				118.
10.00	NONREI MBURSABLE COST CENTERS	05,107	51, 775, 057				
90.00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0				190.
92.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0				192.
200.00							200.
201.00		054 040					201.
202.00	Cost to be allocated (per Wkst. B, Part I)	256, 363	586, 641				202.
203.00		3. 932611	0. 018335				203.
204.00		13, 725	25, 498				203.
	Part II)		.,				

Health Financial Systems	COMMUNITY HOSPI	TAL OF BREMEN		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der		Period: From 05/01/2014 To 04/30/2015		
		Titl	e XVIII	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)		Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	2, 393, 198		2, 393, 19	8 0	0	30.00
43. 00 04300 NURSERY	88, 288		88, 28	8 0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	2, 284, 824		2, 284, 82	4 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	91, 695		91, 69	5 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 437, 772	-	1, 437, 77	2 0	0	54.00
57.00 05700 CT SCAN	487, 501		487, 50	1 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	487, 443		487, 44	3 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0			0 0	0	59.00
60. 00 06000 LABORATORY	2, 626, 418		2, 626, 41	8 0	0	60.00
60.01 06001 BLOOD LABORATORY	0			0 0	0	60.01
64.00 06400 INTRAVENOUS THERAPY	13, 123		13, 12	3 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	13, 363	C	13, 36	3 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	653, 401	C	653, 40	1 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	41	C	4	1 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	15, 701		15, 70	1 0	0	69.00
69. 02 06902 SLEEP LAB	65, 762		65, 76	2 0	0	69.02
70.00 07000 ELECTROENCEPHALOGRAPHY	0			0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	712, 597		712, 59	7 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	214, 617		214, 61	7 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	876, 181		876, 18	1 0	0	73.00
OUTPATIENT SERVICE COST CENTERS			· · · · · · · · · · · · · · · · · · ·			
90. 00 09000 CLI NI C	0	)		0 0	0	90.00
91.00 09100 EMERGENCY	2, 205, 436		2, 205, 43	6 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	761, 675		761, 67	5	0	92.00
200.00 Subtotal (see instructions)	15, 429, 036	C	15, 429, 03	6 0	0	200.00
201.00 Less Observation Beds	761, 675		761, 67	5	0	201.00
202.00 Total (see instructions)	14, 667, 361	C	14, 667, 36	1 0	0	202.00

Health Financial Systems	COMMUNITY HOSPI	TAL OF BREMEN		In Lie	eu of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der		Period: From 05/01/2014 To 04/30/2015		epared: 33 am
		Ti tl	e XVIII	Hospi tal	Cost	
		Charges				
Cost Center Description	I npati ent	Outpati ent		6 Cost or Other	TEFRA	
			+ col. 7)	Rati o	Inpati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS				-		
30. 00 03000 ADULTS & PEDI ATRI CS	2, 223, 005		2, 223, 00			30.00
43. 00 04300 NURSERY	150, 585		150, 58	15		43.00
ANCI LLARY SERVI CE COST CENTERS	1 044 004	4 (40 054	<b>E</b> 0( <b>F</b> 0)	F 0.000540	0.00000	50.00
50.00 05000 OPERATING ROOM	1, 246, 894	4, 618, 951				
52. 00 05200 DELIVERY ROOM & LABOR ROOM	170, 826	2, 842				
54. 00 05400 RADI OLOGY-DI AGNOSTI C	68, 849	2, 502, 245				
57.00 05700 CT SCAN	69, 143	2, 991, 674				
58.00 05800 MAGNETIC RESONANCE I MAGI NG (MRI) 59.00 05900 CARDI AC CATHETERI ZATI ON	30, 691	1, 197, 515				
	0	0 102 520		0 0. 000000 0. 277322		
	368, 131	9, 102, 530	9, 470, 66	0. 000000		
60. 01 06001 BLOOD LABORATORY 64. 00 06400 I NTRAVENOUS THERAPY	0	U 4 EQE	4 50			
65. 00 06500 RESPIRATORY THERAPY	5, 782	4, 585				
66. 00 06600 PHYSICAL THERAPY		27, 482				
67. 00 06700 0CCUPATI ONAL THERAPY	381, 662	824, 632 0		0. 541660 0. 000000		
68. 00 06800 SPEECH PATHOLOGY		0	2, 24			
69. 00 06900 ELECTROCARDI OLOGY	2, 243 28, 041	372, 107				
69. 02 06902 SLEEP LAB	20,041	116, 770				
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	110, 770		0 0.000000		
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	394, 964	520, 488				
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	337, 883	85, 601				
73. 00 07300 DRUGS CHARGED TO PATIENTS	445, 180	1, 095, 233				
OUTPATIENT SERVICE COST CENTERS	443,100	1,075,255	1, 540, 41	0. 300770	0.00000	/ 3.00
90. 00 09000 CLINIC	0	0		0 0.00000	0, 000000	90.00
91. 00 09100 EMERGENCY	19, 718	1, 803, 038				
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	9,467	776, 282				
200.00 Subtotal (see instructions)	5, 953, 064	26, 041, 975				200.00
201.00 Less Observation Beds	0, , 00, 00,	20,0,770				201.00
202.00 Total (see instructions)	5, 953, 064	26, 041, 975	31, 995, 03	9		202.00

	· · · · <b>J</b> · · · ·	COMMUNITY HOSPITAL			u of Form CMS-	2552-1
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151300	Period: From 05/01/2014 To 04/30/2015	Worksheet C Part I Date/Time Pre 9/30/2015 10:	epared: 33 am
			Title XVIII	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11.00				
1	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS					30.0
43.00	04300 NURSERY					43.0
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0. 000000				50.0
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.0
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.0
57.00	05700 CT SCAN	0. 000000				57. C
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000				58.0
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000				59.0
60.00	06000 LABORATORY	0. 000000				60.0
60. 01	06001 BLOOD LABORATORY	0. 000000				60.0
64.00	06400 INTRAVENOUS THERAPY	0. 000000				64.0
65.00	06500 RESPI RATORY THERAPY	0, 000000				65.0
66.00	06600 PHYSI CAL THERAPY	0. 000000				66.0
	06700 OCCUPATI ONAL THERAPY	0. 000000				67.0
	06800 SPEECH PATHOLOGY	0. 000000				68.0
	06900 ELECTROCARDI OLOGY	0. 000000				69.0
69.02	06902 SLEEP LAB	0. 000000				69.0
	07000 ELECTROENCEPHALOGRAPHY	0. 000000				70.0
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.0
	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000				72.0
	07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.0
	OUTPATIENT SERVICE COST CENTERS					1
	09000 CLINIC	0.000000				90.0
	09100 EMERGENCY	0. 000000				91.0
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.0
200.00	Subtotal (see instructions)	0.000000				200.0
200.00						200.0
201.00	Total (see instructions)					201.0

Health Financial Systems	COMMUNITY HOSPI	TAL OF BREMEN		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES				Period: From 05/01/2014 To 04/30/2015	Date/Time Pre 9/30/2015 10:	pared: 33 am
		Tit	le XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)		Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	_					
30. 00 03000 ADULTS & PEDI ATRI CS	2, 393, 198		2, 393, 19			•
43. 00 04300 NURSERY	88, 288		88, 28	8 0	88, 288	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	2, 284, 824		2, 284, 82		2/201/021	
52.00 05200 DELIVERY ROOM & LABOR ROOM	91, 695		91, 69			52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 437, 772		1, 437, 77	2 0	1, 437, 772	54.00
57.00 05700 CT SCAN	487, 501		487, 50	01 0	487, 501	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	487, 443		487, 44	3 0	487, 443	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0			0 0	0	59.00
60. 00 06000 LABORATORY	2, 626, 418		2, 626, 41	8 0	2, 626, 418	60.00
60. 01 06001 BLOOD LABORATORY	0			0 0	0	60. 01
64.00 06400 INTRAVENOUS THERAPY	13, 123		13, 12	3 0	13, 123	64.00
65. 00 06500 RESPI RATORY THERAPY	13, 363	0	13, 36	03 0	13, 363	65.00
66. 00 06600 PHYSI CAL THERAPY	653, 401	0	653, 40	01 0	653, 401	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	41	0	4	1 0	41	68.00
69. 00 06900 ELECTROCARDI OLOGY	15, 701		15, 70	01 0	15, 701	69.00
69. 02 06902 SLEEP LAB	65, 762		65, 76	02 0	65, 762	69.02
70. 00 07000 ELECTROENCEPHALOGRAPHY	0			0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	712, 597		712, 59	07 0	712, 597	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	214, 617		214, 61	7 0	214, 617	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	876, 181		876, 18	0 0	876, 181	73.00
OUTPATIENT SERVICE COST CENTERS			_			
90. 00 09000 CLINIC	0			0 0	0	90.00
91.00 09100 EMERGENCY	2, 205, 436		2, 205, 43	6 0	2, 205, 436	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	761, 675		761, 67	5	761, 675	92.00
200.00 Subtotal (see instructions)	15, 429, 036	0	15, 429, 03	6 0	15, 429, 036	200. 00
201.00 Less Observation Beds	761, 675		761, 67	5	761, 675	201.00
202.00 Total (see instructions)	14, 667, 361	0	14, 667, 36	01 0	14, 667, 361	202.00

Health Financial Systems	COMMUNITY HOSPI	TAL OF BREMEN		In Lie	eu of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 151300	Period: From 05/01/2014 To 04/30/2015		epared: 33 am
		Tit	le XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	I npati ent	Outpati ent		6 Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS				-		
30. 00 03000 ADULTS & PEDI ATRI CS	2, 223, 005		2, 223, 00			30.00
43. 00 04300 NURSERY	150, 585		150, 58	35		43.00
ANCI LLARY SERVI CE COST CENTERS	1 044 004	4 ( 4 0 0 5 4	<b>F</b> 0( <b>F</b> 0)	0 000540	0.00000	50.00
50.00 05000 OPERATING ROOM	1, 246, 894	4, 618, 951				
52. 00 05200 DELIVERY ROOM & LABOR ROOM	170, 826	2, 842				
54. 00 05400 RADI 0LOGY-DI AGNOSTI C 57. 00 05700 CT SCAN	68, 849 69, 143	2, 502, 245 2, 991, 674				
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	30, 691					
59. 00 05900 CARDI AC CATHETERI ZATI ON	30, 091	1, 197, 515 0		0 0.000000		
60. 00 06000 LABORATORY	368, 131	9, 102, 530				
60. 01 06001 BLOOD LABORATORY	500, 151	γ, 102, 330 Ω	9,470,00	0 0.000000		
64. 00 06400 I NTRAVENOUS THERAPY	0	4, 585	4, 58			
65. 00 06500 RESPIRATORY THERAPY	5, 782	27, 482				
66. 00 06600 PHYSI CAL THERAPY	381,662	824, 632				
67. 00 06700 OCCUPATI ONAL THERAPY	001,002	021,002		0 0.000000		
68. 00 06800 SPEECH PATHOLOGY	2,243	0	2,24			
69. 00 06900 ELECTROCARDI OLOGY	28,041	372, 107				
69. 02 06902 SLEEP LAB	0	116, 770				
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0.000000		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	394, 964	520, 488	915, 45	0. 778410	0. 000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	337, 883	85, 601	423, 48	0. 506789	0. 000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	445, 180	1, 095, 233	1, 540, 41	3 0. 568796	0.00000	73.00
OUTPATIENT SERVICE COST CENTERS	· · · · · ·				•	1
90. 00 09000 CLI NI C	0	0	1	0 0.000000	0.00000	90.00
91.00 09100 EMERGENCY	19, 718	1, 803, 038	1, 822, 75	1. 209946	0. 000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	9, 467	776, 282	785, 74	0. 969362	0.00000	92.00
200.00 Subtotal (see instructions)	5, 953, 064	26, 041, 975	31, 995, 03	39		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	5, 953, 064	26, 041, 975	31, 995, 03	39		202.00

leal th Financial Systems		COMMUNITY HOSPITAL			u of Form CMS-	2552-1
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151300	Period: From 05/01/2014 To 04/30/2015	Worksheet C Part I Date/Time Pre 9/30/2015 10:	pared: 33 am
			Title XIX	Hospi tal	Cost	_
	Cost Center Description	PPS Inpatient				
		Ratio				
		11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS					30.0
43.00	04300 NURSERY					43.0
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0. 000000				50.0
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52. C
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54. C
57.00	05700 CT SCAN	0. 000000				57.0
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000				58.0
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000				59.0
60.00	06000 LABORATORY	0. 000000				60.0
60. 01	06001 BLOOD LABORATORY	0. 000000				60.0
64.00	06400 I NTRAVENOUS THERAPY	0. 000000				64.0
65.00	06500 RESPI RATORY THERAPY	0, 000000				65.0
66.00	06600 PHYSI CAL THERAPY	0. 000000				66. (
	06700 OCCUPATI ONAL THERAPY	0. 000000				67.0
	06800 SPEECH PATHOLOGY	0. 000000				68.
	06900 ELECTROCARDI OLOGY	0. 000000				69.1
69. 02	06902 SLEEP LAB	0. 000000				69.0
	07000 ELECTROENCEPHALOGRAPHY	0. 000000				70.0
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.
	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000				72.0
	07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.0
	OUTPATIENT SERVICE COST CENTERS					1
	09000 CLINIC	0.000000				90.0
	09100 EMERGENCY	0. 000000				91.0
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.0
200.00		0.000000				200.
200.00						200.
201.00						201.0

Health Financial Systems	COMMUNITY HOSPI	TAL OF BREMEN		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES			CCN: 151300	Period: From 05/01/2014 To 04/30/2015		pared: 33 am
		Ti	tle V	Hospi tal		
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)		Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	2, 393, 198		2, 393, 19			•
43. 00 04300 NURSERY	88, 288		88, 28	8 0	88, 288	43.00
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	2, 284, 824		2, 284, 82		2/201/021	
52.00 05200 DELIVERY ROOM & LABOR ROOM	91, 695		91, 69		91, 695	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 437, 772		1, 437, 77	2 0	1, 437, 772	54.00
57.00 05700 CT SCAN	487, 501		487, 50	01 0	487, 501	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	487, 443		487, 44	3 0	487, 443	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0			0 0	0	59.00
60. 00 06000 LABORATORY	2, 626, 418		2, 626, 41	8 0	2, 626, 418	60.00
60. 01 06001 BLOOD LABORATORY	0			0 0	0	60.01
64.00 06400 I NTRAVENOUS THERAPY	13, 123		13, 12	3 0	13, 123	64.00
65. 00 06500 RESPI RATORY THERAPY	13, 363	0	13, 36	03 0	13, 363	65.00
66. 00 06600 PHYSI CAL THERAPY	653, 401	0	653, 40	01 0	653, 401	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	41	0	4	1 0	41	68.00
69.00 06900 ELECTROCARDI OLOGY	15, 701		15, 70	01 0	15, 701	69.00
69. 02 06902 SLEEP LAB	65, 762		65, 76	02 0	65, 762	69.02
70.00 07000 ELECTROENCEPHALOGRAPHY	0			0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	712, 597		712, 59	07 0	712, 597	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	214, 617		214, 61	7 0	214, 617	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	876, 181		876, 18	0 0	876, 181	73.00
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLINIC	0			0 0	0	90.00
91.00 09100 EMERGENCY	2, 205, 436		2, 205, 43	6 0	2, 205, 436	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	761, 675		761, 67		761, 675	92.00
200.00 Subtotal (see instructions)	15, 429, 036					
201.00 Less Observation Beds	761, 675		761, 67		761, 675	
202.00 Total (see instructions)	14, 667, 361					

Health Financial Systems	COMMUNITY HOSPI	TAL OF BREMEN		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 151300	Period: From 05/01/2014 To 04/30/2015	Worksheet C Part I Date/Time Pre 9/30/2015 10:	epared: 33 am
		Ti	tle V	Hospi tal		
		Charges				
Cost Center Description	I npati ent	Outpati ent		6 Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS				-		
30. 00 03000 ADULTS & PEDI ATRI CS	2, 223, 005		2, 223, 00			30.00
43. 00 04300 NURSERY	150, 585		150, 58	35		43.00
ANCI LLARY SERVI CE COST CENTERS			5 0/5 0			
50.00 05000 OPERATING ROOM	1, 246, 894	4, 618, 951				
52.00 05200 DELIVERY ROOM & LABOR ROOM	170, 826	2, 842				
54. 00 05400 RADI OLOGY-DI AGNOSTI C	68, 849	2, 502, 245				
57.00 05700 CT SCAN	69, 143	2, 991, 674				
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	30, 691	1, 197, 515			0.00000	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0.000000	0.00000	
60. 00 06000 LABORATORY	368, 131	9, 102, 530	9, 470, 60		0.00000	
60. 01 06001 BLOOD LABORATORY	0	0		0 0.000000		
64.00 06400 INTRAVENOUS THERAPY	0	4, 585				
65. 00 06500 RESPI RATORY THERAPY	5, 782	27, 482			0.00000	
66. 00 06600 PHYSI CAL THERAPY	381, 662	824, 632			0.00000	
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 0.000000		
68.00 06800 SPEECH PATHOLOGY	2, 243	0	-, -			
69. 00 06900 ELECTROCARDI OLOGY	28, 041	372, 107				
69. 02 06902 SLEEP LAB	0	116, 770				
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0.000000	0.00000	
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	394, 964	520, 488				
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	337, 883	85, 601				
73. 00 07300 DRUGS CHARGED TO PATIENTS	445, 180	1, 095, 233	1, 540, 41	3 0. 568796	0.00000	73.00
OUTPATIENT SERVICE COST CENTERS				0 000000	0.00000	00.00
90. 00 09000 CLINIC	0	0		0 0.00000		
91.00 09100 EMERGENCY	19, 718	1, 803, 038				
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	9,467	776, 282			0.00000	1
200.00 Subtotal (see instructions)	5, 953, 064	26, 041, 975	31, 995, 03	59		200.00
201.00 Less Observation Beds	E 052 074	24 041 075	21 005 0			201.00
202.00  Total (see instructions)	5, 953, 064	26, 041, 975	31, 995, 03	94		202.00

Health Financial Systems	COMMUNITY HOSPITAL	OF BREMEN	In Lie	u of Form CMS-2552-1
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151300	Period: From 05/01/2014 To 04/30/2015	Worksheet C Part I Date/Time Prepared 9/30/2015 10:33 am
		Title V	Hospi tal	
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.0
43. 00 04300 NURSERY				43.0
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	0. 000000			50.0
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.0
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.0
57.00 05700 CT SCAN	0. 000000			57.0
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			58.0
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59.0
60. 00 06000 LABORATORY	0. 000000			60.0
60. 01 06001 BLOOD LABORATORY	0. 000000			60.0
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000			64.0
65. 00 06500 RESPI RATORY THERAPY	0. 000000			65.0
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66.0
67.00 06700 OCCUPATI ONAL THERAPY	0, 000000			67.0
68.00 06800 SPEECH PATHOLOGY	0, 000000			68.0
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.0
69. 02 06902 SLEEP LAB	0. 000000			69.0
70. 00 07000 ELECTROENCEPHALOGRAPHY	0, 000000			70.0
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72.0
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.0
OUTPATIENT SERVICE COST CENTERS	0.000000			
90. 00 09000 CLINIC	0.000000			90.0
91. 00 09100 EMERGENCY	0. 000000			91.0
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0, 000000			92.0
200.00 Subtotal (see instructions)	0.000000			200. 0
201.00 Less Observation Beds				200.0
				201.0
202.00  Total (see instructions)				:

Health Financial Systems	COMMUNITY HOSPI	TAL OF BREMEN		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS			Period: From 05/01/2014 To 04/30/2015	Date/Time Pre 9/30/2015 10:	
		Ti tl	e XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
		(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1	1	1	- 1		
50. 00 05000 OPERATI NG ROOM	261, 338					
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 340					
54. 00 05400 RADI OLOGY-DI AGNOSTI C	126, 184	2, 571, 094			1, 797	54.00
57.00 05700 CT SCAN	6, 165	3, 060, 817	0. 00201	4 37, 642	76	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	4, 957	1, 228, 206			89	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0.00000		0	59.00
60. 00 06000 LABORATORY	104, 133	9, 470, 661	0. 01099		1, 632	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0.00000		0	60.01
64.00 06400 INTRAVENOUS THERAPY	1, 481	4, 585	0. 32301	0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	124	33, 264	0. 00372	28 2, 376	9	65.00
66. 00 06600 PHYSI CAL THERAPY	85, 893	1, 206, 294	0.07120	88, 589	6, 308	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0	0.00000	0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	2	2, 243	0.00089	2 1, 592	1	68.00
69. 00 06900 ELECTROCARDI OLOGY	2, 388	400, 148	0.00596	3, 724	22	69.00
69. 02 06902 SLEEP LAB	12, 963	116, 770	0. 11101	3 0	0	69.02
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.00000	0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	65, 725	915, 452	0. 07179	55, 536	3, 987	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 905	423, 484	0.00449	160, 540	722	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	31, 219	1, 540, 413	0. 02026	221, 140	4, 482	73.00
OUTPATIENT SERVICE COST CENTERS		•				1
90. 00 09000 CLI NI C	0	0	0.0000	0 0	0	90.00
91.00 09100 EMERGENCY	213, 252	1, 822, 756	0. 11699	2, 251	263	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	171, 184	785, 749	0. 21786	0	0	92.00
200.00 Total (lines 50-199)	1, 090, 253	29, 621, 449		1, 075, 313	32, 439	200. 00

Health Financial Systems	COMMUNITY HOSPI	TAL OF BREMEN		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PASS			Period: From 05/01/2014 To 04/30/2015		
			e XVIII	Hospi tal	Cost	
Cost Center Description	Non Physician	Nursing School	Allied Healt		Total Cost	
	Anesthetist			Medi cal	(sum of col 1	
	Cost			Education Cost	5	
	1.00	2.00	3.00	4.00	4)	
ANCI LLARY SERVI CE COST CENTERS	1.00	2100	0,00		0100	
50. 00 05000 OPERATI NG ROOM	0	0		0 0	0	50,00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
57.00 05700 CT SCAN	0	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
60. 01 06001 BLOOD LABORATORY	0	0		0 0	0	60. 01
64.00 06400 I NTRAVENOUS THERAPY	0	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
69. 02 06902 SLEEP LAB	0	0		0 0	0	69. 02
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 0	0	
200.00   Total (lines 50-199)	0	0	1	0 0	0	200.00

Health Financial Systems	COMMUNITY HOSPI	TAL OF BREMEN		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PAS	S Provi der		Peri od:	Worksheet D	
THROUGH COSTS				From 05/01/2014		
				Γο 04/30/2015	Date/Time Pre 9/30/2015 10:	pared: 33 am
		Titl	e XVIII	Hospi tal	Cost	<u>55 all</u>
Cost Center Description	Total	Total Charges	Ratio of Cost	Outpati ent	Inpati ent	
	Outpati ent	(from Wkst. C,	to Charges	Ratio of Cost	Program	
	Cost (sum of		(col. 5 ÷ col.		Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)			7)		
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVICE COST CENTERS	1	1	1			
50.00 05000 OPERATI NG ROOM	0	0/000/010				
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	170,000				
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	2, 571, 094				
57.00 05700 CT SCAN	0	3, 060, 817				57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1, 228, 206	0.00000	0. 000000	21, 936	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0.00000		0	59.00
60. 00 06000 LABORATORY	0	9, 470, 661				60.00
60. 01 06001 BLOOD LABORATORY	0	0	0.00000			60. 01
64.00 06400 INTRAVENOUS THERAPY	0	4, 585	0.00000	0. 000000	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	33, 264	0.00000	0. 000000	2, 376	65.00
66. 00 06600 PHYSI CAL THERAPY	0	1, 206, 294	0.00000	0. 000000	88, 589	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0	0.00000	0. 000000	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	2, 243	0.00000	0. 000000	1, 592	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	400, 148	0.00000	0. 000000	3, 724	69.00
69. 02 06902 SLEEP LAB	0	116, 770	0.00000	0. 000000	0	69.02
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.00000	0. 000000	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	915, 452	0.00000	0. 000000	55, 536	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	423, 484	0.00000	0. 000000	160, 540	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	1, 540, 413	0.00000	0. 000000	221, 140	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	0.00000	0. 000000	0	90.00
91.00 09100 EMERGENCY	0	1, 822, 756	0.00000	0. 000000	2, 251	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	785, 749	0.00000	0. 000000	0	92.00
200.00 Total (lines 50-199)	0	29, 621, 449	1		1, 075, 313	200. 00

Health Financial Systems	COMMUNITY HOSPIT	AL OF BREMEN		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PASS		CCN: 151300	Period: From 05/01/2014 To 04/30/2015	Worksheet D Part IV Date/Time Pro 9/30/2015 10:	
			e XVIII	Hospi tal	Cost	
Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 <u>x col. 10)</u> 11.00	Outpatient Program Charges 12.00	Outpatient Program Pass-Throug Costs (col. <u>x col. 12)</u> 13.00			
ANCI LLARY SERVI CE COST CENTERS	11.00	12.00	10.00			
50.00         05000         OPERATI NG ROOM           52.00         05200         DELI VERY ROOM & LABOR ROOM           54.00         05400         RADI OLOGY-DI AGNOSTI C           57.00         05700         CT SCAN           58.00         05800         MAGNETI C RESONANCE I MAGI NG (MRI)           59.00         05900         CARDI AC CATHETERI ZATI ON           60.00         06000         LABORATORY           60.01         06001         BLOOD LABORATORY           64.00         06400         INTRAVENOUS THERAPY           65.00         06500         RESPI RATORY THERAPY           65.00         06500         RESPI RATORY THERAPY           66.00         06600         PHYSI CAL THERAPY           67.00         06700         OCCUPATI ONAL THERAPY           68.00         06800         SPEECH PATHOLOGY           69.00         06900         ELECTROCARDI OLOGY           69.02         06902         SLEEP LAB           70.00         07100         MEDI CAL SUPPLIES CHARGED TO PATI ENTS           72.00         07200         IMPL. DEV. CHARGED TO PATI ENTS           73.00         07300         DURGS CHARGED TO PATI ENTS           0UTPATI ENT SERVI CE COST CENTERS         O						$\begin{array}{c} 50.\ 00\\ 52.\ 00\\ 54.\ 00\\ 57.\ 00\\ 58.\ 00\\ 59.\ 00\\ 60.\ 01\\ 64.\ 00\\ 65.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 68.\ 00\\ 69.\ 02\\ 70.\ 00\\ 71.\ 00\\ 71.\ 00\\ 72.\ 00\\ 73.\ 00\\ \end{array}$
90. 00 09000 CLINIC	0	0	þ	0		90.00
91.00 09100 EMERGENCY	0	0		0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 200.00 Total (lines 50-199)	0	C		0		92.00 200.00

Health Financial Systems (	COMMUNITY HOSPI	TAL OF BREMEN		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der		Peri od:	Worksheet D	
				From 05/01/2014 To 04/30/2015	Part V Date/Time Pre	narod
				10 04/ 30/ 2013	9/30/2015 10:	33 am
		Titl	e XVIII	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
	1.00		(see inst.)	(see inst.)	5.00	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	0.000540		1 000 70			1
50.00 O5000 OPERATING ROOM	0. 389513		1, 239, 73		0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 527990			0 0	0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 559206		629, 00		0	54.00
57.00 05700 CT SCAN	0. 159272		811, 76		0	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 396874		273, 51	1 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			0 0	0	59.00
60. 00 06000 LABORATORY	0. 277322		3, 943, 31	6 0	0	60.00
60.01 06001 BLOOD LABORATORY	0. 000000			0 0	0	60. 01
64.00 06400 INTRAVENOUS THERAPY	2.862159			0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 401726		13, 28		0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 541660		261, 57	4 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000			0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 018279			0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 039238		78, 65	6 0	0	69.00
69. 02 06902 SLEEP LAB	0. 563175			0 0	0	69.02
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 778410		104, 23		0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 506789		40, 67		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 568796	0	730, 80	04 0	0	73.00
OUTPATIENT SERVICE COST CENTERS	1			- 1		
90. 00 09000 CLINIC	0. 000000			0 0	0	
91.00 09100 EMERGENCY	1. 209946		347, 65		0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 969362	0	390, 58		0	
200.00 Subtotal (see instructions)		0	8, 864, 80	01 0	0	200. 00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)		0	8, 864, 80	01 0	0	202.00

Health Financial Systems	COMMUNITY HOSPI	TAL OF BREMEN		In Lie	u of Form CMS-	-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 151300	Period: From 05/01/2014 To 04/30/2015	Worksheet D Part V Date/Time Pro 9/30/2015 103	
			e XVIII	Hospi tal	Cost	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)	-			
	6.00	7.00				-
ANCI LLARY SERVI CE COST CENTERS	402.002	0				50.00
50.00 05000 0PERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	482, 893					50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	351, 743	-				54.00
57. 00 05700 CT SCAN	129, 291					57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	108, 549					58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	100, 549					59.00
60. 00 06000 LABORATORY	1,093,568					60.00
60. 01 06001 BLOOD LABORATORY	1,093,300					60.00
64. 00 06400 I NTRAVENOUS THERAPY	0					64.00
65. 00 06500 RESPIRATORY THERAPY	5, 338					65.00
66. 00 06600 PHYSI CAL THERAPY	141, 684					66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0					67.00
68. 00 06800 SPEECH PATHOLOGY	0					68.00
69. 00 06900 ELECTROCARDI OLOGY	3, 086					69.00
69. 02 06902 SLEEP LAB	0					69.02
70.00 07000 ELECTROENCEPHALOGRAPHY	0	l d	)			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	81, 136	c c	)			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	20, 612	c				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	415, 678	c				73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0	)			90.00
91.00 09100 EMERGENCY	420, 647	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	378, 619	0				92.00
200.00 Subtotal (see instructions)	3, 632, 844	0				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)	3, 632, 844	C				202.00

Heal th	Financial Systems	COMMUNITY HOSPI	TAL OF BREMEN		In Lie	u of Form CMS-:	2552-10
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der		Peri od:	Worksheet D	
			Component		From 05/01/2014		norod.
			Component	CCN: 15Z300	To 04/30/2015	Date/Time Pre 9/30/2015 10:	pared: 33 am
			Ti tl	e XVIII	Swing Beds - SNF		
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
	·	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not	. ,	
		Part I, col. 9	ŗ	Subject To	Subject To		
				Ded. & Coi ns.	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. 389513			0 0	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 527990	0		0 0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 559206	0		0 0	0	54.00
57.00	05700 CT SCAN	0. 159272	0		0 0	0	57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 396874	0		0 0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59.00
60.00	06000 LABORATORY	0. 277322	0		0 0	0	60.00
60.01	06001 BLOOD LABORATORY	0. 000000	0		0 0	0	60.01
64.00	06400 INTRAVENOUS THERAPY	2.862159	0		0 0	0	64.00
65.00	06500 RESPI RATORY THERAPY	0. 401726	0		0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 541660	0		0 0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0. 000000	0		0 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0. 018279	0		0 0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0. 039238	0	1	0 0	0	69.00
69.02	06902 SLEEP LAB	0. 563175	0		0 0	0	69.02
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 778410	0	1	0 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 506789	0		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 568796	0		0 0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0. 000000	0		0 0	0	90.00
91.00	09100 EMERGENCY	1. 209946			0 0	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 969362	0		0 0	0	92.00
200.00			0		0 0	0	200. 00
201.00					0 0		201.00
	Only Charges						
202.00	Net Charges (line 200 +/- line 201)		0		0 0	0	202.00

Health Financial Systems	COMMUNITY HOSPI	TAL OF BREMEN		In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 151300	Peri od:	Worksheet D
		Componen	t CCN: 15Z300	From 05/01/2014 To 04/30/2015	Part V Date/Time Prepared:
		Componen	L CCN. 152500	10 04/ 30/ 2013	9/30/2015 10:33 am
		Ti tl	e XVIII	Swing Beds - SNF	Cost
	Cos	sts			
Cost Center Description	Cost	Cost			
	Rei mbursed	Reimbursed			
	Servi ces	Services Not			
	Subject To	Subject To			
		Ded. & Coins. (see inst.)			
	(see inst.) 6.00	7.00	-		
ANCI LLARY SERVI CE COST CENTERS	0.00	7.00			
50. 00 05000 OPERATI NG ROOM	0	(	)		50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0				54.00
57. 00 05700 CT SCAN	0	(			57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0			59.00
60. 00 06000 LABORATORY	0	0			60.00
60. 01 06001 BLOOD LABORATORY	0	0			60.01
64.00 06400 INTRAVENOUS THERAPY	0	0			64.00
65. 00 06500 RESPI RATORY THERAPY	0	0			65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	D		66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0	p		67.00
68.00 06800 SPEECH PATHOLOGY	0	0	p		68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	D		69.00
69. 02 06902 SLEEP LAB	0	0	D		69.02
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	D		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	D		71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	(	D		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	(	ון		73.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC	0	• • • • •			90.00
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	0				91.00 92.00
200.00 Subtotal (see instructions)	0				200.00
201.00 Less PBP Clinic Lab. Services-Program					200.00
Only Charges					201.00
202.00 Net Charges (line 200 +/- line 201)	0	0			202.00

COMPUTATION OF TRAVILENT OPERATING COST         Provider COS: 151:00         Period Trop         Outchase to -1 Trop         Outchase to -1 (30:2015)           COULD CONTROL RECOMPUTATION (1) - ALL NOWIDER COMPUTATION TO TRAVILENT MASS         If the XVIII - NORTHER ANSS         1.00         1.00           EXEL 1 - ALL NOWIDER COMPUTATION (1) TRAVILENT MASS         1.00         1.00         1.00         1.00           1.00 Institute of the Control optic and opti	Heal th	Financial Systems COMMUNITY HOSPITAL	OF BREMEN	In Lie	u of Form CMS-2	2552-10
Title XVIII         Hespital         Cost           Next 1 - ALL PROVIDER Complexity         1.00         1.00           Next 11- ALL PROVIDER Complexity         1.00         1.00           Next 11- ALL PROVIDER Complexity         1.00         1.00         1.00           Next 11- ALL PROVIDER Complexity         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00 <t< th=""><th>COMPUT</th><th>ATION OF INPATIENT OPERATING COST</th><th>Provider CCN: 151300</th><th>From 05/01/2014</th><th>Date/Time Pre</th><th></th></t<>	COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 151300	From 05/01/2014	Date/Time Pre	
PART 1 - ALL PROVIDER CONFORMENTS         1.00           100         Impatted DAYS         Including private room days and saling-had days. Excluding membern(y)         1,021           100         Impatted DAYS         Including private room days. Excluding saling bed and neaborn days)         1,021           100         Impatted DAYS         Including private room days. Excluding saling bed and neaborn days)         1,221         2,00           100         Total saling bed SM Type Inpattent days (Including private room days) through becember 31 of the cost         0,500         5,000           100         Total saling bed SM Type Inpattent days (Including private room days) through becember 31 of the cost         5,000           100         Total saling bed SM Type Inpattent days (Including private room days) through becember 31 of the cost         2,000           100         Total saling bed SM Type Inpattent days applicable to title avtII and y (Including private room days)         0,000           100         Total saling bed SM Type Inpattent days applicable to title avtII and y (Including private room days)         0,000           100         Saling bed SM Type Inpattent days applicable to title XVII only (Including private room days)         0,000           100         Saling bed SM Type Inpattent days applicable to the Program (excluding saling bed days)         0,000           100         Saling bed SM Type Inpattent days applicable to the Program (excluding pri			Title XVIII	Hospi tal		
IMPAIL ENT DAYS         Institut days (including private room days, ack up any saing-bed days, excluding newborm)         1,681           100         Institut days (including private room days, ack up any bed and newborm days)         1,223         2,000           000         Somi-private room days (including saing-bed and observation bed days)         5,000         5,000           000         Somi-private room days (including saing-bed and observation bed days)         5,000         5,000           000         Total saing-bed NF type inpatient days (including private room days) after December 31 of the cost         5,000           000         Total saing-bed NF type inpatient days (including private room days) after December 31 of the cost         5,000           000         Total saing-bed NF type inpatient days (including private room days) after December 31 of the cost         2,000           000         Total saing-bed NF type inpatient days applicable to title X/III only (including private room days)         0,000           000         Total saing-bed NF type inpatient days applicable to title X/III only (including private room days)         0,000           010         Saing-bed NF type inpatient days applicable to title X/III only (including private room days)         0,000           011         Baing-bed NF type inpatient days applicable to title X/III only (including private room days)         0,000           012         Saing-bed NF type inpatient days applicable to ti		Cost Center Description		-	1.00	
1.00       Inpatient days (including private room days, and swing-bed days, excluding needorm)       1,661       1.00         0       Inpatient days (including private room days, excluding swing-bed and boservation bed days).       17       2.00         3.00       Private room days, (accluding swing-bed and observation bed days).       17       0.00         5.00       Total swing-bed SW type inpatient days (including private room days) through December 31 of the cost       710         6.00       Total swing-bed SW type inpatient days (including private room days) after December 31 of the cost       220         7.00       reporting period (if calendar year, enter 0 on this line)       7.00         7.00       Total swing-bed SW type inpatient days (including private room days) after December 31 of the cost       29         8.00       Total swing-bed SW type inpatient days (including private room days) after December 31 of the cost       29         9.00       Total swing-bed SW type inpatient days applicable to title XVIII only (including private room days)       0         10.00       Swing-bed SW type inpatient days applicable to title XVIII only (including private room days)       0         10.00       Swing-bed SW type inpatient days applicable to title XVIII only (including private room days)       0         10.00       Swing-bed SW type inpatient days applicable to title XVIII only (including private room days)       0       0						
3.00       Private room days (excluding swing-bed and observation bed days). If you have only private room days, do solve the cost on point of the sing.       0       3.00       Solve the cost on the cost of the cos	1.00		, excluding newborn)		1, 681	1.00
do not complete this line.       4.00         Seel private room days (excluding swing-bed and observation bed days)       7.3         5.00       Total swing bed SN type inpatient days (including private room days) after December 31 of the cost       7.0         6.00       Total swing bed SN type inpatient days (including private room days) after December 31 of the cost       7.0         7.01       Total swing-bed SV type inpatient days (including private room days) after December 31 of the cost       7.0         7.01       Total swing-bed SV type inpatient days (including private room days) after December 31 of the cost       9.0         7.02       Total swing-bed SV type inpatient days applicable to title XVII and y (including private room days)       0.0         9.00       Total swing-bed SV type inpatient days applicable to title XVII and y (including private room days)       0.1         10.00       Swing-bed SV type inpatient days applicable to title VXII and y (including private room days)       0.1         10.00       Swing-bed SV type inpatient days applicable to title VXII and y (including private room days)       0         11.00       Swing-bed SV type inpatient days applicable to title VXII and y (including private room days)       0         12.00       Swing-bed SV type inpatient days applicable to title VXII and y (including private room days)       0       13.00         13.00       Swing-bed SV type inpatingerical (incle Applicable to SVII and y) <td></td> <td></td> <td></td> <td>vata room dava</td> <td></td> <td></td>				vata room dava		
5.00       Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period (including private room days) after December 31 of the cost synghed SNF type inpatient days (including private room days) after December 31 of the cost synghed SNF type inpatient days (including private room days) after December 31 of the cost synghed SNF type inpatient days (including private room days) after December 31 of the cost synghed SNF type inpatient days (including private room days) after December 31 of the cost synghed SNF type inpatient days (including private room days) after December 31 of the cost synghed SNF type inpatient days (including private room days) after December 31 of the cost synghed SNF type inpatient days applicable to the Program (excluding private room days)       0         10.00       Swing-bed SNF type inpatient days applicable to title SVIII only (including private room days)       0       10.00         11.00       Swing-bed SNF type inpatient days applicable to title SVIII only (including private room days)       0       12.00         12.00       Swing-bed SNF type inpatient days applicable to title SV ar XIX only (including private room days)       0       13.00         13.00       Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed days)       0       14.00         14.00       Medicaid rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       12.00         15.00       Normal SNF for SNF services applicable to services after December 31 of the cost reporting period       12.00         16.00	3.00		s). If you have only pri	vate room days,	0	3.00
reporting period reporting period (if calendar year, enter 0 on this line) 7. Total wing-bed XF type inpatient days (including private room days) after December 31 of the cost 57 7.00 7. Total wing-bed XF type inpatient days (including private room days) through December 31 of the cost 57 7.00 8. Of the inperiod (if calendar year, enter 0 on this line) 7. Total inpatient days including private room days) after December 31 of the cost 58 0.00 1. Total inpatient days including private room days) after December 31 of the cost 59 0.00 1. Total inpatient days including private room days applicable to the Program (excluding swing-bed and neeborn days) 1. O Swing-bed SF type inpatient days applicable to title XVIII only (including private room days) after 50 0.00 1. O Swing-bed SF type inpatient days applicable to title XVIII only (including private room days) after 50 0.00 1. O Swing-bed SF type inpatient days applicable to title XVIII only (including private room days) after 50 0.00 1. O Swing-bed SF type inpatient days applicable to title XV or XIX only (including private room days) after 50 0.00 1. O Swing-bed SF type inpatient days applicable to title XV or XIX only (including private room days) or 13.00 1. O Swing-bed SF type inpatient days applicable to title XV or XIX only (including private room days) or 14.00 1. O Medicate rate for swing-bed SF services applicable to services through December 31 of the cost 12.00 1. Now flee Datable XF Services applicable to services after December 31 of the cost 12.00 1. Now flee Datable XF Services applicable to services after December 31 of the cost 12.00 1. Now flee Datable XF Services applicable to services after December 31 of the cost 12.00 1. Now flee Datable XF Services applicable to services after December 31 of the cost 12.00 1. Now flee Datable XF Services applicable to services after December 31 of the cost 12.00 1. Now flee Datable XF Services after December 31 of the cost 12.00 1. Now flee Datable XF Services after December 31 of the cost 1				21 - 6 + +		
6.00       Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar yeas, enter 0 on this line)       5.00         7.00       Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period       5.00         8.00       Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period       5.00         9.00       Total inpatient days applicable to the Program (excluding swing-bed and newtorn days)       6.00         10.05       Swing-bed SNF type inpatient days applicable to tile XVII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)       10.00         13.00       Swing-bed MF type inpatient days applicable to the Program (excluding private room days)       0       13.00         14.00       Medically necessary private room days applicable to the Program (excluding swing-bed days)       11.00       13.00         14.00       Medically necessary private room days applicable to services after December 31 of the cost reporting period       13.00         10.00       Kein period       Swing-bed SNF services applicable to services after December 31 of the cost reporting period       14.00         10.00       Kein period       Swing-bed SNF services applicable to services after December 31 of the cost reporting period       12.91         10.00       Kein period	5.00		m days) through December	31 of the cost	0	5.00
7.00       Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if calender year, enter 0 on this line)       57       7.00         8.00       Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calender year, enter 0 on this line)       29       8.00         9.00       Total inpatient days including private room days applicable to the Program (excluding swing-bed and through December 31 of the cost reporting period (if calendar year, enter 0 on this line)       01       0.00         10.00       Swing-bed WF type inpatient days applicable to the Program (excluding private room days) after becember 31 of the cost reporting period       326       0       12.00         13.00       Swing-bed WF type inpatient days applicable to the Program (excluding private room days)       0       12.00         14.00       Nerder year, period       0       14.00       0       15.00       0       16.00         15.00       Total unsreer days (ittle V or XIX only V)       0       16.00       16.00       16.00         16.00       Nerder year, sing-bed SWF type inpatient days applicable to services through December 31 of the cost reporting period       17.00       18.00       18.00       18.00         17.00       Kedi care rate for swing-bed SWF services applicable to services through December 31 of the cost reporting period       18.00       18.00 <td>6.00</td> <td>Total swing-bed SNF type inpatient days (including private roo</td> <td>m days) after December 3</td> <td>1 of the cost</td> <td>372</td> <td>6.00</td>	6.00	Total swing-bed SNF type inpatient days (including private roo	m days) after December 3	1 of the cost	372	6.00
reporting period         8.00           0.00         Total sing-bed MF type inpatient days (including private room days) after December 31 of the cost reporting period (if Calendar year, enter 0 on this line)         8.00           0.00         Total inpatient days including private room days)         387         9.00           0.00         Suing-bed MF type inpatient days applicable to title XVIII only (including private room days)         10.00           1.00         Suing-bed MF type inpatient days applicable to title XVIII only (including private room days)         0         10.00           1.00         Suing-bed MF type inpatient days applicable to title XVIII only (including private room days)         0         12.00           1.00         Suing-bed MF type inpatient days applicable to title XVII only (including private room days)         0         12.00           1.00         Suing-bed MF type inpatient days applicable to title XV or XIX only (including private room days)         0         13.00           1.00         Total unresory days (itle Y or XIX only (including private room days)         0         14.00           1.00         Medically necessary private room days applicable to services through December 31 of the cost reporting period         14.00           1.00         Medical rate for swing-bed MF services applicable to services after December 31 of the cost reporting period         14.00           1.00         Medical rate for swing-bed NF serv	7.00		days) through December	31 of the cost	57	7.00
reporting period (if calendar year, enter 0 on this line)         9.00           0.0         Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)         9.00           1.0         Disk period (if calendar year, enter 0 on this line)         9.00           1.0         Disk period (if calendar year, enter 0 or this line)         10.00           1.0         Disk period (if calendar year, enter 0 or this line)         10.00           1.0         Disk period (if calendar year, enter 0 or this line)         10.00           1.0         Disk period (if calendar year, enter 0 or this line)         12.00           1.0         Disk period (if calendar year, enter 0 or this line)         12.00           1.0         Disk period (if calendar year, enter 0 or this line)         12.00           1.0         Disk period (if calendar year, enter 0 or this line)         13.00           1.0         Disk period (if calendar year, enter 0 or this line)         14.00           1.0         Disk period (if calendar year, enter 0 or this line)         14.00           1.0         Disk period (if calendar year, enter 0 or this line)         14.00           1.0         Disk period (if calendar year, enter 0 or this line)         14.00           1.0         Disk period (if calendar year, enter 0 or this line)         15.00 <tr< td=""><td></td><td>reporting period</td><td></td><td></td><td></td><td></td></tr<>		reporting period				
9.00       Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)       387       9.00         10.00       Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after cost reporting period (icalendar year, enter 0 on this line)       10.00       11.00         10.00       Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after cost reporting period (icalendar year, enter 0 on this line)       386         10.00       Swing-bed NF type inpatient days applicable to title XVIII only (including private room days)       0       13.00         10.00       Swing-bed NF type inpatient days applicable to title XVIII only (including private room days)       0       14.00         10.00       Margery days (title V or XIX only)       0       14.00         10.00       Numsery days (title V or XIX only)       0       16.00         11.00       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       18.00         11.00       Medicaid rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       12.91         12.00       Swing-bed SNF services applicable to services after December 31 of the cost reporting period       18.00         12.01       Data general inpatient routine service cost (see instructions)       2.39, 198       21.00     <	8.00		days) after December 31	of the cost	29	8.00
10.00       Swing-bed Shif type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (incleding private room days) after December 31 of the cost reporting period (incleding private room days) after December 31 of the cost reporting period (incleding private room days) after December 31 of the cost reporting period (incleding private room days) after December 31 of the cost reporting period (incleding private room days) after December 31 of the cost reporting period (incleding private room days)       0       12.00         13.00       Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (incleding revean der 0 on this line))       0       13.00         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       18.00         16.00       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       18.00         17.00       Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period       19.00         10.00       Medical drate for swing-bed NF services after December 31 of the cost reporting period (line 5 x line 17)       2.393, 188       2.100         120.00       Medical drate for swing-bed NF services after December 31 of the cost reporting period (line 5 x line 17)       2.393, 188       2.100 <td>9.00</td> <td>Total inpatient days including private room days applicable to</td> <td>the Program (excluding</td> <td>swing-bed and</td> <td>387</td> <td>9.00</td>	9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	387	9.00
through December 31 of the cost reporting period (see instructions)       346         10.0 Swing-bed SNF type inpatient days applicable to title XV III only (including private room days) after December 31 of the cost reporting period (1f calendar year, enter 0 on this line)       346         10.0 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (1f calendar year, enter 0 on this line)       0         11.00 Boding-bed NF type inpatient 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 Wadicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period       17.00         10.00 Wadicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       18.00         11.00 Wadicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       19.00         11.00 Wadicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (110       2.39.198         11.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (110       2.30.20         11.00 Madicare rate for swing-bed NF services after December 31 of the cost reporting period (110       2.30.20         11.00 Madicare rate for swing-bed NF services after December 31 of the cost reporting period (110       <	10, 00		lv (including private ro	om davs)	0	10.00
December 31 of the cost reporting period (if calendar year, enter 0 on this line)       12.00         12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)       12.00         13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)       01         14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)       01         15.00 Total nursery days (title V or XIX only)       01         16.00 Nursery days (title V or XIX only)       01         17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period       17.00         18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       18.00         10.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       19.00         20.00 Medical drate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       19.00         21.00 Total general inpatient routine service cost (see instructions)       2.393, 198       21.00         22.00 Sing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 7, 361       2.00         23.00 Sing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 7, 361       2.00         23.00 Sing-bed cost applicable to SNF type servic		through December 31 of the cost reporting period (see instruct	i ons)			
12:00       Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line)       0       12:00         13:00       Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line)       0       13:00         14:00       Medically necessary private room days applicable to the Program (excluding swing-bed days)       0       15:00         15:00       Total nursery days (title V or XIX only)       0       16:00         16:00       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       18:00         19:00       Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period       12:00         20:00       Wedicaid rate for swing-bed NF services after December 31 of the cost reporting period       12:00         21:00       Total general inpatient routine service cost (see instructions)       2:393.198       2:00         20:00       Swing-bed cost (see instructions)       2:30.30       2:30.30       2:30.30         20:00       Swing-bed cost (see instructions)       2:30.30       2:30.30       2:30.30         20:00       Swing-bed cost (see instructions)       566.677       2:00       2:00	11.00			om days) after	346	11.00
13.00       Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)       13.00         14.00       Wedically 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         15.00       Wedicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period       17.00         18.00       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost       129.14         19.00       Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost       129.14         12.00       Treporting period       129.14       10.00         20.00       Wedicaid rate for swing-bed NF services applicable to services after December 31 of the cost       129.14         20.00       Wedicaid rate for swing-bed NF services after December 31 of the cost reporting period (line 5 \$ \$ line 17)       23.30         21.00       Total general inpatient routine service cost (see instructions)       2.39.198       21.00         22.00       Swing-bed cost applicable to SF type services after December 31 of the cost reporting period (line 6 \$ \$ \$ line 17)       23.00         21.00       Swing-bed cost (see instructions)       56.677 <td>12.00</td> <td>Swing-bed NF type inpatient days applicable to titles V or XIX</td> <td></td> <td>room days)</td> <td>0</td> <td>12.00</td>	12.00	Swing-bed NF type inpatient days applicable to titles V or XIX		room days)	0	12.00
after December 31 of the cost reporting period (if calendar year, enter 0 on this line)       14.00         41.00       Medically necessary private room days applicable to the Program (excluding swing-bed days)       0         15.00       Total nursery days (title V or XIX only)       0         16.00       Nursery days (title V or XIX only)       0         17.00       Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period       17.00         18.00       Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (acid rate for swing-bed NF services applicable to services after December 31 of the cost 129.14       19.00         20.00       Medicaid rate for swing-bed NF services cost (see instructions)       2.393.198       21.00         21.00       Total general inpatient routine service cost (see instructions)       2.393.198       21.00         22.00       Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 × 1 line 18)       0       23.00         24.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7, 361       24.00         7.10       Swing-bed cost (see instructions)       1.826, 521       27.00         25.00       Swing-bed cost (see instructions)       56.6, 677       26.00         7.00       General	13 00	5 1 51	only (including private	room days)	0	13 00
15.00       Total nursery days (title V or XIX only)       0       15.00         16.00       Nursery days (title V or XIX only)       0       16.00         17.00       Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period       17.00         18.00       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       18.00         19.00       Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period       129.14         20.00       Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 5 x line 17)       2.393.198       21.00         21.00       Total general inpatient routine services through December 31 of the cost reporting period (line 5 x line 17)       2.305.198       21.00         22.00       Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 7 , 361       24.00       24.00         24.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 , 361       24.00         25.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 , 361       24.00         26.00       Total swing-bed cost (see instructions)       566, 677       26.00         27.00       General inpatient		after December 31 of the cost reporting period (if calendar ye	ar, enter 0 on this line	)	-	
16.00       Nursery, days' (title V or XIX only)       0       16.00         SWING BED ADJUSTIONT       0       16.00         17.00       Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period       17.00         18.00       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost       18.00         19.00       Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost       129.14         20.00       Medicaid rate for swing-bed NF service cast (see instructions)       2.393,198       21.00         21.00       Torporting period       2.393,198       21.00       22.00         23.00       Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 17)       23.00         24.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 20)       2.302         25.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)       3.745         26.00       Total swing-bed cost (see instructions)       566.677         26.00       Total swing-bed cost (see instructions)       56.027         27.00       General inpatient routine service cost charges (excluding swing-bed and observation bed charges)       0       0			m (excluding swing-bed d	ays)	-	
17.00       Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period       17.00         18.00       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       18.00         19.00       Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period       19.00         20.00       Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period       129.14         21.00       Total general inpatient routine service cost (see instructions)       2.393,198       21.00         22.00       Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)       2.300, xing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18)       2.300         24.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x, 1ine 20)       3.745       25.00         25.00       Swing-bed cost (see instructions)       566.677       26.00       26.00       7.00         28.00       General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)       0.29.00       29.00         29.00       Swing-bed cost (see instructions)       0.000000       31.00       30.00         29.00       Serviate room charges (excluding sw		Nursery days (title V or XIX only)				
reporting period18.0018.00Medicaid care rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period18.0019.00Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost129.1420.00Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost129.1420.00Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost129.1420.00Total general inpatient routine service cost (see instructions)2.393.19821.00Total general inpatient routine service cost (see instructions)2.30323.00Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line x line 18)7.36124.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line x line 20)7.36125.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line x line 20)7.36125.00Swing-bed cost (see instructions)566.67726.00Total swing-bed cost (see instructions)566.67726.00Total swing-bed cost (see charges (excluding swing-bed charges)028.00General inpatient routine service cost charges28.0029.00Swing-bed cost applicable to narge (line 27 + line 28)0.00000020.00Semi-private room charges (excluding swing-bed charges)029.00Semi-private room charges (excluding swing-bed charges)0.0020.00Semi-private room cha	17 00		s through December 31 of	the cost		17 00
reporting period19.00Medicaid area for swing-bed NF services applicable to services through December 31 of the cost reporting period129.14 19.0020.00Medicaid area for swing-bed NF services applicable to services after December 31 of the cost reporting period129.1420.0021.00Total general inpatient routine service cost (see instructions) 5 x line 17)2, 393, 19821.0023.00Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 18)2, 393, 19821.0024.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 18)7, 36124.0025.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19)7, 36124.0026.00Total swing-bed cost (see instructions) x line 20)566, 67726.0026.00Total swing-bed cost (see instructions)1, 826, 52127.0027.00Seneral inpatient routine service charges (excluding swing-bed cost (line 21 minus line 26)1, 826, 52128.00General inpatient routine service charges (excluding swing-bed charges)028.0030.00Semi-private room charges (excluding swing-bed charges)028.0030.00Average per diem private room charge differential (line 20 + line 23)0.0030.0030.00Average semi-private room per diem charge (line 20 + line 3)0.0031.0031.00Average semi-private room cost differential (line 32 minus line 33) (see instructions)0.0034.00 </td <td></td> <td>reporting period</td> <td></td> <td></td> <td></td> <td></td>		reporting period				
19.00Medical drate for swing-bed NF services applicable to services through December 31 of the cost reporting period19.0120.00Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period129.1420.0021.00Total general inpatient routine service cost (see instructions)2,393,19821.0022.00Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line x line 17)2,303,19821.0023.00Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line x line 19)7,36124.0024.00Gwing-bed cost applicable to NF type services after December 31 of the cost reporting period (line x line 20)3,74525.0025.00General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)1,826,52127.0027.00General inpatient routine service charges (excluding swing-bed charges)028.0029.00Private room charges (excluding swing-bed charges)030.0030.00Average perivate room per diem charge (line 29 + line 3)0.00000031.0031.00Average perivate room cost differential (line 3 × line 31)0.00330.0030.00Average peri of emprivate room charges of lifferential (line 3 × line 35)0.00330.0031.00Of eneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 3 × line 33)0.00330.0031.00Average perivate room cost differential (line 3 × line 35)0.00330.00 <t< td=""><td>18.00</td><td></td><td>s after December 31 of t</td><td>he cost</td><td></td><td>18.00</td></t<>	18.00		s after December 31 of t	he cost		18.00
20.00Nedicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period129.1420.0021.00Total general inpatient routine service cost (see instructions)2,393,19821.0022.00Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line x line 17)023.0023.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line x line 19)023.0024.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line x line 19)7,36124.0025.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 19)3,74525.0026.00Total swing-bed cost (see instructions)566,67726.0027.00General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)1,826,52127.0028.00Of eneral inpatient routine service cost charges (excluding swing-bed and observation bed charges)028.0029.00Average perivate room charges (excluding swing-bed charges)0030.0030.00Average perivate room per diem charge (line 30 + line 4)0.00031.0031.00Average peri diem private room charge differential (line 34 x line 31)0.00031.0032.00Average peri diem private room charge differential (line 34 x line 31)0.00035.0033.00Average peri diem private room charge differential (line 34 x line 31)0.00035.0033.00<	19.00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	129.14	19.00
21.00Total general inpatient routine service cost (see instructions)2, 393, 19821.0022.00Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line x line 18)23.0023.00Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line r x line 19)24.0024.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line r x line 19)7,36125.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)3,74525.00Total swing-bed cost (see instructions)566,67726.00Total swing-bed cost (see instructions)566,67726.00Total swing-bed cost (see instructions)566,67727.00General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)1,826,52127.00Private room charges (excluding swing-bed charges)028.00Semi-private room charges (excluding swing-bed charges)020.00Semi-private room charges (excluding swing-bed charges)031.00General inpatient routine service cost/charge ratio (line 27 + line 28)0.00000031.00Average per diem private room per diem charge (line 30 + line 4)0.0034.00Average per diem private room cost differential (line 3 x line 31)0.0035.00Average per diem private room cost differential (line 3 x line 35)037.00General inpatient routine service cost reporting exicutions)1,826,52137.00Pr	20.00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of th	e cost	129.14	20. 00
22.00Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)022.0023.00Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line x line 18)023.0024.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19)7,36124.0025.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19)3,74525.0026.00Total swing-bed cost (see instructions)566,67726.0027.00General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)1,826,52127.0028.00General inpatient routine service charges (excluding swing-bed and observation bed charges)028.0020.00Semi-private room charges (excluding swing-bed charges)00.0029.0030.00Semi-private room charges (excluding swing-bed charges)00.0031.0031.00Average perivate room per diem charge (line 29 + line 3)0.000.0032.0033.00Average per diem private room per diem charge (line 30 + line 31)0.0033.0035.00Average per diem private room cost differential (line 34 x line 31)0.0035.0036.00Private room cost differential (line 34 x line 31)0.0035.0037.00Private room cost differential (line 34 x line 31)0.0035.0037.00Average per diem private room cost differential (line 34 x line 33)0.18,8	21 00		)		2 202 108	21 00
23.00Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)23.0024.00Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7, 36124.0025.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)3,74526.00Total swing-bed cost (see instructions)566,67726.00General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)1,826,52127.00Private room charges (excluding swing-bed charges)028.00General inpatient routine service charges (excluding swing-bed and observation bed charges)28.0029.00Private room charges (excluding swing-bed charges)030.00General inpatient routine service cost/charge ratio (line 27 + line 28)0.00000031.00Average peri vate room per diem charge (line 30 + line 4)0.0032.00Average per diem private room cost differential (line 32 minus line 33) (see instructions)0.0035.00Average per diem private room cost differential (line 3 x line 35)037.00Privater oom cost differential di submet (line 3 x line 35)037.00Aperage per al inpatient routine service cost per diem (see instructions)1,493.4738.00Adjusted general inpatient routine service cost per diem (see instructions)1,493.4739.00Adjusted general inpatient routine service cost per diem (see instructions)1,493.4739.00Adjusted general inpatient routine service cost per diem (see				ng period (line		
x line 18)x24.00Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line x line 19)7, 36124.0025.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)3, 74525.0026.00Total swing-bed cost (see instructions)566, 67726.0027.00General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)1, 826, 52127.0028.00General inpatient routine service charges (excluding swing-bed and observation bed charges)028.0029.00Private room charges (excluding swing-bed charges)028.0030.00Semi-private room charges (excluding swing-bed charges)030.0031.00General inpatient routine service cost/charge ratio (line 27 + line 28)0.00000031.0032.00Average per diem private room per diem charge (line 30 + line 4)0.0033.0034.00Average per diem private room cost differential (line 34 x line 31)0.0035.0035.00Average per diem private room cost di fferential (line 34 x line 31)0.0035.0036.00Private room cost di fferential di 3 x line 35)0.0035.0037.00PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS1, 493.4738.00Adjusted general inpatient routine service cost per diem (see instructions)1, 493.4739.00Program general inpatient routine service cost per diem (see instructions)1, 493.4739.00Program general inpatient	23 00		31 of the cost reporting	period (line 6	0	23 00
7 x line 19)       7 x line 19)       25.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)       3,745       25.00         26.00       Total swing-bed cost (see instructions)       566,677       26.00         27.00       General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)       1,826,521       27.00         PRIVATE ROOM DIFFERENTIAL ADJUSTMENT       0       0       28.00       0       29.00       29.00       0       29.00       0       29.00       0       29.00       0       29.00       0       29.00       0       29.00       0       29.00       0.000003       0.00       29.00       0       29.00       0.00003       0.00       29.00       0.00003       0.00       29.00       0.00003       0.00       29.00       0.00003       0.00       29.00       0.000003       0.00       29.00       0.00003       0.00       20.00       20.00       0.00003       0.00       20.00       0.000003       0.00       20.00       20.00       20.00       20.00       20.00       20.00       20.00       20.00       20.00       20.00       20.00       20.00       20.00       20.00       20.00       20.00       20.00       20.00 <t< td=""><td>23.00</td><td></td><td>ST OF the cost reporting</td><td>period (inne o</td><td>0</td><td>23.00</td></t<>	23.00		ST OF the cost reporting	period (inne o	0	23.00
25.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)3,745 25.0025.00 x line 20)26.00Total swing-bed cost (see instructions)566,677 	24.00		31 of the cost reportin	g period (line	7, 361	24.00
26.00Total swing-bed cost (see instructions)566,67726.0027.00General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)1,826,52127.00PRIVATE ROOM DIFFERENTIAL ADJUSTMENT28.00General inpatient routine service charges (excluding swing-bed and observation bed charges)028.0029.00Private room charges (excluding swing-bed charges)029.0029.0030.00Semi-private room charges (excluding swing-bed charges)030.0031.00General inpatient routine service cost/charge ratio (line 27 + line 28)0.00000031.0032.00Average per vate room per diem charge (line 30 + line 4)0.0032.0034.00Average per diem private room cost differential (line 34 x line 31)0.0034.0035.00Average per diem private room cost differential (line 3 x line 35)036.0037.00Eneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 37.10038.0038.00Adjusted general inpatient routine service cost per diem (see instructions)1,826,52138.00Adjusted general inpatient routine service cost per diem (see instructions)1,493.4738.00Adjusted general inpatient routine service cost per diem (see instructions)1,493.4739.00Program general inpatient routine service cost (line 9 x line 38)577,97340.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.00Medically necessary private room cost applicable to the Program (line 14 x line 35)	25.00	Swing-bed cost applicable to NF type services after December 3	1 of the cost reporting	period (line 8	3, 745	25.00
27. 00General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)1,826,52127. 00PRIVATE ROOM DIFFERENTIAL ADJUSTMENT28. 00General inpatient routine service charges (excluding swing-bed and observation bed charges)028. 0029. 00Private room charges (excluding swing-bed charges)029. 0030. 00Semi-private room charges (excluding swing-bed charges)030. 0031. 00General inpatient routine service cost/charge ratio (line 27 + line 28)0. 00000031. 0032. 00Average private room per diem charge (line 30 + line 4)0. 0032. 0033. 00Average per diem private room charge differential (line 34 x line 31)0. 0032. 0034. 00Average per diem private room cost differential (line 3 x line 35)0. 0034. 0037. 00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 36)1, 493. 47PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS1, 493. 4738. 0038. 00Adjusted general inpatient routine service cost (line 9 x line 38)577, 97339. 0040. 00Medically necessary private room cost applicable to the Program (line 14 x line 35)040. 00	26 00				566 677	26 00
28.00General inpatient routine service charges (excluding swing-bed and observation bed charges)028.0029.00Private room charges (excluding swing-bed charges)029.0030.00Semi-private room charges (excluding swing-bed charges)030.0031.00General inpatient routine service cost/charge ratio (line 27 + line 28)0.00000031.0032.00Average private room per diem charge (line 29 + line 3)0.0032.0033.00Average per diem private room charge differential (line 32 minus line 33) (see instructions)0.0032.0034.00Average per diem private room cost differential (line 3 x line 31)0.0035.0035.00Average per diem private room cost differential (line 3 x line 35)0.0035.0037.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 826, 52137.0038.00Adjusted general inpatient routine service cost per diem (see instructions)1, 493.4738.00Adjusted general inpatient routine service cost per diem (see instructions)1, 493.4739.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.00Medically necessary private room cost applicable to the Program (line 14 x line 35)0		General inpatient routine service cost net of swing-bed cost (	line 21 minus line 26)			
29.00Private room charges (excluding swing-bed charges)029.0030.00Semi-private room charges (excluding swing-bed charges)030.0031.00General inpatient routine service cost/charge ratio (line 27 ÷ line 28)0.00000031.0032.00Average private room per diem charge (line 29 ÷ line 3)0.0032.0033.00Average per diem private room per diem charge (line 30 ÷ line 4)0.0032.0034.00Average per diem private room cost differential (line 34 x line 31)0.0034.0035.00Average per diem private room cost differential (line 3 x line 35)0.0035.0036.00Private room cost differential adjustment (line 3 x line 35)036.0037.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 826, 52137.0027 minus line 36)PART 11 - HOSPITAL AND SUBPROVIDERS ONLY1, 493.4738.00Adjusted general inpatient routine service cost per diem (see instructions)1, 493.4739.00Program general inpatient routine service cost (line 9 x line 38)577, 97340.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.00	28 00		and observation bed cha	rges)	0	28 00
31.00General inpatient routine service cost/charge ratio (line 27 + line 28)0.00000031.0032.00Average private room per diem charge (line 29 + line 3)0.0000032.0033.00Average semi-private room per diem charge (line 30 + line 4)0.0032.0034.00Average per diem private room cost differential (line 32 minus line 33) (see instructions)0.0033.0035.00Average per diem private room cost differential (line 34 x line 31)0.0034.0036.00Private room cost differential adjustment (line 3 x line 35)0.0036.0037.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 826, 52137.0027 minus line 36)PART 11 - HOSPI TAL AND SUBPROVI DERS ONLY0.0036.0078.00Adjusted general inpatient routine service cost per diem (see instructions)1, 493.4738.00Adjusted general inpatient routine service cost (line 9 x line 38)577, 97340.00Medically necessary private room cost applicable to the Program (line 14 x line 35)0				, geor		
32.00Average private room per diem charge (line 29 + line 3)0.0032.0033.00Average semi-private room per diem charge (line 30 + line 4)0.0033.0034.00Average per diem private room charge differential (line 32 minus line 33) (see instructions)0.0034.0035.00Average per diem private room cost differential (line 34 x line 31)0.0035.0036.00Private room cost differential adjustment (line 3 x line 35)0.0036.0037.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 826, 52137.0027 minus line 36)PART II - HOSPITAL AND SUBPROVIDERS ONLY38.00PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS1, 493.4738.00Adjusted general inpatient routine service cost (line 9 x line 38)577, 97339.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.00Medically necessary private room cost applicable to the Program (line 14 x line 35)0			line 20)		-	
33.00       Average semi-private room per diem charge (line 30 + line 4)       0.00       33.00         34.00       Average per diem private room charge differential (line 32 minus line 33) (see instructions)       0.00       34.00         35.00       Average per diem private room cost differential (line 34 x line 31)       0.00       34.00         36.00       Private room cost differential adjustment (line 3 x line 35)       0.00       35.00         37.00       General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 826, 521       37.00         27 minus line 36)       PART II - HOSPITAL AND SUBPROVIDERS ONLY       37.00         PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS       1, 493.47         38.00       Adjusted general inpatient routine service cost (line 9 x line 38)       577, 973         39.00       Program general inpatient routine service cost applicable to the Program (line 14 x line 35)       0       40.00			TTHE 20)			
35.00       Average per diem private room cost differential (line 34 x line 31)       0.00       35.00         36.00       Private room cost differential adjustment (line 3 x line 35)       0       0       36.00         37.00       General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 826, 521       0       36.00       37.00         27 minus line 36)       PART II - HOSPITAL AND SUBPROVIDERS ONLY       PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS       1, 493.47       38.00         38.00       Adjusted general inpatient routine service cost (line 9 x line 38)       1, 493.47       38.00         39.00       Program general inpatient routine service cost applicable to the Program (line 14 x line 35)       0       40.00	33.00	Average semi-private room per diem charge (line 30 ÷ line 4)				33.00
36.00       Private room cost differential adjustment (line 3 x line 35)       0       36.00       36.00         37.00       General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)       0       1,826,521       37.00         PART 11 - HOSPITAL AND SUBPROVIDERS ONLY       PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS       0       1,493.47       38.00         38.00       Program general inpatient routine service cost (line 9 x line 38)       1,493.47       38.00         39.00       Program general inpatient routine service cost (line 9 x line 38)       577,973       39.00         40.00       Medically necessary private room cost applicable to the Program (line 14 x line 35)       0       40.00				i ons)		
37.00       General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 826, 521 27 minus line 36)       37.00         PART II - HOSPITAL AND SUBPROVIDERS ONLY       PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS         38.00       Adjusted general inpatient routine service cost per diem (see instructions)       1, 493.47         39.00       Program general inpatient routine service cost (line 9 x line 38)       577, 973       39.00         40.00       Medically necessary private room cost applicable to the Program (line 14 x line 35)       0       40.00			e 31)			
PART II - HOSPITAL AND SUBPROVIDERS ONLYPROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS38.00Adjusted general inpatient routine service cost per diem (see instructions)1,493.4739.00Program general inpatient routine service cost (line 9 x line 38)577,97340.00Medically necessary private room cost applicable to the Program (line 14 x line 35)0		General inpatient routine service cost net of swing-bed cost a	nd private room cost dif	ferential (line	-	
PROGRAM I NPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS38.00Adjusted general inpatient routine service cost per diem (see instructions)1,493.4739.00Program general inpatient routine service cost (line 9 x line 38)577,97340.00Medically necessary private room cost applicable to the Program (line 14 x line 35)0		27 minus line 36) PART LL - HOSPITAL AND SUBPROVIDERS ONLY				
39.00Program general inpatient routine service cost (line 9 x line 38)577,97339.0040.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.00			STMENTS			
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
			-			

OMPUT	ATION OF INPATIENT OPERATING COST		Provi	der CCN: 151300	Period: From 05/01/2014	Worksheet D-1	1
					To 04/30/2015		
		T-+-1		itle XVIII	Hospi tal	Cost	
	Cost Center Description	Total Inpatient Cost	Total Inpatient D	Average Pe aysDiem (col. col. 2)	5	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
00	NURSERY (title V & XIX only)	0		0 0.	00 0	0	9 42
00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT		1			1	43
00	CORONARY CARE UNIT						44
00	BURN I NTENSI VE CARE UNI T						45
00	SURGI CAL I NTENSI VE CARE UNI T						46
00	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description					1.00	-
00	Program inpatient ancillary service cost (Wks	st. D-3, col. 3	3, line 200)			493, 762	2 48
00	Total Program inpatient costs (sum of lines 4					1, 071, 735	
	PASS THROUGH COST ADJUSTMENTS					-	_
00	Pass through costs applicable to Program inpa	atient routine	services (f	rom Wkst. D, su	um of Parts I and	0	50
00	) Pass through costs applicable to Program inpa	atient ancillar	ry services	(from Wkst D	sum of Parts II	0	51
00	and IV)		<i>y</i> services		Sum of Turts II		
00	Total Program excludable cost (sum of lines !					0	
. 00	Total Program inpatient operating cost exclud		elated, non-	physician anest	hetist, and	0	53
	medical education costs (line 49 minus line 5 TARGET AMOUNT AND LIMIT COMPUTATION	oZ)					
. 00	Program di scharges					0	54
00	Target amount per discharge					0.00	55
00	Target amount (line 54 x line 55)					0	
00	Difference between adjusted inpatient operati	ng cost and ta	arget amount	: (line 56 minus	s line 53)	0	
. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost rep	porting period	ending 1004	undated and c	compounded by the	0.00	
. 00	market basket	boi tring period	ending 1770		compounded by the	0.00	
. 00	Lesser of lines 53/54 or 55 from prior year of					0.00	60
. 00	If line 53/54 is less than the lower of lines					0	61
	which operating costs (line 53) are less than amount (line 56), otherwise enter zero (see i		ts (lines 54	x 60), or 1% c	of the target		
. 00	Relief payment (see instructions)	listi deti olisj				0	62
. 00	Allowable Inpatient cost plus incentive payme	ent (see instru	uctions)			0	63
~~	PROGRAM INPATIENT ROUTINE SWING BED COST		- 01 C				
. 00	Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only)	is through Dece	ember 31 or	the cost report	ing period (See	0	64
. 00	Medicare swing-bed SNF inpatient routine cost	ts after Decemb	ber 31 of th	e cost reportir	ng period (See	516, 741	65
	instructions)(title XVIII only)						
. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus lir	ne 65)(title XVI	ll only). For	516, 741	66
. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine	a costs through	December 3	1 of the cost r	eporting period	0	67
. 00	(line 12 x line 19)		i December a	in on the cost i	eporting period		1 07
. 00	Title V or XIX swing-bed NF inpatient routine	e costs after [	December 31	of the cost rep	orting period	0	68 (
00	(line 13 x line 20)			i			
. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU		•	,		0	) 69
. 00	Skilled nursing facility/other nursing facili						70
00	Adjusted general inpatient routine service co	ost per diem (I					71
. 00	Program routine service cost (line 9 x line 3	,					72
. 00	Medically necessary private room cost applica Total Program general inpatient routine servi						73
. 00	Capital -related cost allocated to inpatient	•		,	Part II. column		75
55	26, line 45)						^
. 00	Per diem capital-related costs (line 75 ÷ lin	,					76
00	Program capital -related costs (line 9 x line						77
00 00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		orovider rec	ords)			78
00	Total Program routine service costs for compa	• •		· · ·	nus line 79)		80
00	Inpatient routine service cost per diem limit						81
00	Inpatient routine service cost limitation (li		•				82
00	Reasonable inpatient routine service costs (s		ns)				83
00	Program inpatient ancillary services (see ins Utilization review - physician compensation		)				84
00	Total Program inpatient operating costs (sum	•					86
	PART IV - COMPUTATION OF OBSERVATION BED PASS						
. 00	Total observation bed days (see instructions)	)					87
	Adjusted general inpatient routine cost per o	liem (line 27 -	÷line 2)			1, 493. 48	88  8
00 00	Observation bed cost (line 87 x line 88) (see	•				761, 675	

Health Financial Systems	COMMUNITY HOSPI	TAL OF BREMEN		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period:	Worksheet D-1	
				From 05/01/2014 To 04/30/2015	Date/Time Pre 9/30/2015 10:	pared: 33 am
		Titl	e XVIII	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	410, 505	1, 826, 521	0. 22474	7 761, 675	171, 184	90.00
91.00 Nursing School cost	0	1, 826, 521	0.00000	0 761, 675	0	91.00
92.00 Allied health cost	0	1, 826, 521	0. 00000	0 761, 675	0	92.00
93.00 All other Medical Education	0	1, 826, 521	0. 00000	0 761, 675	0	93.00

Heal th	Financial Systems COMMUNITY HOSPITA	L OF BREMEN	In Lie	u of Form CMS-2	2552-10
COMPUT	TATION OF INPATIENT OPERATING COST	Provider CCN: 151300	Peri od:	Worksheet D-1	
			From 05/01/2014		
			To 04/30/2015		
				9/30/2015 10:3	<u>33 am</u>
		Title XIX	Hospi tal	Cost	
	Cost Center Description				
	·			1.00	
	PART I - ALL PROVIDER COMPONENTS				
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day	rs, excluding newborn)		1, 681	1.00
2.00	Inpatient days (including private room days, excluding swing-	bed and newborn days)		1, 223	2.00
3.00	Private room days (excluding swing-bed and observation bed da	ys). If you have only pr	ivate room days,	0	3.00
	do not complete this line.		-		
4 00	Semi-private room days (excluding swing-bed and observation h	(aveh hau		713	4 00

	do not complete this line.		
4.00	Semi-private room days (excluding swing-bed and observation bed days)	713	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		
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	372	6.00
	reporting period (if calendar year, enter 0 on this line)		
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7.00
	reporting period		
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	86	8.00
	reporting period (if calendar year, enter 0 on this line)		
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	13	9.00
7.00	newborn days)	10	7.00
10.00	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)	0	10.00
11.00		0	11.00
11.00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00		0	12.00
12.00	through December 31 of the cost reporting period	0	12.00
13.00		0	13.00
13.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14 00		0	14.00
14.00			
15.00			15.00
16.00		10	16.00
	SWING BED ADJUSTMENT		
17.00			17.00
	reporting period		
18.00			18.00
	reporting period		
19.00	5 11 5	0.00	19.00
	reporting period		
20.00	Medicaid 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)	2, 393, 198	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		558, 164	26.00
27.00	5	1, 835, 034	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	.,	
28.00		0	28.00
29.00		0	29.00
30.00		0	
30.00		0.000000	
31.00			31.00
33.00			33.00
34.00	5 1 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5		34.00
35.00		0.00	
36.00		0	
37 00	Conoral inpationt routing corvice cost not of swing bod cost and private room cost differential (line	1 025 024	27 00

35.00	Average per drem private room cost differential (fille 34 x fille 31)	0.00	33.00
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	1, 835, 034	37.00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 500. 44	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	19, 506	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	19, 506	41.00

JMPUT	ATION OF INPATIENT OPERATING COST		Provi	der	CCN: 151300	Period: From 05/01/2014	Worksheet D-1	1
						To 04/30/2015	Date/Time Pre 9/30/2015 10:	
				Ti t	le XIX	Hospi tal	Cost	. 55 0
	Cost Center Description	Total Inpatient Cost	Total Inpatient I	Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2.00		3.00	4.00	5.00	
00	NURSERY (title V & XIX only)	88, 288		155	569. (	50 10	5, 696	5 42
00	Intensive Care Type Inpatient Hospital Units	S						1 43
00 00	INTENSIVE CARE UNIT CORONARY CARE UNIT							43
00	BURN INTENSIVE CARE UNIT							44
	SURGICAL INTENSIVE CARE UNIT							46
	OTHER SPECIAL CARE (SPECIFY)							47
	Cost Center Description							
00	Description in the second second of the second seco		11.000	<u> </u>			1.00	- 40
00 00	Program inpatient ancillary service cost (W Total Program inpatient costs (sum of lines				ns)		210, 485 235, 687	
00	PASS THROUGH COST ADJUSTMENTS	41 through 40)(	see mstru	ctro	13)		233,007	47
00	Pass through costs applicable to Program in	patient routine	services (	from	Wkst. D, sur	n of Parts I and	C	50
	111)							
. 00	Pass through costs applicable to Program in	patient ancillar	y services	(fr	om Wkst. D, s	sum of Parts II	C	51
. 00	and IV) Total Program excludable cost (sum of lines	50 and $51$						52
. 00	Total Program inpatient operating cost excl		lated non	-phv	sician anesti	netist. and		
. 00	medical education costs (line 49 minus line		ratea, non	ping	si ci un unos ti			
	TARGET AMOUNT AND LIMIT COMPUTATION							
	Program discharges						(	
00	Target amount per discharge						0.00	
00 00	Target amount (line 54 x line 55) Difference between adjusted inpatient opera	ting cost and to	ract amoun	+ (1	ino E4 minuc	Lino E2)		
00	Bonus payment (see instructions)	ting cost and ta	rget allour	L (I	The So milling	TTHE 55)		
. 00	Lesser of lines 53/54 or 55 from the cost r	eporting period	endi na 199	6. u	odated and co	ompounded by the		
	market basket		g	-, -,				
. 00	Lesser of lines 53/54 or 55 from prior year						0.00	
. 00	If line 53/54 is less than the lower of line						C	) 61
	which operating costs (line 53) are less the amount (line 56), otherwise enter zero (see		s (Times 5	4 X (	50), or 1% 01	the target		
. 00	Relief payment (see instructions)	riisti ucti olis)						62
. 00	Allowable Inpatient cost plus incentive pay	ment (see instru	ctions)				C	
	PROGRAM INPATIENT ROUTINE SWING BED COST							
. 00	Medicare swing-bed SNF inpatient routine co	sts through Dece	mber 31 of	the	cost reporti	ng period (See	C	64
. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine co	sts after Decemb	er 31 of t	he ci	ost reporting	n neriod (See	C	65
. 00	instructions) (title XVIII only)				Jac Tepor tring	g period (see		
. 00	Total Medicare swing-bed SNF inpatient rout	ine costs (line	64 plus li	ne 6	5)(title XVI)	I only). For	C	66
	CAH (see instructions)							
. 00	Title V or XIX swing-bed NF inpatient routin	ne costs through	December	31 o	f the cost re	eporting period	C	67
. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routi	ne costs after D	ecember 31	of	the cost ren	orting period	(	68
. 00	(line 13 x line 20)		ceciliber of	01	the cost rept	n tring period		
. 00	Total title V or XIX swing-bed NF inpatient	routine costs (	line 67 +	line	68)		C	) 69
	PART III - SKILLED NURSING FACILITY, OTHER I							
. 00 . 00	Skilled nursing facility/other nursing faci							70
. 00	Adjusted general inpatient routine service Program routine service cost (line 9 x line		ine 70 ÷ i	ine.	2)			71
. 00	Medically necessary private room cost appli	,	(line 14	x li	ne 35)			73
. 00	Total Program general inpatient routine ser				/			74
. 00	Capital-related cost allocated to inpatient	routine service	costs (fr	om W	orksheet B, F	Part II, column		75
~~	26, line 45)							
. 00	Per diem capital -related costs (line 75 ÷ l	,						76
00 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 min							77
00	Aggregate charges to beneficiaries for exce		rovider re	cord	s)			79
00	Total Program routine service costs for com				· · · ·	nus line 79)		80
00	Inpatient routine service cost per diem lim				-			81
00	Inpatient routine service cost limitation (		•					82
00	Reasonable inpatient routine service costs	•	s)					83
. 00	Program inpatient ancillary services (see in		>					84
. 00	Utilization review - physician compensation Total Program inpatient operating costs (su							85
. 00	PART IV - COMPUTATION OF OBSERVATION BED PAS		i Jugii (D)				I	-  °°
							510	5 87
. 00	Total observation bed days (see instruction	S)					510	, 0,
. 00	Total observation bed days (see instruction Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (s	diem (line 27 ÷	line 2)				1, 500. 44 765, 224	1 88

Health Financial Systems	COMMUNITY HOSPI	TAL OF BREMEN		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period: From 05/01/2014	Worksheet D-1	
				To 04/30/2015	Date/Time Pre 9/30/2015 10:	pared: 33 am
		Tit	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	410, 505	1, 835, 034	0. 22370	4 765, 224	171, 184	90.00
91.00 Nursing School cost	0	1, 835, 034	0.00000	0 765, 224	0	91.00
92.00 Allied health cost	0	1, 835, 034	0.00000	0 765, 224	0	92.00
93.00 All other Medical Education	0	1, 835, 034	0.00000			93.00

Health Financial Systems 0	COMMUNITY HOSPITAL OF BREMEN		In Lie	eu of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 151300	Peri od:	Worksheet D-3	
			From 05/01/2014 To 04/30/2015		narod
			10 04/30/2013	9/30/2015 10:	33 am
	Ti tl	e XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			504 745		
30. 00 03000 ADULTS & PEDI ATRI CS			586, 745		30.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS		0.0005	000 540	110.010	50.00
50. 00 05000 OPERATING ROOM		0.3895			
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0.5279			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0.5592			
57.00 05700 CT SCAN		0. 1592			
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 3968			
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.0000		-	
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY		0. 2773			1
		0.0000		-	
64. 00 06400 I NTRAVENOUS THERAPY		2.8621 0.4017		, o	
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY		0. 4017.			
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY		0. 5416			
68. 00 06800 SPEECH PATHOLOGY		0.0000		-	
69. 00 06900 ELECTROCARDI OLOGY		0.0182			
69. 02 06900 ELECTROCARDIOLOGY 69. 02 06902 SLEEP LAB		0. 0392			
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.0000		0	
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS		0. 7784		-	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 5067			
73. 00 07300 DRUGS CHARGED TO PATIENTS		0.5687			
OUTPATIENT SERVICE COST CENTERS		0. 5067	221, 140	125,764	/3.00
90. 00 09000 CLINIC		0.0000	0000	0	90.00
91. 00 09100 EMERGENCY		1. 2099		-	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 9693		0	
200.00 Total (sum of lines 50-94 and 96-98)			1, 075, 313	, v	
201.00 Less PBP Clinic Laboratory Services-Pro	gram only charges (line 61)		., ., ., ., ., ., ., ., ., ., ., ., ., .		201.00
			1, 075, 313		202.00
201.00Less PBP Clinic Laboratory Services-Pro202.00Net Charges (line 200 minus line 201)	ngram only charges (line 61)		0 1, 075, 313		

Health Financial Systems COMMUNITY HOSPITAL OF B	REMEN		In Lie	eu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT Pro	ovi der	CCN: 151300	Peri od:	Worksheet D-3	
			From 05/01/2014		
Con	mponent	CCN: 15Z300	To 04/30/2015	Date/Time Pre	pared:
	T: +1	e XVIII	Swing Beds - SNI	9/30/2015 10:	33 am
Cost Contan Decerintian	<u></u>	Ratio of Cos		F <u>Cost</u> Inpatient	
Cost Center Description			Program	Program Costs	
		To Charges			
			Charges	(col. 1 x col. 2)	
		1.00	2.00	3,00	
INDATIONT POLITING SEDVICE COST CENTEDS		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS			0	1	30.00
			C		
43. 00 O4300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS		0.0005			50.00
50.00 O5000 OPERATING ROOM		0.3895		0	
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 5279		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 5592			
57.00 05700 CT SCAN		0. 1592			
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 3968			
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.0000		0 0	
60. 00 06000 LABORATORY		0. 2773			
60. 01 06001 BLOOD LABORATORY		0.0000		0	
64. 00 06400 I NTRAVENOUS THERAPY		2.8621		0	
65.00 06500 RESPI RATORY THERAPY		0. 4017.	26 C	0	
66.00 06600 PHYSI CAL THERAPY		0. 5416	50 179, 313	97, 127	66.00
67.00 06700 OCCUPATIONAL THERAPY		0.0000	00 C	0 0	67.00
68.00 06800 SPEECH PATHOLOGY		0. 0182	79 651	12	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 0392	38 392	2 15	69.00
69. 02 06902 SLEEP LAB		0. 5631	75 C	0	69.02
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.0000	00 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 7784	10 8, 977	6, 988	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 5067	39 C	0 0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 5687	96 126, 478	71, 940	73.00
OUTPATIENT SERVICE COST CENTERS				· · · · · ·	
90. 00 09000 CLI NI C		0.0000	00 0	0 0	90.00
91. 00 09100 EMERGENCY		1.2099		0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0, 9693		0	1
200.00 Total (sum of lines 50-94 and 96-98)			382, 678	-	
201.00 Less PBP Clinic Laboratory Services-Program only charges (line	e 61)		(	)	201.00
202.00 Net Charges (line 200 minus line 201)	/		382, 678	3	202.00
		I		i	

Health Financial Systems	COMMUNITY HOSPITAL OF BRE			In Lie	u of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Prov	i der	CCN: 151300	Peri od:	Worksheet D-3	
				From 05/01/2014 To 04/30/2015		norod.
				10 04/30/2015	Date/Time Pre 9/30/2015 10:	33 am
		Ti t	le XIX	Hospi tal	Cost	
Cost Center Description			Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS				216, 813		30.00
43. 00 04300 NURSERY				59, 106		43.00
ANCILLARY SERVICE COST CENTERS			1			
50. 00 05000 OPERATI NG ROOM			0. 3895			•
52.00 05200 DELIVERY ROOM & LABOR ROOM			0. 5279			
54. 00 05400 RADI OLOGY-DI AGNOSTI C			0. 5592			
57.00 05700 CT SCAN			0. 1592	72 4, 849	772	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)			0. 3968	74 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON			0.0000	0 00	0	59.00
60. 00 06000 LABORATORY			0. 2773	22 34, 761	9, 640	60.00
60. 01 06001 BLOOD LABORATORY			0.0000	0 00	0	60.01
64.00 06400 INTRAVENOUS THERAPY			2.8621	59 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY			0. 4017	26 3, 317	1, 333	65.00
66. 00 06600 PHYSI CAL THERAPY			0. 5416	60 3, 284	1, 779	66.00
67.00 06700 OCCUPATI ONAL THERAPY			0.0000	0 00	0	67.00
68.00 06800 SPEECH PATHOLOGY			0. 0182	79 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY			0. 0392	38 5, 477	215	69.00
69. 02 06902 SLEEP LAB			0. 5631	75 0	0	69.02
70.00 07000 ELECTROENCEPHALOGRAPHY			0.0000	0 00	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			0. 7784	10 62, 271	48, 472	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS			0. 5067	39 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS			0. 5687		20, 984	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC			0.0000	0 00	0	1 90. OC
91.00 09100 EMERGENCY			1.2099		3, 169	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)			0. 9693		0	
200.00 Total (sum of lines 50-94 and 96-98)				455, 828	210, 485	
201.00 Less PBP Clinic Laboratory Services-	Program only charges (line	61)		0		201.00
202.00 Net Charges (line 200 minus line 201		. ,	1	455, 828		202.00

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT Provider CCN: 151300 Period: From 05/01/201		
		9/30/2015 10:	pared: 33 am
	Title XVIII Hospital	Cost	
		1.00	
1.00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)	3, 632, 844	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	
3.00	PPS payments	0	
4.00	Outlier payment (see instructions)	0	
5.00 6.00	Enter the hospital specific payment to cost ratio (see instructions) Line 2 times line 5	0.000	
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	
8.00	Transitional corridor payment (see instructions)	0	
9.00 10.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 Organ acquisitions	0	
11.00	Total cost (sum of lines 1 and 10) (see instructions)	3, 632, 844	
	COMPUTATION OF LESSER OF COST OR CHARGES		1
10.00	Reasonable charges		1 1 2 . 00
12.00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, col. 4)	0	12.00 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	
	Customary charges		1
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0. 000000	17.00
	Total customary charges (see instructions)	0	
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see	0	20.00
	instructions)		
	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions) Interns and residents (see instructions)	3, 669, 172 0	
	Cost of physicians' services in a teaching hospital (see instructions)	0	
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	
25.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT	22 542	1 25 00
25.00 26.00	Deductibles and coinsurance (for CAH, see instructions) Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	22, 542 986, 556	
27.00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for	2, 660, 074	
~~ ~~	CAH, see instructions)		
	Direct graduate medical education payments (from Wkst. E-4, line 50) ESRD direct medical education costs (from Wkst. E-4, line 36)	0	
	Subtotal (sum of lines 27 through 29)	2, 660, 074	
31.00	Primary payer payments	2, 518	
32.00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	2, 657, 556	32.00
33.00	Composite rate ESRD (from Wkst. 1-5, line 11)	0	33.00
	Allowable bad debts (see instructions)	138, 025	34.00
	Adjusted reimbursable bad debts (see instructions)	104, 899	
	Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (see instructions)	96, 673 2, 762, 455	
	MSP-LCC reconciliation amount from PS&R	2,702,433	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	
	Pioneer ACO demonstration payment adjustment (see instructions)	0	
	Partial or full credits received from manufacturers for replaced devices (see instructions) RECOVERY OF ACCELERATED DEPRECIATION	0	
	Subtotal (see instructions)	2, 762, 455	
40. 01	Sequestration adjustment (see instructions)	55, 249	
41.00 42.00	Interim payments Tentative settlement (for contractors use only)	2, 918, 541 0	
42.00	Balance due provider/program (see instructions)	-211, 335	
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	
	<u>§115.2</u>		
	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)	0	90.00
90 00			
	Outlier reconciliation adjustment amount (see instructions)	0	91.00
91.00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money Time Value of Money (see instructions)		92.00

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der	CCN: 151300	Period: From 05/01/2014 To 04/30/2015		
			e XVIII	Hospi tal	Cost	
		I npati en	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00 2.00	Total interim payments paid to provider Interim payments payable on individual bills, either		896, 33	30 0	2, 918, 541 0	1.00 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 amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	11/25/2014	95, 60	00	0	3. 01
3.02				0	0	3.02
3.03				0	0	3. 03 3. 04
3.04 3.05				0	0	3.04
0.00	Provider to Program	11		0		0.00
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.51				0	0	3.5
3.52 3.53				0	0	3.52 3.53
3.53				0	0	3. 54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		95, 60		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		991, 93	30	2, 918, 541	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
5.01	TENTATI VE TO PROVIDER			0	0	5. 0 ²
5.02				0	0	5.02
5.03				0	0	5.03
	Provider to Program	1		2		
5.50 5.51	TENTATI VE TO PROGRAM			0	0	5.50 5.51
5.52				0	0	5.52
5.99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	5.99
5. 00 5. 01	Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROVIDER			0	0	6. 00 6. 0
6. 02	SETTLEMENT TO PROVIDER		41, 84	-	211, 335	6.02
7.00	Total Medicare program liability (see instructions)		950, 08		2, 707, 206	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
	Name of Contractor	C	)	1.00	2.00	8.00

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		F	eriod: rom 05/01/2014 o 04/30/2015		pared:
		Ti tl	e XVIII S	wing Beds - SNF		oo aiii
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00 2.00	Total interim payments paid to provider Interim payments payable on individual bills, either		671, 718 C		0 0	1.00 2.00
	submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,					
3.00	write "NONE" or enter a zero 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	11/25/2014	47, 300	)	0	3.0
3.02			C		0	3. 02
3.03			C		0	3.03
3.04 3.05					0	3.04 3.05
0.00	Provider to Program	1				
3.50	ADJUSTMENTS TO PROGRAM		C		0	3.50
3.51			C		0	
3.52 3.53					0	3.52 3.53
3.53					0	3.54
3.99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)		47, 300		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		719, 018		0	4.00
	appropriate)					
5.00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after					5.00
5.00	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider	1	1	1		
5.01	TENTATI VE TO PROVIDER		0		0	5.0
5.02 5.03					0	5.02 5.02
0.00	Provider to Program	1				
5.50	TENTATI VE TO PROGRAM		C		0	5.50
5.51			0		0	5.5
5.52 5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines				0	5.52 5.99
J. 77	5. 50-5. 98)				0	0.7
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6. 01	SETTLEMENT TO PROVIDER		C		0	6. 0 ²
6.02	SETTLEMENT TO PROGRAM		18, 049		0	6.02
7.00	Total Medicare program liability (see instructions)		700, 969	Contractor	0 NPR Date	7.00
				Number	(Mo/Day/Yr)	
		(	)	1.00	2.00	

Health Financial Systems COMMUNITY HOSPITAL OF BREMEN In Lieu								
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 151300 Period: From 05/01/2014								
To 04/30/2015 Date/Time I								
	Cost							
	1.00							
TO BE COMPLETED BY CONTRACTOR FOR NON								
HEALTH INFORMATION TECHNOLOGY DATA COL								
1.00 Total hospital discharges as defined i	287 1.00							
2.00 Medicare days from Wkst. S-3, Pt. I, c	387 2.00							
3.00 Medicare HMO days from Wkst. S-3, Pt.	0 3.00 713 4.00							
4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12								
5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 31								
6.00 Total hospital charity care charges fr	1, 079, 621 6. 00							
7.00 CAH only - The reasonable cost incurre	0 7.00							
line 168								
8.00 Calculation of the HIT incentive payme	0 8.00							
9.00 Sequestration adjustment amount (see i	0 9.00							
10.00 Calculation of the HIT incentive payme	0 10.00							
INPATIENT HOSPITAL SERVICES UNDER PPS								
30.00 Initial/interim HIT payment adjustment	0 30.00							
31.00 Other Adjustment (specify)	0 31.00							
32.00 Balance due provider (line 8 (or line	0 32.00							

Heal th	Financial Systems COMMUNITY HOSPITAL	OF BREMEN	In Lie	u of Form CMS-2	2552-10
CALCU	ATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provi der CCN: 151300	Period: From 05/01/2014	Worksheet E-2	
		Component CCN: 15Z300	To 04/30/2015	Date/Time Pre 9/30/2015 10:	
		Title XVIII	Swing Beds - SNF	Cost	
			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)		521, 908	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200 for Pt. A		198, 230	0	3.00
4 00	Part V, cols. 6 and 7, line 202 for Pt. B) (For CAH, see instr			0.00	4 00
4.00	Per diem cost for interns and residents not in approved teachi	ng program (see		0.00	4.00
F 00	instructions)		24/	0	F 00
5.00	Program days		346	0	5.00
6.00	Interns and residents not in approved teaching program (see in			0	
7.00	Utilization review - physician compensation - SNF optional met	nod only	700, 100	0	7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		720, 138	0	
9.00	Primary payer payments (see instructions)		700 100	0	
10.00	Subtotal (line 8 minus line 9)		720, 138	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applic professional services)	able to physician	0	0	11.00
12.00	Subtotal (line 10 minus line 11)		720, 138	0	12.00
13.00	Coinsurance billed to program patients (from provider records) for physician professional services)	(excl ude coi nsurance	4, 864	0	13.00
14.00	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 1	4)	715, 274	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions	5)	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 instr	ructions)	0	0	18.00
19.00	Total (see instructions)		715, 274	0	19.00
19.01	Sequestration adjustment (see instructions)		14, 305	0	19.01
20.00	Interim payments		719, 018	0	20.00
21.00	Tentative settlement (for contractor use only)		0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, a	ind 21)	-18, 049	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordan §115.2	nce with CMS Pub. 15-2,	0	0	23.00

	Financial Systems COMMUNITY HOSPITA ATION OF REIMBURSEMENT SETTLEMENT	AL OF BREMEN Provider CCN: 151300	Peri od:	Worksheet E-3	2552-10
CALCUL			From 05/01/2014	Part V	
			To 04/30/2015	Date/Time Pre	
				9/30/2015 10:	33 am
		Title XVIII	Hospi tal	Cost	
				1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE	E PART A SERVICES - COST	REIMBURSEMENT		
1.00	Inpatient services			1, 071, 735	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructi	i ons)		0	2.00
3.00	Organ acqui si ti on			0	
4.00	Subtotal (sum of lines 1 through 3)			1, 071, 735	
5.00	Primary payer payments			0	
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			1, 082, 452	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES				_
	Reasonabl e charges				
7.00	Routine service charges			0	
8.00	Ancillary service charges			0	
9.00	Organ acquisition charges, net of revenue			0	
10.00	Total reasonable charges Customary charges			0	10.00
11.00	Aggregate amount actually collected from patients liable for	navmont for corvinces on	a chargo bacis	0	1 11. 00
12.00	Amounts that would have been realized from patients liable for	1 5	9	0	
12.00	had such payment been made in accordance with 42 CFR 413.13(		n a charge basis	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	6)		0. 000000	13.00
14.00	Total customary charges (see instructions)			0.000000	
15.00	Excess of customary charges over reasonable cost (complete or	nlvifline 14 exceeds li	ne 6) (see	0	
	instructions)			-	
16.00	Excess of reasonable cost over customary charges (complete or	nly if line 6 exceeds lin	e 14) (see	0	16.00
	instructions)				
17.00	Cost of physicians' services in a teaching hospital (see ins	tructions)		0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E	-4, line 49)		0	
19.00	Cost of covered services (sum of lines 6, 17 and 18)			1, 082, 452	
20.00	Deductibles (exclude professional component)			122, 964	1
21.00	Excess reasonable cost (from line 16)			0	
22.00	Subtotal (line 19 minus line 20 and 21)			959, 488	
23.00 24.00	Coinsurance Subtotal (line 22 minus line 23)			0 959, 488	
24.00	Allowable bad debts (exclude bad debts for professional servi	icas) (sag instructions)		959, 488 13, 144	
26.00	Adjusted reimbursable bad debts (see instructions)			9, 989	
27.00	Allowable bad debts for dual eligible beneficiaries (see inst	tructions)		6, 174	1
27.00	Subtotal (sum of lines 24 and 25, or line 26)			969, 477	
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0,477	
29.50	Pioneer ACO demonstration payment adjustment (see instruction	ns)		0	
29.99	Recovery of Accel erated Depreciation	,		0	
30.00	Subtotal (see instructions)			969, 477	
30.01	Sequestration adjustment (see instructions)			19, 390	
31.00				991, 930	
32.00	Tentative settlement (for contractor use only)			0	
33.00	Balance due provider/program (line 30 minus lines 30.01, 31,	and 32)		-41, 843	33.00
	Protested amounts (nonallowable cost report items) in accorda			0	34.00

MCRI F32 - 7.8.157.0

ALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151300	Period: From 05/01/2014 To 04/30/2015	Worksheet E-3 Part VII Date/Time Pre	pare
				9/30/2015 10:	33 a
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVIC	ES FOR TITLES V OR V		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	ES FOR TITLES V OR X	IX SERVICES		-
00	Inpatient hospital/SNF/NF services		235, 687		1 1.
00	Medical and other services		233,007	0	2.
00	Organ acquisition (certified transplant centers only)		0	0	3
00	Subtotal (sum of lines 1, 2 and 3)		235, 687	0	4
00	Inpatient primary payer payments		0		5
00	Outpatient primary payer payments			0	6
00	Subtotal (line 4 less sum of lines 5 and 6)		235, 687	0	7
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
00	Routine service charges		275, 919		8
	Ancillary service charges		455, 828	0	9
	Organ acquisition charges, net of revenue		0		10
	Incentive from target amount computation		0	_	11
. 00	Total reasonable charges (sum of lines 8 through 11)		731, 747	0	12
~~	CUSTOMARY CHARGES	· · ·			1 4 9
. 00	Amount actually collected from patients liable for payment for se	rvices on a charge	0	0	13
. 00	basis Amounts that would have been realized from patients liable for pa	ymont for sorvices o	n O	0	14
. 00	a charge basis had such payment been made in accordance with 42 C		0	0	14
. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	11 3413. 13(e)	0, 000000	0.000000	15
	Total customary charges (see instructions)		731, 747	0	
	Excess of customary charges over reasonable cost (complete only i	fline 16 exceeds	496, 060	0	
	line 4) (see instructions)				
. 00	Excess of reasonable cost over customary charges (complete only i	fline 4 exceeds lin	e 0	0	18
	16) (see instructions)				
	Interns and Residents (see instructions)		0	0	19
	Cost of physicians' services in a teaching hospital (see instruct	ions)	0	0	
. 00	Cost of covered services (enter the lesser of line 4 or line 16)		235, 687	0	21
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be com	pleted for PPS provi			
	Other than outlier payments		0	0	22
	Outlier payments		0	0	
	Program capital payments		0		24
	Capital exception payments (see instructions)		0	0	25
	Routine and Ancillary service other pass through costs Subtotal (sum of lines 22 through 26)		0	0	
	Customary charges (title V or XIX PPS covered services only)		0	0	
	Titles V or XIX (sum of lines 21 and 27)		235, 687	0	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		200,007		1 - 1
. 00	Excess of reasonable cost (from Line 18)		0	0	30
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		235, 687	0	31
	Deductibles		0	0	32
. 00	Coinsurance		0	0	33
. 00	Allowable bad debts (see instructions)		0	0	34
	Utilization review		0		35
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33 $$	)	235, 687	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	37
	Subtotal (line 36 ± line 37)		235, 687	0	
	Direct graduate medical education payments (from Wkst. E-4)		0		39
	Total amount payable to the provider (sum of lines 38 and 39)		235, 687	0	40
	Interim payments		73, 417	0	41
	Balance due provider/program (line 40 minus line 41)		162, 270	0	
. 00	Protested amounts (nonallowable cost report items) in accordance	WITH CMS PUB 15-2,	0	0	43

	SHEET (If you are nonproprietary and do not maintain			Period: From 05/01/2014	Worksheet G	
und-ty	pe accounting records, complete the General Fund column onl	l y)		o 04/30/2015	Date/Time Pre	
		General Fund	Speci fi c	Endowment Fund	9/30/2015 10: Plant Fund	33 8
			Purpose Fund			
C	CURRENT ASSETS	1.00	2.00	3.00	4.00	-
-	Cash on hand in banks	967, 096	0	) 0	0	1
	Temporary investments	650, 000			0	
00 1	Notes receivable	0	( C	0	0	3
	Accounts receivable	2, 826, 012	C	0 0	0	4
	Other receivable	0	( C	-	0	
	Allowances for uncollectible notes and accounts receivable	0	0	0	0	
	Inventory	0		0	0	
	Prepaid expenses Other current assets	727, 646	-	-	0	
	Due from other funds	/2/,040		-	0	
	Total current assets (sum of lines 1-10)	5, 170, 754			0	
-	I XED ASSETS	0, 1, 0, 701				1
	Land	0	(	0 0	0	12
. 00   1	Land improvements	0	c	0	0	13
1.00 A	Accumul ated depreciation	0	C	0 0	0	14
	Bui I di ngs	0	0	-	0	
	Accumulated depreciation	0	0	-	0	
	Leasehold improvements	0	0		0	
	Accumulated depreciation Fixed equipment	15, 279, 119			0	
	Accumul ated depreciation	15, 279, 119		-	0	
	Automobiles and trucks				0	
	Accumulated depreciation			-	0	
	Major movable equipment	Ö		-	0	
	Accumulated depreciation	0	C	0	0	24
	Minor equipment depreciable	0	0	0 0	0	25
5.00 A	Accumulated depreciation	0	c	0 0	0	26
	HIT designated Assets	0	C	-	0	
	Accumulated depreciation	0	C	-	0	
	Minor equipment-nondepreciable	0	0	-	0	
	Total fixed assets (sum of lines 12-29) THER ASSETS	15, 279, 119	(	0 0	0	30
	Investments	0	0	0	0	3.
	Deposits on Leases	0			0	
	Due from owners/officers	Ö		-	0	
	Other assets	977, 226	c c	0	0	
5. 00 1	Total other assets (sum of lines 31-34)	977, 226		0 0	0	35
5.00	Total assets (sum of lines 11, 30, and 35)	21, 427, 099	C	0	0	36
	CURRENT LIABILITIES	1				
	Accounts payable	220, 665			0	
	Salaries, wages, and fees payable	689, 883	0		0	
	Payroll taxes payable	0	0	0	0	
	Notes and Loans payable (short term) Deferred income				0	
	Accel erated payments			0	0	42
	Due to other funds		(	0	0	
	Other current liabilities	761, 867	-	-	0	
	Total current liabilities (sum of lines 37 thru 44)	1, 672, 415		0	0	
	ONG TERM LIABILITIES		•			
5.00 🛛	Mortgage payable	0	0	0 0	0	46
	Notes payable	14, 167, 810	C	0 0	0	
	Jnsecured Loans	0	0	0	0	
	Other long term liabilities	0	0	-	0	
	Total long term liabilities (sum of lines 46 thru 49	14, 167, 810		-	0	
	Total liabilites (sum of lines 45 and 50) CAPITAL ACCOUNTS	15, 840, 225	L (	U U	0	
	General fund balance	5, 586, 874				52
	Specific purpose fund	3, 300, 874	(			5
	Donor created - endowment fund balance - restricted			0		54
	Donor created - endowment fund balance - unrestricted			0		5!
	Governing body created - endowment fund balance			0		50
	Plant fund balance - invested in plant				0	
	Plant fund balance - reserve for plant improvement,				0	58
	replacement, and expansion					
	Total fund balances (sum of lines 52 thru 58)	5, 586, 874		0	0	
). 00   1	Total liabilities and fund balances (sum of lines 51 and	21, 427, 099	I (	0	0	60

Heal th	Financial Systems (	COMMUNITY HOSPIT	AL OF BREMEN		In Lie	eu of Form CMS-2	2552-10
STATEM	IENT OF CHANGES IN FUND BALANCES	_	Provi der	CCN: 151300	Period: From 05/01/2014 To 04/30/2015		
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
$\begin{array}{c} 1.00\\ 2.00\\ 3.00\\ 4.00\\ 5.00\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 12.00\\ 13.00\\ 14.00\\ 15.00\\ 16.00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)		2, 00 5, 143, 749 443, 125 5, 586, 874 0 5, 586, 874			0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$
17.00 18.00 19.00	Total deductions (sum of lines 12–17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 Endowment Fund	0 5, 586, 874 Pl ant	Fund	0 00		17.00 18.00 19.00
		6.00	7.00	8.00			
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	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	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) 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 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

	Financial Systems COMMUNITY HOSPITAL (		0.011 454000		u of Form CMS-2	
	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der	CCN: 151300	Period: From 05/01/2014 To 04/30/2015	Date/Time Pre 9/30/2015 10:	pared:
	Cost Center Description		Inpati ent	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I - PATIENT REVENUES General Inpatient Routine Services					+
1.00	Hospi tal		2, 373, 5	90	2, 373, 590	1 1.00
2.00	SUBPROVIDER - IPF		2,0,0,0	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	2,010,010	2.00
3.00	SUBPROVIDER - IRF					3.00
4.00	SUBPROVIDER					4.00
5.00	Swing bed - SNF			0	0	5.00
6.00	Swing bed - NF			0	0	1 0.00
7.00	SKILLED NURSING FACILITY					7.00
8.00	NURSI NG FACI LI TY					8.00
9.00	OTHER LONG TERM CARE		2 272 5	00	2 272 500	9.00
10.00	Total general inpatient care services (sum of lines 1-9)		2, 373, 5	90	2, 373, 590	10.00
11.00	Intensive Care Type Inpatient Hospital Services					1 11. 00
12.00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
16.00	Total intensive care type inpatient hospital services (sum of I	nes		0	0	
	11-15)					
17.00	Total inpatient routine care services (sum of lines 10 and 16)		2, 373, 5	90	2, 373, 590	17.00
18.00	Ancillary services		3, 550, 2			
19.00	Outpatient services		29, 1			•
20.00	RURAL HEALTH CLINIC			0 0		
21.00 22.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	21.00
22.00	HOME HEALTH AGENCY AMBULANCE SERVICES					22.00
23.00	CMHC					23.00
25.00	AMBULATORY SURGICAL CENTER (D. P. )					25.00
26.00	HOSPICE					26.00
27.00	PROFESSIONAL FEES		33, 3	42 1, 305, 461	1, 338, 803	
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 t	o Wkst.	5, 986, 4	06 27, 347, 436	33, 333, 842	28.00
	G-3, line 1)					
	PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)			17, 329, 852		29.00
30.00	ADD (SPECIFY)			0		30.00
31.00 32.00				0		31.00
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	DEDUCT (SPECIFY)			0		37.00
38.00				0		38.00
39.00				0		39.00
40.00				0		40.00
41.00				0		41.00
42.00	Total deductions (sum of lines 37-41)			0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer		17, 329, 852		43.00
	to Wkst. G-3, line 4)			I		1

Heal th	Financial Systems C	OMMUNITY HOSPITAL OF	- BREMEN		In Lie	eu of Form CMS-2	2552-10
STATEN	ENT OF REVENUES AND EXPENSES		Provi der	CCN: 15130		Worksheet G-3	
					From 05/01/2014 To 04/30/2015	Date/Time Pre	oared [.]
						9/30/2015 10:	
						1.00	
1.00	Total patient revenues (from Wkst. G-2, Part		8)			33, 333, 842	1.00
2.00	Less contractual allowances and discounts on	patients' accounts				16, 273, 862	
3.00	Net patient revenues (line 1 minus line 2)	5				17, 059, 980	
4.00	Less total operating expenses (from Wkst. G-2					17, 329, 852	
5.00	Net income from service to patients (line 3 m	inus line 4)				-269, 872	5.00
( 00	OTHER I NCOME						( 00
6.00	Contributions, donations, bequests, etc					0	6.00
7.00	Income from investments					0	7.00
8.00	Revenues from telephone and other miscellaneo	us communication se	rvices			0	8.00
9.00	Revenue from television and radio service					0	
10.00 11.00	Purchase discounts					-	
12.00	Rebates and refunds of expenses Parking lot receipts					0	12.00
12.00	Revenue from Laundry and Linen service						12.00
14.00	Revenue from meals sold to employees and gues	te					13.00
15.00	Revenue from rental of living guarters	15					14.00
16.00	Revenue from sale of medical and surgical sup	nlies to other than	nationte				16.00
	Revenue from sale of drugs to other than pati		patrents	<b>&gt;</b>		0	
18.00	Revenue from sale of medical records and abst					0	
19.00	Tuition (fees, sale of textbooks, uniforms, e					0	
20.00	Revenue from gifts, flowers, coffee shops, an					0	20.00
21.00	Rental of vending machines					0	
22.00	Rental of hospital space					0	
23.00	Governmental appropriations					0	
24.00	OTHER REVENUE & GRANTS					598, 216	
24.01	CONTRIBUTIONS FROM FOUNDATION					114, 781	
25.00	Total other income (sum of lines 6-24)					712, 997	
26.00	Total (line 5 plus line 25)					443, 125	
27.00	OTHER EXPENSES (SPECIFY)					0	
28.00	Total other expenses (sum of line 27 and subs	cripts)				0	28.00
29.00	Net income (or loss) for the period (line 26					443, 125	29.00